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2019-21 Ways and Means
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2019-21 Governor's Budget for OHA: Director's message

I'm pleased to submit the Governor's Budget for the Oregon Health Authority for the 2019-21 biennium. This budget reflects a health care vision we share with Governor Brown: to provide Oregonians access to affordable health care no matter who they are or where they live. They also reflect her priorities to:

- Move health transformation forward and put the Oregon Health Plan on a sustainable funding path.
- Help children achieve their full potential.
- Improve health outcomes.

The Governor's Budget would fund OHA at $22.048 billion for the 2019-21 biennium, an increase of 9 percent in Total Funds from our current funding level. The budget includes approximately $30 million in savings from vacancy reductions and lower spending on services and supplies in the agency.

Building on Oregon's success in transforming health care

The Governor's 2019-21 budget proposal builds on the success of Oregon's health transformation efforts:

- **Expanded Health coverage**: Today, 94 percent of all Oregonians have health insurance. In 2018, under Senate Bill 558, Oregon expanded Oregon Health Plan coverage to low-income children who previously lacked health coverage and gave more women access to reproductive health services.
- **Improved health outcomes**: Oregon has moved the needle on a variety of public health measures. Fewer people are dying from opioids. HIV infections have slowed. Teen pregnancies have plummeted. Fewer adults and youth are smoking, especially eighth-graders. Immunization rates for two-year-olds are rising.
- **Lowered health care costs and better care**: A recent independent evaluation by OHSU shows Oregon's health reforms are working: Costs are lower compared to Washington while quality, member satisfaction, and member reported health status have improved.

Investing in a healthier Oregon

The increase in OHA's budget closes an $830 million gap in health care funding, which threatens Oregon Health Plan coverage, benefits and provider rates, and sustains health programs that serve communities across the state. That budget gap is the product of reduced federal funding, caseload changes and the expiration of one-time funds, including the expiration of temporary assessments, which voters approved earlier this year with the passage of Measure 101. The Governor's proposed solutions include:

- Continue current reimbursable hospital assessments ($98 million) and insurance taxes ($320 million) for 6 years.
- Ensure fair and equitable health care funding by assessing self-insured plans and employers who do not offer health coverage ($120 million).
- Increase the price of tobacco and vaping by $2 per pack ($95 million) to reduce consumption, save lives and prevent tobacco-related disease.

The Governor's Budget also funds OHA policy proposals that would expand services for families, strengthen behavioral health services and modernize systems that protect and improve the health of all Oregonians. Here are some highlights:

Better health outcomes

- **Support CCO 2.0 implementation**: This budget request supports staffing necessary to implement new CCO contracts and monitor CCO performance ($1.9 million).
- **Expand Hepatitis C treatment**: This request expands Medicaid coverage for Direct Acting Anti-Viral Medications to treat all stages of Hepatitis C – and stop its spread ($107 million).
- **Modernize public health**: This proposal would advance public health modernization by strengthening clean drinking water protections, reducing communicable disease risks and helping communities across the state address environmental health threats, such as wildfire. It would strengthen the public health infrastructure in more local Oregon communities and help deliver public health services in more flexible and cost-effective ways ($13.9 million in state tobacco funds).

A stronger behavioral health system

- **Improve behavioral health services:** This proposal would support the Governor's priority in CCO 2.0 to strengthen behavioral health services and provide a more seamless system for consumers by creating behavioral health homes (mental health and substance use clinics that also provide on-site medical care), expanding access to effective medications and improving treatment practices ($5.7 million).
- **Expand community services for mentally ill misdemeanor defendants**: This proposal would relieve crowding pressure at the Oregon State Hospital and create more community-based services for people with mental health problems who are charged with non-violent misdemeanor offenses and do not have the capacity to aid in their own legal defense ($7.6 million).
- **Expand in-home behavioral health services for youth**: This proposal would expand access to in-home and community-based services for youth with specialized needs, reduce the strain on residential programs and give families

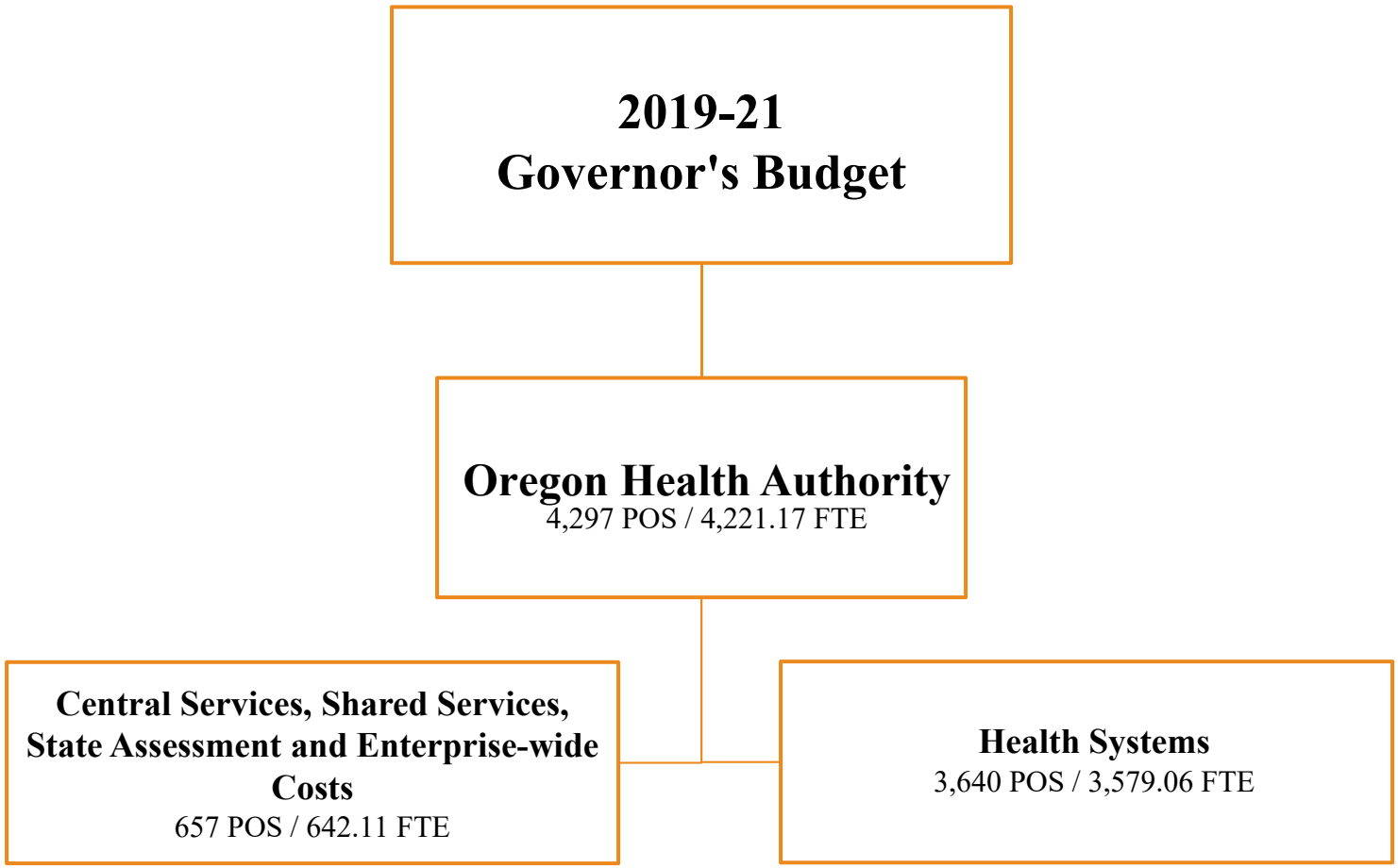
less restrictive treatment options closer to home, helping to reduce racial disparities in outcomes for this high-need population ($19.6 million).

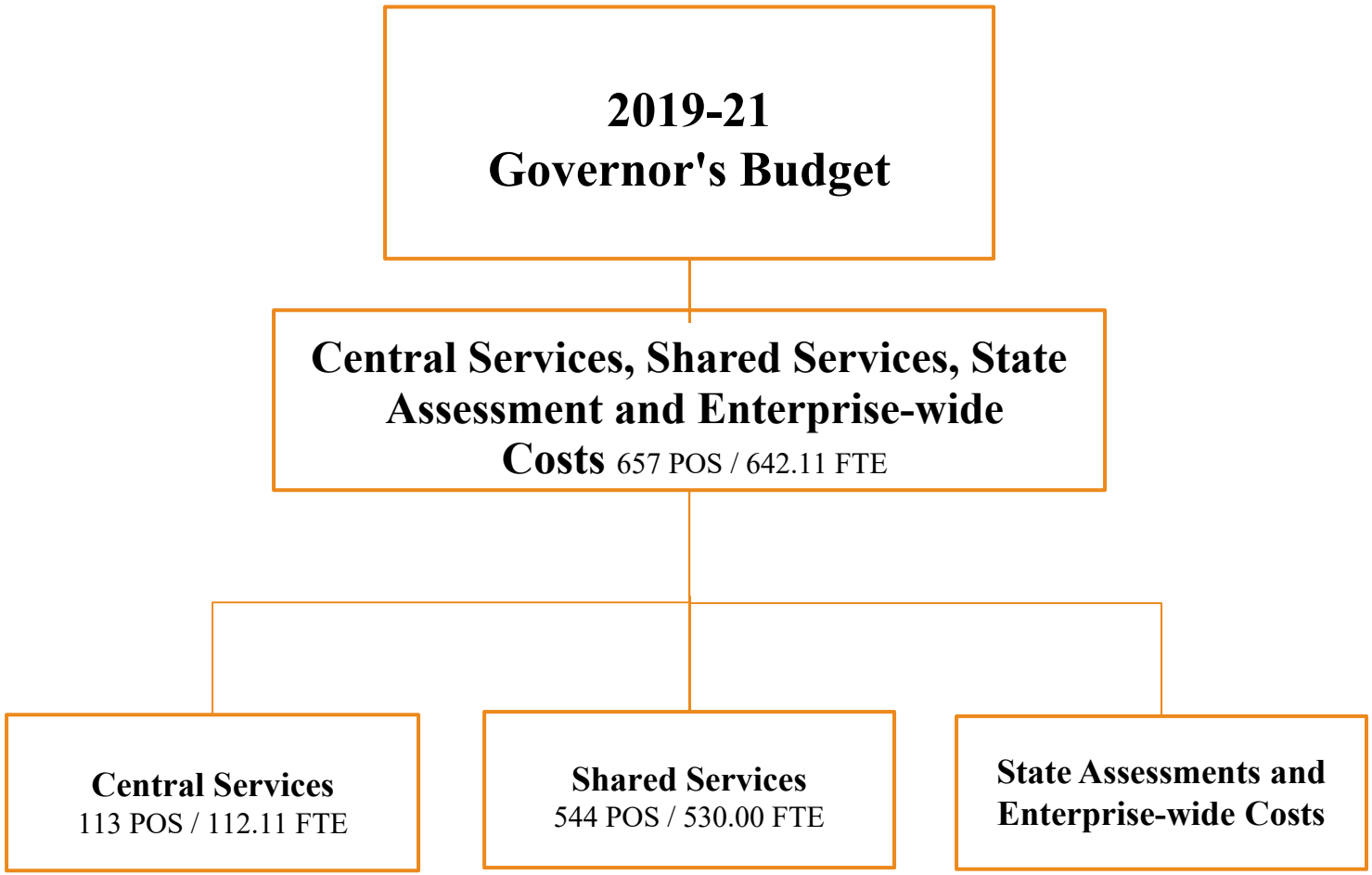
Help children achieve their potential

- **Expand home visiting**: This proposal would increase evidence-based home visiting after birth, which strengthens parenting skills, foster safer home environments and support maternal mental health ($8.7 million).
- **Prevent Suicide**: This proposal would support interventions youth and adults at high risk of suicide. It would provide sustainable support for Oregon's suicide hotline and other crisis services ($13.1 million).
- **Establish Office of Child Health**: This request would create an Office of Child Health that would bring together experts in children's health, expand innovative, potentially cost-saving programs to improve children's health and help align statewide efforts to give every child an opportunity for a more equitable start in life ($900,000).

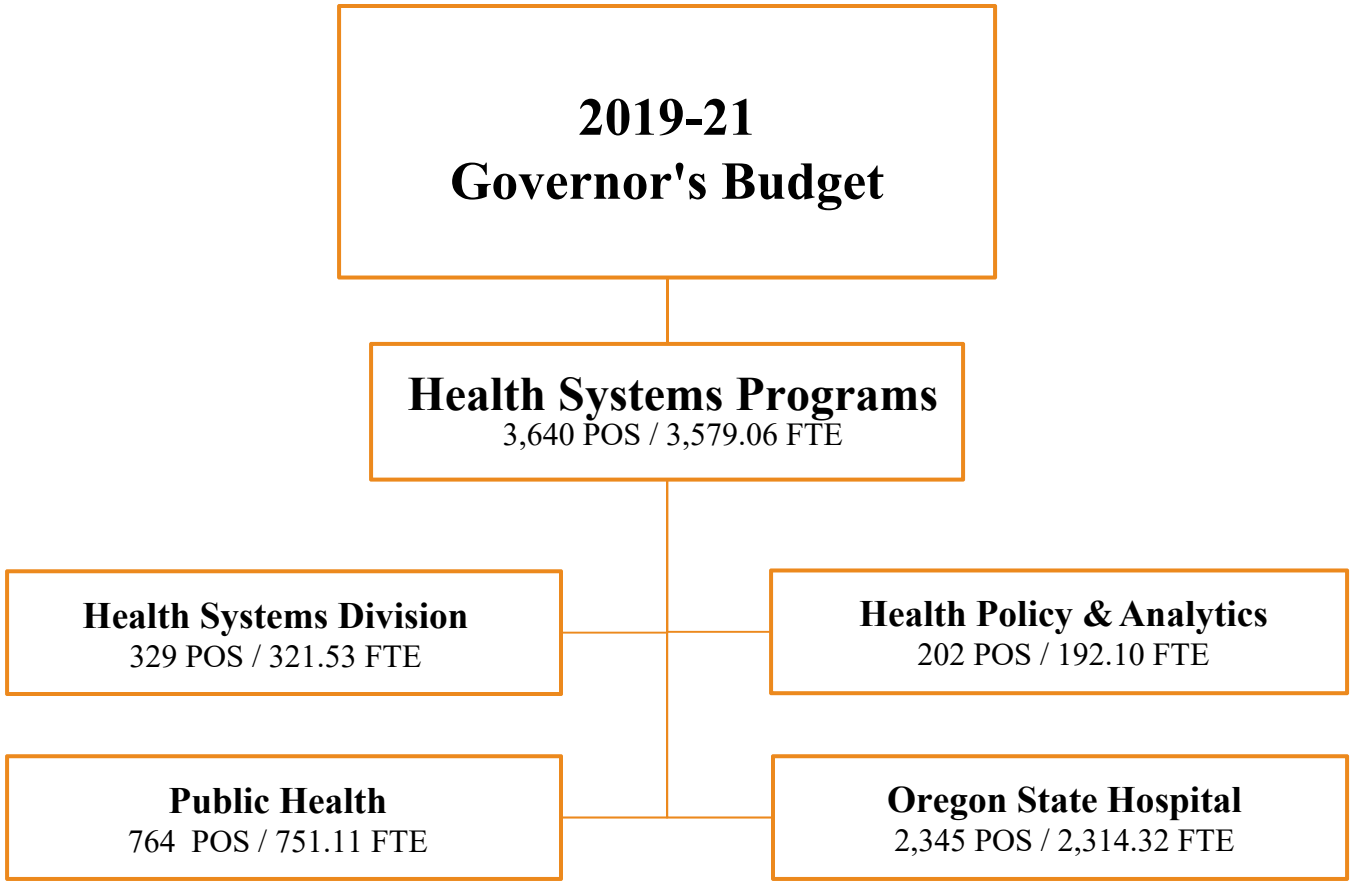
I appreciate Governor Brown's focus on health and her commitment to sustaining and strengthening our health care system. In addition, I'm grateful for the many community partners, providers, local governments and others who work with us every day to make health care better and more affordable for Oregonians, tackle Oregon's most challenging health issues and improve the health and well-being of every Oregonian.

Patrick Allen
Director

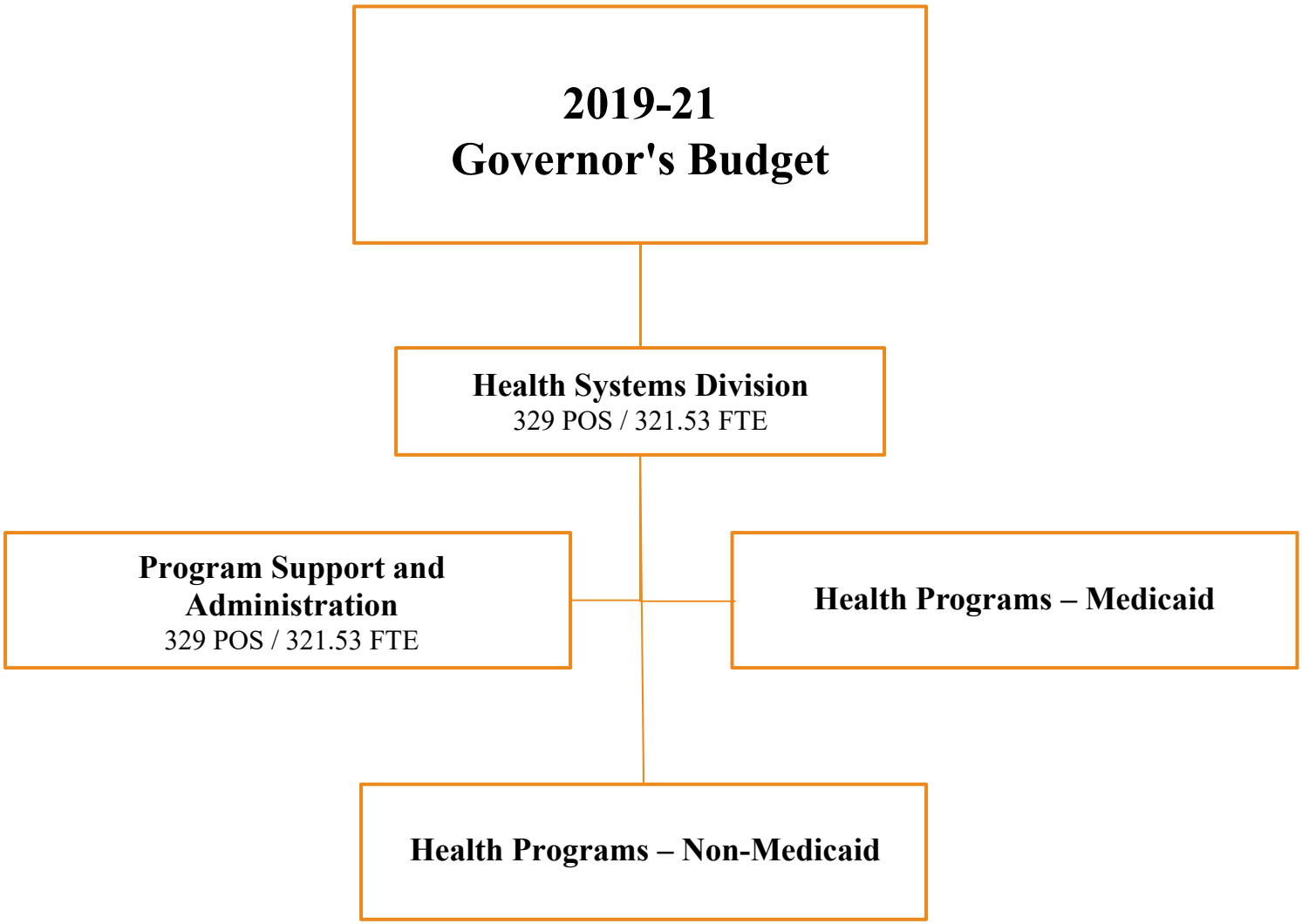

2019-21
Governor's Budget
Oregon Health Authority
4,297 POS / 4,221.17 FTE
Central Services, Shared Services, State Assessment and Enterprise-wide Costs
657 POS / 642.11 FTE
Health Systems
3,640 POS / 3,579.06 FTE

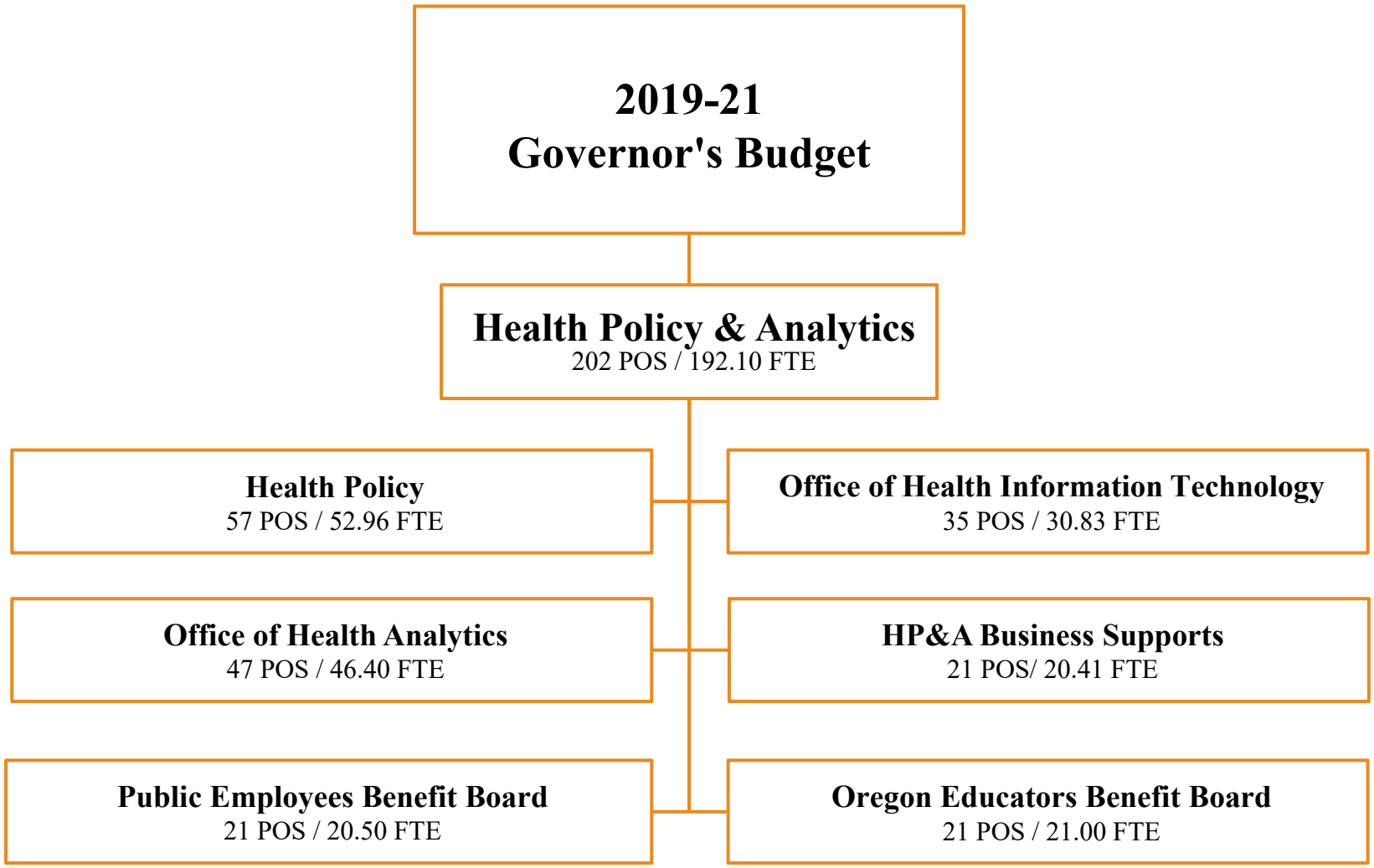


Oregon Health Authority

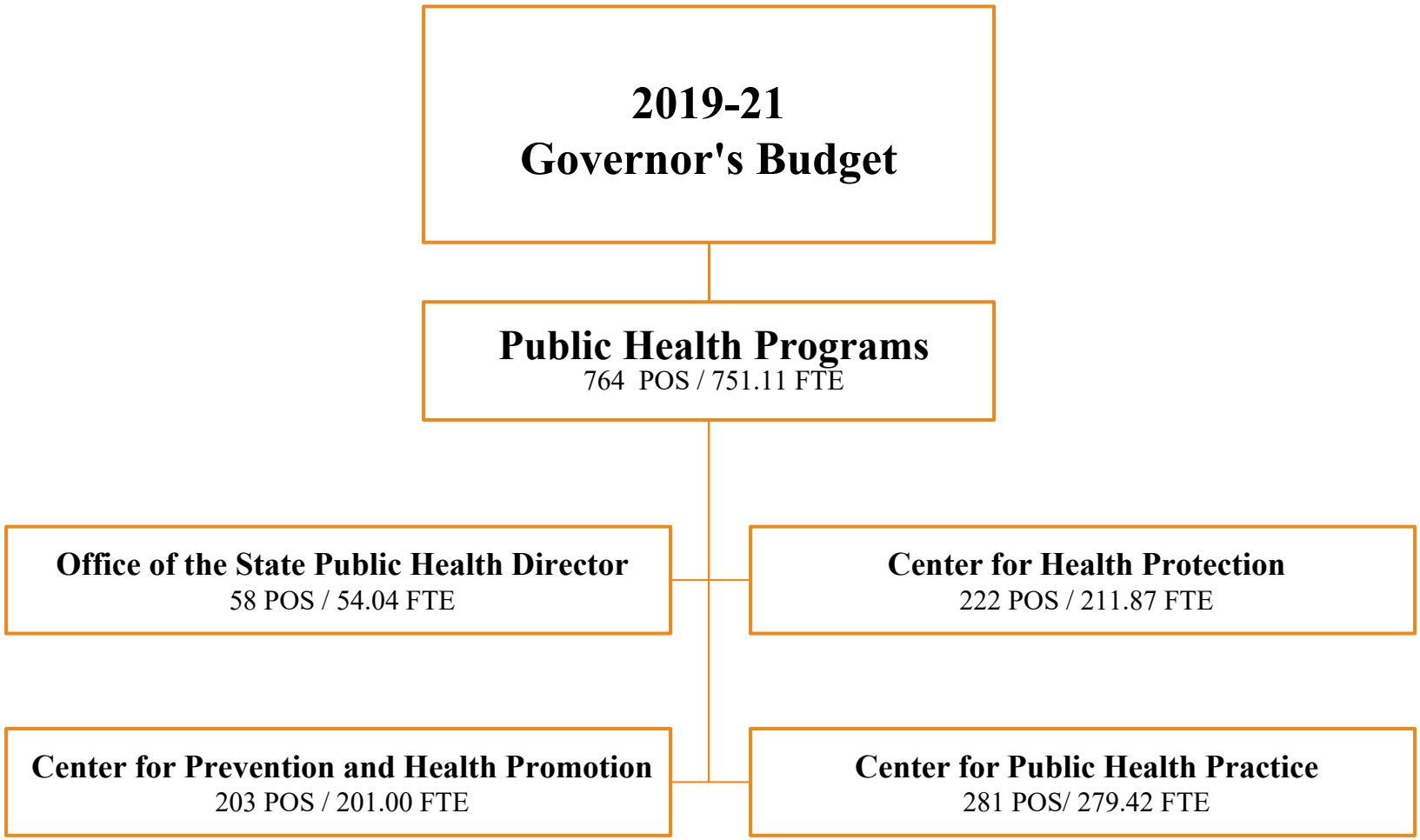


Oregon Health Authority

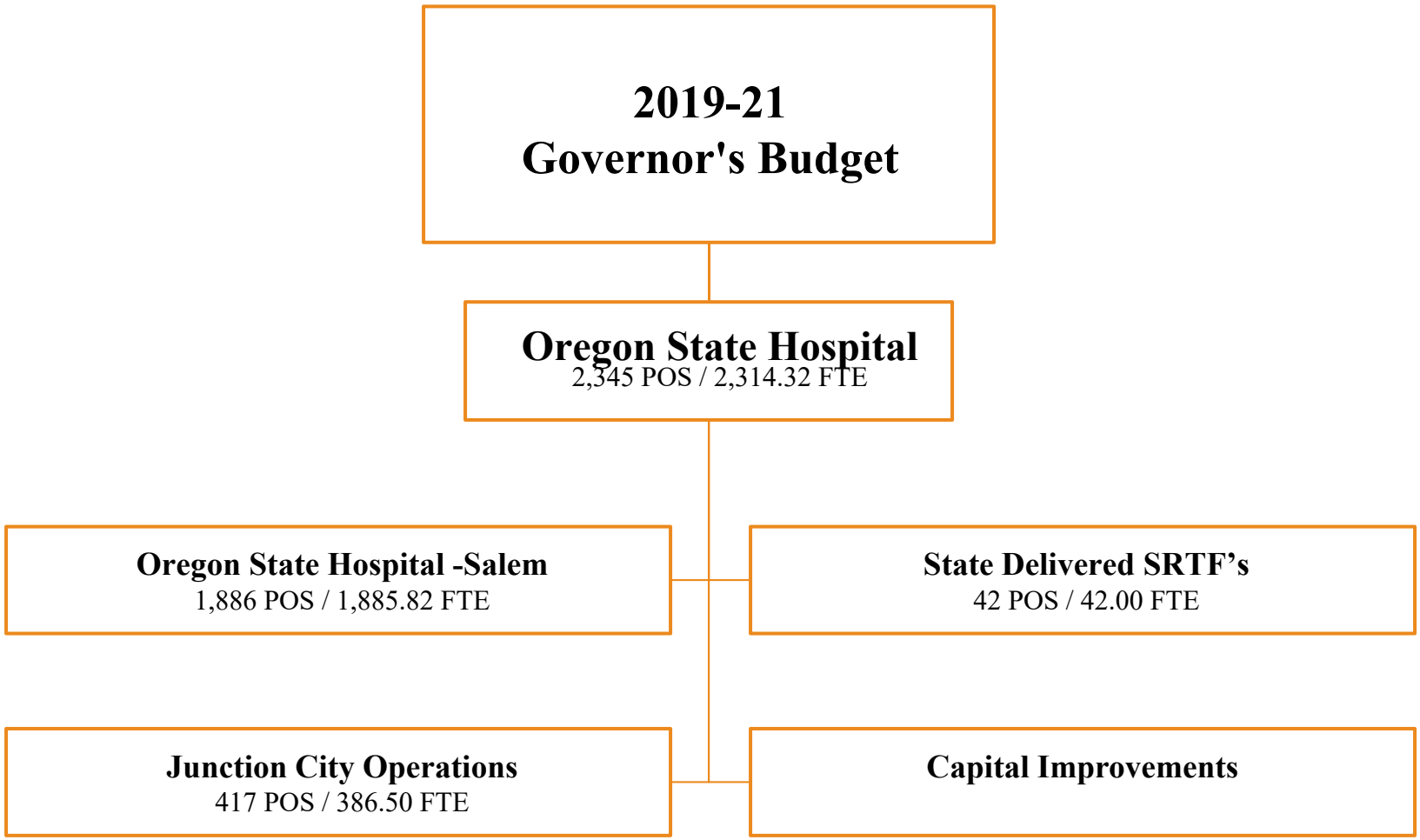

2019-21
Governor's Budget
Health Systems Division
329 POS / 321.53 FTE
Program Support and Administration
329 POS / 321.53 FTE
Health Programs – Medicaid
Health Programs – Non-Medicaid



Oregon Health Authority



Oregon Health Authority


2019-21
Governor's Budget
Oregon State Hospital
2,345 POS / 2,314.32 FTE
Oregon State Hospital -Salem
1,886 POS / 1,885.82 FTE
State Delivered SRTF's
42 POS / 42.00 FTE
Junction City Operations
417 POS / 386.50 FTE
Capital Improvements

OREGON HEALTH AUTHORITY: AGENCY SUMMARY NARRATIVE

MISSION STATEMENT

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

AGENCY PRIORITIES AND INITIATIVES

With our mission in mind, OHA is focused on accelerating the transformation of Oregon's health care system. Our goals are to expand health coverage and provide easier access to care, deliver better health outcomes, improve health care quality and contain health costs for Oregon Health Plan members, while eliminating health disparities in all Oregon communities.

OHA's goals and priorities, detailed below, directly support safer, healthier and thriving Oregonians. OHA is committed to transparency, accountability and wise use of public resources. Our priorities and strategies are guided by a focus on health equity.

Sustain Health Transformation in Oregon. To accomplish this goal, we will:

- Implement CCO 2.0 and focus on improving behavioral health, expanding efforts to address social factors that fuel poor health (such as lack of stable housing and food insecurity), continuing to hold down costs and expanding the use of value-based payment tools that reward providers for better, more efficient care.
- Close Oregon's Medicaid funding gap through proposed solutions that would provide long-term, sustainable options to maintain health coverage and stabilize Medicaid funding.

Provide healthy, safe and successful supports for children, teens and families. To accomplish this goal we will:

- Increase home-visiting statewide.
- Align services and expand in-home behavioral health services for youth with specialized needs.
- Improve coordination of children's health programs and initiatives.
- Provide prevention, intervention and access through the lifespan.

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

- Expand the portion of Oregonians who 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.

Promote accountability, transparency and wise use of public resources. To accomplish this goal, we will:

- Institute an agency performance system to strengthen business rigor in OHA's operations.
- Develop and implement a strategic plan that is informed by input from stakeholders.
- Continue to be accountable and transparent by posting issue resolution reports and public records requests on the OHA website.

PROGRAM DESCRIPTIONS

OHA Central Services

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

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

The Director's Office provides leadership in achieving the agency's mission. 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 **Agency Operations Division** provides operational support and human resources services to OHA. The division includes the following functional areas:

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

The **Fiscal Division** provides leadership and oversight of financing policies and coordinates budget development and execution for OHA. 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. Developing and updating the agency budget as it progresses through the statewide budget process, including Agency Request Budget, Governor's Budget, the Legislatively Adopted Budget, rebalance reports and various Emergency Board actions.

The Actuarial Services Unit and Office of Program Integrity are also functionally within the Fiscal Division of Central Services; however, they are budgeted in the Health Systems Division Program Support and Administration unit.

The **Office of Equity and Inclusion (OEI)** works on behalf of OHA 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
- Diversity, Inclusion, Training, Compliance & Civil Rights
- Business Support and Administration

These units develop programs and initiatives relating to health equity policy and practice, including the social determinants of health and equity; universal access for people with disabilities, people with limited English proficiency, etc.; diversity and inclusion; non-discrimination; the development of culturally and linguistically responsive practices and services; and training among other things. 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 experienced predominantly by racially, ethnically, culturally and linguistically diverse populations of Oregon so that everyone can achieve greater health equity and participate in a more robust and inclusive health delivery system.

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

- Governmental Relations team provides timely health data and analysis to the Legislature, federal partners, and local elected officials to inform evidence-based health policies and legislation. It also develops OHA legislative concepts to ensure access to quality health care, contain costs of health care, and improve overall health for Oregonians.
- The Community Partner Outreach Program provides community outreach and coordination with coordinated care organizations (CCOs), OHA, and local community partners.
- The Ombuds Program responds to customer calls related to all facets of OHA operations, with an emphasis on complaints related to Medicaid enrollment and eligibility.
- Communications provides accurate and accessible information about OHA's mission and programs, responds to requests for information from the public and media, and produces content for a wide range of agency publications, websites and other channels for keeping the public informed.

Health Systems Division

The Health Systems Division (HSD) supports the triple aim of better health, better care, and lower costs by promoting integrated services through administration of the Medicaid program and Non-Medicaid behavioral health programs to improve long-term outcomes for Oregonians. The HSD budget includes funding for health care services to over 1 million Oregonians on the Oregon

Health Plan, mental health services for over 130,000 people, and substance use disorder treatment and support services for over 40,000 people.

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

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

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

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

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

- Physical, dental and behavioral health program development, operations policy and special projects.
- Coordination of policy development and implementation of waivers and State Plan authorities with federal Medicaid partners.
- Quality assurance and hearings.
- Provider services which includes delivery system support, provider support and enrollment, provider services training, provider clinical support, CCO contracting, and encounter data reporting and claims.

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

Medicaid

The Medicaid program budget supports the triple aim of better health, better care, and lower costs by deploying state and federal funds to pay for health care services to over 1 million Oregon Health Plan (OHP) members. The HSD Medicaid budget funds implementation of federal and legislative mandates under the Oregon State Plan and Title XIX of the Social Security Act Medical Assistance Program. This includes payments to individual health care providers and Coordinated Care Organizations (CCOs) that serve over 90 percent of all OHP members.

In July 2012, the Centers for Medicaid and Medicare Services (CMS) approved Oregon's 1115 Medicaid Demonstration waiver that was necessary to implement coordinated care organizations and initiate health system transformation for the Oregon Health Plan. This initial waiver was for a five-year period, running from July 2012 through June 2017. Oregon's Medicaid Demonstration renewal request was approved by CMS and runs from January 12, 2017 through June 30, 2022.

The renewal continues and expands on elements of the 2012 waiver, particularly around integration of behavioral, physical and oral health care, and has included a focus on social determinants of health, population health, and health care quality. Under the agreement, Oregon will advance the coordinated care model to improve quality and outcomes and offer evidence-based benefits through the state's prioritized list of services. The agreement also includes a commitment to an ongoing sustainable rate of growth, paying for value rather than volume of services, and advancing the use of value-based payments.

Statutory Authority

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

Non-Medicaid (Behavioral Health)

Non-Medicaid budget includes resources for behavioral health programs that help all Oregonians achieve physical, mental and social well-being through access to mental health and addiction services and support (including housing services) for adults and children. Ongoing supports and services improve a person's ability to be successful with their family, education, employment and in their community.

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. They also include residential treatment services or adult foster care and supervision of people in the community who have committed crimes but were found "Guilty Except for Insanity."

Non-Medicaid behavioral health programs use numerous partnerships to develop and administer a community-based continuum of care delivered in outpatient, residential, school, acute, hospital, and criminal justice and community settings. In partnership with coordinated care organizations (CCOs), county governments, local community stakeholders and consumers, these programs provide funding and technical support for service provision.

Health Policy and Analytics

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

- The Office of Health Policy.
- The Office of Delivery Systems Innovation.
- The Office of Health Analytics.
- The Office of Health Information Technology.
- The Public Employees Benefit Board and the Oregon Educators Benefit Board (each are budgeted separately from HPA).
- The Office of Business Operations.

These offices provide agency-wide policy development; strategic planning; clinical 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 Health Policy and Analytics Division is accountable for leading the next phase of health system transformation by:

- Supporting and incentivizing payments for value, moving away from paying for volume.
- Supporting the Oregon Health Policy Board's work including implementation of the Action Plan for Health.
- Focusing on social determinants of health in addition to medical care.
- Providing the clinical leadership to shape the management of high cost pharmaceuticals.
- Innovating and implementing solutions using health information technology.
- Implementing legislative directives to align metrics.
- Facilitating multi-payer alignment to support primary care sustainability with improved performance.

Statutory Authority

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

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

Public Employees' Benefit Board

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

PEBB designs, contracts for and administers health plans, group policies and flexible spending accounts for PEBB members. More than 139,000 Oregonians are enrolled as 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.

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

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) provides a comprehensive selection of benefit plan options for most of Oregon's K-12 school districts, education service districts and community colleges, as well as a number of charter schools and local governments across the state. OEBB provides benefits for 152,585 individuals, including actively employed and retired subscribers and their dependents.

OEBB offers a multitude of plans that resemble an "exchange." OEBB started offering medical, dental, and vision coverage in 2008 and has since added a broad range of additional benefits including life, accidental death and dismemberment (AD&D), short-term and long-term disability and long-term care insurance, as well as an employee assistance program (EAP), a health savings account (HSA), flexible spending accounts (FSAs), and commuter savings accounts. Each of the 249 employer entities OEBB serves maintains a unique service area, eligibility requirements, cost sharing, and population. OEBB's plans are designed to be flexible and accommodate the needs of all employers participating in OEBB and the members enrolled in OEBB plans.

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

Public Health

The Public Health Division's (OHA-PHD) mission is to promote health and prevent the leading causes of death, disease and injury in Oregon. The OHA-PHD vision is lifelong health for all people in Oregon. To achieve this vision, the PHD 2017-2020 Strategic Plan includes two goals: promote and protect safe, healthy and resilient environments to improve quality of life and prevent disease; and strengthen public health capacity to improve health outcomes.

Oregon's State Health Improvement Plan (SHIP) aims to address leading causes of death and disability in Oregon, and includes seven focus areas: preventing and reducing tobacco use; slowing the increase of obesity; improving oral health; reducing harms associated with alcohol and substance use; preventing deaths from suicide; improving immunization rates; and protecting the population from communicable diseases.

OHA-PHD is a part of a broader governmental public health system, which includes the federal government as well as local and tribal public health authorities. Public health services are delivered either directly by PHD or through contracts with local and tribal public health authorities, clinics and nonprofit organizations. The major cost drivers to Oregon's public health system are the increasing volume of public health threats and a consistent decrease in federal funding over time.

OREGON HEALTH AUTHORITY: AGENCY SUMMARY NARRATIVE

Oregon's public health modernization effort includes rethinking business practices so they align with current public health threats. A modernized public health system will provide core public health functions and maintain the flexibility needed to focus on new health challenges, which include emerging infectious diseases, climate change, threats from human-caused and natural disasters, and an increase in chronic diseases. The Public Health Advisory Board recently adopted public health accountability metrics, which monitor the progress of Oregon's public health system over time. Many of the public health accountability metrics align with coordinated care organization incentive metrics so that the public health and Medicaid system are working together toward common goals.

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

Oregon State Hospital

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

OSH operates two campuses with the capacity to serve up to 766 Oregonians, with 592 beds in Salem and 174 beds in Junction City. Services are provided 24 hours per day, seven days a week. OSH currently operates 592 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. These individuals are under the jurisdiction of the PSRB.
- **Aid and Assist** – People who have been charged with a crime but are unable to participate 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, and vocational and educational services. The hospital is accredited by the Joint Commission on the Accreditation of Health Organizations and all 24 hospital-licensed units (21 on the Salem Campus and 3 in Junction City) are certified by the Centers for Medicare & Medicaid Services (CMS). Services are provided by psychiatrists, nurses, and mental health professionals. Upon 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 a job.

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.

Statutory Authority
The following ORS references provide OSH its authority:

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

OHA Shared Services

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, 7 days a week.

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.

The Office of Information Services manages a portfolio of technology projects averaging over $100 million, with a focus on implementing technology solutions that simplify processes, streamline services and create a better experience for the Oregonians we serve. OIS is managing several projects including:

- DHS|OHA Integrated Eligibility project: This joint effort with DHS will go live in a pilot setting after Labor Day in 2019. It will provide a “no wrong door” approach for Oregonians applying for Medicaid, Supplemental Nutrition Assistance Program services, Employment Related Daycare, and Cash Assistance. Clients will be able to apply for benefits online through our Applicant Portal, in-person at any DHS field office, or by calling to one of several new Virtual Eligibility Centers.
- Tracking Home Visiting Effectiveness in Oregon (THEO): This project will implement a new solution for the Maternal and Child Health section of the Public Health Division for home visiting data collection, claims processing, case management.
- TWIST to Web: This project will replace the current system (TWIST) supporting the Women, Infants and Children (WIC) program to provide a modern, web-based solution for screening, certification and reporting.
- Health Information Portfolio: This project includes a new Provider Directory that will allow health care entities access to a state-level directory of health care practitioner and practice setting information and a Clinical Quality Metrics Registry. The registry will eliminate manual processes of capturing patient-level and aggregate key clinical quality data for the

Medicaid program, develop benchmarks and other quality improvement reporting, and calculate clinical quality metrics for paying quality incentives to CCOs and Medicaid Electronic Health Record (EHR) program incentive payments to providers.

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 budget 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.

Senate Bill 90 (2017) was enacted to transition certain IT security functions to the DAS Office of the State Chief Information Officer (OSCIO). While the effective date of the bill was January 1, 2018, the details of this centralization continue to evolve. Once agreements have solidified, the description of the ISPO will be updated.

ENVIRONMENTAL FACTORS

Oregon Health Authority programs are directly affected by the following environmental factors and are risks to the agency's budget:

- Economic changes, such as poverty and unemployment rates, affect Oregon Health Plan caseload growth.
- Social issues, including untreated mental health and substance abuse, homelessness, and disparities affect service delivery needs.
- Federal policy and funding changes affect state funding needs (e.g., Medicaid match rates, Health System Transformation).
- Medical inflation and utilization affect the cost for provide health coverage to Oregon Health Plan members.
- New health challenges, which include emerging infectious diseases, climate change, threats from human-caused and natural disasters, and an increase in chronic diseases all put pressure on Oregon's Public Health system.
- The adequacy and effectiveness of community behavioral health systems affect the Oregon State Hospital census.

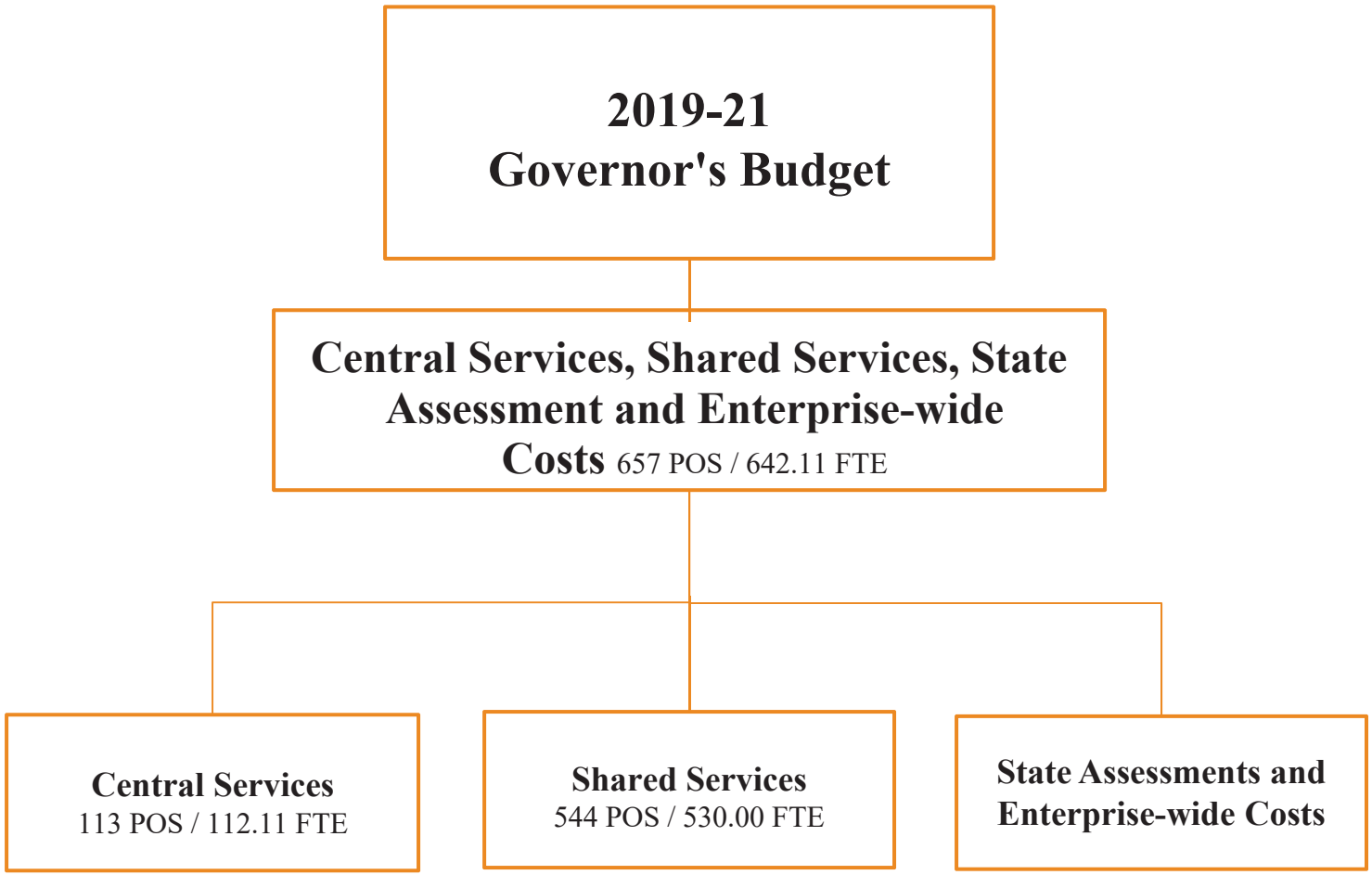
MAJOR INFORMATION TECHNOLOGY PROJECTS/INITIATIVES

OIS expects to have several IT projects underway during the 2019-21 biennium. The details of these projects are outlined in the IT Related Projects/Initiatives report in the Special Reports section.

Projects and initiatives that are either partially or fully aligned with Policy Packages (POPs) in OHA and DHS Governor's Budgets include:

- **Medicaid Modularization**: POP #202 provides continued funds and additional positions for the planning effort to explore modularization opportunities for Oregon's Medicaid program. This work initiated in 2017-2019 biennium and will include contracting with a Strategic Advisor to update Oregon's Medicaid Information Technology Assessment, assess other state's modularization approaches, identify options for modular solutions and define Oregon's approach to modularization to meet federal requirements.
- **Integrated Eligibility**: POP #201 would provide additional funds and positions for the final rollout and maintenance and operations of the Integrated ONE system for eligibility determination of Medicaid, TANF, SNAP and ERDC benefits and the impacted legacy systems. This is a joint effort with DHS.
- **COMPASS**: POP #414 would fund the procurement of expert contract services for the analysis, acquisition, and implementation of a standardized reporting system for behavioral health services.
- **OEBB/PEBB Benefit Management System**: POP #421 would fund the procurement of a centralized, standardized, supportable, and scalable solution to replace both MyOEBB and pebb.benefits to provide easier enrollment and better coordination of benefits management.

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

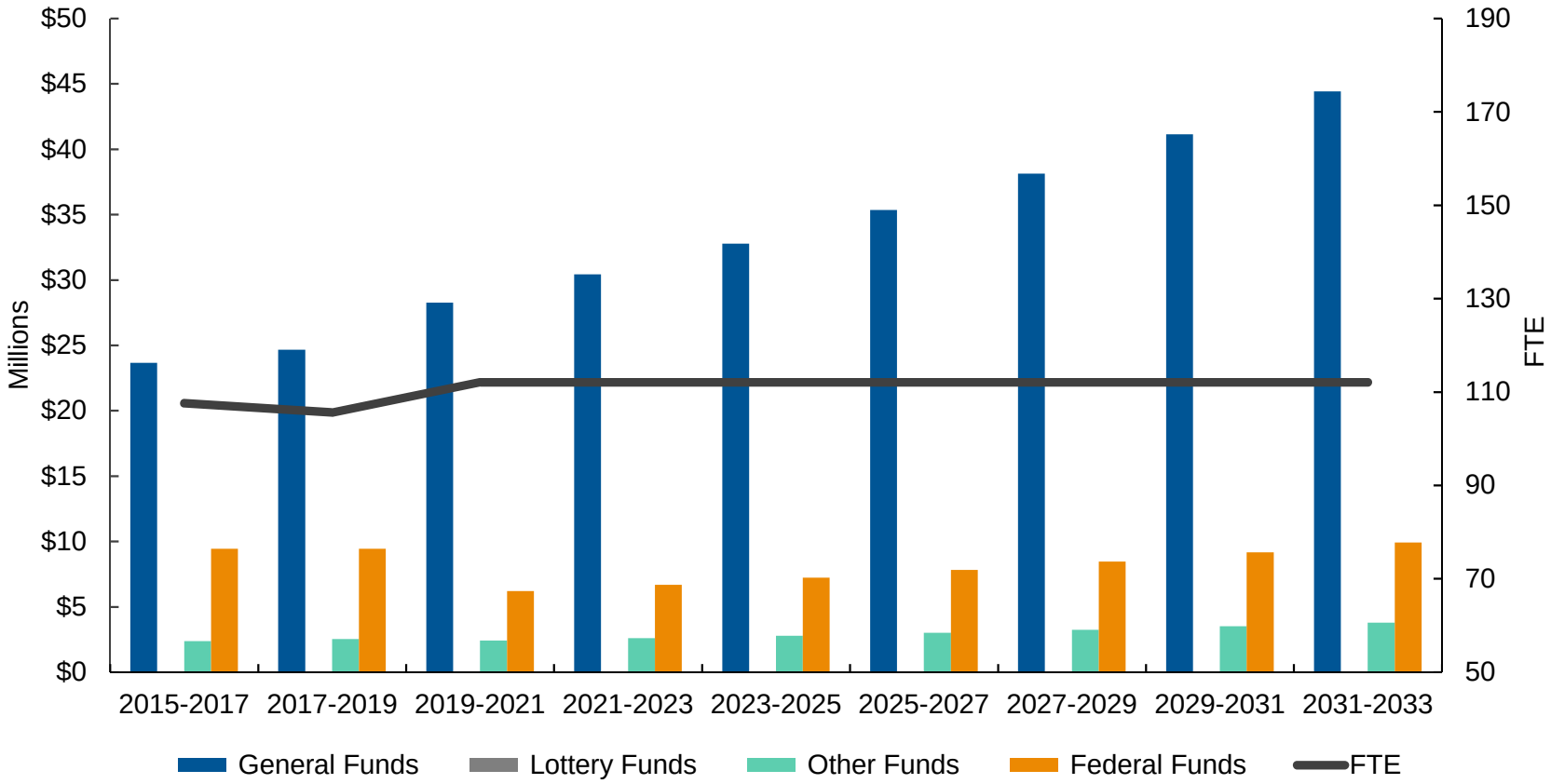


Oregon Health Authority

OREGON HEALTH AUTHORITY: CENTRAL SERVICES

Executive Summary

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



OREGON HEALTH AUTHORITY: CENTRAL SERVICES

Executive Summary

Program overview

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

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

Program funding request

The Governor's Budget of $36.9 million Total Funds continues funding at current service levels for the 2019-21 biennium.

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.

OREGON HEALTH AUTHORITY: CENTRAL SERVICES

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- Lower or contain the cost of care so it is affordable to everyone.

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

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

The **Fiscal Division** provides leadership and oversight of financing policies and coordinates budget development and execution for 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. Developing and updating the agency budget as it progresses through the statewide budget process, including Agency Request Budget, Governor's Budget, the Legislatively Adopted Budget, rebalance reports and various Emergency Board actions.

The Actuarial Services Unit and Office of Program Integrity are also functionally within the Fiscal Division of Central Services; however, they are budgeted in the Health Systems Division Program Support and Administration unit.

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:

OREGON HEALTH AUTHORITY: CENTRAL SERVICES

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- Equity and Policy
- Diversity, Inclusion, Training, Compliance & Civil Rights
- Business Support and Administration

These units develop programs and initiatives relating to health equity policy and practice, including the social determinants of health and equity; universal access for people with disabilities, people with limited English proficiency, etc.; diversity and inclusion; non-discrimination; the development of culturally and linguistically responsive practices and services; and training among other things. 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 experienced predominantly by racially, ethnically, culturally and linguistically diverse populations of Oregon so that everyone can achieve greater health equity and participate in a more robust and inclusive health delivery system.

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

- Governmental Relations team provides timely health data and analysis to the Legislature, federal partners, and local elected officials to inform evidence-based health policies and legislation. It also develops OHA legislative concepts to ensure access to quality health care, contain costs of health care, and improve overall health for Oregonians.
- The Community Partner Outreach Program provides community outreach and coordination with coordinated care organizations (CCOs), OHA, and local community partners.
- The Ombuds Program responds to customer calls related to all facets of OHA operations, with an emphasis on complaints related to Medicaid enrollment and eligibility.

OREGON HEALTH AUTHORITY: CENTRAL SERVICES

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- Communications provides accurate and accessible information about OHA's mission and programs, responds to requests for information from the public and media, and produces content for a wide range of agency publications, websites and other channels for keeping the public informed.

Program justification and link to long-term outcomes

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

Program performance

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

- **6,549** applications for positions, each of which HR manually grades to determine minimum qualifications
- **1,056** hires
- **286** promotions and **24** transfers
- **58** HR investigations, **39** that required corrective action
- **106** manager fact findings, **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 support the agency in achieving its mission and goals. HR works closely with

Executive Summary

internal customers on workforce initiatives and strategies at the program and agency level. It promotes a healthy workplace culture of ongoing development and feedback to ensure the workforce has the needed skills to be successful and engaged. HR is committed to assisting the agency in moving toward the vision of a healthy Oregon.

Within the Fiscal Division, 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 Health Care Finance staff provided financial oversight of coordinated care organizations, which receive over $4.5 billion dollars annually in gross premiums.

As of December 2017 the **Office of Equity and Inclusion** completed the following:

- Certified and enrolled on the state registry a total of 2,641 traditional health workers (community health workers, peer support specialists, peer wellness specialists, doulas and patient health navigators), and approved 36 trainings and continuing education programs.
- Qualified and certified 523 health care interpreters, representing 16 languages, and approved 15 training programs.
- Collected data on or related to completion of cultural competency continuing education training by the licensees of 23 health care professional boards.
- Reviewed 26 Cultural Competency Continuing Education training applications, approved 11 trainings, and conditionally approved13 trainings, as of May 4, 2018.
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- As of 2017 Developing Equity Leadership through Training and Action (DELTA) has recruited and trained a total of 141 individuals representing communities of color, tribal health clinics, public health departments, hospitals, health systems (including OHA and CCOs), and non-health sectors such as education, environment, housing and law enforcement.
- Resolved or referred approximately 20 internal (employee) civil rights matters in CY 2017.
- 72 internal (employee) civil rights cases investigated or closed in CY 2017.
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- Eight community outreach and job fairs attended by OEI staff between July 1, 2016 and June 30, 2017.
- Formally recognized four employee resource groups with a total of approximately 188 members and allies (as of June 2018).
- Over $69 million awarded to Oregon's Certification Office for Business Inclusion and Diversity-certified vendors for minority-owned, women-owned, and service-disabled veteran-owned businesses and emerging small businesses from July 1, 2016 to June 30, 2017.
- Two DHS|OHA Leadership Academy cohorts (totaling approximately 46 individuals) trained in intercultural conflict styles

The External Relations Division, according to average annual metrics:

- 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.

OREGON HEALTH AUTHORITY: CENTRAL SERVICES

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Enabling legislation/program authorization

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

Funding streams

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

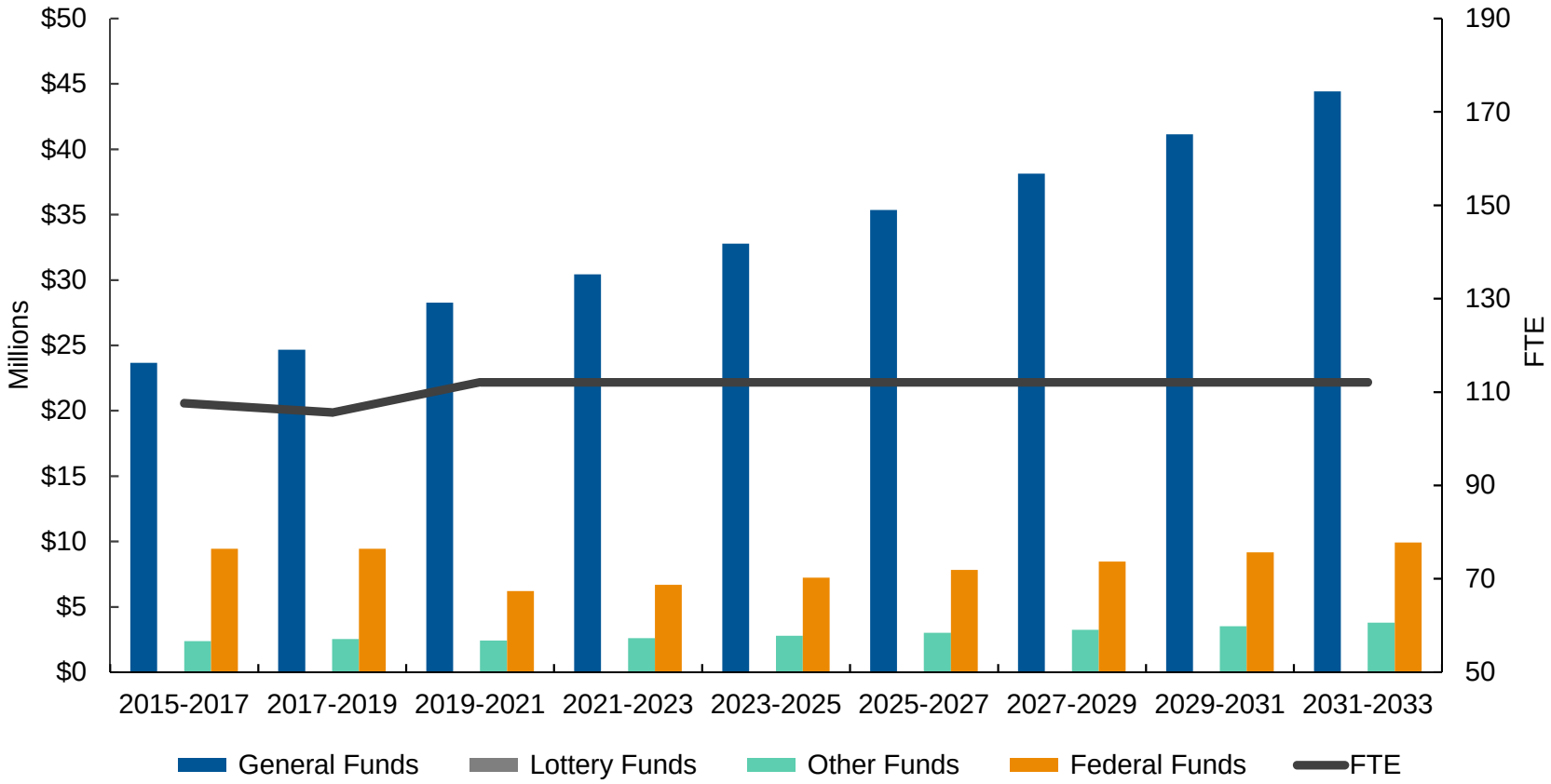
Significant proposed program changes from 2017-19

None.

OREGON HEALTH AUTHORITY: CENTRAL SERVICES

Executive Summary

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



OREGON HEALTH AUTHORITY: CENTRAL SERVICES

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Program description

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OREGON HEALTH AUTHORITY: CENTRAL SERVICES

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Significant proposed program changes from 2017-19

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OREGON HEALTH AUTHORITY: CENTRAL SERVICES

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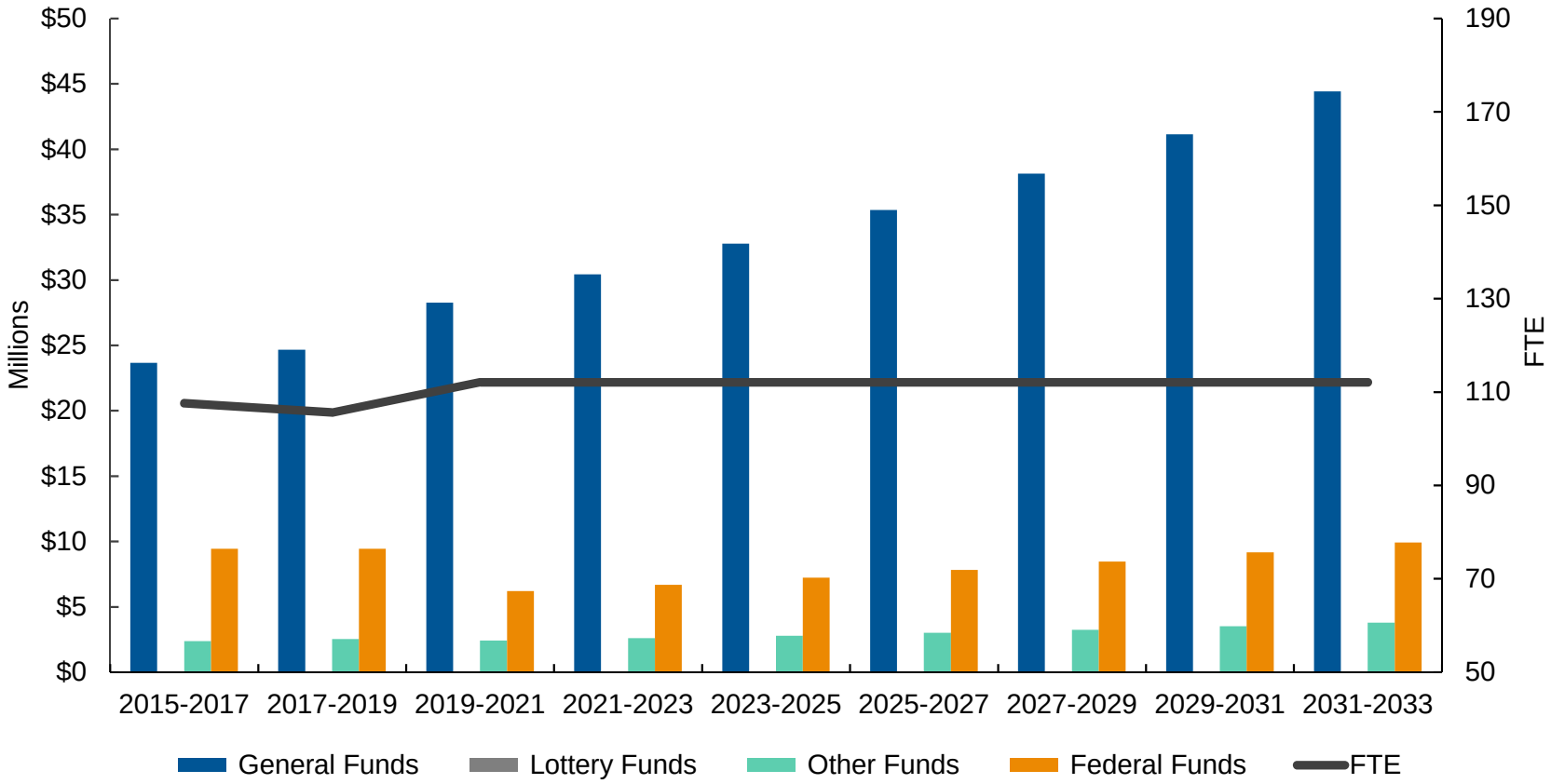

OREGON HEALTH AUTHORITY: CENTRAL SERVICES

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- Two DHS|OHA Leadership Academy cohorts (totaling approximately 46 individuals) trained in intercultural conflict styles

The External Relations Division, according to average annual metrics:

- 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.

OREGON HEALTH AUTHORITY: CENTRAL SERVICES

Executive Summary

Enabling legislation/program authorization

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

Funding streams

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

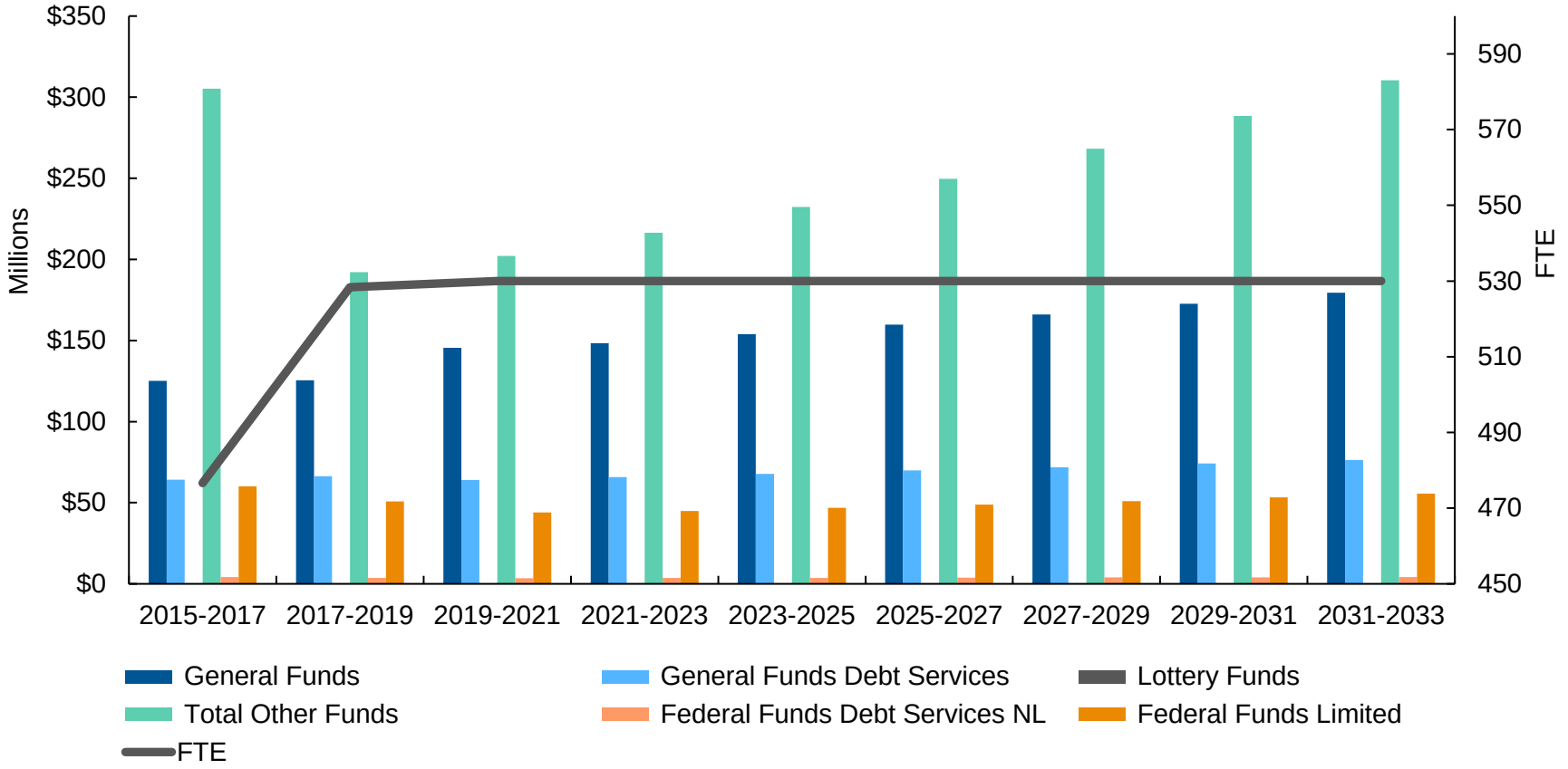
Significant proposed program changes from 2017-19

None.

OREGON HEALTH AUTHORITY: SHARED SERVICES & STATE ASSESSMENTS & ENTERPRISE-WIDE COSTS

Executive Summary

Program contact: Sara Singer, DHS|OHA Shared Services Budget Administrator
503-945-5629



Executive Summary

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

Executive Summary

Risk Management Program, price list

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

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

Enterprise Technology Services (ETS), price list

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

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

Telecom, price list and usage based

The telecommunications budget is partially price-list based, as DAS provides the budgeted rate per budgeted headset count. During the 2015-17 budget period, DAS elected to change to IBM as vendor for telecommunication services. The cost per

Executive Summary

headset budget and DAS financing charges for the new telecommunications system are budgeted here. Expenditures for work contracted to IBM for phone system adjustments is paid out of this budget as well, but is above and beyond the price list budget. While most of the telecommunication services are paid to IBM for the 2019-21 budget, there are still some services that are billed through DAS.

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

Executive Summary

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

Debt service
Debt service is the obligation to repay principal and interest on funds borrowed through the sale of certificates of participation (COPs) and bonds. The state uses proceeds of COPs and bonds to build and improve its facilities. They also are used to provide staff support for related activities including project management, community development coordination and fiscal services support. Repayment periods range from 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 can refinance existing debt, which can reduce or delay debt obligations.

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

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

Office of Administrative Hearings

Executive Summary

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

Program funding request

The Governor's Budget of $459.2 million Total Funds continues funding for the Office of Information Services for 2019-21 at the current service level, less a 5 percent vacancy factor and removal of standard inflation. The policy package for the next phase of the Integrated Eligibility and Medicaid Eligibility system was also included in the Governor's Budget.

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.

Executive Summary

- 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.

Senate Bill 90 (2017) was enacted to transition certain IT security functions to the DAS Office of the State Chief Information Officer (OSCIO). While the effective date of the bill was January 1, 2018, the details of this centralization continue to evolve. Once agreements have solidified, the description of the ISPO will be updated.

Executive Summary

Program justification and link to long-term outcomes

OHA Shared Services provides critical business supports necessary for OHA programs to achieve the agency's 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 to deliver services in a rational way.
- Begun implementing more integrated systems to support the performance of all our employees.

Executive Summary

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.

OREGON HEALTH AUTHORITY: SHARED SERVICES & STATE ASSESSMENTS & ENTERPRISE-WIDE COSTS

Executive Summary

	RANGE			
Measure Name	Red	Yellow	Green	STATUS
Customer Service and Support				
Customer ticket first contact response: Customer tickets resolved in first contact with the Service Desk.	<35%	35 - 60%	>60%	54%
Customer ticket resolution: Average time to resolve Service Desk ticket.	<7	3 - 7	< 3	1.8 days
IT acquisition/purchase request response: Respond to IT acquisition/purchase requests within one business week (five 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 email is available for our customers.	<98%	98 - 99.8%	>99.8%	99.98%
System availability - Mainframe environment: Percent of time mainframe environment is available for our customers.	<98%	98 - 99.8%	>99.8%	99.99%
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%	99.99%
System availability - OR-Kids System: Percent of time OR-Kids application is available for our customers.	<98%	98 - 99.8%	>99.8%	99.76%
System availability - Avatar System: Percent of time application is available for our customers (contractual).	<99.6%	99.6 - 99.89%	>99.9%	99.50%
Information Security and Privacy				
Agreement process timeliness: Percent of Information Exchange agreements processed within eight weeks.	<70%	70 - 85%	>85%	57%
Employee required training	<70%	70 - 89%	≥90%	93.72%

Executive Summary

Enabling legislation/program authorization

HB 2009 created the Oregon Health Authority in 2009.

Funding streams

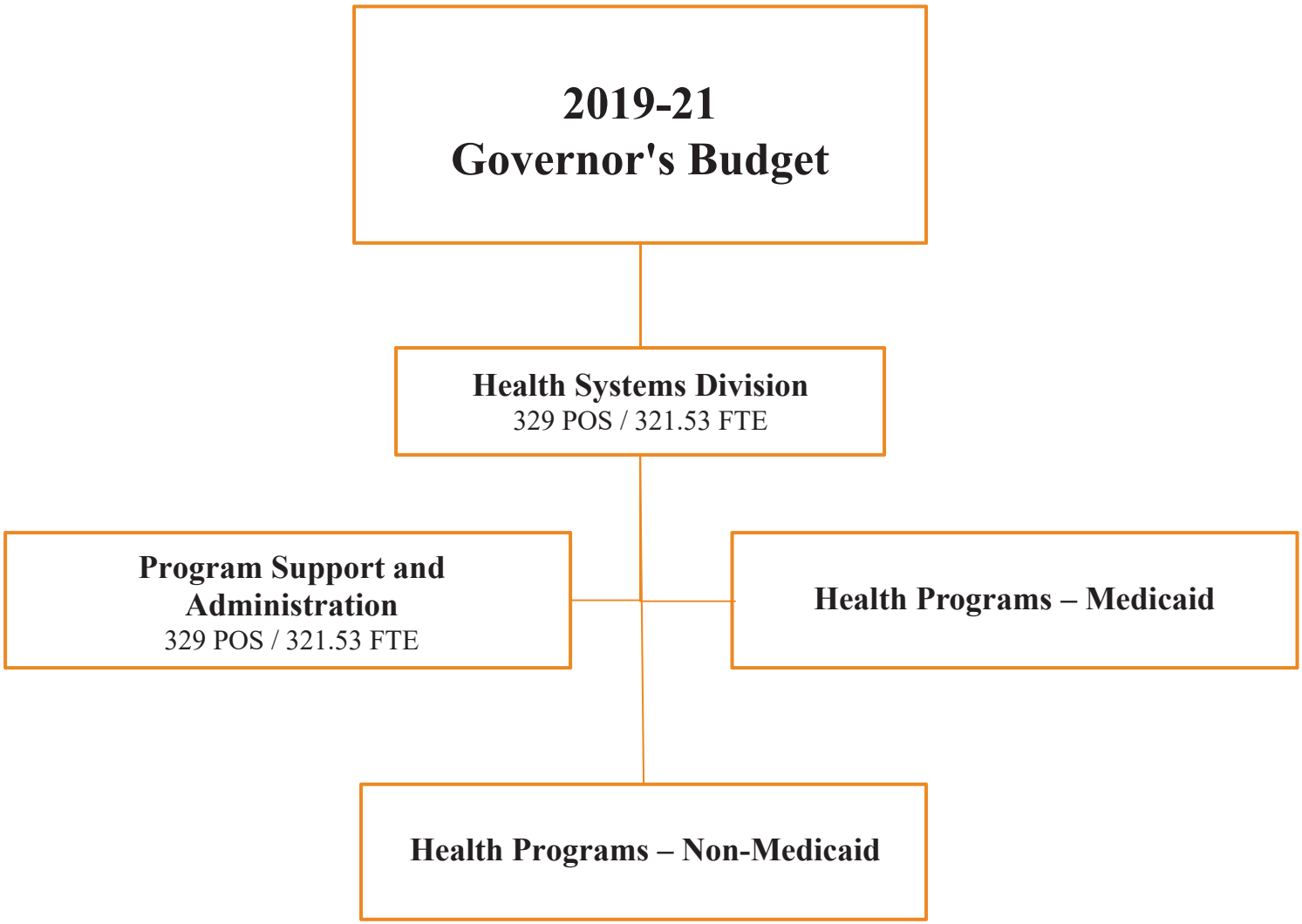
Funding streams in support of Shared Services are billed through a federally approved cost allocation plan. The model contains a billing allocation module and a grant allocation module.

The billing allocation module first allocates Shared Services costs to the two agencies. The billing module then allocates the costs to customers within each agency. The grant allocation module allocates those costs to their respective state and federal funding sources.

Both modules allocate aggregated costs monthly as outlined in the federally approved plan.

Significant proposed program changes from 2017-19

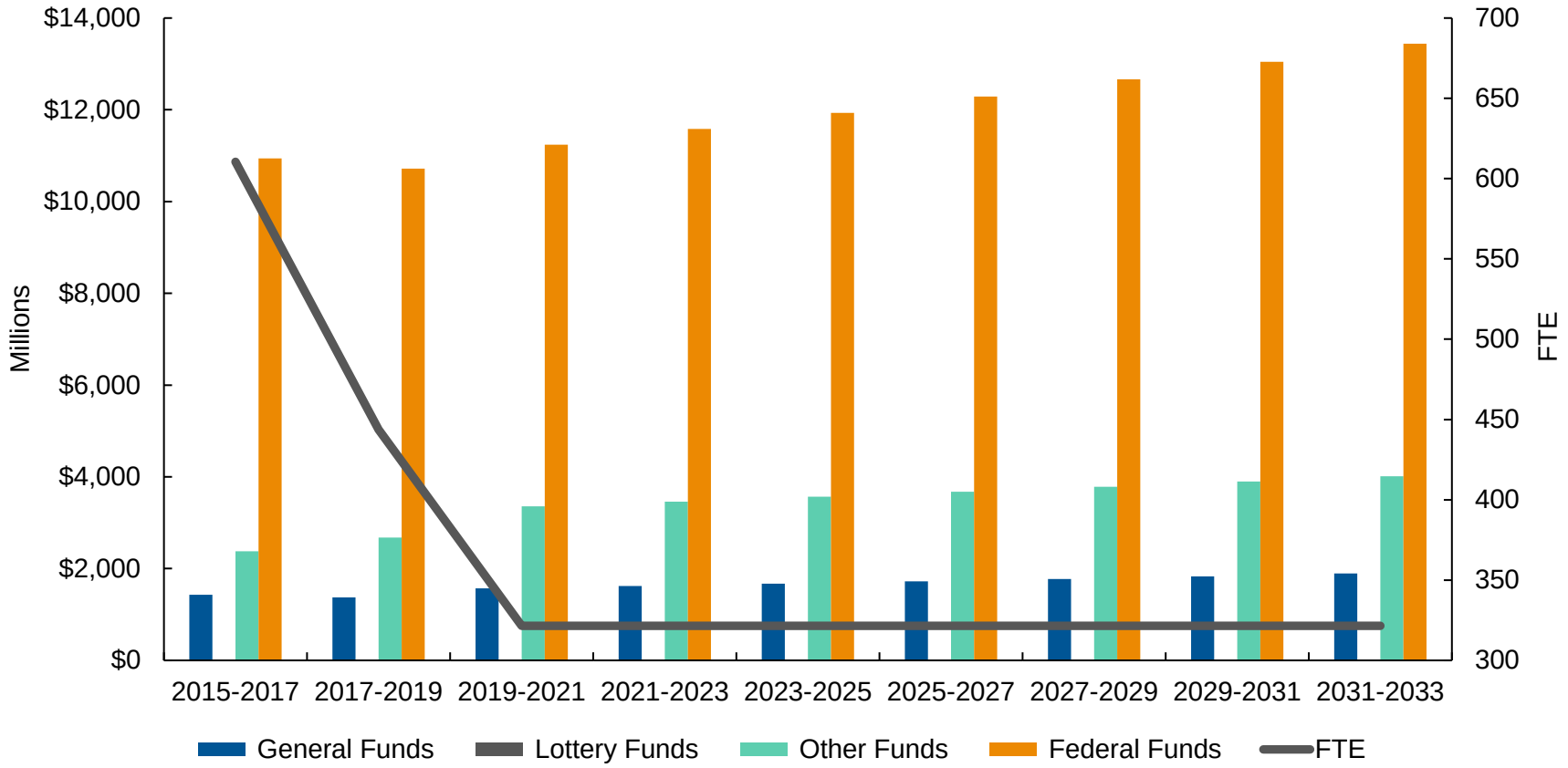
None.


2019-21
Governor's Budget
Health Systems Division
329 POS / 321.53 FTE
Program Support and Administration
329 POS / 321.53 FTE
Health Programs – Medicaid
Health Programs – Non-Medicaid

OREGON HEALTH AUTHORITY: HEALTH SYSTEMS DIVISION

Executive Summary

Program Contact: Margie Stanton, Director
503-947-2658



OREGON HEALTH AUTHORITY: HEALTH SYSTEMS DIVISION

Executive Summary

Program overview

A statewide system of integrated physical, behavioral and oral health care supports the triple aim of better health, better care, and lower costs by increasing access to preventive, coordinated care for Oregon's medical assistance program members and behavioral health consumers.

Funding request

The Governor's Budget of $16.2 billion Total Funds continues funding for Health Systems Division programs at the current service level for 2019-21. It includes policy option packages to improve access to preventive behavioral health care services and improve Oregon Medicaid information systems (Integrated Eligibility/Medicaid Eligibility, Oregon Eligibility and the Medicaid Management Information System).

Program descriptions

The Health Systems Division's (OHA-HSD) mission is to build and advance a system of care to create a healthy Oregon. The OHA-HSD vision is a coordinated, responsive and integrated system of care that serves and respects the diversity, cultures and languages spoken in each Oregon population and community.

OHA-HSD works with the federal government, local and tribal programs, and other state agencies to maintain and improve access to physical, behavioral and oral health care. OHA-HSD administers state and federal funds to deliver and pay for health care services to over 1 million people in Oregon, primarily through the Oregon Health Plan (OHP). Enrollment in OHP contributes to Oregon achieving one of the lowest uninsured rates in the nation.

OHA-HSD also administers community mental health and addiction programs statewide. During 2017 more than 300,000 Oregonians accessed non-Medicaid behavioral health services.

OREGON HEALTH AUTHORITY: HEALTH SYSTEMS DIVISION

Executive Summary

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

OHA-HSD's major cost drivers are:

- Increased demand for community-based behavioral health services and affordable housing;
- Rising health care costs, including the continued increase in prescription drug costs; and
- The cost of new and emerging technology.

Program justification and link to long-term outcomes

Funding and promoting a statewide, integrated system of care helps drive down health care costs and improve outcomes through increasing access to quality physical and behavioral health care. OHA-HSD incentivizes evidence-based, preventive practices through quality payments to coordinated care organizations and hospitals.

OHA-HSD works with partners to develop and strengthen culturally and linguistically responsive services. Examples of this include the Medicaid Program's implementation of OHA's Tribal Consultation Policy to inform decision-making on behalf of the tribes and the state; the Problem Gambling Program's partnership with Asian-American and Latino advisory councils; and applying the Race, Ethnicity, Language and Disability (REAL D) data collection standards mandated by House Bill 2134 (2013) to better inform equitable service delivery.

Program performance

OHA-HSD measures behavioral health system performance through the Oregon Performance Plan, which monitors key indices such as access, utilization, quality, effectiveness and family/patient engagement. CCO metrics measure the success of the coordinated care model in increasing preventive care visits and services.

OREGON HEALTH AUTHORITY: HEALTH SYSTEMS DIVISION

Executive Summary

Enabling legislation/program authorization

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

Funding streams

For the 2019-21 biennium, OHA-HSD's budget comprises 10 percent General Fund, 69 percent Federal Funds and 21 percent Other Funds. Federal revenue sources include Medicaid (with 63:37 match for services to approximately 950,000 OHP members), the Children's Health Insurance Program (with 82:18 match for services to 90,000 OHP members) and various federal mental health and substance use disorder grants.

OHA-HSD's Other Funds include a hospital tax, insurers tax, an intergovernmental transfer from Oregon Health & Sciences University, tobacco taxes, the Tobacco Master Settlement Agreement, recreational marijuana taxes, the Community Housing Trust Fund, beer and wine taxes, the Intoxicated Driver Program Fund and state lottery revenues.

In 2019-21, the division anticipates decreases in funding due to a reduction in marijuana tax receipts and the end of the Access to Recovery grant, and the sunset of the insurer assessment effective December 31, 2019. The 2019-21 Governor's Budget extends the insurer assessment at 2.0 percent and broadens the tax base by including stop-loss coverage. The Governor also proposes a new subsidized employer assessment for certain employers who do not meet threshold health care contributions on behalf of their workers.

Significant proposed program changes from 2017-19

In the 2019-21 biennium, OHA-HSD proposes to further integrate health care delivery systems and increase access to physical, behavioral and oral health care by advancing in the following areas:

OREGON HEALTH AUTHORITY: HEALTH SYSTEMS DIVISION

Executive Summary

- **Medicaid Programs:** Continue progress with cost containment strategies, value-based payments, metrics associated with population health and health outcomes, automation of systems related to service delivery, and overall health system transformation through the coordinated care model. This includes expanding CCO responsibilities on or after January 1, 2020 to further integrate behavioral health care; pursue alternate payment methodologies; address the social determinants of health, including housing; and further integrate health care delivery systems into communities to expand the opportunities for partnership and collaboration.
- **Behavioral Health Programs:** Improve the timeliness and quality of data systems; improve the quality and capacity of community-based, culturally responsive behavioral health services; standardize adult mental health residential rates; and expand access to appropriate levels of care in all Oregon communities, with an emphasis on early identification and prevention.

OREGON HEALTH AUTHORITY: HEALTH SYSTEMS DIVISION

Program Unit Narrative: Medicaid

Expenditures by fund type, positions and full-time equivalents

	General	Lottery	Other	Federal	Total Funds	Pos.	FTE
Leg Approved 17-19	$1,025.1	$0.0	$2,516.3	$10,506.5	$14,048.0	0	0.00
Governor's Budget 19-21	$1,150.1	$0.0	$3,207.5	$11,037.0	$15,394.8	0	0.00
Difference	$125.0	$0.0	$691.2	$530.5	$1,346.8	0	0.00
Percent Change	12%	0%	27%	5%	10%	0%	0%

The Governor’s Budget of $15,394.8 million Total Funds continues funding for Oregon’s medical assistance programs at the current service level for 2019-21. This budget does not include any policy package requests.

Activities, programs and issues in the program unit base budget

The Medicaid program budget supports the triple aim of better health, better care, and lower costs by deploying state and federal funds to pay for health care services to over 1 million Oregon Health Plan (OHP) members. The HSD Medicaid budget funds implementation of federal and legislative mandates under the Oregon State Plan and Title XIX of the Social Security Act Medical Assistance Program. This includes payments to individual health care providers, OHA’s Independent and Qualified Agent to assess eligibility for Medicaid Home and Community-Based mental health habilitation services, and Coordinated Care Organizations (CCOs) that serve over 90 percent of all OHP members.

The Medicaid program budget is based on caseload forecasts and cost estimates projected for the coming two years. Due to the budget's size, even minor deviations from forecasted to actual caseloads can result in significant changes from the projected budget—either shortfalls or savings. For all medical assistance program recipients, OHA projects the 2019-21 biennial average caseload to be 1,052,020 individuals, which is relatively unchanged from the 2017-19 biennial average.

Other issues driving cost for managed care capitation rates and health care delivered on a fee-for-service basis are in part driven by increasing costs for the provision of services and high cost of new and emerging treatments. Social issues, including untreated mental health and substance abuse, homelessness, and disparities also affect service delivery needs of OHP members.

Background information

In July 2012, the Centers for Medicaid and Medicare Services (CMS) approved Oregon's 1115 Medicaid Demonstration waiver that was necessary to implement coordinated care organizations and initiate health system transformation for the Oregon Health Plan. This initial waiver was for a five-year period, running from July 2012 through June 2017. Oregon's Medicaid Demonstration renewal request was approved by CMS and runs from January 12, 2017 through June 30, 2022.

The renewal continues and expands on elements of the 2012 waiver, particularly around integration of behavioral, physical and oral health care, and has included a focus on social determinants of health, population health, and health care quality. Under the agreement, Oregon will continue to provide integrated physical, behavioral and oral health care services to OHP members through CCOs; advance the coordinated care model to improve quality and outcomes; and offer evidence-based benefits through the state's prioritized list of services. The agreement also includes a commitment to an ongoing sustainable rate of growth and adopting a payment methodology and contracting protocol for CCOs that promotes paying for value rather than volume of services and advances the use of value-based payments.

In addition to continuing the core components of Oregon's existing coordinated care model, the waiver allows Oregon additional flexibility to:

- **Promote increased investments in health related and flexible services**. The waiver provides clarity on how non-traditional services that improve health are accounted for in global budgets. CCOs will be encouraged to invest in

services that improve quality and outcomes, and CCOs that reduce costs through use of these services can receive financial incentives to offset those cost reductions.

- **Promote primary care and pay for value**. Oregon will advance the use of value-based payments by CCOs. The state received authority to provide new performance incentive payments to primary care providers under the "Patient-Centered Primary Care" medical homes and "Comprehensive Primary Care Plus" initiative.
- **Advance Tribal Health Programs**. The Tribal Uncompensated Care Program (UCCP) was transitioned to become a Medicaid benefit, making the program easier to manage for tribes. Important services and protections for American Indians and Alaska Natives in Oregon were strengthened.
- **Expand access to coordinated care**. The state received authority to make enrollment into a coordinated care organization easier for Oregonians who are dually eligible for both Medicaid and Medicare. This expands coverage into high quality, cost effective, person-centered care for some of Oregonians most vulnerable population.

In 2018, under Senate Bill 558, Oregon expanded Oregon Health Plan coverage to low-income children who previously lacked health coverage. The implementation of bill led to the transition of some CAWEM members into the Cover All Kids program, which is Non-Medicaid funded, while the remaining CAWEM members maintained Medicaid funding.

Revenue sources and proposed revenue changes

The 2019-21 budget for the Medicaid program comprises 7 percent General Fund, 72 Federal Funds, and 21 percent Other Funds.

General Fund revenue supports Oregon's medical assistance programs. The Medicaid program receives Federal Funds through the following sources supporting the Oregon Health Plan (1115 Medicaid demonstration waiver):

Program Unit Narrative: Medicaid

- The Medicaid Title XIX entitlement provides a 63:37 match on health care services to Medicaid members. This means for every dollar OHA spends on health care services to Medicaid members, the federal Centers for Medicare & Medicaid Services (CMS) funds 63 cents and OHA funds the rest. Medicaid also provides a 50:50 match on staff and administrative expenditures that support the Medicaid program and a 75:25 match for administrative expenditures directly related to eligibility determinations and enrollment.
- The Children's Health Insurance Program (CHIP) Title XXI entitlement provides a 97:3 match on health care services to CHIP members. However, this rate will decrease to an 86:14 match effective October 1, 2020.

Other Funds revenues include tobacco tax revenues, hospital assessments, an intergovernmental transfer agreement with the Oregon Health & Science University (OHSU), insurers assessments (which sunset December 31, 2019), grants, third party recoveries, pharmaceutical rebates, and the Tobacco Master Settlement Agreement (TMSA).

Proposed new laws that apply to the program unit

The Governor's Budget for the Medicaid program includes an increase in tobacco tax revenues to offset General Fund need for the Oregon Health Plan. These revenues would be generated by increasing prices of tobacco products in House Bill 2270 (2019 Regular Session). Additional information on this concept is included in the Public Health Division's Center for Prevention and Health Promotion program unit summary.

The Governor's Budget proposes to continue the insurers assessment past December 31, 2019 and increase the assessment from 1.5 to 2.0 percent. House Bill 2010 (2019 Regular Session) provides the statutory changes to support the Governor's proposed insurer assessment.

OREGON HEALTH AUTHORITY: HEALTH SYSTEMS DIVISION

Program Unit Narrative: Program Support and Administration

Expenditures by fund type, positions and full-time equivalents

	General	Lottery	Other	Federal	Total Funds	Pos.	FTE
Leg Approved 17-19	$87.6	$3.2	$18.7	$149.9	$259.5	301	443.70
Governor's Budget 19-21	$88.5	$3.2	$18.5	$115.3	$225.5	329	321.53
Difference	$0.9	$0.0	-$0.2	-$34.6	-$34.0	28	-122.17
Percent Change	1%	1%	-1%	-23%	-13%	9%	-28%

The Governor's Budget of $225.5 million Total Funds continues funding for Program Support and Administration at the current service level for 2019-21. The budget request does not include any policy packages.

Activities, programs and issues in the program unit base budget

The Program Support and Administration budget includes funding for administrative support, services and oversight for both Medicaid and Non-Medicaid programs. Program Support and Administration staff work directly with program staff, leadership, and other agency partners to support effective programs and achieve agency goals.

Critical business support for the Health Systems Division is provided by the following units:

- The Business Office oversees the administrative budget, manages positions, hiring and facilities, office management, and program and administrative invoices.
- The Contracts Unit oversees the county contracts and grants that fund Oregon mental health and substance use disorder programs. These include intergovernmental agreements with local mental health authorities (LMHAs) and CMHPs, direct contracts with tribes and tribal organizations, and contracts administered by the Oregon Health Authority.

- The Project Management Office includes portfolio management of major program and agency initiatives, and service and support for process improvement. It also manages business continuity efforts.

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

Physical, dental and behavioral health program development, operations policy and special projects.
Staff manage the 27 Oregon Administrative Rules programs that contain the policies, rules and processes related to covered health care services, eligible health care providers and participating managed care plans, including coordinated care organizations, under the Oregon Health Plan.

Staff work with provider associations, community partners, and other OHA and DHS divisions to implement and promote changes to benefits or programs. Recent efforts include Medicare-Medicaid coordination, access to doula services, the ground emergency medical transportation program required by House Bill 4030 (2016), increasing fee-for-service dental rates, and adding hippotherapy (equine therapy) as a covered physical therapy service.

Policy development and implementation of Oregon's Medicaid and CHIP State Plans and the Medicaid 1115 Demonstration Waiver with federal Medicaid partners. Combined, these documents explain how Oregon administers its federally funded medical assistance programs and the requirements for members and providers to participate in these programs.

Staff also coordinate with the Department of Human Services on updates in state policies, programs and information systems when federal Medicaid and CHIP eligibility rules change. Staff inform system enhancements, such as "automated renewal" functionality in November 2017, Hospital Presumptive Eligibility in April 2018, and 100% annual income gap-filling determinations in April 2018. These enhancements have not only improved accuracy but have also allowed for faster, more automated, and more consistent determinations.

Quality assurance and hearings. These include both contested case hearings for OHP members and administrative reviews for OHP providers who disagree with a state or CCO decision to deny, reduce or end coverage of a specific health care service.

Hearings staff work with members, health care providers, CCOs and Oregon's Office of Administrative Hearings to coordinate the contested case hearing process for Oregon Health Plan members. From July 2017 through June 2018, Hearings staff processed 2,427 hearing requests.

Quality Assurance staff work with Oregon's External Quality Review Organization (EQRO) to provide technical assistance and oversight to help CCOs demonstrate compliance with state and federal requirements.

Provider services for over 50,000 health care providers.
Services include clinical and technical review of health care claims and requests to approve payment of health care services; enrollment of participating providers; and the Provider Services customer service line for help with billing, provider enrollment, prior authorization requests and MMIS access. It also includes working with Oregon's contracted managed care entities to ensure they submit data about the health care encounters they coordinate for OHP members.

Administrative oversight of all Medicaid programs operated by the Department of Human Services, such as Long-Term Supports and Services (LTSS).

Medicaid staff also work with coordinated care organizations, community partners, OHA's Tribal Director and the OHA Office of Equity and Inclusion to develop and strengthen culturally and linguistically responsive services and applying the Race, Ethnicity, Language and Disability (REAL D) data collection standards mandated by House Bill 2134 (2013) to better inform equitable service delivery.

Program Unit Narrative: Program Support and Administration

With CCO 2.0, the social of determinants of health will be a new focus for the Medicaid program. As part of CCO 2.0, HSD will be involved in the implementation and operationalization of social determinants of health activities as they relate to the CCO Care Delivery System. The RFA for CCO 2.0 specifically calls out the following areas:

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

The Program Support and Administration budget also includes the following administrative supports to Medicaid and Non-Medicaid Behavioral Health programs.

Actuarial Services Unit

OHA's Fiscal Division of Central Services oversees the Actuarial Services Unit, which develops OHA's capitation rates for Medicaid managed care entities (CCOs, dental care organizations and mental health organization) and the Program of All-inclusive Care for the Elderly (PACE). Also known as a "per member per month" payment, capitation rates are based on the total number of OHP-eligible members each organization serves. Each calendar year OHA contracts with an independent actuarial vendor to certify the capitation rates as actuarially sound and the federal government reviews and approves the rates.

The unit also supports CCOs and OHA through data analysis and collaboration, develops and implements cost-containment strategies, reviews and analyzes fee-for-service provider payments, evaluates alternative payment methodologies, and develops financial policy in support of Oregon's health system transformation.

Office of Program Integrity

Also part of the Fiscal Division of Central Services, the Office of Program Integrity (OPI) ensures that Oregon's Medicaid program follows federal Medicaid Program Integrity regulations. It also oversees programs supported by state funds. OPI detects, prevents and investigates Medicaid and non-Medicaid fraud and abuse claims.

This work is pivotal to ensuring public resources maximize the health care benefits delivered to people in Oregon. Investment in this office enables OHA to improve its programs 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.

Information Systems

The state's **Medicaid Management Information System (MMIS)** manages benefits, enrollment, claim processing and payments for services delivered to more than 1 million Oregonians who receive benefits through the Oregon Health Plan. The MMIS issues payments to coordinated care organizations and individual providers.

MMIS staff coordinate system changes mandated by state and federal requirements, as well as system improvements. MMIS staff work with multiple state agencies and the contracted MMIS vendor, DXC, to make these changes.

The major cost drivers are the number of required MMIS system changes, and rising cost of making these changes. The existing system requires a variety of changes to implement any single policy or benefit change, as well as intensive work by MMIS staff and DXC. CCO 2.0 will also require many system changes to prepare for 2020 implementation.

- Changes to the MMIS are driven by a descending order of priority, beginning with federal requirements, followed by state rules and legislatively mandated changes, and finally by business need.
- Recent examples of mandated changes are the legislatively mandated REAL D changes and changes to conform to federal Transformed Medicaid Statistical Information System (TMSIS) reporting guidelines.

Program Unit Narrative: Program Support and Administration

The MMIS will undergo modular changes in the next few years, which will allow for future changes without replacing an entire system. Modularity is approved and encouraged by CMS and will also change the cost of change requests and change orders. The Governor's Budget includes funding for MMIS modular changes in policy package 202.

The **Community Outcome Management and Performance Accountability Support System (COMPASS)** collects and reports data on behavioral health and substance use disorder services provided to people in Oregon through approximately 250 behavioral health agencies. COMPASS staff collaborate with the Office of Information Services, OHA-HSD Behavioral Health program staff, and behavioral health providers to maintain MOTS and improve data submission quality.

- The Measures and Outcomes Tracking System (MOTS) is used by providers to submit client status and non-Medicaid service data for required state and federal reporting for continued funding and to report client trends and outcomes. As of December 1, 2018, MOTS tracks 132,386 people with an active behavioral health treatment status.
- Oregon Web Infrastructure for Treatment Services (OWITS) is an open-source Electronic Behavioral Health Record (EBHR) system available to providers to use for their client assessment and clinical practice to promote data availability and exchange necessary for quality care. HSD pays the EBHR contractor, Focused E-health Innovations (FEi), to host the EBHR. The providers using OWITS contract directly with FEi for EBHR maintenance and updates. OHA supports OWITS by answering provider questions about OWITS and resetting passwords.
- The Oregon Patient and Resident Care System (OP/RCS) is a system used by Acute Care Hospitals to submit client admit, transfer, and discharge data to HSD. This data is used for required state and federal reporting, budget and forecast reporting, program analysis, and gun control verification.

For COMPASS, the high cost of maintaining outdated computer systems requires time-consuming and costly work-arounds to meet the data and reporting needs of OHA-HSD Behavioral Health Programs. Existing information systems do not work easily with providers' external systems (including electronic health records systems), which affects the frequency and accuracy of reporting. Upgrading these systems will decrease system and administrative costs for Behavioral Health Programs and their partners. The Governor's Budget includes funding to modernize these systems in policy package 414.

OREGON HEALTH AUTHORITY: HEALTH SYSTEMS DIVISION

Program Unit Narrative: Program Support and Administration

Background information

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

- Administrative support for nearly 300 permanent full-time employees.
- Oversight and support for Medicaid, Non-Medicaid services and administrative budget and invoices.
- Development and support for over 278 non-Medicaid contracts and grants.
- Support for three to five initiatives continuously during each biennium. Recent implementations include:
    - Senate Bill 558 (2017), mandating full medical assistance coverage for CAWEM-eligible children effective January 1, 2018.
    - The budget note in House Bill 5026-A (2017), mandating rate standardization for adult mental health residential facilities.
    - The Mental Health Parity Final Rule (CMS-2333-F), to ensure Oregon Health Plan coverage criteria for mental health and substance use disorder services are the same as, or better than, criteria for medical/surgical services.
    - The Medicaid Managed Care Final Rule (CMS-2390-F), the first major update to Medicaid and the Children's Health Insurance Program (CHIP) managed care regulations in more than a decade.

MMIS:

- Provides more than 120 annual trainings to end users
- Completes hundreds of system changes per year

COMPASS:

- Provides more than 12 annual trainings to end users
- Provides up to three monthly reports to 250 behavioral health agencies

Revenue sources and proposed revenue changes

The 2019-21 budget for Program Support and Administration comprises 39 percent General Fund, 51 Federal Funds, 8 percent Other Funds, and 1 percent Lottery Fund.

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

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

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

- The Tobacco Master Settlement Agreement,
- Tobacco taxes,
- Marijuana taxes,
- A portion of court fines, fees and assessments related to Driving Under the Influence of Intoxicants program, and
- Licensing revenue and small contracts for data reporting to the federal government and education about the U.S. Supreme Court's *Olmstead* decision.

Proposed new laws that apply to the program unit

None.

OREGON HEALTH AUTHORITY: HEALTH SYSTEMS DIVISION

Program Unit Narrative: Non-Medicaid (Behavioral Health)

Expenditures by fund type, positions and full-time equivalents

	General	Lottery	Other	Federal	Total Funds	Pos.	FTE
Leg Approved 17-19	$261.9	$9.1	$143.2	$63.7	$477.9	0	0.00
Governor's Budget 19-21	$329.9	$9.4	$134.9	$88.9	$563.2	0	0.00
Difference	$68.0	$0.4	-$8.3	$25.2	$85.2	0	0.00
Percent Change	26%	4%	-6%	40%	18%	0%	0%

The Governor's Budget of $563.2 million Total Funds continues funding for Non-Medicaid Behavioral Health programs at the current service level for 2019-21. It includes policy packages to expand prevention, earlier intervention, and access to services to Oregonians of all ages. These investments aim to:

- Stem rising suicide rates,
- Expand availability of mental health consultation and treatment services in schools,
- Expand access to community-based services for youth with high needs,
- Increase local capacity to serve the "Aid and Assist" population to reduce long-term costs and provide additional beds at Oregon State Hospital for civil commitment patients, and
- Improve behavioral health data collection, reporting and analysis.

Activities, programs and issues in the program unit base budget

Non-Medicaid Behavioral Health programs help all Oregonians achieve physical, mental and social well-being through access to mental health and addiction services and support (including housing services) for adults and children. Ongoing supports and services improve a person's ability to be successful with their family, education, employment and in their community. This often

reduces public safety problems, negative health-related consequences and suicide risk. Timely access to behavioral health care is a critical aspect for increasing protective factors and reducing risk factors that lead to suicide.

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

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

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

- Funding and oversight of intoxicated driver services
- Funding and oversight of problem gambling treatment and prevention programs in all 36 counties through community mental health programs and by for-profit and non-profit providers. The state also has one residential treatment program.
- Funding, development and oversight of several initiatives to address opioid use and misuse issues, in partnership with the Public Health Division and community partners throughout the state. This includes increasing patient access to Naloxone and office-based opioid treatment options, especially in underserved, rural and frontier areas.

- Funding and oversight of peer-delivered addiction treatment and recovery services. This is an evidence-based practice that uses trained and certified recovery mentors as part of a comprehensive recovery support team. This investment also funds sobering centers, a vital component of the safety net system for people struggling with substance use disorders.

Adult Behavioral Health and Housing Services promote the health, well-being and safety of Oregonians over age 25 living with mental illness or substance use disorders. The unit:

- Monitors, funds and develops strategies to expand access to safe, affordable housing. This includes rental assistance, supported housing grants, and renovation grants for existing mental health residential facilities;
- Monitors and funds the mental health supports identified by Oregon tribes in their biennial Behavioral Health Implementation Plans.
- Supports community-based crisis intervention services such as transportation, assessment, de-escalation and referral to treatment. This helps people experiencing a mental health crisis avoid needing a higher level of care that their community may not offer.
- Monitors, funds and develops strategies to expedite discharge of Oregon State Hospital (OSH) residents and prevent re-hospitalization. This includes ensuring safety and stability in housing, employment and community integration. This includes work with the Psychiatric Security Review Board, OSH treatment teams and community mental health programs to ensure individuals are placed in the appropriate level of care and receive the treatments and services needed to live as independently as possible.
- Oversees the Senior Behavioral Health Investment and provides technical assistance to 24 care coordinators throughout Oregon. The coordinators help seniors and people with disabilities access care, navigate multiple systems and learn about the resources in their community.
- Funds and monitors evaluation and restoration services for people with mental illness who have been accused or convicted of a crime. For people accused of a crime, restoration services can be court-ordered to restore them to a condition in which they can assist in their defense. For those convicted of a crime, restoration services divert them from jail and into treatment. Restoration services can be provided in the community or at the Oregon State Hospital depending on several factors.

Program Unit Narrative: Non-Medicaid (Behavioral Health)

Behavioral Health Policy provides overall policy direction for behavioral health services.

- Plans and administers federal behavioral health block grants for non-Medicaid services.
- The Office of Consumer Activities ensures that consumers provide input into the planning and delivery of services and supports at state and local levels.
- Monitors and directs the implementation of the services to reach metrics identified in the US-DOJ Oregon Performance Plan, which seeks to improve mental health services for adults with serious and persistent mental illness.
- Develops and supports policies that foster the integration of behavioral and physical health care.

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

- System of Care is "a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life." [1]
- Serving children, youth and their families in their local communities through robust community-based interventions can safely support youth, including assessing them for suicide risk, in their homes and reinforce a foster care network serving those who need substitute care.

The unit does this through:

- Funding and oversight of technical support in coordinating care for children, youth and young adults with emotional and behavioral disorders served across multiple systems such as the juvenile justice system, educational system, child welfare system, and mental health system.

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

- Promoting peer-delivered services, where a person with lived experience provides supports and services to parents, caregivers and youth experiencing behavioral health challenges.
- Reporting, coordination and oversight to implement the 117 action items in Oregon's Youth Suicide Intervention and Prevention Plan, 2016-2020 per ORS 418.704. This includes an array of resiliency building activities such as the best practice Sources of Strength program.
- Funding, promotion and oversight of effective interventions that improve outcomes for children and their families experiencing parent-child relationship problems, behavioral problems, or mental health disorders. Parent-Child Interaction Therapy (PCIT)is a preferred treatment for families with young children. Collaborative Problem Solving reduces the use of seclusion and restraint in child programs and improves parent-child communication.
- Investments that support early identification and community-based treatment, such as the Early Assessment Support Alliance for young adults with psychosis and the Oregon Psychiatric Access Line about Kids (OPAL-K) and the Oregon Psychiatric Access Line about Adults (OPAL-A) to provide clinical consultation to primary care physicians about their patients' behavioral health needs.
- Funding community mental health programs to bring behavioral health care to children and their families in the schools through School Based Mental Health services and supports.
- Funding of the Commercial Sexual Exploitation of Children residential program, which works with law enforcement, child welfare, Oregon Youth Authority, faith-based organizations, service providers, survivors and advocates to make certain that all sexually exploited children in Oregon have their best chance at leaving "the life" for good.
- Funding of juvenile Fitness to Proceed services for youth who have been charged with a crime and have been found to be not competent to fully participate in their court process, due to their inability to understand the nature of the court proceedings, inability to assist and cooperate with counsel, and/or ability to participate in their own defense. This program provides Restorative Services to assist youth in gaining competency in these areas.
- Funding Crisis and Acute Transition Services (CATS), community-based emergency room diversion services (rapid response intervention, crisis mitigation, access to prescriber, family partner, and care coordination for access to ongoing supports), so

that youth and families are served in the communities they live in, crises are resolved, youth don't return to the ER, and families acquire resources and supports.

- Engaging youth and their families in policy development, planning and oversight of youth behavioral health programs and systems through engagement with the Children's System Advisory Council and the Youth and Young Adult Engagement Advisory group.

The Licensing and Certification Unit regulates provider compliance with state laws related to residential and outpatient behavioral health facilities and programs. This includes licensing, certification and oversight of 1,167 behavioral health providers, including:

- Adult Foster Homes
- Child and Adolescent Programs: Intensive Treatment Services (ITS) and Children's Emergency Safety Intervention Specialists (CESIS)
- Civil Commitment, including Training and Certifying Examiners and Investigators
- Community-Based Structured Housing
- Outpatient Programs: Mental Health, Substance Use Disorders, and Problem Gambling; Alcohol and Other Drug Screening Specialists (ADSS); suicide risk assessment, lethal means counseling and safety planning
- Residential Treatment Facilities: Mental Health Adult Residential Treatment Homes and Facilities, and Secure Residential Treatment Facilities; Adolescent and Adult Substance Use Disorders and Problem Gambling programs
- Sobering Facilities

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

- A youth suicide rate that has been increasing since 2011.
- Growth in demand for services.
- Need for more community-based care.
- The number of individuals entering mental health treatment through crisis services.

- The number of individuals entering treatment who have multiple and complex physical and mental health needs.
- Access to heroin and other opioid drugs, which drives social problems including death and the demand for addiction treatment.
- Lack of safe, affordable and drug-free housing.
- The cost of emergency room visits and treatment for addiction services.
- The need to serve people being released from prisons and local jails.
- Ease of access to highly addictive gambling games.
- Community norms that minimize the effects of gambling by young people, and norms in particularly Latino and Asian communities that stigmatize seeking help for gambling disorders.

The number of people sent to OSH for "Aid and Assist" services has grown significantly over the past several years, putting a significant burden on General Fund dollars. As OSH shifts resources for this growing population, they must use housing units not designed for their specific needs. One way to address this issue is through collaboration among OSH, community partners, and the provider community to implement new systems that would make data available in a timelier manner and allow a better understanding of how to improve the quality of services. Behavioral health mapping is a critical piece of this work.

The 2019-21 continuing caseload is forecast for a biennial average of 50,164 clients, which is 3.9 percent lower than the 2017-19 biennium. The caseload includes clients in forensic, aid and assist, guilty except for insanity (GEI), civil commitments, previously committed, never committed populations.

Opportunities to improve behavioral health performance include:

- Partnering with the behavioral health provider community to implement new and improved data systems.
- Developing a comprehensive map of the behavioral health system to identify resource challenges and opportunities.
- Expanding access to a range of mental health services that engage individuals in the community with the services and supports they need, when they need them, where they need them, and at the right intensity.

Opportunities to build on one-time funding allocated by the Legislature for youth suicide prevention in 2018 are included in POP 402. These essential activities for implementation of the Youth Suicide Prevention and Intervention Plan, include:

- Coordination of youth engagement, establishing a cadre of youth prevention leaders and identification of safe online practices in social media by and for youth.
- Funding immediate post-suicide response to communities experiencing multiple suicides or attempts;
- Training in reducing suicide contagion risk to impacted communities.
- Certification of psychological autopsy and collection of these data to more fully inform prevention efforts;
- Technical assistance and training to Child Fatality review teams in counties.
- Building resilience in schools through specific programs which include the PAX Good Behavior Game in the early grades, Sources of Strength in middle and high schools, and mini grants to pilot schools for specific needs and projects.
- Addressing disproportionate efforts to date in vulnerable, higher risk communities including tribal youth, LGBTQ youth, and youth who are either suicide survivors or have lost a loved one to suicide (bereavement survivors).

Background information

Overall in 2017, 134,743 individuals received mental health services and 40,517 received substance use disorder treatment and support services.

Addiction Treatment, Recovery and Prevention Services

Problem Gambling Services

- Ongoing funding of 50 treatment programs through 34 agencies, ensuring problem gambling treatment services are offered in every county. These programs include traditional outpatient, residential, respite, home-based, and prison-based programs as well as a full-service help line.
- Ongoing funding of 37 prevention programs, ensuring that problem gambling prevention services are offered in every county.

- In FY 2018, 1,058 Oregonians received problem gambling treatment services, including individuals with gambling disorders and their family members at a cost of $1,706 per case. Of the individuals in outpatient services, 35 percent successfully completed treatment. Of those who completed treatment, 51 percent reported they were still abstaining from gambling six months later.
- In FY 2018, partnered with the Department of Corrections to conduct a prevalence study that found individuals in the criminal justice system are at greater risk for disordered gambling. Three statewide prison-based problem gambling treatment programs served 95 incarcerated individuals who were more racially and ethnically diverse than the overall criminal justice system population.
- In FY 2018-19, awarded special project funding to problem gambling prevention providers to conduct community readiness assessments to obtain metrics to guide future planning.

DUII

- 117 certified DUII Services Providers
- 56 certified Alcohol & Other Drug Screening Specialists
- Approximately 12,000 screenings/referrals to treatment conducted each year
- Approximately 1,500 individuals (DUII & MIP) served by Intoxicated Driver Prevention Funds (IDPF) between July 1, 2017 to June 30, 2018
- Conducted 5 Regional trainings on DUII OARs – trained approximately 350 people
- Provided access to 10 hours of American Society of Addiction Medicine (ASAM) Criteria training to 350 DUII clinicians

Opioid State Targeted Response

- Two new Opioid Treatment Programs in rural Oregon: Springfield and Pendleton.
- Through Project ECHO, over 200 providers (including MDs, DOs, PA and NPs) have been trained in buprenorphine waiver management and working with high-risk patients in clinical settings.

- Two coordinated housing service providers in rural Oregon funded to provide access to individuals to Intensive Outpatient and Day Treatment for Opioid Use Disorders (OUD) in conjunction with housing coordination.
- Increased access to naloxone, a life-saving drug that can reverse overdoses. Eight counties have received funding to distribute naloxone and train law enforcement in naloxone administration.
    - In Lane County, the Harm Reduction Program distributed approximately 1,700 doses of naloxone to individuals with OUD. 121 overdoses have been reversed through this distribution alone.
    - In Multnomah, Clatsop, Columbia, Washington and Clackamas counties, 927 individuals have been trained in naloxone distribution and provided with naloxone for distribution. Through these new avenues for naloxone distribution, 331 individuals have been referred to OUD treatment.
- All 9 tribes and Oregon's Urban Indian Program are developing Medication Assisted Treatment (MAT) implementation models to fit into their Tribal wellness model.
- Partnered with the Department of Corrections to train 8 inmates as Substance Use Disorder peer mentors in Coffee Creek Correctional Institution and will train more inmates in Pendleton's Eastern Oregon Correctional Institution. The Yamhill County Jail MAT and Peer program connected 41 individuals in Yamhill County Jail to OUD treatment while incarcerated and to MAT through Certified Peers upon release.

State Opioid Response

- 23 new rural SUD providers now qualify for the National Health Service Corps Substance Use Disorder Workforce Loan Repayment Program. This program supports the recruitment and retention of health professionals to expand access to SUD treatment and prevent overdose deaths in underserved areas.
- 7 of these providers are also funded through federal opioid grants to implement and expand MAT and associated wraparound services in the areas they serve.

Program Unit Narrative: Non-Medicaid (Behavioral Health)

Medication Assisted Treatment/Prescription Drug and Opioid Addiction (MAT – PDOA)

- Increasing treatment access by funding opioid treatment program (OTP) expansion in Douglas and Coos Counties, underserved geographically isolated areas with few medication-assisted treatment (MAT) options.
- Expanding office based opioid treatment (OBOT) options in the rural health care/primary care setting in the North Coast region of Oregon, an area with some of the highest overdose, hospitalization and prescribing rates over the last 5-6 years.
- Training, education and case consultation for the addiction medicine workforce statewide through the ECHO Program focusing on MAT and addiction treatment.
- Staffing for improved outreach and intake capacity at Central Oregon's only OTP and expanding partnerships with community stakeholders to develop a comprehensive continuum of care and coordinate with these stakeholders on community wide priorities related to opioid use and misuse in the region.

Adult Behavioral Health and Housing Services:

- Evidence-based programs including Assertive Community Treatment (ACT) provide services to over 1,248 individuals in their homes and communities. Supported Employment (SE) is also available statewide and currently serves over 731 individuals.
- Mobile Crisis and Jail Diversion services are provided in every county to assist individuals in getting services prior to encounters with law enforcement and to encourage treatment options instead of jail.
- Aid and Assist population growth has been expanding. OHA-HSD is working with each Community Mental Health Program to ensure community consultations are completed as required in statute and restoration services are available when needed in community settings.
- OHA-HSD and Oregon Housing and Community Services awarded $4.8 million in housing funds, adding 101 additional supportive housing residential units in the 2017-19 biennium.
- Rental assistance is available statewide for up to 1,254 individuals, which includes providing rental supports (teaching skills related to being a renter and connection to community resources to help with housing needs), rental services to help

individuals address barriers to housing (such as payment of outstanding electric bills or resolving a past eviction) and rental assistance in permanent supported housing.

- 114 Residential Programs serve 869 individuals in the community in various levels of licensed care including Residential Treatment Homes and Facilities as well as Secure Residential Treatment Homes.
- Older Adult Programs sponsor 24 Behavioral Specialists working in communities statewide to ensure services are available and federally mandated Preadmission Screening and Resident Review evaluations are completed.
- CHOICE services are provided to assist individuals diagnosed with severe and persistent mental illness who are needing coordination of care to move from acute care hospitalization through the system of residential supports into more independent settings with the right treatment and services available.

Behavioral Health Policy:

- Applied for and initially administered two federal Opioid grants.
- Made significant progress on meeting the objectives of the US-DOJ Oregon Performance Plan.

Child and Family Behavioral Health Services:

- 1,471 parent-child pairs received Parent-Child Interaction Therapy (PCIT) services between January 1, 2017 and June 30, 2018. Of those pairs who attended 4 or more PCIT sessions, 89 percent demonstrated an improved parent-child relationship, positive communication skills and/or reductions in parent-reported behavior problems. More than 89 percent of parents who complete PCIT treatment report that the child problems which brought them into treatment have improved.
- Six counties were awarded grants to expand school-based mental health services as mandated by House Bill 5201 (2018). OHA will report to the Legislature about the progress of these grants by January 1, 2019.
- Three regional facilitation centers were established to provide technical assistance, training and "tool kits" of best practices for providing peer-delivered services. The populations selected for research and best practices are medically assisted treatment, people who have been incarcerated, people without homes, rural (poverty), seniors, and young adults in transition.

Program Unit Narrative: Non-Medicaid (Behavioral Health)

- Collaborative Problem Solving (CPS) is a relationship promoting strategy that involves caregivers and youth working out a mutual solution through collaborative processes. OHA contracts with Oregon Health & Sciences University (OHSU) for training. consultation and coaching to multiple organizations, including Behavior Rehabilitation Services providers, over 100 members of the CPS Foster Care Coalition, Doernbecher Children's Hospital, Oregon State Hospital, Education Service Districts (ESDs), the Department of Human Services and Oregon Youth Authority.
    - Because of the contractual relationship with OHSU to provide these trainings, 67 organizations have trainers or mentors on staff and an additional 56 organizations have staff trained in CPS. One such organization, Oregon Family Support Network (OFSN), has 5 parents certified in CPS providing peer support, with 4 more training who will be able to train other parents in the model.
    - Oregon is home to almost half of all Think:Kids certified trainers and nearly 25% of the Think:Kids certified community.
- The Oregon Psychiatric Access Line about Kids (OPAL-K) makes psychiatric consultation for children up to age 18 available to primary care providers and mental health clinicians in need of psychiatric expertise. OPAL-K has received over 2,300 calls from medical providers throughout Oregon since it began services in June 2014. Over 1,700 medical providers have enrolled, with numbers increasing daily. OPAL-K also provides case reviews for children who are in the foster care system and have been prescribed complex psychiatric medications. As of September 2018, 193 foster care cases have been reviewed.
- The Oregon Psychiatric Access Line about Adults (OPAL-A) for those 18 and over began services on October 1, 2018. During its first week, the call center received 14 consult calls from medical providers caring for their adult patients in different regions of Oregon. On the first four days, 25 medical providers enrolled for the OPAL-A service. These services increase a provider's ability to manage complex cases, improve effective use of medications and facilitate connections with additional mental health treatment when needed.
- The Early Assessment and Support Alliance (EASA) is a clinical program serving young adults ages 12 to 25 experiencing symptoms consistent with early or initial onset of psychosis. Young adults served in this program are less likely to be hospitalized and more likely to keep their lives on track. Family and psychoeducational support are critical components of

this very successful program. From April 2017 through March 2018, EASA received 804 referrals and served 674 young adults. The ongoing current caseload is just over 400 individuals and families throughout the state of Oregon.

  - Oregon is the first U.S. state to commit to universal access to early psychosis intervention and is an established national leader. Congress has required all states to begin developing early psychosis or similar efforts. Oregon's expertise, experience and leadership are proving an important model.

- Commercially Sexually Exploited Children (CSEC) program is conducted through a contract for residential treatment for victims of commercial sexual exploitation. This program began in 2014 and serves 12 female-identified clients, with lengths of stay averaging between 12 and 18 months.
- Crisis and Acute Transition Services (CATS), or Emergency Department (ED) Diversion, began in 2014 with four sites to address increased numbers of youth being boarded in EDs. These sites provide services with the goal of diverting youth from the ED and reducing time spent in the ED when diversion is not possible. Currently eleven sites connect families to needed supports and services, such as rapid response, care coordination, clinical supports, family peer support, access to medication management, and connectivity to longer-term supports.
  - From January to June 2018, eleven sites served 286 youth, of which 113 identified as Male, 165 as Female, and 8 as Trans, Non-Binary, or Other; 145 were enrolled in the Oregon Health Plan, 117 had private insurance, and 12 were uninsured; 166 presented with suicidality and 184 had a diagnosable mental health condition.
  - Only 4.5 percent of youth re-presented to the emergency room while in the CATS program. Family peer support specialists provided 1,186 service hours.
- Our Wraparound model for services and supports, now implemented statewide, is being monitored and supported for fidelity implementation through technical assistance, and refinement through the development of specific administrative rules (OAR). This model is critical to youth and families directing their care, receiving care coordination, and for improved collaboration across multiple agencies serving youth, insuring community based and team-based planning.
- Programs for rapid response to suicide, resiliency-building, hotline services, programs by and for youth, and postvention training utilizing one-time funding for 2017-19 only. Funding to continue these services in the 2019-21 biennium is included in policy package 402.

Since 2016, Oregon has experienced a shortage in acute psychiatric residential levels of care for youth under age 18. OHA is actively engaged with the Department of Human Services to determine how to maintain or expand the short-term capacity while looking for a middle- to long-term solution that incorporates CCOs, counties, stakeholders and partners in alternatives to the current model.

Licensing and Certification:

- Responded to 397 annual new program onsite inspections, renewal onsite visits, unannounced visits, complaint visits, follow-up visits, and requests for technical assistance.
- Implemented the Community-based structured housing (CBSH) registry.
- Developed process improvements including a desk-audit system for ADSS certification, standardized rule development process for behavioral health rules and standardized complaint resolution process.
- Improvements have increased the unit's on-time license and certificate renewal rate to approximately 98 percent.

Revenue sources and proposed revenue changes

The 2019-21 Non-Medicaid Behavioral Health Programs revenues include 59 percent General Fund, 16 percent Federal Funds, 24 percent Other Funds, and 2 percent Lottery Fund.

General Fund revenue supports Oregon's behavioral health programs. Behavioral Health Programs receive Federal Funds through the following federal grants:

- The Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment (SAPT) Block Grant
- The SAMHSA Community Mental Health Services Block Grant
- The SAMHSA Projects for Assistance in Transition from Homelessness formula grant
- The Department of Health & Human Services Temporary Assistance for Needy Families (TANF) Block Grant

Program Unit Narrative: Non-Medicaid (Behavioral Health)

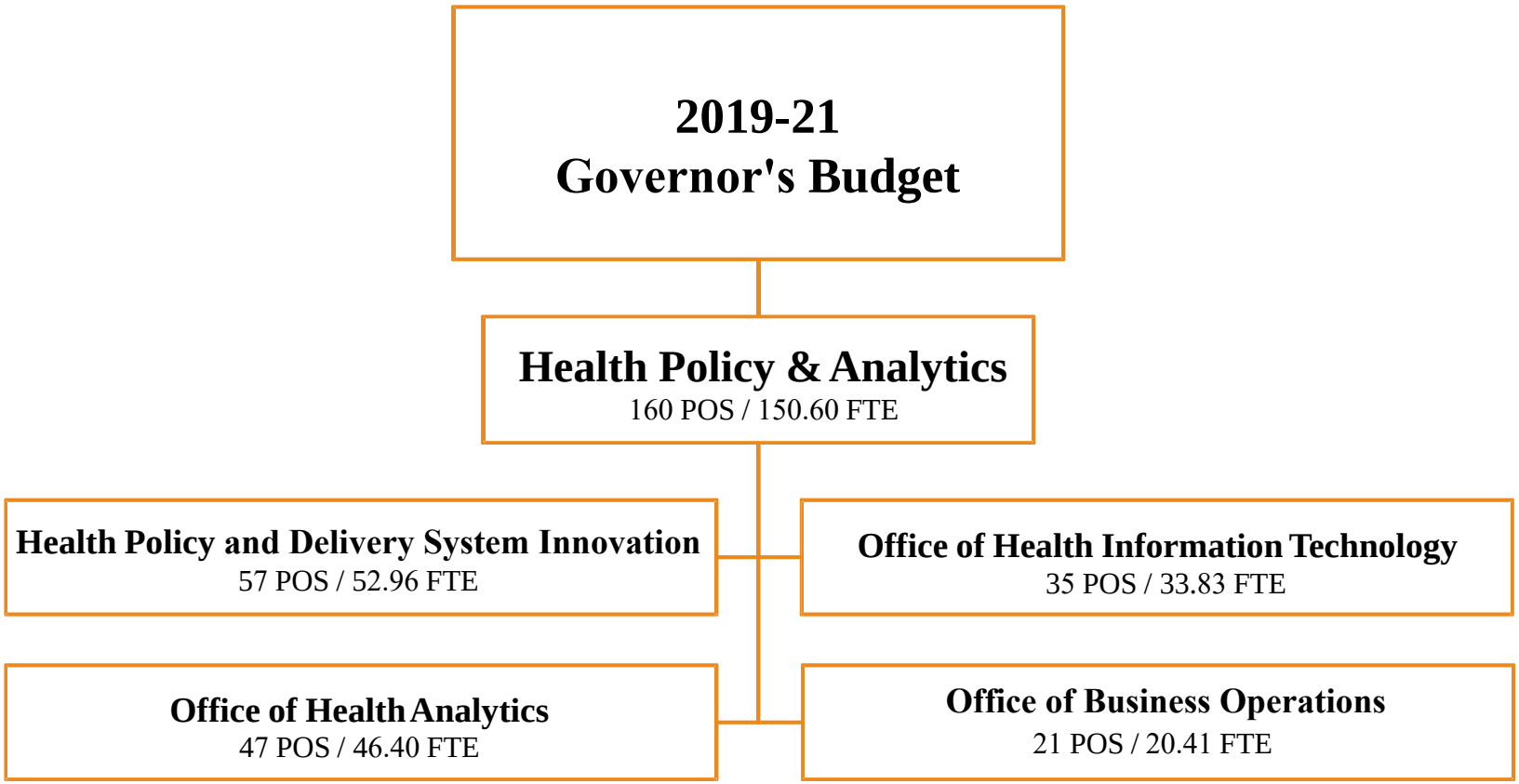
Other Funds revenues include:

- Statutorily dedicated funds under the Tobacco Use Reduction Account (TURA), Intoxicated Driver Prevention Fund (IDPF), Driving Under the Influence of Intoxicants (DUII) fund, Community Housing Trust Funds, and Lottery Fund;
- Tax revenue from beer, wine, tobacco and marijuana sales; and
- Miscellaneous revenue from contract settlements, sponsored travel reimbursements, and the Tobacco Master Settlement Agreement (TMSA).

Lottery funds are frequently reduced in times of economic decline, and there has been a recent decline in TMSA funds. Continued decline will require reductions to programs or new revenue sources to support current service levels.

Proposed new laws that apply to the program unit

None.

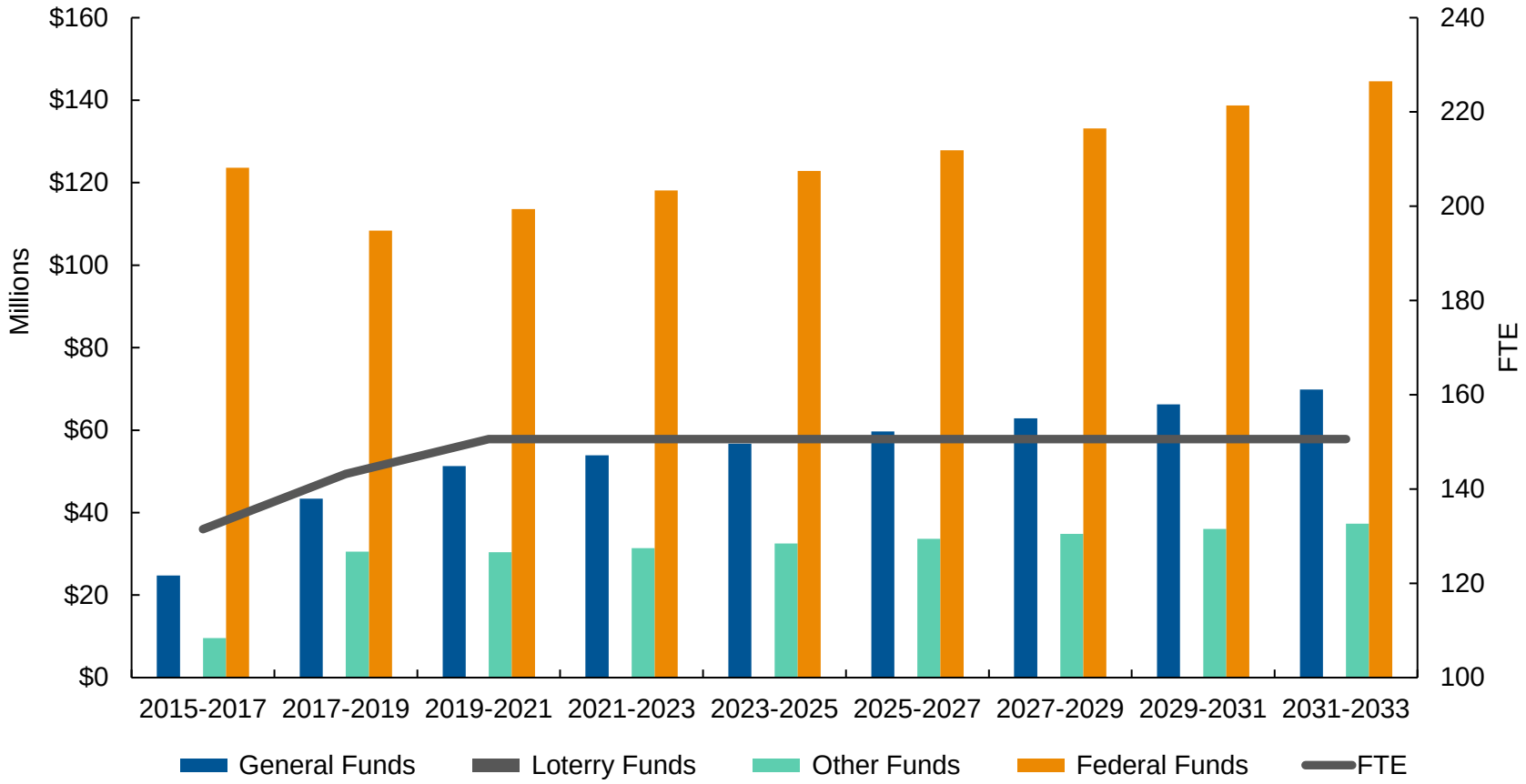


Oregon Health Authority

OREGON HEALTH AUTHORITY: HEALTH POLICY & ANALYTICS

Executive Summary

Program contact: Jeremy Vandehey, Director of Health Policy & Analytics
971-304-8433



OREGON HEALTH AUTHORITY: HEALTH POLICY & ANALYTICS

Executive Summary

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

- Office of Health Policy and Delivery Systems Innovation (which includes the Director of Health Policy and Analytics).
- Office of Health Analytics.
- Office of Health Information Technology.
- Office of Business Operations.

Program overview

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

- The Office of Health Policy.
- The Office of Delivery Systems Innovation.
- The Office of Health Analytics.
- The Office of Health Information Technology.
- The Public Employees Benefit Board and the Oregon Educators Benefit Board (each are budgeted separately from HPA).
- The Office of Business Operations.

These offices provide agency-wide policy development, strategic planning, clinical 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 Health Policy and Analytics Division is accountable for leading the next phase of health system transformation by:

- Supporting and incentivizing payments for value, moving away from paying for volume.
- Supporting the Oregon Health Policy Board's work including implementation of the Action Plan for Health.

OREGON HEALTH AUTHORITY: HEALTH POLICY & ANALYTICS

Executive Summary

- Focusing on social determinants of health in addition to medical care.
- Providing the clinical leadership to shape the management of high cost pharmaceuticals.
- Innovating and implementing solutions using health information technology.
- Implementing legislative directives to align metrics.
- Facilitating multi-payer alignment to support primary care sustainability with improved performance.

Program funding request

The Governor's Budget of $207.8 million Total Funds continues funding for Health Policy and Analytics programs at the current service level for the 2019-21 biennium and includes the following five policy packages (POPs).

1. Create the Office of Child Health in OHA. POP 404 would support the goals of the Children's Cabinet, created by the Governor to fulfill one of her priorities, improving prenatal and early childhood health. This office and staffing would focus on the health of Oregon children from before birth through age 5.

2. The Governor has declared opioid addictions and other substance use disorders a public health crisis and priority. POP 409 would address the opioid crisis by expanding training and technical resources for providers pertaining to appropriate opioid prescribing and alternative approaches to pain management. Specifically, this POP would:
   - Enable the Oregon Pain Management Commission to build and maintain four to six pain education modules per biennium (building on their existing, nationally-recognized 2018 pain module). These modules would aim to change the prescribing practices that helped cause the opioid addiction emergency and promote effective alternative approaches for pain management.
   - Enable OHA to add technical resources to further analyze the prevalence, treatment and health impacts of substance use disorders, especially opioid addictions.

Executive Summary

3. Improving the behavioral health system is one of the Governor's top priorities for Oregon's Coordinated Care Organization (CCO) 2.0 process. POP 411 has three objectives that support this priority:
   - Invest in a more connected behavioral health system by providing incentives for investments in foundational technology to advance integration.
     - This package would create the Behavioral Health Electronic Health Record (EHR) Incentive Program to support and encourage behavioral health agencies' investments in EHR. This would help reduce the disparity between behavioral health and physical health in terms of care coordination, health information exchange, electronic reporting, patient care, and value-based payments.
   - Adapt the primary care home model to advance integration within behavioral health settings.
     - This package would enable OHA to conduct reviews and provide technical assistance to recognize behavioral health homes. This would integrate primary care services into behavioral health service settings.
   - Improve access to evidence-based pharmaceutical treatments and practice guidelines to improve health outcomes of individuals experiencing mental illness.
     - This package would continue the Mental Health Clinical Advisory Group's effort to make recommendations to the Pharmacy and Therapeutics committee on treatment of mental illness including medications.

4. OHA has committed to furthering health system transformation both in CCOs and by spreading transformation to PEBB, OEBB, and commercial insurance markets. At the direction of the Governor, OHA is undertaking a significant advancement of the coordinated care model in Medicaid (dubbed CCO 2.0). POP 416 funds staff and support necessary for the significant policy development work over the next several years. This will include work on prescription drug costs, long term financing of health care, and strategies for better leveraging the state's purchasing power to advance transformational efforts, maintain access to coverage, and ensure a stable Marketplace. In preparation for a new procurement of CCOs in 2019 and 2020, the Governor has asked the Oregon Health Policy Board to focus on four areas to further transformation within "CCO 2.0": improving the behavioral health system, increasing the use of value-based payments, controlling costs, and addressing CCO members' social determinants of health and health equity.

Executive Summary

5. The final POP would expand the capacity of the Oregon Prescription Drug Program to adequately analyze and provide oversight of existing programs and adapt to rapid changes in the pharmacy field.

Program description

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

The **Office of Delivery Systems Innovation** (DSI) is designed to align and integrate clinical resources and policies to support implementation of the coordinated care model throughout all provider and payer organizations including OHA. The chief medical officer's focus is to direct and guide implementation of clinical services so they support quality improvement outcomes and integrate delivery of behavioral, physical, and oral health care as well as pharmacy purchasing. This role includes oversight of the Transformation Center, Patient Centered Primary Care Home program, the Health Evidence Review Commission, and the Quality Council.

The **Office of Health Policy** provides policy analysis, development, and evaluation services to support the health system transformation work of the Oregon Health Policy Board, the Medicaid Advisory Committee, OHA programs, and other stakeholder. The office 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, stores, integrates and statistically analyzes 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.

OREGON HEALTH AUTHORITY: HEALTH POLICY & ANALYTICS

Executive Summary

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

- Accelerate state and federal health reform goals through organized support for adoption, implementation and integration of health information technologies.
- Leverage health IT funding opportunities from federal agencies, 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 **Public Employees' Benefit Board and the Oregon Educators Benefit Board** have made a priority of transforming the health care delivery system, advancing health care transformation with plans that coordinate care, and managing the cost of care. They accomplish this through offering value-added plans that provide high quality care and services, implementing measurable programs that support member health status improvement, encourage members to take responsibility for their own health outcomes, and capping per-member-per-month cost increases at 3.4 percent.

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

While operationally situated in HPA, PEBB and OEBB each have their own budgets and are not included in the HPA budget.

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

- Program contracts management.
- Program staffing.

OREGON HEALTH AUTHORITY: HEALTH POLICY & ANALYTICS

Executive Summary

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

Program justification and link to long-term outcomes

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

- Reducing per capita costs.
- 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.

OREGON HEALTH AUTHORITY: HEALTH POLICY & ANALYTICS

Executive Summary

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, and Health Information Technology Electronic Health Record funds. It receives Other Funds from various grants (National Association of Chronic Disease Directors), fees (workforce, inpatient data, ambulatory surgical data, All Payer All Claim, J1 Visa, Oregon Prescription Drug Program), and Health Care Incentive Fund.

HPA no longer receives Federal Funds from the Office of National Coordinator for HIT (ONC) grant, which ended during the 2017-19 biennium.

Significant proposed program changes from 2017-19

OHA proposes to move the behavioral health director and staff from the Health Policy and Analytics Division to the Health Systems Division; and to move the state Medicaid director and Medicaid policy staff to the Health Systems Division. The policy work of the Health Policy and Analytics Division and the program work of the Health Systems Division are closely tied and will require close collaboration to ensure alignment to the agency goals of better health, better care and lower costs. This realignment is incorporated in the Governor's Budget.

OREGON HEALTH AUTHORITY: HEALTH POLICY AND ANALYTICS

Program Unit Narrative: The Office of Business Operations

Expenditures by fund type, positions and full-time equivalents

	General	Lottery	Other	Federal	Total Funds	Pos.	FTE
Leg Approved 17-19	$2.14	$0.00	$0.29	$2.00	$4.44	18	17.91
Governor's Budget 19-21	$2.01	$0.00	$0.37	$1.94	$4.33	21	20.41
Difference	-$0.14	$0.00	$0.08	-$0.06	-$0.11	3	2.50
Percent Change	-6%	0%	27%	-3%	-2%	17%	14%

Activities, program and issues in the program unit base budget

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

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

Contracts and Project Management:

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

OREGON HEALTH AUTHORITY: HEALTH POLICY AND ANALYTICS

Program Unit Narrative: The Office of Business Operations

Budget, Grants Management and Technology Management:

- Leads the initial biennial budget build and projections process for the division and each of its offices.
- Provides rebalance and reshoot budget tracking for the division budget.
- Builds and maintains active operating budgets for each program area in the division.
- Builds, monitors and maintains project budgets for the division's high-level projects.
- Provides all accounts payable and receivable services for the division.
- Supports the division's technology including SharePoint, Web development, deskside support, asset management, etc.
- Provides rule making and policy writing services for the division and tracks legislation during the legislative sessions.
- Provides grant maintenance services including documentation and version control, carry-over process, operational setup and maintenance, and closeout.

Staffing and Administrative Support:

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

OREGON HEALTH AUTHORITY: HEALTH POLICY AND ANALYTICS

Program Unit Narrative: The Office of Business Operations

Background information

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

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

Revenue sources and proposed revenue changes

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

Proposed new laws that apply to the program unit

None.

OREGON HEALTH AUTHORITY: HEALTH POLICY AND ANALYTICS

Program Unit Narrative: Health Policy

Expenditures by fund type, positions and full-time equivalents

	General	Lottery	Other	Federal	Total Funds	Pos.	FTE
Leg Approved 17-19	$28.22	$0.02	$15.08	$15.10	$58.43	160	150.60
Governor's Budget 19-21	$31.80	$0.02	$28.54	$16.14	$76.50	57	52.96
Difference	$3.57	$0.00	$13.46	$1.04	$18.07	-103	-97.64
Percent Change	13%	0%	89%	7%	31%	-64%	-65%

Activities, program and issues in the program unit base budget

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 – the triple aim. 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 value-based payments to provide incentive for health outcomes.
- Managing within a fixed rate of growth.
- Spreading evidence-based best practices and innovations.

The Health Policy program unit includes the Office of Health Policy and the Office of Delivery System Innovation, which is led by the chief medical officer. Each office 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.

OREGON HEALTH AUTHORITY: HEALTH POLICY AND ANALYTICS

Program Unit Narrative: Health Policy

The Office of Health Policy

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

- Providing oversight of Oregon's Medicaid policies in collaboration with the Health Systems Division Medicaid Policy Office. These include the State Plan, which defines all Medicaid eligibility, benefits and reimbursement policies; the 1115 waiver; and home and community-based waivers. The office also serves as the single point of contact for the Centers for Medicare & Medicaid Services.
- Staffing the Medicaid Advisory Committee, and OHPB and its committees and work groups.
- Developing and analyzing policy on health system transformation, rural health care initiatives, health care financing and other topics, as legislatively directed.
- 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.
- Oversight on the Primary Care Office, Primary Care Incentive Fund Program, and Oral Health Workforce grant.

The Office of Delivery System Innovation

In 2015 OHA 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 was to better align medical management practices and coordinate clinical policies across coordinated care organizations (CCOs), the fee-for-service population, other plans and payers, and all OHA departments. The goals of the chief medical officer and the Office of Delivery System Innovation (formerly known as the Office of Clinical Services Improvement) are to:

OREGON HEALTH AUTHORITY: HEALTH POLICY AND ANALYTICS

Program Unit Narrative: Health Policy

- Integrate clinical policies and resources to support the coordinated care model.
- Align and coordinate health care delivery strategies and systems throughout OHA.
- Pursue further integration of behavioral, physical and oral health care.
- Support innovation and quality improvement within Oregon's health system transformation efforts.
- Establish and maintain effective working relationships with Oregon's providers and health care delivery system representatives.
- Coordinate quality improvement efforts across OHA, PEBB- and OEBB-contracted plans, 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 directly supervises several existing positions in OHA that have historically reported through a variety of chains of command. These include the:

- Statewide dental director.
- Transformation Center director.
- Health Evidence Review Commission (HERC) director.
- Quality Improvement director.
- Oregon Prescription Drug Program and pharmacy purchasing director.

This unit also coordinates with the Public Health and Health Systems divisions to align OHA's clinical policies and program strategies. This involves working with the behavioral health director, the Medicaid medical director, and the state health officer and epidemiologist. The unit also coordinates with the OHA Equity and Inclusion division to better integrate health equity strategy and practice into its work.

Background information

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 clinical effectiveness and cost-effectiveness of medical treatments and technologies.

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

The Office of Delivery System Innovation 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 Delivery System Innovation 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 Delivery System Innovation 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.

OREGON HEALTH AUTHORITY: HEALTH POLICY AND ANALYTICS

Program Unit Narrative: Health Policy

The Transformation Center identifies, supports and shares innovation at the system, community and practice levels. It does this by providing technical assistance and through learning collaboratives and other convenings to a variety of health system stakeholders. The center also includes the Patient-centered Primary Care Home Program.

The CMO also oversees the Pharmacy and Therapeutics committee and Oregon Prescription Drug Program. The Office of Delivery System Innovation pharmacy role also includes evaluating and monitoring pharmacy benefits across Medicaid populations, in CCOs and traditional fee-for-service coverage. The office also leads development of strategies for fiscally sustainable administration of pharmacy benefits.

The CMO also oversees the work of the statewide dental director focusing on innovations for improving oral health outcomes, including dental pilot projects and oral health integration. The dental program is coordinated across the Public Health, Health Systems, and Health Policy and Analytics divisions.

Enabling legislation

The Office of Delivery System Innovation supports the following state mandates:

- Health Evidence Review Commission (ORS 414.688-704)
- Pain Management Commission (ORS 413.570-599)
- Palliative Care and Quality of Life Interdisciplinary Advisory Council (ORS 413.270-273)
- Patient Centered Primary Care Home Program (ORS 442.210, 414.655) and 414.655 adds CCOs under PCPCH program
- Oregon Prescription Drug Program (ORS 414.312, 414.314, 414.318, and 414.320)
- Pharmacy and Therapeutics Committee (ORS 414.351 to 414.414)
- Mental Health Clinical Advisory Committee (ORS 414.337)
- Office of the Statewide Dental Director (ORS 413.083)

Program Unit Narrative: Health Policy

Funding streams

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 Health Resources and Services Administration (HRSA) Primary Care grant and Other Fund grant awards 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; ORS 676.450 and HB 3261).

Proposed new laws that apply to the program unit

Legislative Concept 367: Senate Bill 152 (2015) gave optometrists the ability to prescribe opioid medications. However, they were not added to ORS 413.590, which outlines which professionals are required to complete the Pain Management Commission's Pain Module. It is important to align pain education for all providers who prescribe opioids; therefore, it is necessary to add "Optometrists licensed under ORS chapter 683" to the list of professionals who are required to complete the module.

Legislative Concept 368 – The Mental Health Clinical Advisory Group (MHCAG) is set to sunset on December 31, 2018. House Bill 2300 (2017) requires it to be established in the Oregon Health Authority. Based on the work done by the MHCAG to date, OHA recommends this group continue indefinitely. This will help ensure Oregonians receive the safest, most effective treatment and services at the lowest cost possible for all mental and behavioral disorders addressed in the DSM-5. ORS 414.334 will require amendment.

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	Lottery	Other	Federal	Total Funds	Pos.	FTE
Leg Approved 17-19	$5.37	$0.00	$13.81	$85.09	$104.28	37	33.50
Governor's Budget 19-21	$7.97	$0.00	$0.00	$88.14	$96.11	35	30.83
Difference	$2.59	$0.00	-$13.81	$3.05	-$8.17	-2	-2.67
Percent Change	48%	0%	-100%	4%	-8%	-5%	-8%

Activities, program and issues in the program unit base budget

The Office of Health Information Technology (OHIT) 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 clinical 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 among health care providers, patients, or other users of HIT systems. This can include finding (query); sharing (send), and exchanging (receive) patient information. Health information exchange also sometimes refers to an organization that provides HIE 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 has significant HIT and HIE programs in place and new projects in development:

- More than half of OHIT's budget are Federal Funds that pay for Oregon's Medicaid Electronic Health Record (EHR) Incentive Program. These funds cover 100 percent of incentives paid 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 HIT Commons in January 2018. This is a public/private partnership to govern and jointly fund key statewide HIT efforts. HIT Commons has two main initiatives. The first is operating the Emergency Department Information Exchange (EDIE) and overseeing the adoption and spread of PreManage. These two programs 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. The second initiative is the Oregon Prescription Drug Monitoring Program Integration (PDMP) Initiative, which officially launched in summer 2018. It provides all Oregon prescribers, pharmacists and their delegates electronic access to PDMP data within their workflows, to better inform prescribing of controlled substances including opioids.
- In 2018 OHIT is preparing to launch a new assistance program to support providers who serve Medicaid members in onboarding to a community-based HIE.
- 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 HIT to transform Oregon's health care system. This effort includes a state-level provider directory and a registry of clinical quality metrics data.

Background information

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

Program Unit Narrative: Office of Health Information Technology

Since 2011 thousands of Oregon providers have been able to participate in EHR incentive programs (either Medicare or Medicaid), and take advantage of federal incentive payments. As of May 2018, more than $515 million in federal incentive payments have been disbursed to all Oregon hospitals and 8,425 Oregon providers. Included in that total, Oregon's Medicaid EHR Incentive Program has disbursed more than $186 million to eligible hospitals and health care providers.

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 HIE efforts.

- In 2015 OHA established the Oregon HIT 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.
- Oregon's HIT Oversight Council (HITOC) updated its Strategic Plan for HIT/HIE, with approval from the Oregon Health Policy Board. The updates include a "network of networks" model to achieve statewide health information sharing, leveraging existing regional, statewide and national HIE networks. HITOC also produced a Behavioral Health HIT Scan report in 2018. It includes results from a statewide survey of licensed behavioral health agencies, providing a baseline on HIT use and challenges.
- OHIT partnered with the Oregon Health Leadership Council to launch a new public/private partnership, the HIT Commons, to provide long-term sustainability for statewide HIT efforts. The HIT Commons governs two initiatives:
    - EDIE, which connects all Oregon hospitals and provides emergency rooms with critical, concise information about patients who are high utilizers of emergency department (ED) services and patients with complex care needs. And PreManage, a companion service to EDIE, brings real-time hospital event notifications from EDIE to participating CCOs, health plans, and providers who 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 and other states. By

the end of 2018, all 15 CCOs are subscribed to PreManage. Nearly all of them are extending their license to their key contracted clinics. More than 200 primary care and behavioral health clinic sites in Oregon are live.

- The Oregon PDMP Integration Initiative, which provides all Oregon prescribers, pharmacists and their eligible delegates electronic access to PDMP data within their workflows, to better inform prescribing of controlled substances including opioids. This program is rolling out across the state beginning in mid-2018. As of December 2018, more than 900 Oregon prescribers and 240 pharmacists have access to PDMP data through their electronic work flows. This includes 27 hospitals, with more than 600 prescribing physicians, who are live with PDMP data in their EDIE alerts. More than 70 other entities have begun the process to integrate PDMP access into their EHRs, including many major health systems, rural hospitals, independent practices, and locally hosted EHR organizations.

- OHIT 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 November 2018, the Flat File Directory includes more than 16,300 Direct addresses from 24 interoperable, participating entities that represent more than 700 unique health care organizations (primary care, hospital, behavioral health, dentistry, FQHC, etc.).
- Since 2016 OHIT has offered 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 helps 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 2019. It has enrolled more than 1,500 providers at over 350 clinics as of November 2018.
- In 2018, OHIT is preparing to launch the HIE Onboarding Program to increase Medicaid providers' capability to exchange health information. This program will support the costs to onboard high-priority physical, behavioral, and oral health Medicaid providers, and their major trading partners, to Reliance eHealth Collaborative, a community-based HIE.

- OHIT has two new HIT services in implementation in 2018/early 2019, 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. The projects include:
    - The Oregon Provider Directory is preparing to launch with initial capacity in early 2019. It is critical to supporting HIE, analytics and population management, accountability efforts, and operational efficiencies.
    - The Clinical Quality Metrics Registry to capture robust clinical quality metrics data from EHRs. It has an initial focus on required CCO quality metric reporting and Medicaid EHR Incentive Program reporting. The registry will also offer the option of supporting reporting for Medicare and other payers, including the Comprehensive Primary Care Plus (CPC+) payers and CMS's Merit-based Incentive Payment System (MIPS).

Revenue sources and proposed revenue changes

OHIT is funded by state General Fund along with HITECH and Medicaid Management Information System (MMIS) federal matching dollars. More than half of OHIT's budget is federal funding through the HITECH Act to provide incentive payments to Oregon hospitals and providers under Oregon's Medicaid EHR Incentive Program. OHIT's General Fund dollars are used as a match to acquire HITECH and MMIS funds. For most expenditures, OHIT receives a 90:10 (FF to GF) federal match rate and receives additional funding at 75:25 and 50:50 match rates. Federal match rates depend on several factors, including whether the money is spent on planning, implementation or operations. This means that for every state dollar invested, between five and nine federal matching dollars are drawn into the Oregon economy.

The 2017-19 budget included Other Funds limitation from fees related to the Oregon Common Credentialing Program. The Governor's Budget reflects the removal of this limitation for the July 2018 program suspension.

Enabling legislation

In the 2009 regular session, House Bill 2009 established the HIT Oversight Council (HITOC), which coordinates Oregon's public and private statewide efforts in EHR adoption, HIT and HIE. Since its creation, HITOC has created strategic and operational plans for achieving statewide electronic health information exchange and other HIT needed to support Oregon's health care transformation objectives. 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, defined health care transformation in Oregon. It included significant HIT requirements, including that CCOs use HIT 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 of applying for and maintaining credentialing information for Oregon practitioners. Today practitioners must complete credentialing applications and provide supporting documentation for each credentialing organization. Senate Bill 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 July 2018, OHA made the difficult decision to suspend the implementation of the program, after consultation with stakeholders and legislators.

In 2015, Oregon passed legislation to align HIT efforts with health system transformation goals, formalize and support OHA's HIT efforts, and improve OHA's ability to advance the necessary HIT to support CCOs and the spread of the coordinated care model. House Bill 2294 (2015) updates the original HITOC components of House Bill 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 allows OHA 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.

Proposed new laws that apply to the program unit.

None.

OREGON HEALTH AUTHORITY: HEALTH POLICY AND ANALYTICS

Program Unit Narrative: The Office of Health Analytics

Expenditures by fund type, positions and full-time equivalents

	General	Lottery	Other	Federal	Total Funds	Pos.	FTE
Leg Approved 17-19	$7.64	$0.00	$1.33	$6.19	$15.16	41	41.00
Governor's Budget 19-21	$9.52	$0.00	$1.47	$7.39	$18.38	47	46.40
Difference	$1.88	$0.00	$0.14	$1.20	$3.22	6	5.40
Percent Change	25%	0%	11%	19%	21%	15%	13%

Activities, program and issues in the program unit base budget

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 to support and inform sound policy development and decision making. Examples include hospital utilization, quality and costs; health care workforce capacity; insurance coverage, and the All Payer All Claims (APAC) database. The office also collects and analyzes OHA program performance data, including behavioral health services evaluation and coordinated care organization incentive metrics.

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

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

- An annual CCO metrics report on performance.
- Health Plan quality metrics driven by Senate Bill 440.
- Reports from the Clinical Quality Metrics Registry.

- Evaluations, including the Oregon Health Plan Medicaid demonstration waiver.
- Consumer surveys, including the Consumer Assessment of Health Providers and Systems Survey (CAHPS), and the Patient Experience of Care surveys for adults and children receiving mental health services.
- Metric development to ensure OHA is tracking the most innovative aspects of the health care transformation, including the use of social determinants of health.

The Research and Data Program supplies data and analytics services to other state government partners and to external partners. These include:

- Maintaining Oregon's APAC database – collecting, compiling, releasing (to approved users) and reporting claims data.
- Collecting, analyzing and reporting health care workforce data from licensees of 17 health care licensing boards.
- Collecting, analyzing and reporting survey data on health insurance coverage and access to care.
- Collecting, analyzing and reporting hospital inpatient and outpatient data, and hospital financial information, including community benefit data.

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

- Oregon Health Plan and Medicaid support metrics and 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.
- Analysis and data support for the Office of Health Information and Technology.
- Internal program performance metrics.
- Data extractions for external research and evaluations.

Program Unit Narrative: The Office of Health Analytics

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.

Background information

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

- Collects and analyzes data to inform policy development, program implementation, and system evaluation.
- Collaborates with professional researchers to develop a body of knowledge that can be used to help lower and contain costs, improve quality, and increase access to health care to improve the lifelong health of Oregonians.
- Provides important information that individuals can use to help inform their care decisions.

Health Analytics' primary roles are:

- To be the single point of accountability for continual improvement of health analytics coordination and data integration across OHA and DHS programs.
- To develop analyses, data strategies, and monitoring tools to assess the performance of OHA programs.
- To support OHA policy development, implementation, and evaluation.

Revenue sources and proposed revenue changes

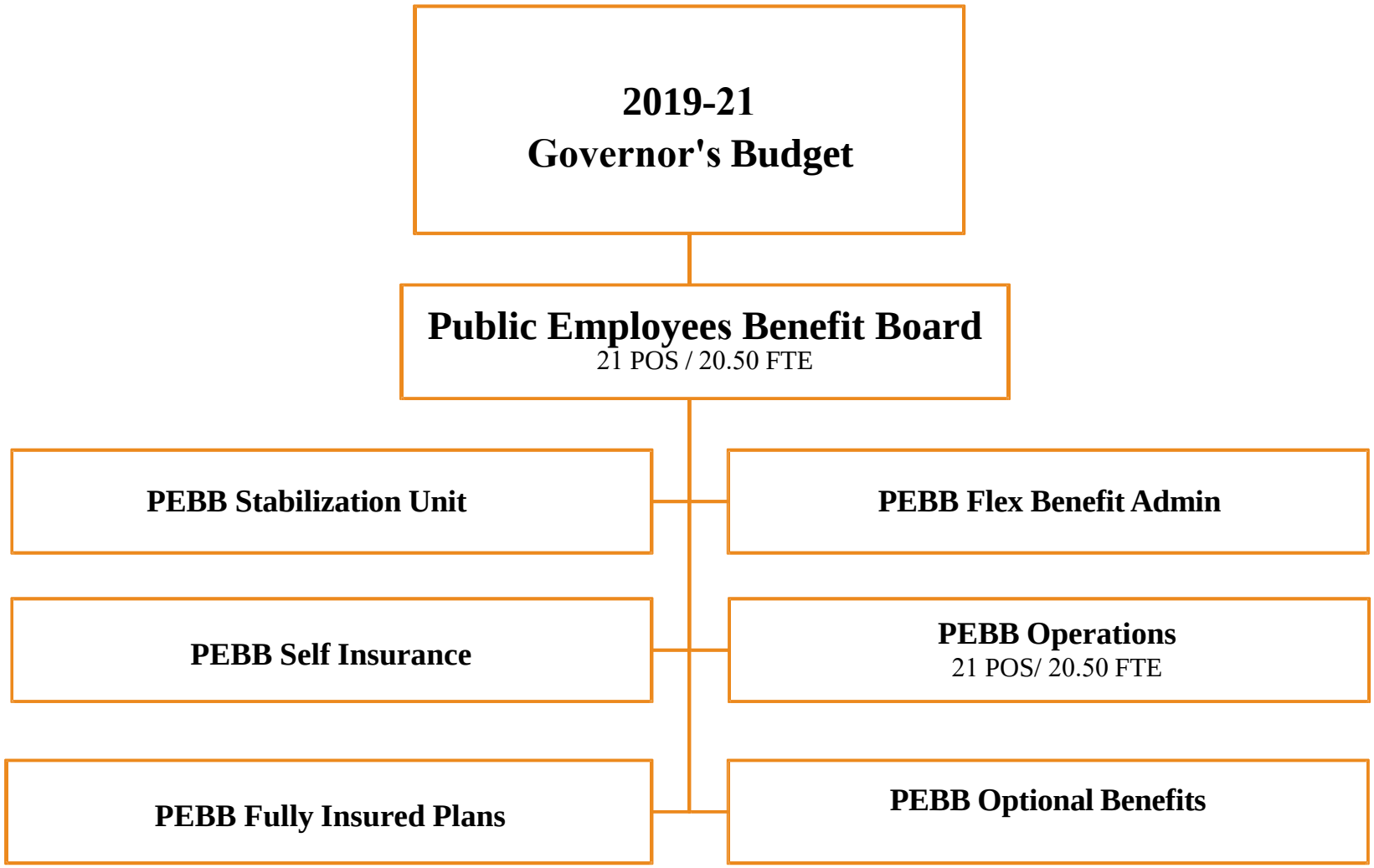
The Office of Health Analytics leverages Medicaid administrative match for eligible programs and activities, including Medicaid-related health system transformation, research and evaluation, and staffing.

The office receives Other Funds fees for health care workforce data collection and reporting and APAC.

Proposed new laws that apply to the program unit

House Bill 2265 - ORS 413.017. Currently the statute states that members of the health plan quality metrics committee are appointed by Governor. This concept modifies the statute to state that members are appointed by the OHA Director. Additionally, the statute does not permit staff to perform health care workforce-related analyses using other data sources, which would contribute to conversations of the Oregon Health Policy Board's Health Care Workforce Committee and others involved with Oregon health care workforce policy. This concept includes small changes to the statute that would allow staff to consider other data sources in their work on health care workforce issues.

Senate Bill 23 - OHA does not have access to sufficient emergency department discharge data to develop or evaluate some important statewide health policy imperatives. This adds emergency discharge data to existing statute; amends the statute to define data requirements by administrative rule; and adds other amendments to simplify and clarify the law.

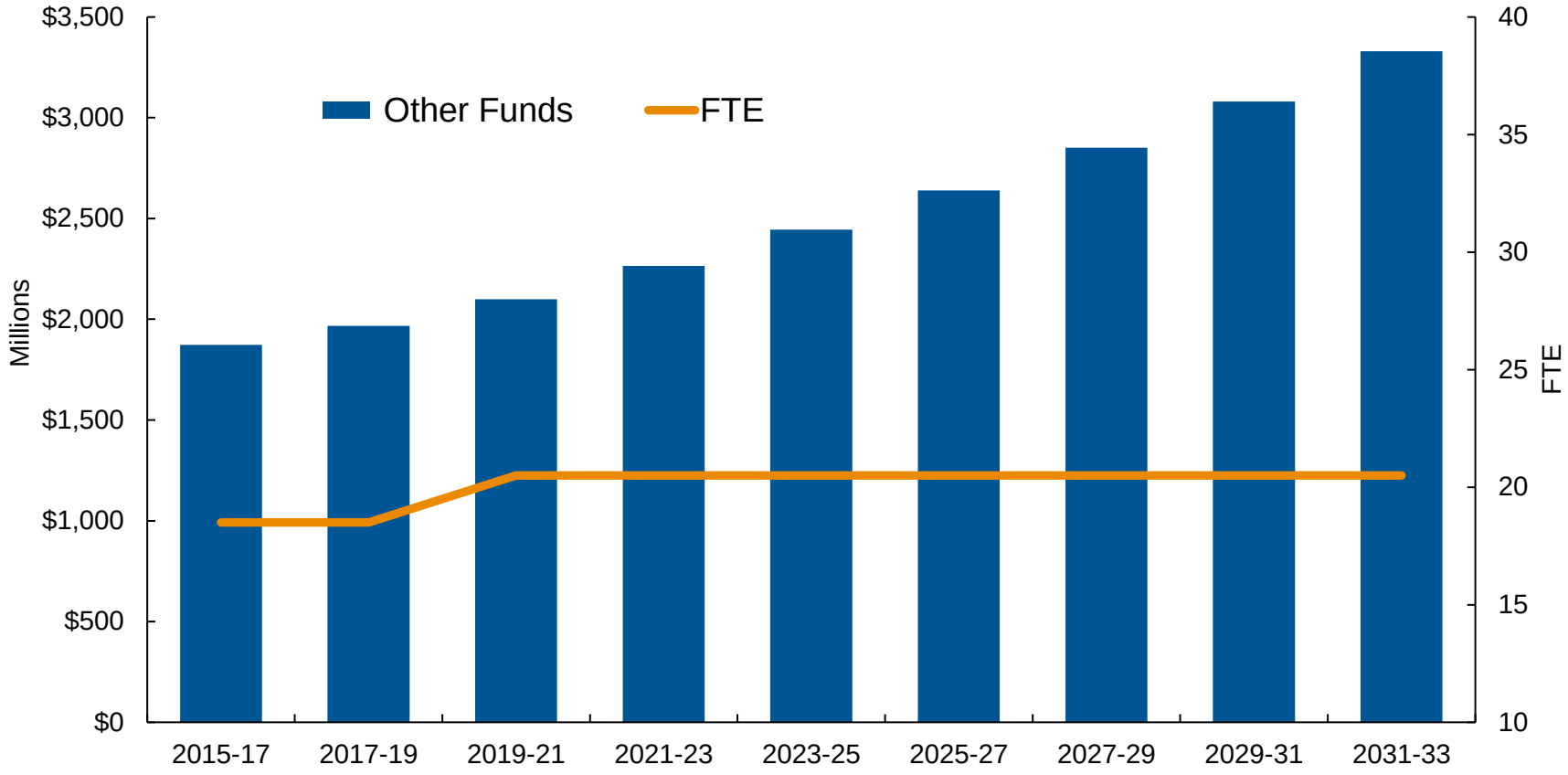


Oregon Health Authority

OREGON HEALTH AUTHORITY: PUBLIC EMPLOYEES' BENEFIT BOARD

Executive Summary

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



OREGON HEALTH AUTHORITY: PUBLIC EMPLOYEES' BENEFIT BOARD

Executive Summary

Program overview

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

Program funding request

The 2019-21 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. 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. The 2019-21 Governor's Budget is built on a PEPM basis. The PEBB Board receives quarterly updates on PEBB's budget status.

Program description

PEBB designs, contracts for and administers medical, dental, vision, life, disability, and accidental death and dismemberment plans and flexible spending accounts for PEBB members. More than 139,000 members are enrolled in PEBB coverage. They include active employees, retirees, spouse and domestic partner dependents, child dependents up to age 26, and adult children with disabilities over age 26. They are drawn from state agencies, universities, Lottery and semi-independent agencies, and local governments and special districts.

The PEBB board serves diverse populations and constituencies and provides a critical public service to the taxpayers of Oregon. PEBB members reside in all Oregon counties and out of state. PEBB is a Federal IRS Section 125 Cafeteria Plan benefits program and is required to offer the same benefits to all members.

OREGON HEALTH AUTHORITY: PUBLIC EMPLOYEES' BENEFIT BOARD

Executive Summary

PEBB's major cost driver is rising health care costs, which makes controlling premium costs a major challenge. Premium costs are affected by external drivers such as member use of services; uncoordinated care; inflation in health care costs, such as the high prescriptions costs; and sedentary occupations that lead to long-term risks and chronic conditions.

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

Program justification and link to long-term outcomes

Transforming health care

The PEBB board has made transforming the health care delivery system a priority, advancing this with plans that coordinate care. PEBB has partnered with its "sister program" the Oregon Educators Benefit Board (OEBB) in the shared innovation strategy referred to as "Coordinated Care Model" plans. Both boards are continuing to expand these systems of care throughout the state with a focus on integrated care and reducing health care costs and health disparities.

Value-based benefits

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

OREGON HEALTH AUTHORITY: PUBLIC EMPLOYEES' BENEFIT BOARD

Executive Summary

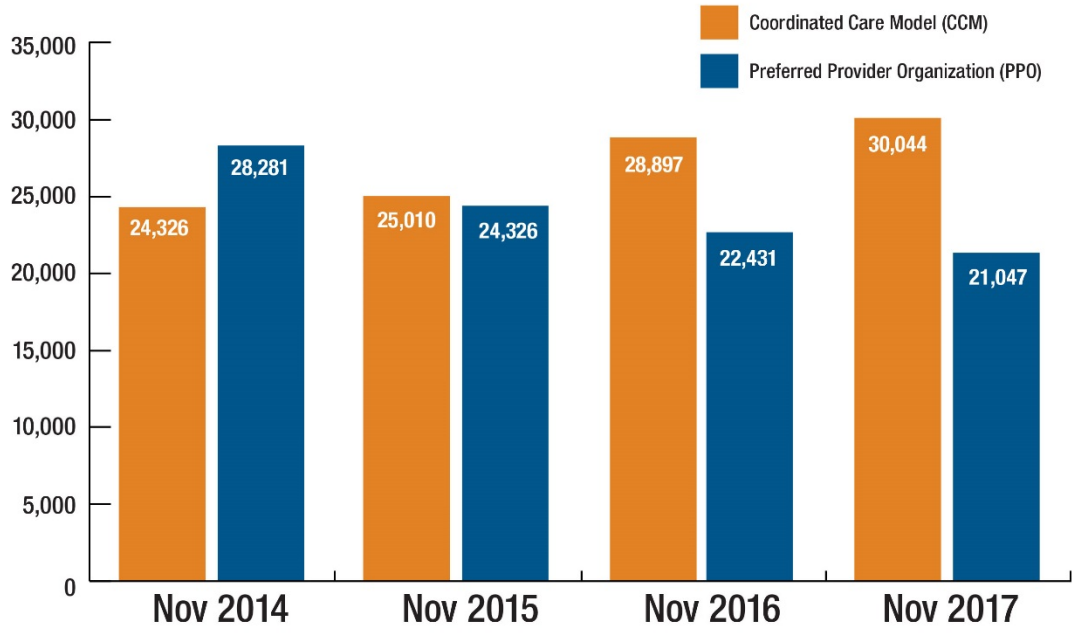
Wellness initiatives and promoting member health

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

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

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

PEBB member migration from a PPO plan to a CCM plan



OREGON HEALTH AUTHORITY: PUBLIC EMPLOYEES' BENEFIT BOARD

Executive Summary

PEBB/OEBB quality measures and fees-at-risk

In the 2019-21 biennium PEBB will continue to include quality measures and performance targets in health plan contracts to support movement toward better health, better care, and lower cost. The specific quality measures selected will be based on the Statewide Aligned Quality Measures menu developed by the Health Plan Quality Metrics Committee for CCOs, PEBB and OEBB plans, and the Oregon Health Insurance Marketplace. PEBB and OEBB contracts will include performance improvement targets for each measure and require that health plans put a portion of administrative fees or premiums paid to them at risk, with retention of at-risk dollars contingent on the plan achieving their targets. Performance improvement targets established for each measure will consider the health plan's current performance in comparison to national benchmarks, gold standard performance rates, and organizational priorities to achieve improvement in specific areas of health care quality.

Program performance

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

PEBB medical benefit design did not change significantly between 2017 and 2018. PEBB still continues to cover:

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

PEBB also limits out-of-pocket costs to:

- $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.

To date, PEBB health plan quality measures have been selected to align with the quality measures established for care delivered by coordinated care organizations. PEBB plans' performance levels are compared to national benchmarks for commercial health plans and improvement targets are set to ensure plans make continuous progress toward benchmark rates. For the 2017 plan year (most recent available) PEBB's contracted medical plans generally met their quality targets, as the plans are required to do to retain the fees placed at risk for quality performance. PEBB will continue to use quality metrics that align with OHA's overarching goals of system transformation and health outcomes improvement. PEBB will continue to look to best available regional and national benchmarking data to inform improvement targets.

Addressing health care inflation and implementing cost containment measures

Escalating trends in the cost of care industry-wide affects 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.
- Providing 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.

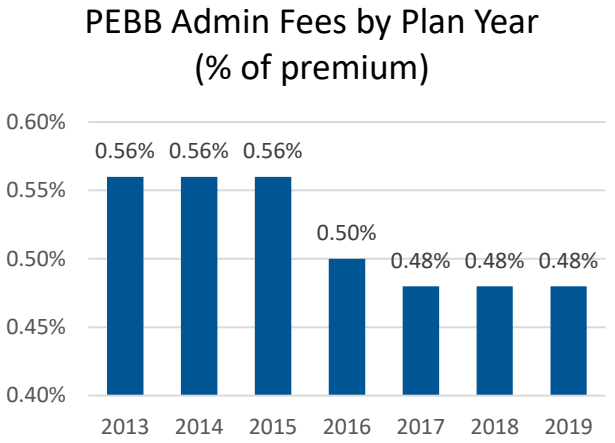
OREGON HEALTH AUTHORITY: PUBLIC EMPLOYEES' BENEFIT BOARD

Executive Summary

- 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

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

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

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

OREGON HEALTH AUTHORITY: PUBLIC EMPLOYEES' BENEFIT BOARD

Executive Summary

Significant proposed program changes from 2017-19

Senate Bill 1067 (2017 Legislative Session) cost containment bill

The SB 1067 Committee was formed in August 2017, meeting several times to discuss various models for merging the PEBB and OEBB boards. The goals of the committee reflected those as directed in SB 1067: to reduce overall costs, create efficiencies and eliminate duplication in the OEBB and PEBB programs. The SB 1067 Committee grappled with striking a balance between gaining efficiencies, limiting member disruption, ensuring financial sustainability and managing risk.

The bill's following directives are to be implemented by October 1, 2019, for OEBB and January 1, 2020, for PEBB:

- Appointing the PEBB executive director to also serve as the OEBB executive director in a permanent capacity.
- The OEBB/PEBB executive director to combine administrative and operational functions of the boards and report to the Legislature annually on the progress.
- A dependent eligibility audit must be performed by a third-party administrator every year.
- A request for proposals (RFP) for actuarial services must be completed every three years.
- The adoption of policies and procedures that limit annual premium increases and per member per month costs to a 3.4 percent cap.
- Limiting in-network hospital reimbursements to 200 percent of Medicare and out-of-network hospital reimbursements to 185 percent of Medicare (with certain exceptions).
- Prohibits "opt-out" for full cash incentives in lieu of coverage for OEBB or PEBB employees enrolled as a dependent on another OEBB or PEBB plan.
- Prohibits "double-coverage" for OEBB or PEBB employees who enroll as a subscriber on an OEBB or PEBB plan when already enrolled as a dependent on another OEBB or PEBB plan.

OREGON HEALTH AUTHORITY: PUBLIC EMPLOYEES' BENEFIT BOARD

Executive Summary

Implementation of Senate Bill 1067

The committee unanimously selected a hybrid merger of the OEBB and PEBB boards. The boards would maintain their separate legal structure and governance and create a combined "innovation" subgroup of the OEBB and PEBB boards and a "shared services" subgroup for administrative efficiencies. The board selected members for the Innovation Subgroup in the summer of 2018 and the subgroup began monthly meetings in the fall. Membership will include equal representation from the boards, and non-voting legislative members.

Reducing administrative costs

Senate Bill 1067 directed OEBB and PEBB to merge administrative functions and operations. Staff has started merging units in areas such as financial services, contracts, IT systems, member services, and communications. These steps have allowed PEBB to reduce its legislatively authorized position budget by 14 percent from the previous biennium.

PEBB	2015-17 Leg. Approved Budget	2017-19 Leg. Approved Budget	Staffing Decrease
Positions	22	19	(-14%)
FTE	21.50	18.50	(-14%)

OREGON HEALTH AUTHORITY: PUBLIC EMPLOYEES' BENEFIT BOARD

Program Unit Narrative: Public Employees' Benefit Board

Expenditures by fund type, positions and full-time equivalents

	General	Other	Federal	Total Funds	Pos.	FTE
Leg Approved 17-19	$0.0	$1,966.8	$0.0	$1,966.8	19	18.50
Governor's Budget 19-21	$0.0	$2,099.7	$0.0	$2,099.7	21	20.50
Difference	$0.0	$132.9	$0.0	$132.9	2	2.00
Percent Change	0%	7%	0%	7%	11%	11%

Activities, programs and issues in the program unit base budget

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

PEBB designs, contracts for and administers health plans, group policies and flexible spending accounts for PEBB members. More than 139,473 Oregonians are enrolled as 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.

OREGON HEALTH AUTHORITY: PUBLIC EMPLOYEES' BENEFIT BOARD

Program Unit Narrative: Public Employees' Benefit Board

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

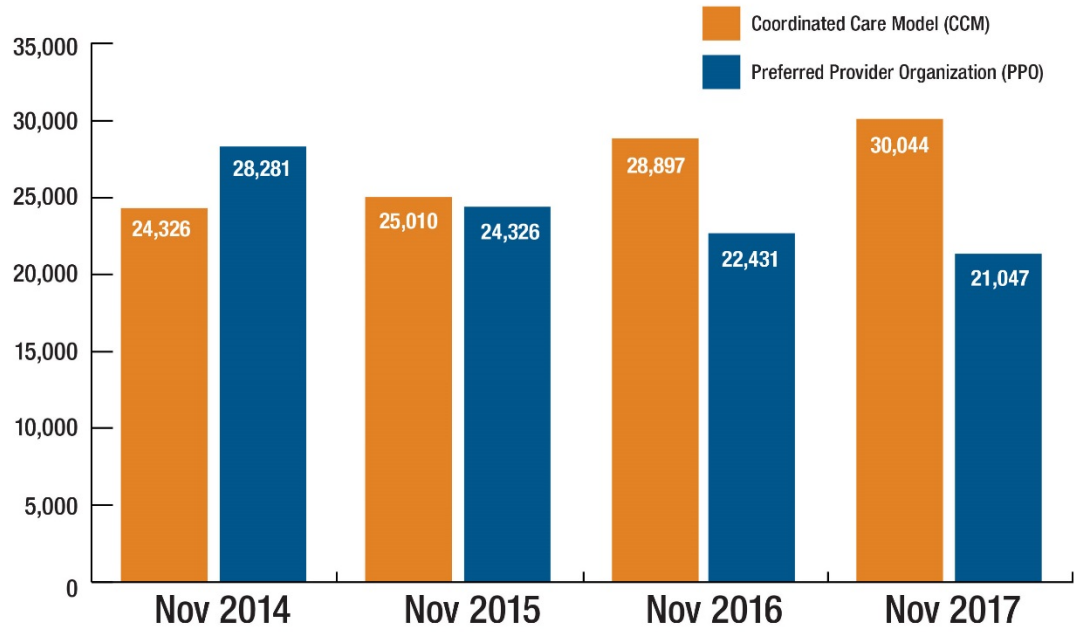
Transforming health care

The PEBB Board has made a priority of transforming the health care delivery system and envisions further advancing health care transformation with plans that coordinate care. PEBB has partnered with its "sister program" the Oregon Educators Benefit Board (OEBB) in the shared innovation strategy referred to as "Coordinated Care Model" plans. OEBB and PEBB believe the coordinated care model (CCM) is essential for achieving success in managing overall costs. PEBB offers coordinated care model health plans that use patient-centered medical homes to improve quality, enhance member experience, and contain costs. Both boards are continuing to add these systems of care throughout the state with a focus on integrated care and reducing health care costs and health disparities. The boards would like to further pursue plans and providers that use creative and innovative evidence-based practices.

In PEBB's implementation of coordinated care model plans the board focused on:

- Promoting alternative payment methodologies such as risk sharing and global payments for obstetrics and joint replacements.
- Integrating behavioral and physical health.
- Supporting the use of medical homes.
- Improving payments for primary care.
- Putting fees at risk for meeting agreed-upon outcome metrics.
- Managing costs to a 3.4 percent annual increase.

PEBB: Member migration from a PPO plan to a CCM plan



PEBB cost containment programs

Another shared innovation strategy revolves around the use of alternative payment models (APMs). Controlling premium costs is a major challenge for PEBB. Premium costs are affected by external drivers such as member utilization; lack of care coordination; inflation in health care costs, such as high prescriptions costs; and sedentary occupations that lead to long-term risks and chronic conditions.

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

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

Value-based benefits

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

- No or lowered costs for visits for diabetes, coronary artery disease, asthma and chronic obstructive pulmonary disease. Regular office visits keep people with these diagnoses out of the emergency room and hospital.
- No or lowered costs for medications that help prevent or manage chronic diseases such as statins for cholesterol, asthma inhalers and depression medications.

- Additional copayment for endoscopies, sleep studies and advanced imaging technologies (CT, MRI, PET scans).
- Additional copayment for shoulder and knee arthroscopic surgery, total knee and total hip joint replacement surgery.

These benefits were highlighted in the November 2010 issue of Health Affairs.

Wellness initiatives and promoting member health

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

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

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

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

PEBB/OEBB quality measures and fees-at-risk

In the 2019-21 biennium PEBB will continue to include quality measures and performance targets in health plan contracts to support movement toward better health, better care, and lower cost. The specific quality measures selected will be based on the Statewide Aligned Quality Measures menu developed by the Health Plan Quality Metrics Committee for CCOs, PEBB and OEBB plans, and the Oregon Health Insurance Marketplace. PEBB and OEBB contracts will include performance improvement targets on each measure and will require that health plans put at risk a portion of administrative fees or premiums paid to them, with retention of at-risk dollars contingent on the plan achieving its targets. Performance improvement targets established for each measure will consider the health plan's current performance in comparison to national benchmarks, gold standard performance rates, and organizational priorities to achieve identified rates of improvement in specific areas of health care quality.

Additional budget drivers

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

Background information

Senate Bill 1067 (2017 Legislative Session) cost containment bill

The SB 1067 Committee was formed in August 2017 and several times to discuss models for merging the two boards. The committee's goals reflected those in SB 1067: to reduce overall costs, create efficiencies and eliminate duplication in the OEBB and PEBB programs. The SB 1067 Committee grappled with striking a balance between gaining efficiencies, limiting member disruption, ensuring financial sustainability and managing risk.

The bill's following directives are to be implemented by October 1, 2019, for OEBB and January 1, 2020, for PEBB:

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- A request for proposals (RFP) for actuarial services must be completed every three years.
- The adoption of policies and procedures that limit annual premium increases and per member per month costs to a 3.4 percent cap.
- Limiting in-network hospital reimbursements to 200 percent of Medicare and out-of-network hospital reimbursements to 185 percent of Medicare (with certain exceptions).
- Prohibits "opt-out" for full cash incentives in lieu of coverage for OEBB or PEBB employees enrolled as a dependent on another OEBB or PEBB plan.
- Prohibits "double-coverage" for OEBB or PEBB employees who enroll as a subscriber on an OEBB or PEBB plan when already enrolled as a dependent on another OEBB or PEBB plan.

Implementation of Senate Bill 1067

The committee unanimously selected a hybrid merger of the OEBB and PEBB boards. The boards will maintain their separate legal structure and governance, and create a combined "innovation" subgroup of the OEBB and PEBB boards and a "shared services" subgroup for administrative efficiencies. The board selected members for the Innovation Subgroup in the summer of 2018 and the subgroup began monthly meetings in the fall. Membership will include equal representation from the boards and non-voting legislative members.

OREGON HEALTH AUTHORITY: PUBLIC EMPLOYEES' BENEFIT BOARD

Program Unit Narrative: Public Employees' Benefit Board

The Senate Bill 1067 Innovative Subgroup is tasked with:

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 population.
- Most PEBB members have sedentary occupations.
- PEBB members continue to migrate to coordinated care model plans year over year; however, 41 percent are still enrolled in the statewide preferred provider organization, the plan that offers least amount of coordinated care.
- ACA tax applied to all fully insured plans for 2017.

PEBB will be assessed a 1.5 percent premium tax for plan years 2018 and 2019. This tax will be paid using stabilization funds to reduce costs to employers and employees.

Reducing administrative costs

Senate Bill 1067 directed OEBB and PEBB to merge administrative functions and operations. Staff has started the process of merging units in areas such as financial services, contracts, IT systems, member services, and communications. These steps have allowed PEBB to reduce its legislatively authorized position budget by 14 percent from the previous biennium.

PEBB	2015-17 Leg. Approved Budget	2017-19 Leg. Approved Budget	Staffing Decrease
Positions	22	19	(-14%)
FTE	21.50	18.50	(-14%)

OREGON HEALTH AUTHORITY: PUBLIC EMPLOYEES' BENEFIT BOARD

Program Unit Narrative: Public Employees' Benefit Board

Revenue sources and proposed revenue changes

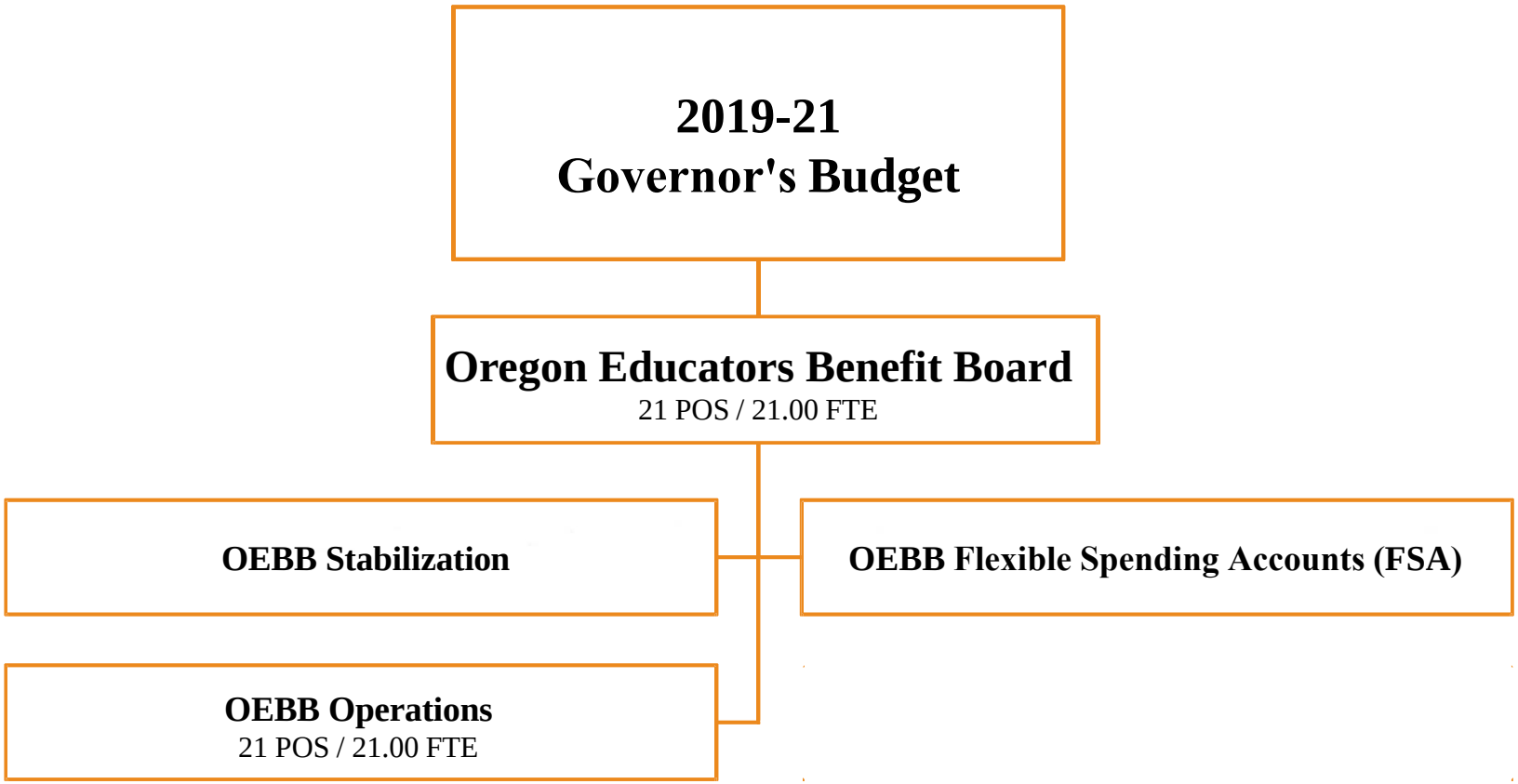
Other Funds revenue pays for PEBB administration through an administrative assessment added to medical and dental insurance premiums and premium equivalents. By statute (ORS 243.185), PEBB can collect an amount that equals up to 2 percent of total premiums to meet administrative and operational costs.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

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

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

Proposed new laws that apply to the program unit

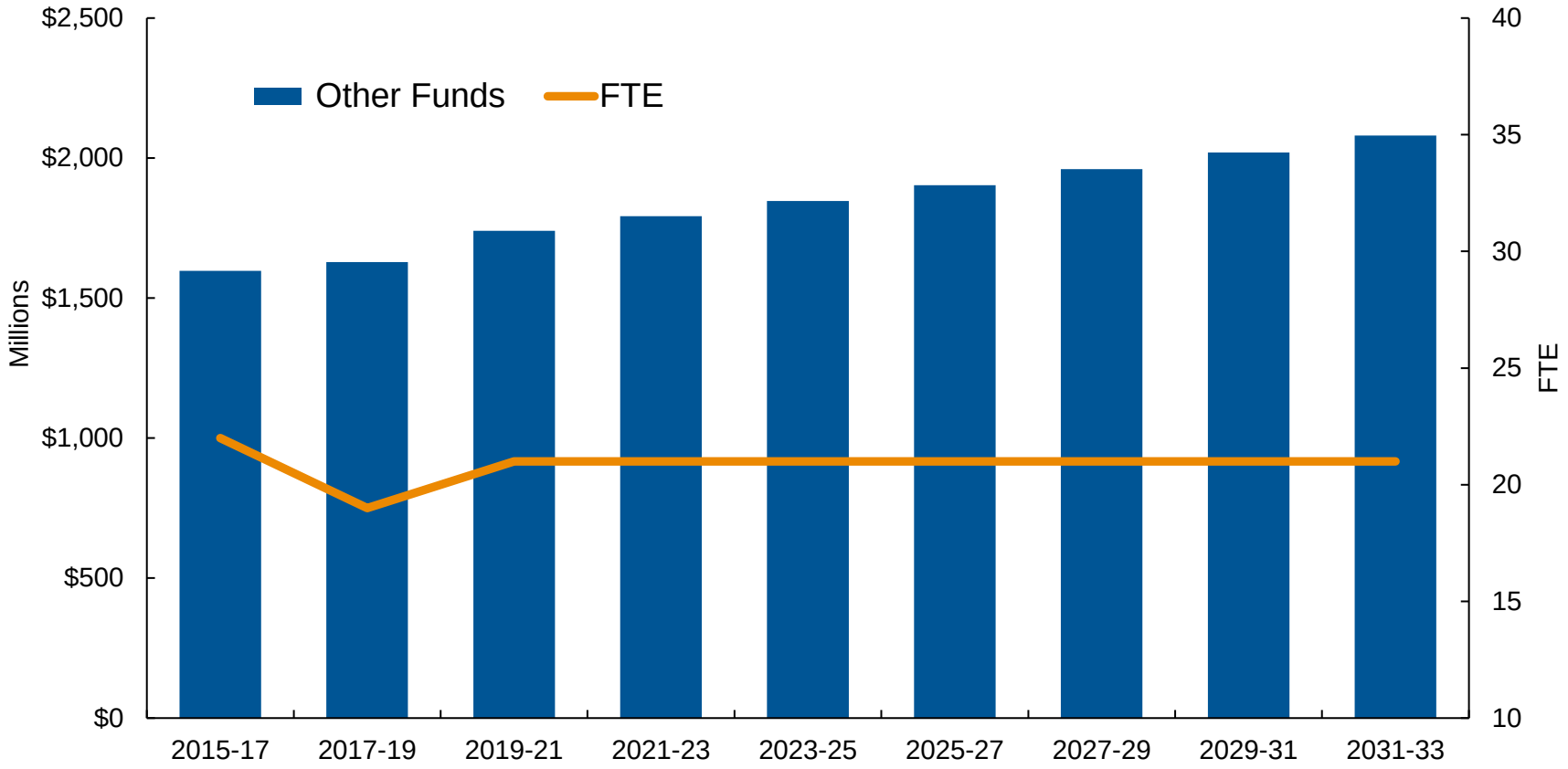
None.


2019-21
Governor's Budget
Oregon Educators Benefit Board
21 POS / 21.00 FTE
OEBB Stabilization
OEBB Flexible Spending Accounts (FSA)
OEBB Operations
21 POS / 21.00 FTE

OREGON HEALTH AUTHORITY: OREGON EDUCATORS BENEFIT BOARD

Executive Summary

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



OREGON HEALTH AUTHORITY: OREGON EDUCATORS BENEFIT BOARD

Executive Summary

Program overview

The Oregon Educators Benefit Board (OEBB) is a division of the Oregon Health Authority (OHA). It provides a comprehensive selection of benefit plan options for most of Oregon's K-12 school districts, education service districts and community colleges, as well as a number of charter schools and local governments. OEBB's plans are designed to be flexible and accommodate the needs of employers and members.

Program funding request

OEBB's proposal requests funding at the 2017-19 biennium level plus allowed inflation factors. It also requests cost growth for OEBB medical premiums at 3.4 percent for the 2018-19 plan year and 3.4 percent for the 2019-20 plan year. This will allow the program to continue to: achieve the goals set forth in the OEBB Board's guiding principles; promote and advance health care transformation in Oregon; provide its members a high level of customer service and access to reliable, high-quality and lower-cost health care from OHA-certified patient-centered primary care homes (PCPCHs) and recognized providers under coordinated care model health plans. The requested funding level will also allow OEBB to continue to promote ongoing improvement in the health of its members, making a major contribution to the overall health of Oregonians.

Program description

With a staff of 19, 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 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

Executive Summary

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.

Rising health care costs are a primary cost driver for OEBB. OEBB has recognized and taken steps to provide incentives for appropriate care and condition management through benefit plan design with the goal of containing costs:

- Members have no copayment, coinsurance, or deductible for office visits associated with management of certain chronic conditions (asthma, diabetes, cardiovascular disease and congestive heart failure).
- Value pharmacy benefit provides medications used to manage common chronic conditions with no copayment.
- Condition management and prevention programs offered at no out-of-pocket cost to members under OEBB and PEBB medical plans, including evidence-based programs for members living with a chronic condition and prevention programs that specifically target members at risk for development of diabetes.
- Additional copays were included to discourage the use of certain procedures and treatments that had less-invasive options that were equally effective.

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

- Reference pricing for joint replacement and gastric bypass services, setting a maximum amount the plan will pay for these services.
- Shared risk payment models for its Summit and Synergy medical plans.

OREGON HEALTH AUTHORITY: OREGON EDUCATORS BENEFIT BOARD

Executive Summary

Program justification and link to long-term outcomes

OEBB was established to eliminate the wide-ranging disparities among health plans offered by school districts and to respond to the rapidly rising costs of health care. A statewide pool such as OEBB creates purchasing power and avoids unstable premium swings experienced by school districts that have volatile claims experience. Streamlining administration and eliminating third-party fees and duplication of work were also large cost savers upon the formation of OEBB. School districts benefit from cost predictability and controlling of expenditures year-over-year. Since its inception in 2008, OEBB's average annual cost to members has increased at 2.9 percent annually.

Key components of the OEBB program

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

Transforming health care

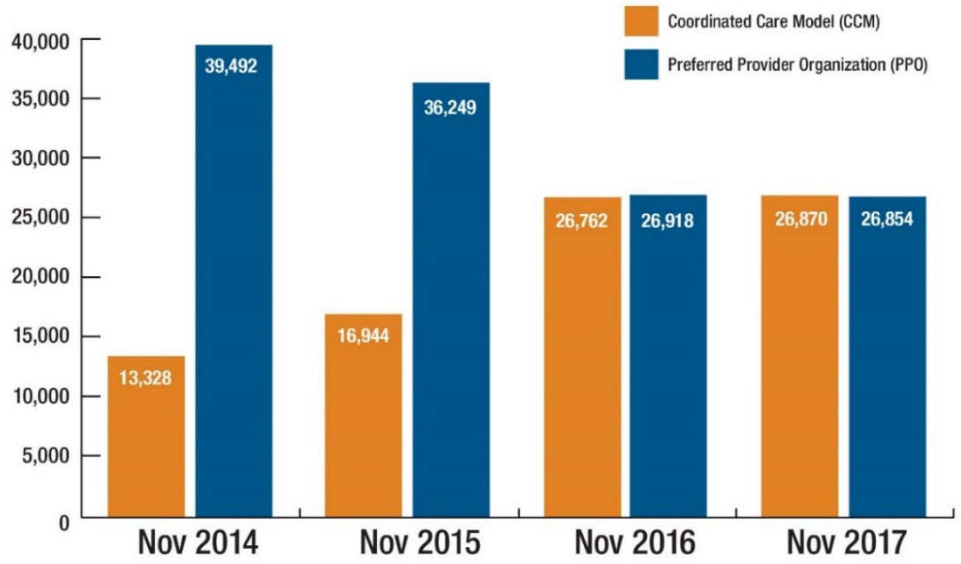
The OEBB board has made a priority of transforming the health care delivery system and envisions further advancing health care transformation with plans that coordinate care. OEBB has partnered with its "sister program" the Public Employees' Benefit Board (PEBB) in the shared innovation strategy referred to as "Coordinated Care Model" plans. Both boards are continuing to add these systems of care throughout the state with a focus on integrated care and reducing health care costs and health disparities.

OREGON HEALTH AUTHORITY: OREGON EDUCATORS BENEFIT BOARD

Executive Summary

The following graphic illustrates OEBB members moving from a preferred provider organization (PPO) plan to a coordinated care model (CCM) plan with a lower premium share.

OEBB Member migration from a PPO plan to a CCM



OEBB quality measures and fees at risk

In the 2019-21 biennium OEBB will continue to include quality measures and performance targets in health plan contracts to support movement toward better health, better care, and lower cost. The specific quality measures selected will be based on the Statewide Aligned Quality Measures menu developed by the Health Plan Quality Metrics Committee for CCOs, PEBB and OEBB plans, and the Oregon Health Insurance Marketplace. PEBB and OEBB contracts will include performance improvement targets on each measure. Plans will be required to put a portion of administrative fees or premiums paid to them at risk, with retention of at-risk dollars contingent on the plan achieving its targets. Performance improvement targets established for each

Executive Summary

measure will consider the health plan's current performance in comparison to national benchmarks, gold standard performance rates, and organizational priorities to achieve identified rates of improvement in specific areas of health care quality.

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

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.

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.

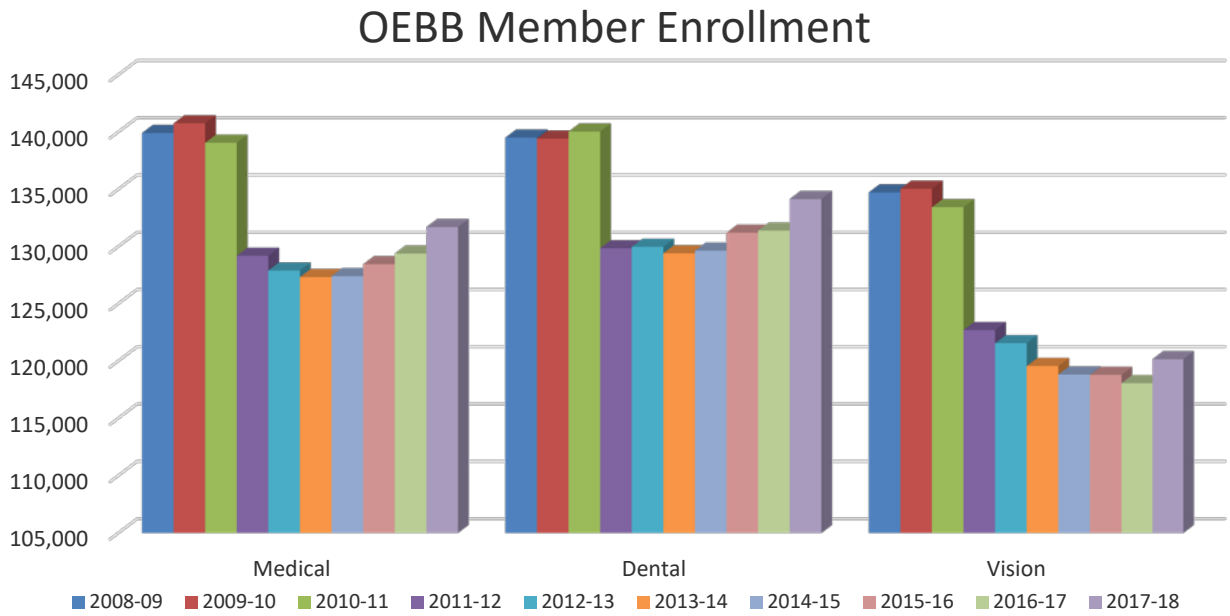
OREGON HEALTH AUTHORITY: OREGON EDUCATORS BENEFIT BOARD

Executive Summary

- Cultivate a customer service culture.
- Create a financially sustainable organization.

Benefit highlights for the 2018-19 plan year

- Life and disability plan rates have decreased.
- Phone counseling sessions added to the Employee Assistance Program.
- Kaiser Permanente expanding in to Eugene/Springfield area effective October 1, 2018.
- HSA compatible plans will no longer require an HSA contribution.



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

OREGON HEALTH AUTHORITY: OREGON EDUCATORS BENEFIT BOARD

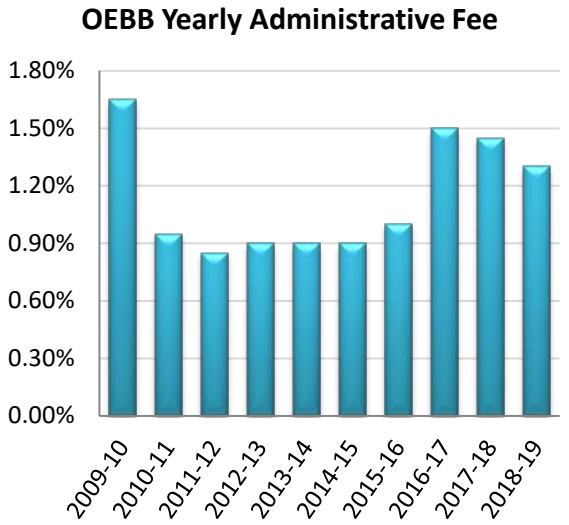
Executive Summary

Enabling legislation/program authorization

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

Funding streams

OEBB is funded entirely with Other Funds. ORS 243.880 authorizes the Oregon Educators Benefit Account to cover administration expenses. The account's revenue is generated by an administrative assessment paid by members along with their premiums. The administrative assessment cannot exceed 2 percent of total monthly premiums. As of the 2017-18 plan year, the administrative fee is 1.45 percent. The OEBB Board voted to decrease the fee to 1.30 percent effective October 1, 2018, for the 2018-19 plan year. The decrease will maintain funding at an appropriate level. The administrative fee is the sole source of revenue for the OEBB benefits program.



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 2017-19

Senate Bill 1067 (2017 Legislative Session) cost containment bill

The SB 1067 Committee was formed in August 2017, meeting several times to discuss various joint board models for merging the two boards. The goals of the committee reflected those as directed in SB 1067: to reduce overall costs, create efficiencies and eliminate duplication in the OEBB and PEBB programs. The SB 1067 Committee grappled with striking a balance between gaining efficiencies, limiting member disruption, ensuring financial sustainability and managing risk.

OREGON HEALTH AUTHORITY: OREGON EDUCATORS BENEFIT BOARD

Executive Summary

The bill's following directives are to be implemented by October 1, 2019, for OEBB and January 1, 2020, for PEBB:

- Appointing the PEBB executive director to also serve as the OEBB executive director in a permanent capacity.
- The OEBB/PEBB executive director to combine administrative and operational functions of the boards and report to the Legislature annually on the progress.
- A dependent eligibility audit must be performed by a third-party administrator every year.
- A request for proposals (RFP) for actuarial services must be completed every three years.
- The adoption of policies and procedures that limit annual premium increases and per member per month costs to a 3.4 percent cap.
- Limiting in-network hospital reimbursements to 200 percent of Medicare and out-of-network hospital reimbursements to 185 percent of Medicare (with certain exceptions).
- Prohibits “opt-out” for full cash incentives in lieu of coverage for OEBB or PEBB employees enrolled as a dependent on another OEBB or PEBB plan.
- Prohibits “double-coverage” for OEBB or PEBB employees who enroll as a subscriber on an OEBB or PEBB plan when already enrolled as a dependent on another OEBB or PEBB plan.

Implementation of Senate Bill 1067

The committee unanimously selected a hybrid merger of the OEBB and PEBB boards. The boards would maintain their separate legal structure and governance and create a combined “innovation” subgroup of the OEBB and PEBB boards and a “shared services” subgroup for administrative efficiencies. The board selected members for the Innovation Subgroup in the summer of 2018 and the subgroup began monthly meetings in the fall. Membership will include equal representation from the boards, and non-voting legislative members.

OREGON HEALTH AUTHORITY: OREGON EDUCATORS BENEFIT BOARD

Executive Summary

The SB 1067 Innovative Subgroup is tasked with 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.
- New state premium tax on all fully insured plans.

Legislative cap on premium rate increases

- Limiting renewal rate increases at or below the 3.4 percent 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.

Reducing administrative costs

SB 1067 directed OEBB and PEBB to merge administrative functions and operations. Staff has started the process of merging units in areas such as financial services, contracts, IT systems, member services, and communications. These steps have allowed OEBB to reduce its legislatively authorized position budget by 14 percent from the previous biennium.

OEBB	2015-17 Leg. Approved Budget	2017-19 Leg. Approved Budget	Staffing Decrease
Positions	22	19	(-14%)
FTE	22.00	19.00	(-14%)

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	Federal	Total Funds	Pos.	FTE
Leg Approved 17-19	$0.0	$1,628.9	$0.0	$1,628.9	19	19.00
Governor's Budget 19-21	$0.0	$1,740.4	$0.0	$1,740.4	21	21.00
Difference	$0.0	$0.0	$0.0	$0.0	0	0.00
Percent Change	0%	0%	0%	0%	0%	0%

Activities, programs and issues in the program unit base budget

The Oregon Educators Benefit Board (OEBB) was established by the 2007 Legislature. OEBB provides a comprehensive selection of benefit plan options for most of Oregon's K-12 school districts, education service districts and community colleges, as well as a number of charter schools and local governments across the state. OEBB provides benefits for 152,585 individuals, including actively employed and retired subscribers and their dependents. OEBB offers a multitude of plans that resemble an "exchange." OEBB started offering medical, dental, and vision coverage in 2008 and has since added a broad range of additional benefits including life, accidental death and dismemberment (AD&D), short-term and long-term disability and long-term care insurance, as well as an employee assistance program (EAP), a health savings account (HSA), flexible spending accounts (FSAs), and commuter savings accounts. Each of the 249 employer entities OEBB serves maintains a unique service area, eligibility requirements, cost sharing, and population. OEBB's plans are designed to be flexible and accommodate the needs of all employers participating in OEBB and the members enrolled in OEBB plans.

The purpose in creating OEBB was to eliminate the wide-ranging disparities among health plans offered by school districts and to respond to the rapidly rising costs of health care. A statewide pool such as OEBB creates purchasing power and avoids unstable premium swings experienced by school districts that have volatile claims experience. Streamlining administration and

eliminating third-party fees and duplication of work were also large cost savers upon the formation of OEBB. School districts benefit from cost predictability and controlling of expenditures year-over-year. Since its inception in 2008, OEBB's average annual cost to members has increased at 2.9 percent annually. OEBB's authority lies in ORS 243.860 through ORS 243.886. House Bill 2279 (2013) expanded participation eligibility to include local governments and special districts.

Key components of the OEBB program

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

Transforming health care

The OEBB Board has made a priority of transforming the health care delivery system and envisions further advancing health care transformation with plans that coordinate care. OEBB has partnered with its "sister program" the Public Employees' Benefit Board (PEBB) in the shared innovation strategy referred to as "Coordinated Care Model" plans. OEBB and PEBB believe the coordinated care model (CCM) is essential for achieving success in managing overall costs. OEBB offers coordinated care model health plans that use "organized systems of care" to improve quality, enhance member experience, and contain costs. Both boards are continuing to add these systems of care throughout the state with a focus on integrated care and reducing health care costs and health disparities. The boards would like to further pursue plans and providers that use creative and innovative evidence-based practices.

OREGON HEALTH AUTHORITY: OREGON EDUCATORS BENEFIT BOARD

Program Unit Narrative: Oregon Educators Benefit Board

OEBB introduced new medical plans for the 2016-17 plan year. As the board evaluated plan offerings, it 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. Strategies included:

- Engage employers at regular intervals to ensure the affordability definition remains relevant to all participating entities.
- Monitor and audit utilization and plan performance to ensure high quality benefits.
- Incorporate criteria specific to legislative cost requirements (3.4 percent renewal increase cap) into carrier contracts.
- Require proposers to outline their plans and specific steps they will take to promote these criteria in medical offices and care locations around the state.

Organized systems of care

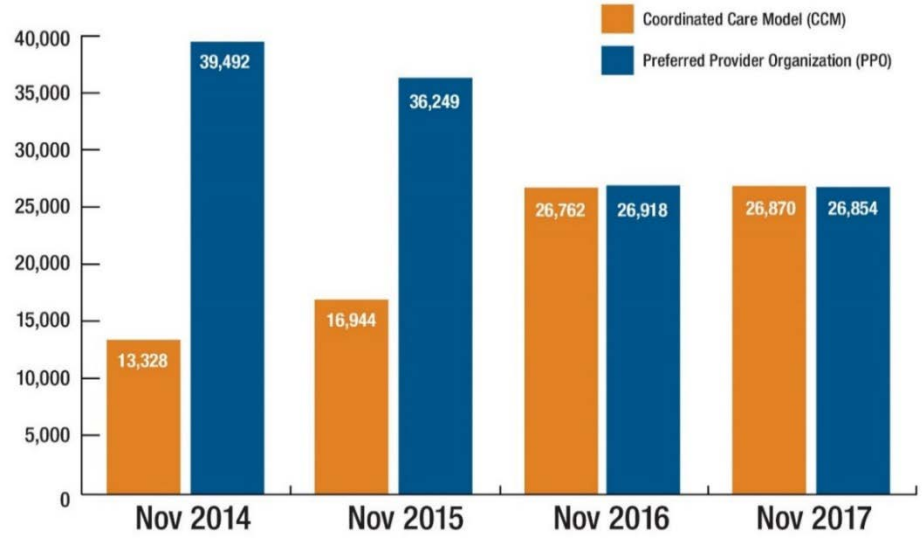
Systems of care are designed to support advanced primary care, coordinate providers across the continuum of care, and engage in risk-sharing arrangements focused on appropriately managing care. OEBB expanded its regional systems of care, which provide members improved, better-integrated care at an affordable cost. Regional systems of care focus on primary care and prevention and encourage members to share responsibility for their own health outcomes.

- Coordinate care and improve access to services.
- Integrate coordinated, patient-centered care – physical, mental and dental.
- Demonstrate better health outcomes.
- Embrace alternative payment models.
- Engage new partnerships and strengthen existing ones, including:
    - Primary Care Payment Reform Collaborative.
    - Health Plan Quality Metrics Committee to support adoption of aligned quality incentives.
    - Pharmacy Cost Collaborative

Program Unit Narrative: Oregon Educators Benefit Board

The following graphic illustrates OEBB members moving from a preferred provider organization (PPO) plan to a coordinated care model (CCM) plan with a lower premium share:

OEBB: Member migration from a PPO plan to a CCM plan



OEBB cost containment programs

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

- Members have no copayment, coinsurance, or deductible for office visits associated with management of certain chronic conditions (asthma, diabetes, cardiovascular disease and congestive heart failure).
- Value pharmacy benefit provides medications used to manage common chronic conditions with no copayment.
- Condition management and prevention programs offered at no out-of-pocket cost to members under OEBB and PEBB medical plans, including evidence-based programs for members living with a chronic condition and prevention programs that specifically target members at risk of developing diabetes.

Program Unit Narrative: Oregon Educators Benefit Board

OEBB quality measures and fees at risk

In the 2019-21 biennium OEBB will continue to include quality measures and performance targets in health plan contracts to support movement toward better health, better care, and lower cost. The specific quality measures selected will be based on the Statewide Aligned Quality Measures menu developed by the Health Plan Quality Metrics Committee for CCOs, PEBB and OEBB plans, and the Oregon Health Insurance Marketplace. PEBB and OEBB contracts will include performance improvement targets on each measure and will require that health plans put at risk a portion of administrative fees or premiums paid to them, with retention of at-risk dollars contingent on the plan achieving its targets. Performance improvement targets for each measure will consider the health plan's current performance in comparison to national benchmarks, gold standard performance rates, and organizational priorities to achieve identified rates of improvement in specific areas of health care quality.

Wellness initiatives and promoting member health

OEBB supports prevention and member wellness by offering members no-cost programs:

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

Background information

Senate Bill 1067 (2017 Legislative Session) cost containment bill

The SB 1067 Committee was formed in August 2017 and met several times to discuss models for merging the two boards. The committee's goals as directed by SB 1067 were to reduce overall costs, create efficiencies and eliminate duplication in the OEBB and PEBB programs. The SB 1067 Committee grappled with striking a balance between gaining efficiencies, limiting member disruption, ensuring financial sustainability and managing risk.

OREGON HEALTH AUTHORITY: OREGON EDUCATORS BENEFIT BOARD

Program Unit Narrative: Oregon Educators Benefit Board

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Implementation of Senate Bill 1067

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OREGON HEALTH AUTHORITY: OREGON EDUCATORS BENEFIT BOARD

Program Unit Narrative: Oregon Educators Benefit Board

The SB 1067 Innovative Subgroup is tasked with:

Controlling premium costs

Premium costs are affected by external drivers, such as:

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- Prevalence of chronic conditions.
- Significant percent of population are obese or overweight.
- New state premium tax on all fully insured plans.

Legislative cap on premium rate increases

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

Reducing administrative costs

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OREGON HEALTH AUTHORITY: OREGON EDUCATORS BENEFIT BOARD

Program Unit Narrative: Oregon Educators Benefit Board

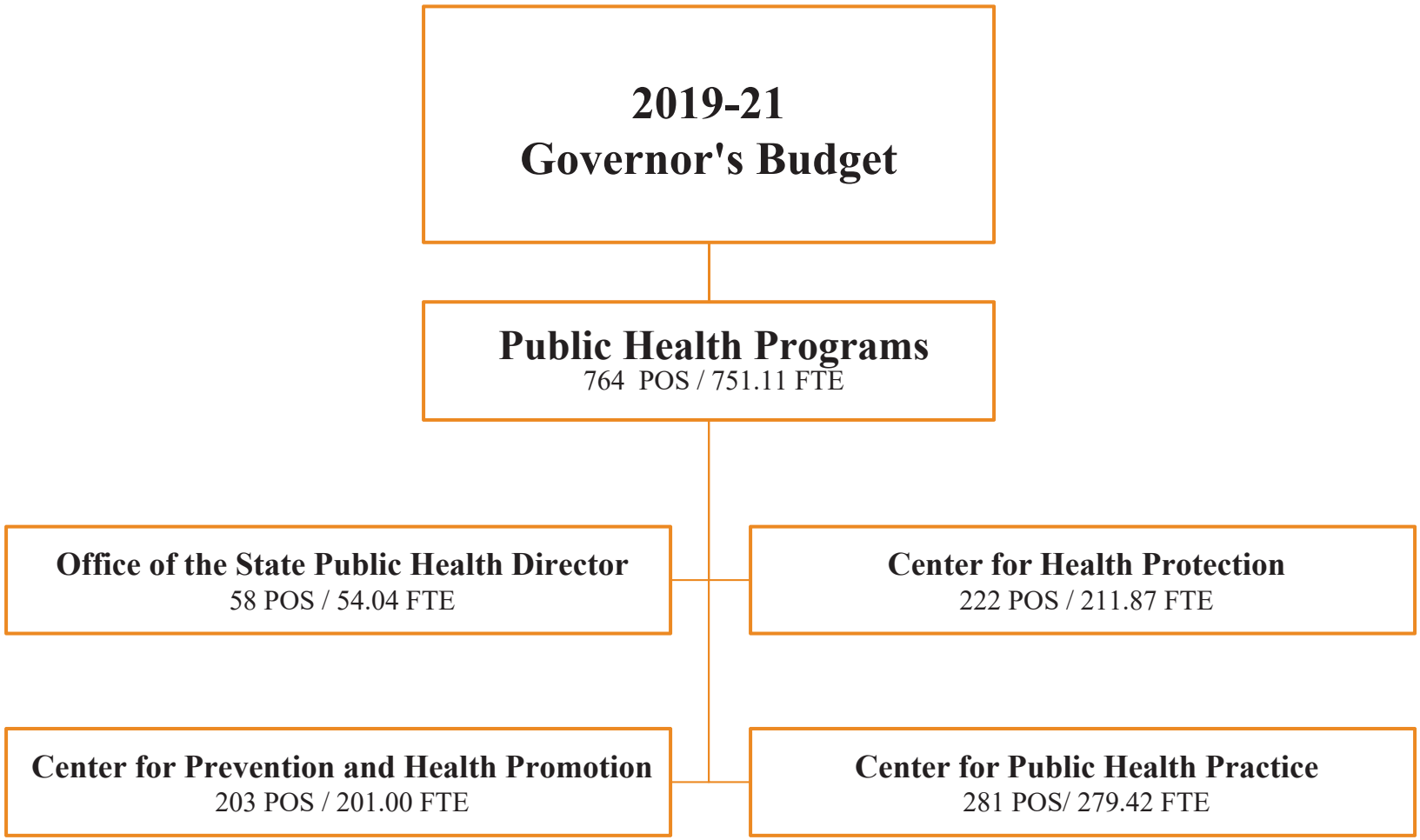
Revenue sources and proposed revenue changes

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

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

Proposed new laws that apply to the program unit

None.

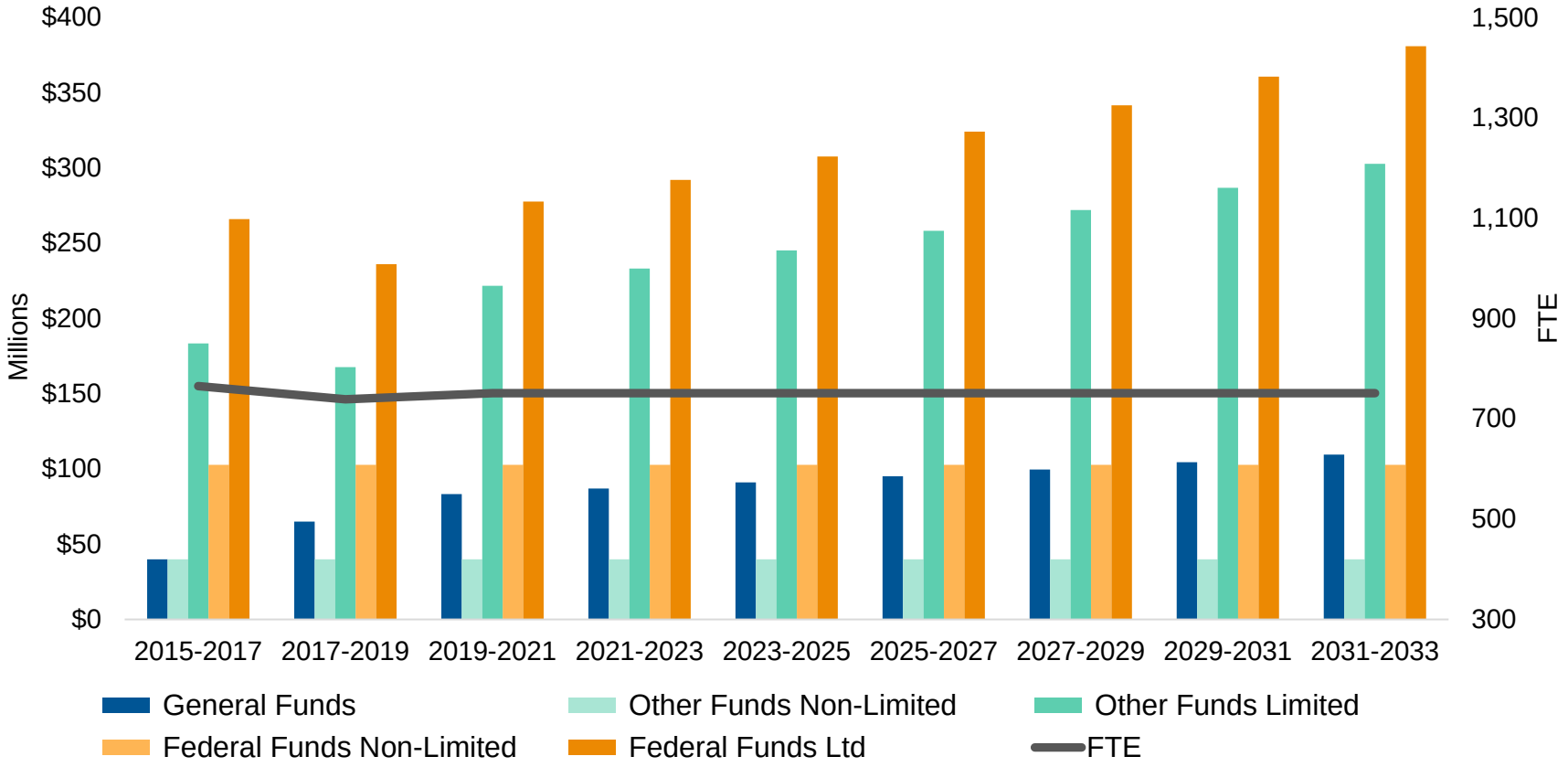


Oregon Health Authority

OREGON HEALTH AUTHORITY: PUBLIC HEALTH DIVISION

Executive Summary

Program contact: Lillian Shirley, Public Health Director
971-673-1300



OREGON HEALTH AUTHORITY: PUBLIC HEALTH DIVISION

Executive Summary

Program overview

Public health is a proven 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.

Program funding request

The Governor's Budget of $725.4 million Total Funds continues funding for Public Health programs at the current service level for 2019-21 and includes policy packages aimed at improving the lifelong health of all people in Oregon by supporting child and family well-being, advancing public health modernization by reducing communicable disease risks and increasing surveillance and response and strengthening local health infrastructure in more Oregon communities.

The Public Health Division's budget for 2019-21 includes $18.0 million in Other Funds limitation and $17.3 million in Federal Funds limitation for a new indirect costs rate for division-wide expenses. These costs do not represent new expenditures nor a funding increase and are excluded from statewide reporting.

Program description

The Public Health Division's (OHA-PHD) mission is to promote health and prevent the leading causes of death, disease and injury in Oregon. The OHA-PHD vision is lifelong health for all people in Oregon. To achieve this vision, the PHD 2017-2020 Strategic Plan includes two goals: promote and protect safe, healthy and resilient environments to improve quality of life and prevent disease; and strengthen public health capacity to improve health outcomes.

Oregon's State Health Improvement Plan (SHIP) aims to address leading causes of death and disability in Oregon, and includes seven focus areas: preventing and reducing tobacco use; slowing the increase of obesity; improving oral health; reducing harms associated with alcohol and substance use; preventing deaths from suicide; improving immunization rates; and protecting the population from communicable diseases.

OREGON HEALTH AUTHORITY: PUBLIC HEALTH DIVISION

Executive Summary

OHA-PHD is a part of a broader governmental public health system, which includes the federal government as well as local and tribal public health authorities. Public health services are delivered either directly by PHD or through contracts with local and tribal public health authorities, clinics and nonprofit organizations. The major cost drivers to Oregon's public health system are the increasing volume of public health threats and a consistent decrease in federal funding over time.

Oregon's public health modernization effort includes rethinking business practices so they align with current public health threats. A modernized public health system will provide core public health functions and maintain the flexibility needed to focus on new health challenges, which include emerging infectious diseases, climate change, threats from human-caused and natural disasters, and an increase in chronic diseases. The Public Health Advisory Board recently adopted public health accountability metrics, which monitor the progress of Oregon's public health system over time. Many of the public health accountability metrics align with Coordinated Care Organization (CCO) incentive metrics so that the public health and Medicaid system are working together toward common goals.

Program justification and link to long-term outcomes

Public health programs help drive down health care costs and improve outcomes through the prevention of disease. OHA-PHD uses evidence-based and culturally appropriate interventions to perform its work. OHA-PHD collects health data to determine what populations and conditions to prioritize to have the greatest impact and to evaluate programs and improve quality.

Program performance

OHA-PHD has a strong system of performance measurement and quality improvement for its programs, including data related to the return on investment for many of these programs. Specifically, OHA-PHD collects and reports annually on SHIP health outcome measures, which are also reflected in the Oregon Health Authority Key Performance Measures; public health accountability measures; and OHA-PHD Strategic Plan measures.

OREGON HEALTH AUTHORITY: PUBLIC HEALTH DIVISION

Executive Summary

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 a wide range of public health activities carried out by state public health and its county partners. Federally-funded public health programs are implemented according to federal laws.

Funding streams

For the 2019-21 biennium, OHA-PHD's budget comprises 12 percent General Fund, 52 percent Federal Funds and 36 percent Other Funds. Federal revenue sources include Medicaid (with 90-10 match for contraceptive care) as well as more than 90 grants that are each dedicated to different public health programs such as emergency preparedness and hospital preparedness, cancer prevention and control, and safe drinking water.

In addition, OHA-PHD's Other Fund revenue sources include fees for activities in such areas as newborn screening tests (including test services for three 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. Typically, fees are entirely dedicated to supporting the program that assesses the fee, except Medical Marijuana program funds, which are legislatively approved to support additional public health programs.

Significant proposed program changes from 2017-19

In the 2019-21 biennium, the Governor's Budget continues advancements in public health modernization by using a proposed increase in tobacco tax to further close the funding gap in communicable disease response system recognized in the 2016 public health assessment. Additional investment allows for timely response to emerging public health issues and modernized methods for data collection and reporting.

OREGON HEALTH AUTHORITY: PUBLIC HEALTH DIVISION

Executive Summary

Fee changes are proposed to maintain sufficient funding for services that ensure all public drinking water systems are safe and to implement the last phase of the 2015 Toxic-Free Kids Act.

OHA-PHD will launch the Maternal Morbidity and Mortality Review Committee and the Advanced Directives Adoption Committee, as directed by the Legislature during the 2018 legislative session.

OHA-PHD continues to be primarily funded through federal grants. During the 2017-19 biennium, several federal grants decreased or remained flat funded. This decline in federal funding is expected to continue during the 2019-21 biennium and the programs will need to adjust services accordingly.

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	Federal	Total Funds	Pos.	FTE
Leg Approved 17-19	$11.7	$13.5	$7.4	$32.6	52	50.73
Governor's Budget 19-21	$17.9	$27.6	$18.0	$63.5	58	54.04
Difference	$6.2	$14.1	$10.6	$30.9	6	3.31
Percent Change	53%	104%	143%	95%	12%	7%

The Governor's Budget continues funding for the Office of the State Public Health Director programs at the current service level for 2019-2021. This budget also includes funding to further advance public health modernization and to backfill state support for local public health which provides funding for communicable disease surveillance and investigation in local communities. Policy package 405 allocates revenue from the proposed increase on tobacco products outlined in Legislative Concept 388 to public health modernization efforts.

Activities, programs and issues in the program unit base budget

The Office of the State Public Health Director (OSPHD) guides the strategy, operations, scientific activities, communication and policies of all public health programs and ensures that Oregon's public health system is effective, efficient and coherent. The office sets state and division-wide public health priorities in collaboration with state and local agencies and organizations. Under the leadership of the OSPHD, the state public health system is organized by three centers: Center for Public Health Practice, Center for Prevention and Health Promotion, and Center for Health Protection.

OSPHD provides scientific, fiscal, policy and operations leadership to all public health programs and is organized into three units: Fiscal and Business Operations, Science and Epidemiology, and Policy and Partnerships.

OREGON HEALTH AUTHORITY: PUBLIC HEALTH DIVISION

Program Unit Narrative: Office of the State Public Health Director

The Fiscal and Business Operations Unit manages the Oregon Health Authority Public Health Division (OHA-PHD) budget process, fiscal management, contracts, human resources, building operations, risk and safety, business continuity, volunteer coordination, quality improvement activities and workforce development.

The Science and Epidemiology Unit includes population health data collection and reporting, program evaluation, clinical aspects of state public health service delivery, and ethical review of public health studies involving human subjects through the OHA-PHD Institutional Review Board.

The Policy and Partnerships Unit is responsible for developing and implementing public policy and executing division and statewide plans, including Oregon's State Health Improvement Plan (SHIP) and the OHA-PHD Strategic Plan. The unit develops systems across OHA-PHD to improve health equity; coordinates with the Legislature; and cultivates strategic partnerships with local public health authorities, federally-recognized tribes, community-based organizations, coordinated care organizations and other state agencies.

The Policy and Partnerships Unit manages efforts to further advance health equity across OHA-PHD by facilitating a division-wide health equity workgroup charged with accomplishing three broad goals:

1. Fostering a shared understanding of and will to achieve health equity, cultural responsiveness, and trauma-informed approaches in the Public Health Division;
2. Adopting organizational structures, policies, and systems as described in the Public Health Modernization Manual to advance health equity, diversity, and cultural responsiveness in OHA-PHD; and
3. Adopting policies, systems, and structures to engage non-dominant groups as described in the Public Health Modernization Manual to co-create objectives and metrics for goals set forth in the health equity workgroup work plan.

Program Unit Narrative: Office of the State Public Health Director

The work to accomplish these goals includes:

- Revisiting previous health equity assessments and plans to identify gaps.
- Developing and implementing a communication plan to advance health equity.
- 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 OHA-PHD's ability to detect and locate inequities in communities.
- Finding opportunities to increase the collection of race, ethnicity, language and disability (REAL D) data, highlighting the most striking inequities, and communicating those to key stakeholders and partners.
- Examining data on the social determinants of health by race, ethnicity and language, gender identity, place, and poverty status.
- Selecting, designing, implementing and evaluating additional health equity strategies for Oregon's 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 workforce diversity.

Background information

OSPHD responds to public health issues by providing leadership and oversight to public health programs that:

- Protect health through public health regulations.
- Identify and respond to disease outbreaks.
- Develop public health policies, systems and environmental changes that prevent disease and promote optimal health for every person in Oregon.

Program Unit Narrative: Office of the State Public Health Director

OSPHD 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 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 local public health authorities and federally recognized tribes. 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 Transportation, Education, Environmental Quality, and other divisions within the Oregon Health Authority.

OSPHD is responsible for maintaining OHA-PHD's status as a nationally accredited health department. This includes development of an annual report and ongoing support for three prerequisites: a state health assessment, a state health improvement plan, and an organizational strategic plan, developed every five years. In 2017-18, OSPHD collected data needed for Oregon's State Health Assessment, which includes a set of quantitative State Population Health Indicators available by race/ethnicity and county. State Population Health Indicators are updated annually and serve as the backbone for OSPHD's reporting of OHA-PHD's key metrics, including key performance measures, Oregon's State Health Improvement Plan (SHIP) measures, and public health accountability measures. OSPHD continues to prioritize implementation of the REAL D law and support the use of data to identify and meaningfully address health disparities. In the 2017-19 biennium, OSPHD is working with partners to analyze the State Health Assessment and identify priorities for the 2020-2024 SHIP. OSPHD will also work with partners to set measurable objectives and develop statewide strategies for achieving health goals for people in Oregon between 2020 and 2024.

While work on the State Health Assessment and future SHIP continues, OSPHD is also supporting implementation of the current 2015-2019 SHIP. That plan includes seven priority areas organized by health equity interventions, population-

wide interventions and health system interventions. OHA-PHD anticipates that the SHIP, when fully implemented, will contribute to substantial improvements in the health of people in Oregon and cost savings to the health care delivery system. The seven priority areas included in Oregon's SHIP are:

- 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.

Progress on SHIP objectives is reported annually on the OHA-PHD website.

To implement the SHIP, OSPHD works closely with OHA-PHD programs to implement evidence-based strategies in partnership with health care, community-based organizations, state agencies and other key partners. OSPHD partners with the OHA Transformation Center to help implement 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.

Since 2013 OSPHD has provided leadership for Oregon's public health modernization initiative. This effort began with House Bill 2348 (2013), which established the Task Force on the Future of Public Health Services, recommendations from which were used to create House Bill 3100 (2015). Since then, the Office of the State Public Health Director has worked to implement House Bill 3100, which:

Program Unit Narrative: Office of the State Public Health Director

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

Further refinements to the implementation of public health modernization were made with the passage of House Bill 2310 (2017). For the 2017-19 biennium, the Legislature made an initial $5 million General Fund investment in public health modernization. In November 2017 OSPHD awarded $3.9 million of this investment in eight regions of the state, collectively covering 33 of Oregon's 36 counties. At the local level, the public health modernization investment is being used to:

- Work across local public health authorities, in partnership with regional health equity coalitions, tribes, coordinated care organizations, health care providers, hospitals, education and other partners to address the leading communicable disease risks in each region.
- Assess communicable disease-related health disparities and develop a health equity plan to improve health among populations most at risk for communicable diseases within the region.

OSPHD is using the remaining $1.1 million to:

- Provide technical assistance and support to local public health modernization grantees and coordinate statewide communicable disease control efforts.
- Collect and report population health data by race/ethnicity and county.

Program Unit Narrative: Office of the State Public Health Director

- Evaluate the effectiveness of the public health modernization investment, including annual collection and reporting of public health accountability measures.
- Support statewide interventions to improve immunization delivery.

Per ORS 431.123, the Public Health Advisory Board, a 17-member committee of the Oregon Health Policy Board, supports implementation of public health modernization. The Public Health Advisory Board also oversees Oregon's State Health Assessment, SHIP and the Preventive Health and Health Services Block Grant. The Public Health Advisory Board has two subcommittees:

- The Incentives and Funding Subcommittee is charged with developing a formula for distributing state funds for local public health authorities using the criteria set forward in ORS 431.380.
- The Accountability Metrics Subcommittee manages a series of quality measures for which state and local public health authorities will be financially accountable through the implementation of public health modernization.

The Public Health Advisory Board has adopted a health equity policy and procedure to ensure all board decisions promote equity and do not promote or further health disparities. The local public health authority funding formula includes several variables related to health equity so that future General Fund resources can be targeted to communities experiencing the greatest burden of poor health outcomes.

OSPHD continues to lead OHA-PHD's performance improvement efforts and has established performance dashboards for each of the division's programs as well as a monthly reporting and review process. A new robust, agency-wide performance management system will replace current processes late in the 2017-19 biennium.

Revenue sources and proposed revenue changes

The 2019-21 budget for the Office of the State Public Health Director is composed of 43 percent Other Funds, 28 percent Federal Funds (primarily through the agency's federally approved cost allocation plan), and 28 percent General Fund. Of the General Fund, 51 percent is pass-through funding to local health departments to support local communicable disease outbreak surveillance. The remaining General Fund is used to meet state participation requirements under the agency's federally approved cost allocation plan.

The 2019-21 Governor's Budget includes funding to continue the implementation of the provisions included in HB 3100 (2015), the Modernization of the Public Health system. In 2017-19, the Legislature appropriated $5 million General Fund to help OHA-PHD and local public health authorities address public health system gaps and build a sustainable infrastructure to support public health modernization in the long term. The additional investment will fill the health equity and communicable disease investigation service gaps as documented in the 2016 comprehensive assessment of state and local public health. This funding will also provide data needed to monitor public health problems by modernizing how public health collects and reports data to inform timely and fact-based decision making. A large portion of this new investment will fund local and tribal public health authorities to carry out public health interventions in communities experiencing the greatest burden of poor health outcomes. A smaller portion will fund positions and contracts at the state level that are essential for the delivery of public health protections and coordination across the public health system to ensure services are delivered effectively and efficiently.

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. The Governor's Budget includes $5.5 million General Fund in policy package 417 that continues support for local communicable disease outbreak surveillance at the current service level. This General Fund replaces Oregon Medical Marijuana Program (OMMP) revenues which are no longer available to support other public health programs.

Proposed new laws that apply to the program unit

Senate Bill 253: This concept refines existing statutes to allow for better management of the transfer of local public health authority to OHA-PHD.

House Bill 2270: Tobacco is the leading cause of preventable death and disease in Oregon. Through increases in the price of tobacco, this legislative concept would reduce cigarette consumption among adults and youth and would particularly reduce smoking among Oregon Health Plan members. This concept would further OHA and OHA-PHD's mission by improving population health.

This concept aims to increase the price of tobacco products by:

- Adding a $2.00 per pack tax on cigarettes.
- Implementing an excise tax on inhalant delivery systems.
- Defining little cigars as cigarettes to ensure they are not sold singly.
- Creating a minimum pack size for inexpensive cigars.
- Removing the tax cap on cigars.

OREGON HEALTH AUTHORITY: PUBLIC HEALTH DIVISION

Program Unit Narrative: Center for Health Protection

Expenditures by fund type, positions and full-time equivalents

	General	Other	Federal	Total Funds	Pos.	FTE
Leg Approved 17-19	$10.3	$34.6	$17.6	$62.4	228	212.53
Governor's Budget 19-21	$11.2	$38.3	$19.0	$68.4	222	216.65
Difference	$0.9	$3.7	$1.4	$6.0	-6	4.12
Percent Change	9%	11%	8%	10%	-3%	2%

The Governor's Budget of $68.4 million Total Funds continues funding for most Center for Health Protection programs at the current service level for 2019-21. The budget includes fee changes in the Environmental Public Health and Drinking Water Services sections.

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 people in Oregon from environmental health hazards in areas including drinking water, radiation, recreational waters, and foodborne illness. The center develops and helps set health care policy. It requires patient safety efforts and quality improvement activities by health care providers. The center's six sections partner with local health departments, private practitioners and medical experts.

Radiation Protection Services (RPS) protects 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.

Program Unit Narrative: Center for Health Protection

Drinking Water Services (DWS) ensures the safety of drinking water provided by all public water systems in Oregon. The program administers and enforces state and federal safe drinking water quality standards; prevents contamination of public drinking water systems by protecting drinking water sources; ensures 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 low-cost financing to communities to construct safe drinking water infrastructure, including 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 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. EPH's priorities are that all people in Oregon benefit from healthy air and water; healthy homes and neighborhoods; communities that are resilient to flood, fire, drought and other changing climate effects; land-use and built-environment policies that support health; and rules that ensure safe food, lodging, and recreational facilities.

Oregon Medical Marijuana Program (OMMP*)* administers the Oregon Medical Marijuana Act (OMMA). The OMMP oversees the medical marijuana cardholder registry for patients and regulates medical marijuana dispensaries, processing sites, growers 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's compliance and enforcement unit ensures compliance with OMMA and administrative rules by medical marijuana dispensaries, processing sites, growers, and grow sites. To comply with OMMA, the program also administers a database for registering patients, growers and facilities, and for reporting and tracking the production and transfer of medical marijuana products.

Program Unit Narrative: Center for Health Protection

Health Care Regulatory and Quality Improvement (HCRQI) regulates an array of health facilities and providers through two programs: the Health Facility Licensing and Certification program and the Emergency Medical Services and Trauma Systems (EMS/TS) program.

The Health Facility Licensing and Certification program licenses and certifies 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 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 violate 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.

- Providing funding assistance for safe drinking water system construction projects in underserved and economically disadvantaged communities.
- 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.

Background information

Most Center for Health Protection programs are grounded in the principles of population-based public health, providing services and oversight for all people in Oregon.

Radiation Protection Services (RPS) licenses or registers 14,000 sources of radiation statewide. It routinely inspects those radiation sources in more than 4,100 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.

Drinking Water Services (DWS) regulates more than 3,400 public water systems statewide. The section certifies 1,700 public water system operators and 1,500 backflow device testers and specialists. Contracts with county health departments and the Oregon Department of Agriculture help facilitate the inspections of these public water systems. The section provides technical expertise and best management practices related to emerging contaminants that may affect drinking water quality, including Harmful Algal Blooms and Legionella. In addition, section staff have provided expertise to assist the Department of Education and Early Learning Division develop drinking water sampling requirements for lead in schools and child care facilities. Workload has increased over the past several years as program staffing has been substantially reduced. Current staffing levels are insufficient to fully meet all program mandates, which means the section must prioritize its regulatory work. With the fee change proposed in the Governor's Budget, DWS will recognize increased staffing capacity.

Program Unit Narrative: Center for Health Protection

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 built and natural environments. EPH is organized into regulatory, assessment and surveillance units. During 2017-2019, the program worked in partnership with the Oregon Department of Environmental Quality in the Governor's "Cleaner Air Oregon" initiative, which significantly increased the section's workload.

EPH's primary regulatory program is Food, Pool and Lodging Health and Safety, which assists 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.

EPH assessment programs evaluate areas of environmental concern to ensure impacts to public health are included in action plans for air quality, contamination from hazardous waste sites, brownfield redevelopment plans, transportation and land use plans, hazards related to climate change, harmful algae blooms, and fish consumption. Assessments and stakeholder engagement activities take into consideration that some communities face greater risks or are more vulnerable to risks and make recommendations to address environmental health inequities.

EPH surveillance programs monitor data on lead poisoning, radon, pesticide exposures, occupational health, domestic well safety, beach safety and other environmental hazards leading to potential related health outcomes. The surveillance programs inform people in Oregon about measures to prevent and respond to exposures to these environmental hazards. EPH uses an equity lens to identify priority populations at disproportionate risk from environmental health hazards.

Oregon Medical Marijuana Program (OMMP) serves medical marijuana patients and their caregivers, and regulates medical growers, grow sites, dispensaries, and processing sites. The program continues to undergo major changes as the Legislature works to define the regulatory scheme for the medical and retail marijuana markets. SB 1057 (2017) required OMMP medical

dispensaries, processing sites and specific grow sites to begin using the Oregon Liquor Control Commission's (OLCC) cannabis tracking system (CTS) by July 1, 2018, to track the propagation of marijuana. HB 2198 (2017) established the Oregon Cannabis Commission within OHA. The commission is tasked with advising OHA and OLCC on the administration of medical and recreational cannabis regulations.

Registrations and associated fee revenues have significantly declined since legalization of marijuana in 2015. Many factors have contributed to this decline, including:

- An influx of medical patient, dispensary, and processor applications right before legalization that temporarily inflated the number of registrants in the medical program.
- Few medical processing sites and dispensaries provide marijuana products other than flower to patients.
- New laws for the tracking and reporting of marijuana that reduced the number of growers growing for multiple patients.

Also, the continued transition of registered medical facilities to licensed recreational facilities with OLCC has significantly affected revenue. The number of registered dispensaries has fallen from 423 to five. Processing sites declined from 178 applications to three registered sites. Additionally, the number of patients paying full price for medical cards has decreased as most applicants now pay a reduced fee. Currently approximately 34,892 patients, 16,600 growers, and 13,959 grow sites are registered with OMMP.

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 oversees approximately 92 ambulatory surgical centers, 15 birthing centers, 72 dialysis facilities, 723 hemodialysis technicians, 74 home health agencies, 60 hospice agencies, 65 hospitals, 160 in-home care agencies, 63 rural health clinics, five special inpatient care facilities and 43 designated trauma hospitals.

Program Unit Narrative: Center for Health Protection

The Health Facilities Planning and Safety program works to ensure that newly constructed facilities are safe and effective. This program reviews design and construction plans and issues project approvals for approximately 200 health facility projects annually. The Certificate of Need program evaluates whether a proposed service or facility is needed 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 11,735 emergency medical services providers (EMSPs): 1,874 electronic medical records (EMR), 5,030 emergency medical technicians (EMT), 754 EMT-intermediate, 172 advanced EMTs and 3,905 paramedics. The program also licenses 134 ambulance service agencies and 734 ambulances. It also certifies all EMT training courses and its mobile training unit provides training services to over 4,000 individuals in nearly 200 rural and frontier communities.

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 16 boards, councils and programs: Athletic Trainers; Cosmetology; Denture Technology; Respiratory Therapy and Polysomography; Environmental Health Specialists; Hearing Aid Specialists; Direct Entry Midwifery; Sex Offender Treatment; Long Term Care Administrators; Licensed Dietitians; Electrologists and Body Art Practitioners; Behavior Analysis, Certified Advanced Estheticians, Lactation Consultant, Art Therapy and Music Therapy. In 2017 HLO administered 7,951 examinations, issued 7,265 licenses and registrations, renewed 45,589 licenses and registrations, conducted 7,016 inspections, investigated 449 complaints, and monitored 5,327 facilities and 40,330 licensees.

Funding streams

The 2019-21 Center for Health Protection budget comprises 56 percent Other Funds, primarily in the form of fees for services, 28 percent Federal Funds, and 16 percent General Fund. Funding for each program is described below.

Radiation Protection Services (RPS) 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 that 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 (DWS) receives funding from federal grants, fees and the General Fund. DWS receives about $3.6 million per biennium from the General Fund, constituting 22 percent of program revenue. DWS also collects approximately $2 million in revenue per biennium, 12 percent of program revenues, from four fee-based programs: Backflow Tester/Specialist Certification, Water System Operator Certification, Water System Inspections and Water System Plan Review. Revenue from fees and the General Fund contribute to the required state match for federal grants.

DWS receives two federal grants from the Environmental Protection Agency (EPA): the Drinking Water Primacy grant and the Drinking Water State Revolving Fund (DWSRF) capitalization grant. The DWSRF includes support for infrastructure project financing (69 percent) and set-asides for specific program functions (31 percent). Excluding transfers for infrastructure financing projects, federal grants comprise 66 percent of program operating revenue.

Environmental Health Protection (EPH) receives funding from federal grants, fees, and intergovernmental agreements with state and county partners. The section also receives a small amount of General Fund to help support its assessment and surveillance efforts, and the establishment of the Toxic Free Kids Act (TFKA) program authorized in Senate Bill 478 during the 2015 legislative session. The TFKA included fee authority for some requirements within the Act. The 2019-21 Governor's Budget includes establishing two new fees to support a subsequent phase of program implementation to be adopted through rulemaking in 2019. It also includes updates to food, pool, and lodging marker fees last revised in 2003.

EPH receives Other Funds revenues 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 through an interagency agreement with Oregon Department of Agriculture, while the Brownfield Program is funded

through Business Oregon. Fee-based revenue also supports the Clandestine Drug Lab Program and some lead-based paint activities.

EPH receives Federal Funds revenue from the Centers for Disease Control and Prevention (CDC) grants for Climate and Health, Environmental Public Health Tracking, Domestic Well Safety, and Childhood Lead Poisoning Prevention. It also receives the National Institute for Occupational Safety and Health grant for Occupational Public Health; CDC's Agency for Toxic Substances and Disease Registry (ATSDR) grant for Environmental Health Assessment; and Environmental Protection Agency (EPA) grants for monitoring and public outreach for radon, beach monitoring, and lead-based paint programs.

Oregon Medical Marijuana Program (OMMP) section collects fees for issuing medical marijuana cards to qualifying patients and maintains a registry of those patients. The program also collects fees for the registration of grow sites, dispensaries and processing sites and collects a pass-through fee for entities required to use the OLCC cannabis tracking system. Projected revenues are approximately $14.7 million for the 2019-21 biennium. Program revenue has declined due to the legalization of recreational marijuana. In 2017-19, this program transferred $7.1 million to support local public health departments, reducing their General Fund need. Due to revenue declines, this is no longer feasible in 2019-21. OMMP also receives $250,000 General Fund, appropriated in House Bill 2198 (2017), to support the newly established Oregon Cannabis Commission.

Health Care Regulation and Quality Improvement (HCRQI) section receives federal funding from the Centers for Medicare and Medicaid Services to perform health facility surveys and certification. The section also has several regulatory responsibilities supported by fees. The Health Facility Licensing and Certification program funding sources include: certificate of need, health facility and long-term care facility plans review, ambulatory surgery centers, birthing centers, dialysis facilities, hemodialysis technicians, home health agencies, hospice, caregiver registries, in home care agencies.

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. It receives about $3.2 million General Fund per biennium and roughly $331,000 per biennium from the Criminal Fines and Assessment Account, as directed by ORS 137.

EMS/TS also receives $1.95 million General Fund 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 and renewals of licenses and registration, disciplinary actions and other administrative fees. Each board, council and program has its own fees, which are used to cover their administrative costs 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

Senate Bill 27 would revise the fee authority of Drinking Water Services and would enable an increase in fee revenue sufficient to support adequate regulation of all public drinking water systems. Specifically, authority to charge an inspection (sanitary survey) fee would be replaced with authority to charge an annual regulatory fee based on the number of connections served by the water system, ensuring more equitable regulation of state drinking water systems. By broadening fee authority and generating additional revenue, the Drinking Water program would be able to build the capacity to adequately regulate all public water systems equitably, ensure protection of public health and maintain the public's trust in the safety of public drinking water supplies.

Senate Bill 28 would modify statutory food, pool, and lodging regulatory program fees for the first time since 2003. The concept proposes fee increases to cover OHA's costs of implementing regulatory programs directly or through contractors, addressing a gap by establishing a new fee for processing variances from food sanitation rules, and modifying the fee structure for reviewing new public pool and spa plans. Current statutory fees aren't sufficient to cover costs for OHA to license, inspect, enforce, and carry out other food, pool, and lodging safety rules when a county transfers public health authority to OHA,

making OHA responsible for regulations previously delegated to a county. Counties with delegated authority have the ability under statute to increase fees, and have done so over time, but OHA is able to charge only statutory fees.

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	Federal	Total Funds	Pos.	FTE
Leg Approved 17-19	$31.8	$72.5	$244.5	$348.8	203	198.51
Governor's Budget 19-21	$42.5	$72.7	$254.6	$369.8	203	201.00
Difference	$10.7	$0.2	$10.1	$21.0	0	2.49
Percent Change	34%	0%	4%	6%	0%	1%

The Governor's Budget of $369.8 million Total Funds continues funding for the Center for Prevention and Health Promotion programs at the current service level for 2019-21. The budget also includes additional funding to expand home visiting services for Medicaid covered infants. While the OHA-PHD policy package to Reduce Tobacco Use & Improve Population Health by Increasing Prices of Tobacco Products as proposed in the Agency Request Budget is not going forward, Governor Brown is pursuing this strategy that will support OHA-PHD's mission to improve population health by introducing Legislative Concept 388.

Activities, programs and issues in the program unit base budget

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

- Prevention of risks leading to lifelong and costly chronic diseases, including substance use disorders.
- Provision of adequate nutrition and access to healthy foods.
- Preventing child developmental delays.
- Ensuring adolescent health and well-being.
- Oral health across the lifespan.

Program Unit Narrative: Center for Prevention and Health Promotion

- Prevention of injuries, overdose, suicide, toxic stress, violence and unsafe relationships.
- Access to preventive clinical services.
- Reproductive health.

The center promotes population-based strategies, and policy, environment and system changes to:

- Reduce tobacco, alcohol and other drug use.
- Increase access to healthy food, healthy eating and physical activity for all people in Oregon.
- Reduce risky prescribing of opioids.
- Reduce suicide.
- Increase stability and safety in families.
- Increase equitable access to healthy options and preventive health services.
- Decrease the burden of health disparities borne by historically margnalized communities of color and promoting health equity.
- Decrease exposure to and availability of dangerous products.

In collaboration with stakeholders and partners, the center invests resources to prevent and address health problems and inequities statewide. Those partners and stakeholders include:

- Local public health departments and mental health providers.
- Early child care, early learning, primary and secondary education systems.
- Health care systems and providers (including Dental, Mental and Primary Care systems).
- Substance use disorder treatment programs.
- Emergency departments.
- Food systems and anti-hunger organizations.
- Community-based organizations serving populations experiencing health inequities.

- Aging services.
- Land use and transportation agencies.
- Emergency medical service providers.
- Law enforcement.
- Tribes and urban American Indians and Alaska Natives.
- Academic institutions.
- Employers.
- Parents and youth.
- Regional health equity coalitions.

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

Background information

The Center for Prevention and Health Promotion has the following five sections that work to achieve its mission: Adolescent, Genetics and Reproductive Health, Health Promotion and Chronic Disease Prevention, Injury Prevention and Violence Prevention, Maternal and Child Health, and Nutrition and Health Screening.

Adolescent, Genetics and Reproductive Health (AGRH) promotes health, well-being and quality of life for all people in Oregon through the development and use of evidence-based policies, tools, educational resources, programs and clinical preventive services to support adolescent, sexual and reproductive health across the lifespan. More specifically, the section:

- Monitors the health status of adolescents by race and ethnicity, sex, gender identity, sexual orientation and geography.

Program Unit Narrative: Center for Prevention and Health Promotion

- Encourages the adoption of evidence-based programs and practices that support positive youth development.
- Promotes the ability of all individuals to achieve their reproductive life plan goals.
- Reduces breast and cervical cancer disparities by promoting and supporting equitable access to early detection, risk factor screening, linkage to medical treatment and education, and surveillance for the public.
- Engages with community partners to advance health equity, inform policies, clinical services and activities.
- Supports and ensures the provision of culturally and linguistically appropriate practices and services at the state and local levels through funding and establishment and endorsement of standards of care.
- 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.
- Provides access to essential preventive health services through a statewide network of school-based health centers (SBHCs), reproductive health clinics, school nurses, and ScreenWise providers regardless of gender identity, sexual orientation, race, sex, disability or immigration status, collectively serving over 125,000 adolescents and adults each year.
- Recognizes the role of trauma and resilience in health behavior and outcomes and creates prevention policy and programming that acknowledges trauma and adverse experiences while building on and enhancing developmental strengths and protective factors.

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.
- 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.
- 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, motor vehicle crashes, child maltreatment, and unintentional injuries. Some strategies include:

- Providing the web-based Prescription Drug Monitoring Program, which serves 17,000 prescribers, pharmacists and their delegates to inform clinical practice.
- Establishing opioid prescribing guidelines and working within health systems and CCOs to use them to improve patient safety, reduce incidence of opioid use disorder, improve pain care, and reduce unintentional prescription opioid overdose.
- Working with health systems to improve pain care to include non-pharmacological pain care options.
- Working with pharmacies and community human services organizations to make naloxone rescue universally available to prevent deaths due to opioid overdose.
- Maintaining a web-based data dashboard that is interactive, queriable, accessible to the public and contains all available data from a variety of sources on the topic of drug overdose, prescribing, and rescue.
- Working with diverse communities, tribal health clincs, as well as, health care and behavioral health care agencies to establish zero-suicide initiatives to reduce suicide.
- Improving patient care and care coordination regarding opioid prescription.
- Leading the State Child Fatality Review Team to identify systems level changes that can reduce child fatalities.
- Evaluating the implementation of two statewide policies intended to: 1) reduce the burden of sexual violence among youth, and 2) reduce the burden of traumatic brain injury among youth participating in sports.
- Working with partners statewide to develop and maintain the Oregon Emergency Medical Services Information System and the Oregon Trauma Registry that provide data on patient care to inform the statewide trauma system.

- Providing a wide range of educational, training, technical assistance, and consulting services through conferences, summits, telehealth, webinars and conference calls.

Additionally, IVPP manages the Oregon Violent Death Reporting System and provides injury surveillance and epidemioligic study of the leading causes of injury. This work informs policy, prevention practice, academic research, and program and policy evaluation. Data on outcomes and performance are used to track key information on the health status of Oregonians.

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); monitors the prevalence of birth anomalies through our Birth Anomalies Surveillance System (BASS) and monitors the state of oral health through the Oregon Oral Health Surveillance System. The program manages data systems for infant hearing screenings, the home visiting system and its programs, and statewide oral health, disaggregating data by race and ethnicity. For example, the Oral Health Unit has begun implementing the REAL D standards in its school-based program forms and data collection.

MCH houses Oregon's Title V Maternal and Child Health Services block grant programs that support promoting and improving the health and well-being of mothers, children, and their families. Oregon's Title V programs focus on well-women care, breastfeeding, child physical activity, adolescent wellness 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 activities such as:

- Assessment and monitoring of MCH health needs and disparities.

Program Unit Narrative: Center for Prevention and Health Promotion

- 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) provides a foundation of health and prevention for the future of participating children and society at large. The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) safeguards the health of over 138,000 low-income women, infants, and children up to age 5 each year who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating and referrals to health care. Oregon WIC participants use an electronic benefit transfer (EBT) system to purchase healthy foods. In addition, the Oregon Farm Direct Nutrition Program (FDNP) also provides over 25,000 WIC participants and 43,000 low-income seniors with FDNP checks once a year to purchase fresh, locally-grown fruits, vegetables and cut herbs directly from local farmers. WIC services are delivered through public health, tribal health clinics 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-focused counseling.
- Promotion of a healthy lifestyle and prevention of chronic diseases including obesity.
- Culturally and linguistically appropriate services and materials.

NHS program staff provide a variety of training to local paraprofessional staff who deliver WIC services, including annual civil rights training.

The WIC program also influences the availability of nutritious foods in Oregon's communities by requiring large and small WIC-authorized grocery stores in all areas of the state to carry a minimum stock of healthy foods including low-fat milk, whole grains, low-sugar cereals, and produce. The foods available through WIC offer a variety that is culturally appropriate for the wide range of families served. The Oregon FDNP program collaborates with farmers and farmers markets statewide to provide vouchers for fresh produce for WIC families and low-income seniors.

WIC also provides critical surveillance data on the maternal and child population by race, and ethnicity and other demographics; and evaluates programs and carries out competitively funded research studies.

Funding streams

The Center for Prevention and Health Promotion revenues include 11 percent General Fund, 69 percent Federal Funds and 20 percent Other Funds.

General Fund revenue supports the School Based Health Centers program, the Oregon Contraceptive Care program (1115 family planning Medicaid demonstration waiver), and the Oregon Reproductive Health Equity Act as authorized with the passage of HB 3391 (2017) to provide expanded coverage for a full range of reproductive health services, including female sterilization and abortion.

The center receives Federal Funds through the following federal grants and programs:

- 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 & Services Administration (HRSA) for Maternal & Child Health Title V and Home Visiting programs.
- The Medicaid Title XIX entitlement supporting the Oregon Contraceptive Care program (1115 family planning Medicaid demonstration waiver), which provides a 9:1 Medicaid match through the Centers for Medicare and Medicaid Services.

Federal grant award amounts continue to remain flat or decline through 2017-19. This trend is expected to continue during 2019-21. Since the center is primarily funded through competitive federal grants, the center will need to adjust program service levels accordingly.

The Center's Other Funds revenues include statutorily dedicated funds under the Tobacco Use Reduction Account (TURA), as well as beer and wine tax revenues for substance abuse prevention.

Proposed laws that apply to the program unit

House Bill 2270: Tobacco is the leading cause of preventable death and disease in Oregon. Through increases in the price of tobacco, this legislative concept would reduce cigarette consumption among adults and youth and would particularly reduce smoking among Oregon Health Plan members. This change would further OHA and OHA-PHD's mission by improving population health.

This legislation aims to increase the price of tobacco products by:

- Adding a $2.00 per pack tax on cigarettes.
- Implementing an excise tax on inhalant delivery systems.
- Defining little cigars as cigarettes to ensure they are not sold singly.
- Creating a minimum pack size for inexpensive cigars.
- Removing the tax cap on cigars.

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	Federal	Total Funds	Pos.	FTE
Leg Approved 17-19	$11.3	$87.0	$69.3	$167.7	279	277.10
Governor's Budget 19-21	$11.6	$105.2	$71.5	$188.3	281	279.42
Difference	$0.3	$18.1	$2.2	$20.6	2	2.32
Percent Change	3%	21%	3%	12%	1%	1%

The 2019-21 Governor's Budget of $188.3 million Total Funds continues funding for the Center for Public Health Practice programs at the current service level.

Activities, programs and issues in the program unit base budget

The Center for Public Health Practice protects the health of individuals and communities through the prevention and control of infectious diseases, provision of integrated care and treatment for persons living with HIV, issuing Oregon vital records, monitoring population health, and ensuring emergency public health services in natural and human-caused disasters. The center's programs provide 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 (CHS).
- Acute and Communicable Disease Prevention (ACDP).
- Oregon State Public Health Laboratory (OSPHL).
- HIV, Sexually Transmitted Diseases and Tuberculosis Prevention (HST).
- Immunizations.
- The federally funded programs for Health Security, Preparedness and Response (HSPR).

OREGON HEALTH AUTHORITY: PUBLIC HEALTH DIVISION

Program Unit Narrative: Center for Public Health Practice

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. The center coordinates interventions to control disease outbreaks; screens all newborn infants for biochemical disorders to prevent disability or death; and collects and analyzes vital record data needed to understand and plan for health trends. As part of public health emergency preparedness, the center conducts testing for biological agents of mass destruction (e.g., anthrax, plague) and emerging public health events and diseases such as wildfires, Zika, and Ebola.

The Center for Public Health Practice delivers core public health services necessary to maintain a healthy population and recover from disasters. Preventable disease vaccine programs ensure 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. The center's HIV/STD and TB programs work with local partners and the community to prevent and eliminate disease transmission. Its HSPR programs track the surge capacity of hospitals and public health agencies to respond in health emergencies (e.g., floods, wildfires, pandemics and earthquakes). The center's services are delivered every day of every week throughout the year. Duty officers are on call 24/7 to provide technical support at the public health lab, for epidemiology guidance, and for assessing the initial stage of a public health incident and coordinating responders.

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

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

Additional program-specific strategies are identified in section narratives.

OREGON HEALTH AUTHORITY: PUBLIC HEALTH DIVISION

Program Unit Narrative: Center for Public Health Practice

Background information

Center for Public Health Practice program activities are highlighted below.

Center for Health Statistics 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 130,000 vital events that occur in Oregon annually.
- Issuing 166,000 certified copies of records and 40,000 amendments annually.

Vital records and statistics are part of the Assessment and Epidemiology foundational capability of a modern Public Health System. Information from vital records is used to assess the health of people in Oregon and identify health disparities so that public health programs can develop programs to improve health equity.

Acute and Communicable Disease Prevention (ACDP) works to identify and prevent the spread of communicable diseases that cause significant illness and death, including salmonellosis, *E. coli* O157 infection, meningococcal disease, influenza, hepatitis, antibiotic-resistant bacteria, and vector-borne diseases. ACDP collaborates with a large array of stakeholders to reduce disease transmission through various pathways including food, water, animals, insects, human contact, and in health care. The 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 transmission routes, protect exposed individuals, and control disease transmission. ACDP is a key resource for all of Oregon to gather and then use important data to implement strategies to prevent the spread of communicable diseases.

Communicable disease control is a foundational program in the modernization of Oregon's public health system and ACDP's work integrates all the foundational capabilities. ACDP is actively working to identify and prevent disparities in groups disproportionately affected by communicable disease. It does this by collecting data and intervening on any diseases identified

to disproportionately affect people of color, people with limited English proficiency, people with access and functional needs, and the people in the lesbian, gay, bisexual, transgender and queer communities.

The Oregon State Public Health Laboratory performs 10.4 million tests on 332,000 human specimens annually, including newborn screening of all infants born in Oregon, 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. This includes laboratories that monitor the safety of drinking water, cannabis, and the environment in Oregon. The OSPHL is also responsible for emergency laboratory response to emerging pathogens and 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 10.3 million tests annually on 253,000 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.
- Regulation to ensure 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 works collaboratively with local health departments, health care providers, community-based organizations and planning entities to prevent the transmission of HIV/STD and TB disease and improve health outcomes. The primary program functions include:

- Prevention and communicable disease control.
- Surveillance and monitoring.

The HIV/STD/TB section specifically monitors the incidence and prevalence of disease, using data to develop public health policy and interventions. The section develops rules, policy, procedure, and standards of care, and provides training, consultation and technical assistance for outreach, testing, disease investigation, outbreak response, linkage to care, and treatment. The section's client population includes individuals at risk for or diagnosed with HIV, STDs or TB. The section 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 funded promote the elimination of HIV/STD/TB transmission and improved health outcomes and include locally based outreach and education, testing, condoms, lab costs, medications, case management and adherence support.

The **Immunization** section works 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 people in Oregon.
- Maintaining the federal Vaccines For Children (VFC) entitlement program.

Program Unit Narrative: Center for Public Health Practice

The program maintains: the ALERT Immunization Information System (IIS); provider compliances to the federal VFC program; school immunization law; and vaccine-preventable disease readiness and epidemiology, which includes serving as a CDC IIS Sentinel Site. Immunization promotes the health of all people in Oregon by investing in activities that ensure access to vaccines for all. These efforts include the work of the VFC 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. It also includes partnering to ensure vaccine opportunities for underrepresented communities; the use of the ALERT IIS data to identify pockets of need across gender, race or ethnicity; supporting the Immunize Oregon coalition, and an equity workgroup that 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. Public health emergency preparedness is one of the modernization foundational capabilities and is the cornerstone of the HSPR section. HSPR emphasizes cultural responsiveness through community partnerships with tribal governments, hospitals and health care systems, emergency medical services, law enforcement, fire and local public health authorities to build community resiliency through emergency preparedness planning, training, exercises and coalition development. These partnerships include funding for health care and public health programs in local and tribal agencies, as well as support for essential public health functions related to communications, laboratory services and communicable disease control. The program 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.
- Mass casualty response.
- Health equity planning.
- Seasonal hazards such as wildfires, floods, heat waves, and drought.

HSPR also manages:

- The State Emergency Registry of Volunteers in Oregon, with 2,902 registered licensed health professionals providing 3,827 hours of emergency services in the past year and participating in 3,827 hours of training to help all communities during a disaster.
- The AmeriCorps VISTA program, which places new public health professionals in public health and nonprofit agencies for one year of national service to build public health capacity and eliminate poverty. HSPR oversees 60 national service volunteers annually.
- Critical public health information platforms such as the Health Alert Network and Hospital Capacity System, which allow for 24/7/365 mass communication and situational awareness between public health and health care organizations with the option for hearing-impaired communication.

Revenue sources and proposed revenue changes

The 2019-21 Center for Public Health Practice revenues include 6 percent state General Fund, 38 percent Federal Funds, and 56 percent Other Funds.

While the center has been successful in writing grants, much of its 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 the people in Oregon 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.

The center's General Fund is used to pay for staff, supplies and equipment necessary to coordinate and deliver services to people in Oregon. The center pays counties to deliver the Vaccines for Children program, using Medicaid matching funds 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 flat in recent years. The CAREAssist program has available funding generated because of its pharmacy model. Factors such as restricted use of the funds and staffing limitations have inhibited the program's ability to spend all available resources within the biennium, which is estimated to result in a $45 million restricted Other Funds carryover balance from the 2017-19 to 2019-21 biennium. The program introduced a plan to eliminate new HIV transmissions in December 2016 and has currently obligated over $50 million to this five-year initiative.

All other programs in the HST section are seeing funding stabilize after several years of 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 local public health authorities; a maintenance and support contract with Hewlett Packard Enterprise for ALERT immunization information system; and general staff and infrastructure support. 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 maintaining our support for Oregon counties.

The Acute and Communicable Disease Prevention section receives about $20 million in Federal Funds per biennium from the CDC, primarily through the Emerging Infections Program and the Epidemiology and Laboratory Capacity grants. Along with roughly $1 million General Fund, these grants support communicable disease monitoring, outbreak investigation, interventions and evaluation activities. The program maintains Orpheus, a statewide case reporting and outbreak information system, as well as ESSENCE, a statewide syndromic surveillance system that monitors all emergency department visits (data available by race and ethnicity via a medical record or using CDC-specified designations). As 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 revenues for the 2019-21 Governor's Budget are approximately $30 million Total Funds, of which 11 percent is General Fund, 20 percent Federal Funds, and 69 percent Other Fund fee revenue. In the 2017-19 biennium, the cost of operating OSPHL outpaced revenues.

A fee increase for the newborn screening program went into effect on April 1, 2018, following the results of a fee structure evaluation conducted in 2016.

Recently, revenue generated from communicable disease testing fees has not kept pace with increasing costs, prompting OSPHL to review those fee structures. Communicable disease testing increases access to health care by providing testing regardless of ability to pay or insurance coverage. Primary submitters are local health departments and community clinics. OSPHL bills for as many tests as possible using the Medicaid fee-for-service fee schedule, but does not recover enough revenue to fund the testing. New laboratory technology is changing the number and types of specimens sent to OSPHL, shifting the workload to OSPHL without corresponding funding to support the testing. OSPHL is also experiencing increased costs associated with maintaining laboratory information systems to support electronic data collection and transmission among local, state and federal partners. Significant effort is being made to capture the real cost of conducting laboratory tests through Random Moment Sampling (RMS) and other time studies.

Evaluations of additional of fee structures will continue in 2019-21.

The Center for Health Statistics' revenues for the 2019-21 Governor's Budget include mostly Other Funds, primarily in the form of fees for services, and some Federal Funds, in the form of deliverable-based contracts for timely and accurate birth and death data. Other funding includes payments from state agencies that use vital records information to conduct their business.

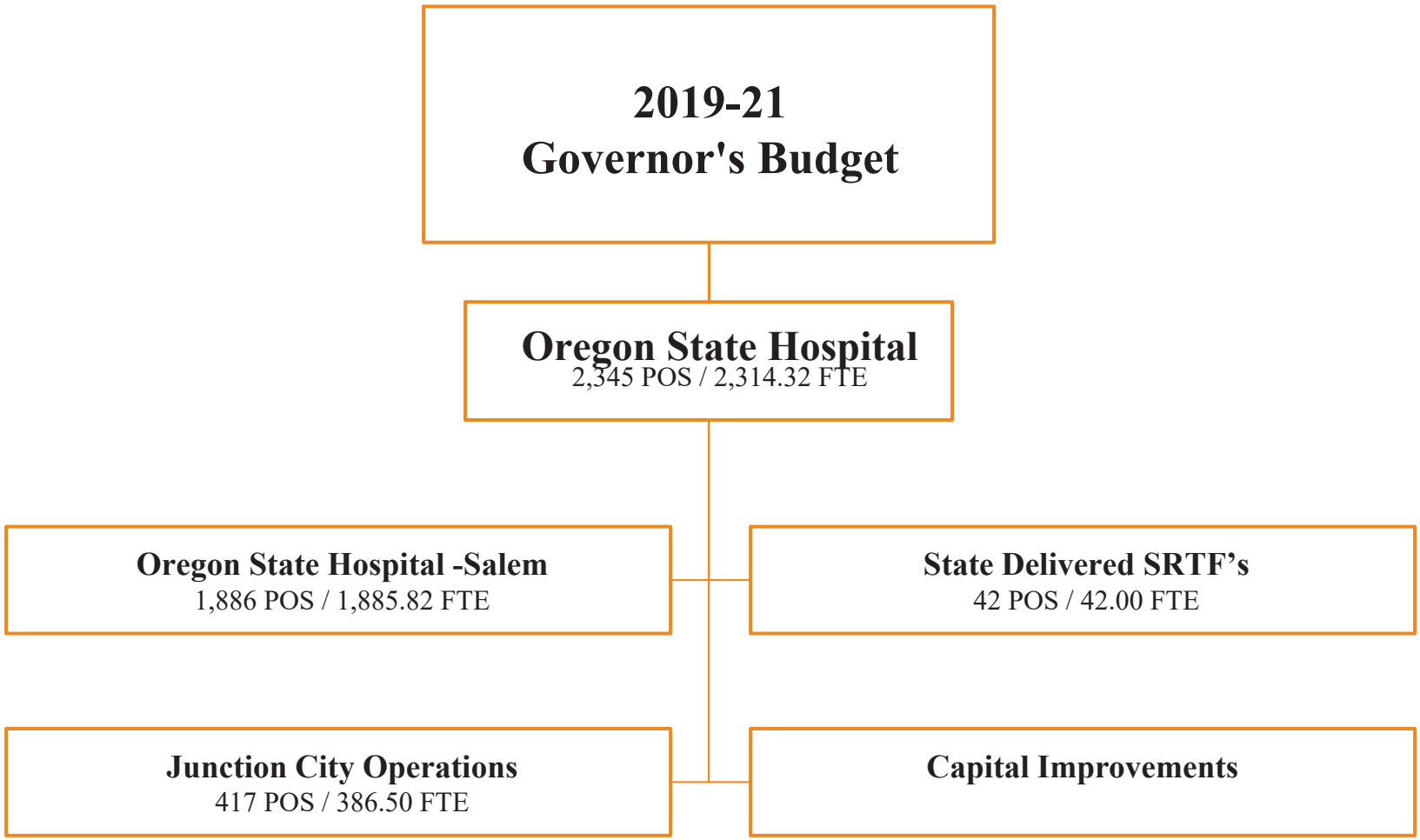
Program Unit Narrative: Center for Public Health Practice

The second phase of the vital records fee increase went into effect January 1, 2018. Fees from the sale of birth certificates comprise most of the fee revenue. The remaining revenue comes from sales of other types of certificates and extra fees for expedited processing and amendments.

The Health Security, Preparedness and Response section is funded through two federal grants, Public Health Emergency Preparedness and the Healthcare Preparedness Program. These funds support state and local health department preparedness staff and activities, regional health care coalitions, and grants to partners for innovative community planning and response.

Proposed new laws that apply to the program unit

None.

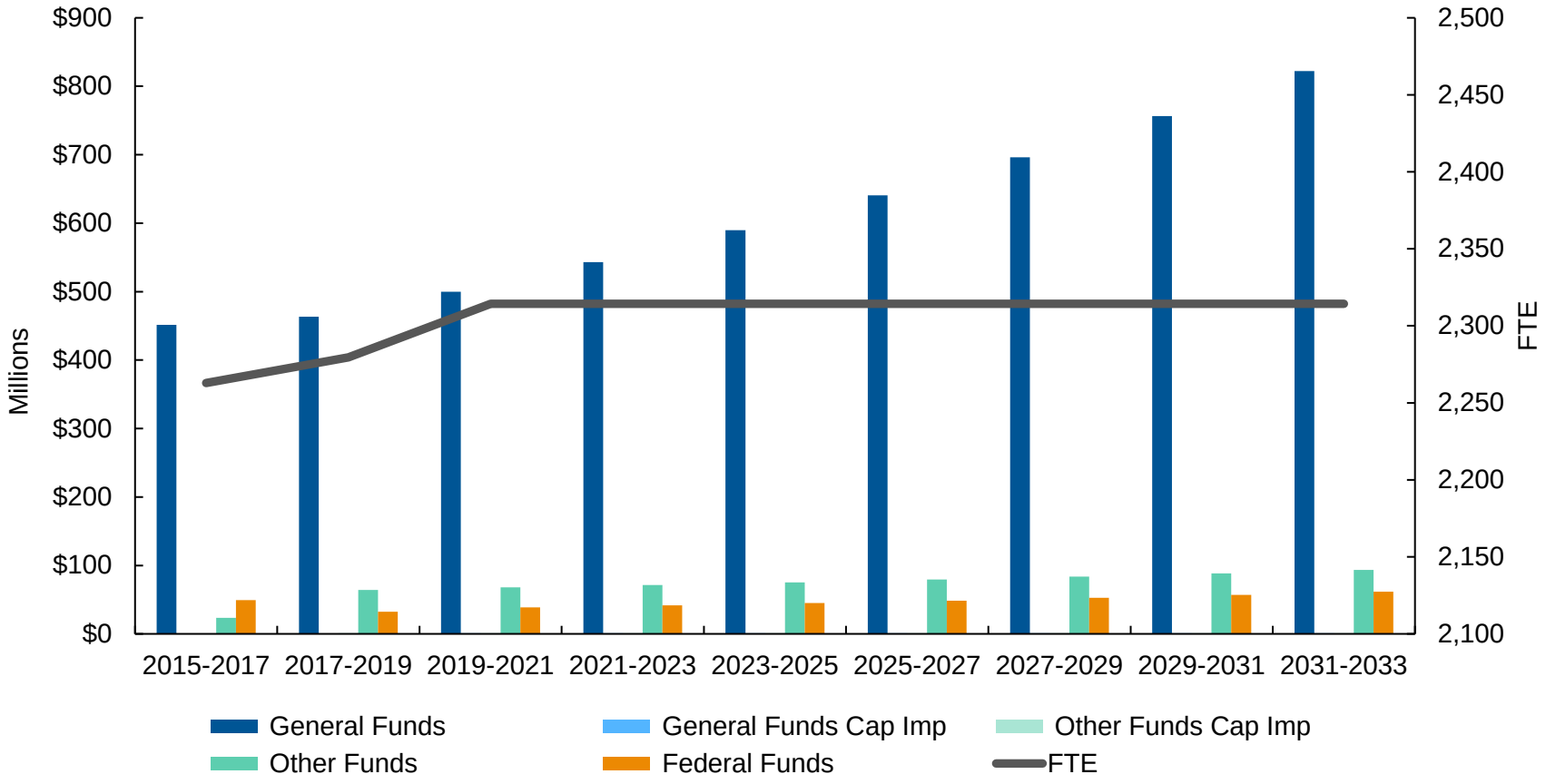


Oregon Health Authority

OREGON HEALTH AUTHORITY: OREGON STATE HOSPITAL

Executive Summary

Primary contact: Dolores “Dolly” Matteucci, CEO-Superintendent
503-945-2850



** Inflation factors used for 2021-23, 2023-25, 2025-27 and 2027-29 in the graph above were provided by DAS-CFO.*

OREGON HEALTH AUTHORITY: OREGON STATE HOSPITAL

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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, contributing to healthy and safe communities for all Oregonians. Oregon State Hospital promotes public safety by treating people who are dangerous to themselves or others in a secure, therapeutic setting. The hospital works in partnership with the other divisions of the Oregon Health Authority including the Health Systems Division (HSD), the Psychiatric Security Review Board (PSRB), regional hospitals, community mental health programs, advocacy groups and other community partners to ensure people with mental illness get the right care, at the right time, in the right place.

OSH operates two campuses with the capacity to serve up to 766 Oregonians, with 592 beds in Salem and 174 beds in Junction City. Services are provided 24 hours per day, seven days a week. OSH currently operates 592 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. These individuals are under the jurisdiction of the PSRB.
- **Aid and Assist** – People who have been charged with a crime but are unable to participate 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, and vocational and educational services. The

Executive Summary

hospital is accredited by the Joint Commission on the Accreditation of Health Organizations and all 24 hospital-licensed units (21 on the Salem Campus and 3 in Junction City) are certified by the Centers for Medicare & Medicaid Services (CMS). Services are provided by psychiatrists, nurses, and mental health professionals. Upon 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 a job.

Management of the overall behavioral health system has a huge impact on the success of OSH. To ensure 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 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

The Governor's Budget of $608.1 million Total Funds continues funding for the Oregon State Hospital at the current service level for the 2019-21 biennium, less a 5 percent vacancy factor and standard inflation, and includes opening a new unit at the Junction City campus for 12 months as a stop-gap solution to resolve immediate capacity needs driven by the growing number of Aid and Assist patients sent to the hospital under court orders.

Executive Summary

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/occupational therapy
- Social work
- Treatment care planning

Patients also are considered members of their own treatment team, as well as designated family members when appropriate. Treatment teams may also 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 to 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.

Executive Summary

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 experience 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 the symptoms of their 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 the services

Of the 2,244 positions currently budgeted for both campuses, 71 percent are direct-care staff such as nurses, psychiatrists, psychologists, etc. Salaries, taxes and benefits for staff comprise 85 percent of OSH's 2017-19 Legislatively Approved Budget. Per ORS 441.154 and ORS 441.155, the staffing plan for OSH is set by the nurse staffing committee, composed of both nurse management and AFSCME-RN union members. The number of staff the hospital needs is based on the level of acuity (the severity of symptoms, how much care patients need) and commitment type (civil, guilty except for insanity, aid and assist). Sufficient staffing 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.

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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 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 communicating, taking action and evaluating results.

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

OREGON HEALTH AUTHORITY: OREGON STATE HOSPITAL

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The Performance System works by addressing the two major components of running the hospital. The first component is the fundamentals (all 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.

OREGON HEALTH AUTHORITY: OREGON STATE HOSPITAL

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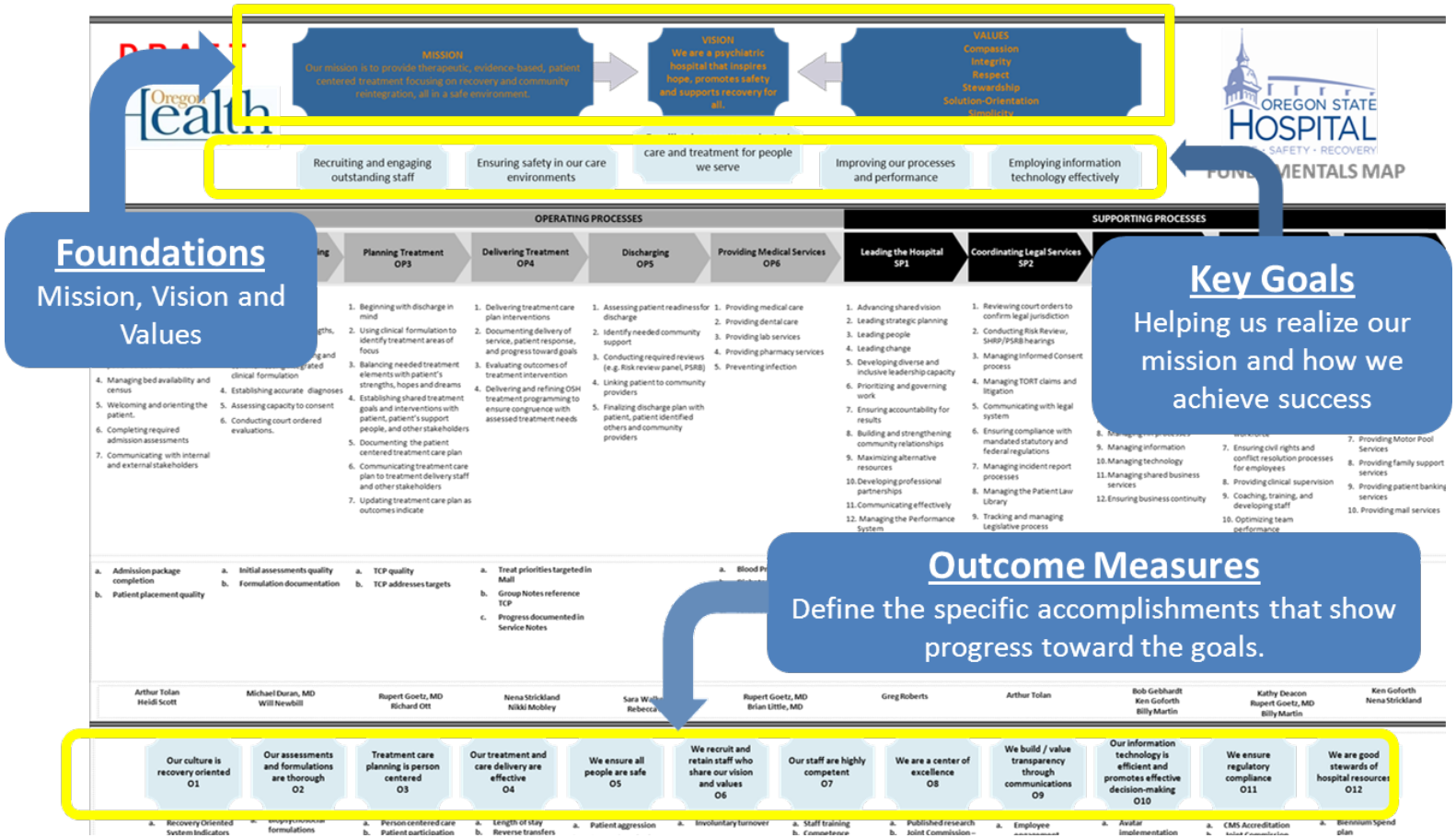

The second component is the breakthroughs, new competencies and major function improvements in existing work processes (all the strategic initiatives).

OREGON HEALTH AUTHORITY: OREGON STATE HOSPITAL

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

Some examples of metrics tracked on the scorecard are:

- Incidents of aggression
- Patient and staff injuries
- Incidents and duration of seclusion and restraint
- Length of stay
- Wait list times
- Hospital funding – non-General-Fund
- 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 the status of the routine work (fundamentals) and initiatives (breakthroughs), and to drive problem solving as needed to achieve the goals of the organization.

Enabling legislation/program authorization

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

Executive Summary

Funding streams

All OSH programs receive a combination of state General Fund, Other Funds, and Federal Funds.

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 2017-2019

Expanding collaborative problem-solving hospital-wide

Improving safety is a key component of CMS certification, and collaborative problem solving (CPS) has been 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.

Currently, two-thirds of the hospital units at OSH's Salem and Junction City campuses now have access to CPS resources. The CPS coaches are recognized as value-added resources who are often invited to train all levels of staff in how to better work with

Executive Summary

patients to address problems and conflicts, offering options, empowerment, and skill building, and reducing coercive means of control. CPS also dovetails with the roll-out of Trauma Informed Care (TIC). CPS uses many of the TIC principles outlined by Substance Abuse and Mental Health Services Administration (SAMHSA), including those of collaboration, safety, trustworthiness and transparency, and empowerment.

Many departments and units that do not have assigned CPS coaches actively request CPS consultation because of their effective work. The CPS coaches have been identified by hospital leadership as highly effective in securing positive outcomes during the success of multiple hospital ventures including the recent patient property initiative in December 2017. CPS coaches are also being included in the creation of new standard work processes aimed at increasing patient care quality while reducing enhanced supervision.

In addition, patient feedback indicates support for CPS, as they feel it empowers them in their treatment while building important life skills. Patients have asked for CPS to be available on all units, commenting on the disruption to care and therapeutic experience when they are transferred from a unit with a CPS coach to a unit without one. In addition, patients' family members and community partners have also asked for CPS training to provide patients with a continuity of care.

The CPS department (currently funded for 19 coaches and 1 PEM/E) is not sufficiently staffed to provide services to all hospital units. An additional five coaches and one PEM/D (who will participate in administrative duties and oversight of the coaches) are needed to allow the CPS department to provide training and services to all patient units across both Junction City and Salem campuses.

OREGON HEALTH AUTHORITY: OREGON STATE HOSPITAL

Program Unit Narrative: Salem Campus

Expenditures by fund type, positions and full-time equivalents

	General	Other	Federal	Total Funds	Pos.	FTE
Leg Approved 17-19	$393.3	$54.4	$28.3	$476.0	1,887	1,880.45
Governor's Budget 19-21	$414.5	$57.2	$33.4	$505.1	1,886	1,885.82
Difference	$21.2	$2.8	$5.1	$29.1	-1	5.37
Percent Change	5%	5%	18%	6%	0%	0%

Activities, programs and issues in the program unit base budget

Salem Campus detail

- Capacity – 24 units (592 beds)
- Operating – 24 units (592 beds)
- Population served – civil commitment (includes voluntary commitments by guardian), neuropsychiatric (high medical need), guilty except for insanity (GEI), aid and assist
- Census – 499 (Daily average population for 2017)
- Square feet – 1.3 million

Background information

Populations served

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

Program Unit Narrative: Salem Campus

There are four 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 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 pleaded Guilty Except for Insanity (GEI) for crimes related to their mental illness. These patients are under the jurisdiction of the Psychiatric Security Review Board.

- **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.

Program Unit Narrative: Salem Campus

- **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 lower 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. Available programs 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 who 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.

Program Unit Narrative: Salem Campus

Background information

Increasing aid and assist population

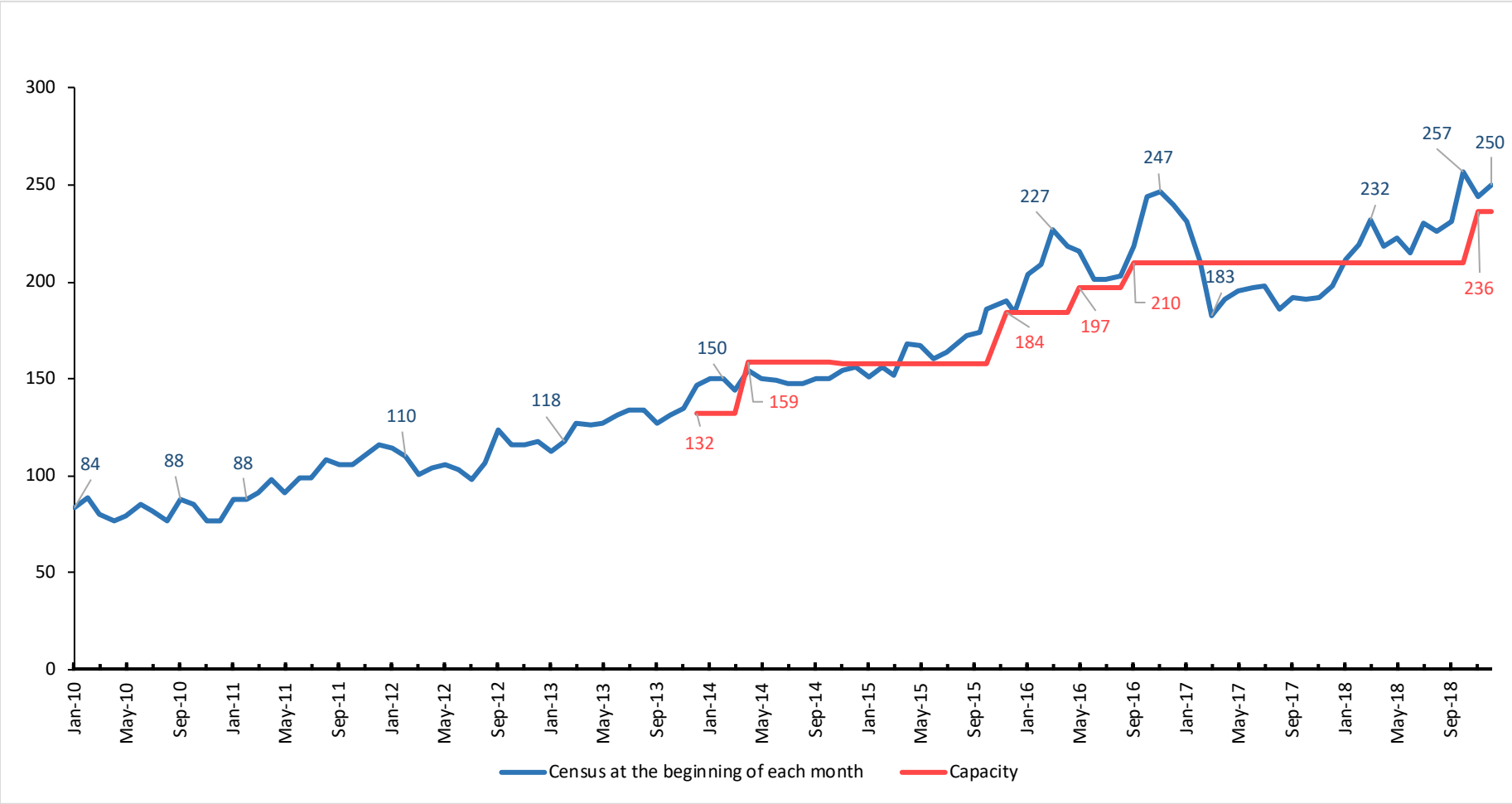
The number of people sent to OSH to be restored to competency so they can assist in their own defense has grown significantly over the past several years. If this trend continues, OSH will not have sufficient capacity to serve this population without cutting back on services to other populations.

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 their staff to open its last vacant unit (26 beds) to meet Aid and Assist population demands. Even with these additional beds, the Aid and Assist census has spiked above capacity several times, resulting in some individuals residing on living units that are not designed to serve them. The Aid and Assist population at OSH spiked again in October 2018, forcing the hospital to convert a 26-bed unit from civil to Aid and Assist. This diminished the hospital's designated-bed capacity to serve people who have been found by a judge to be a danger to themselves or others.

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.

OREGON HEALTH AUTHORITY: OREGON STATE HOSPITAL

Program Unit Narrative: Salem Campus



Nurse staffing

OREGON HEALTH AUTHORITY: OREGON STATE HOSPITAL

Program Unit Narrative: Salem Campus

Adequate nurse staffing is fundamental for patient and staff safety and effective patient treatment at OSH. Per Oregon Revised Statute 441.154 and 441.155 (Senate Bill 469), 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 10.6 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. To meet the staffing plan's minimum staffing requirements, the hospital asks direct-care staff to volunteer for overtime. If not enough people volunteer, the hospital must mandate staff work overtime. However, even with overtime shifts, the hospital's staffing needs are not always met.

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

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

Per SB 469, the OSH Nurse Staffing Committee established a nurse staffing plan in April 2017 (revised in 2018 for implementation in 2019). In addition to meeting the requirements of the law regarding the length of shifts, lunch break coverage and mandatory overtime, etc., the staffing plan also ensures the hospital meets the standards needed to maintain Centers for Medicare & Medicaid Services (CMS) certification.

The prevalence of staff call-outs (unplanned absences) and physician-ordered patient precautions has driven staffing needs well beyond the Nurse Staffing Committee's staffing plan. Historically and currently, OSH has relied on overtime as the primary means to meet staffing needs when direct-care staff are absent and to staff patient acuity/precaution needs. Over the past three

biennia OSH has averaged 23,460 hours and $835,753 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."*

Further, in 2016 The Joint Commission visited OSH to follow up on concerns of inadequate staffing levels. The surveyor investigated the following standard: *EP 3 §482.62(d)(2) - (B150) - (2) There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient's active treatment program.* Because the surveyor observed the high level of unplanned direct-staff absences at OSH, 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."*

OSH established a nurse staffing float pool composed of limited duration positions and increased its use of agency contract nursing staff. These strategies limited the hospital's reliance on overtime and helped ensure adequate nurse staffing to provide active treatment. The cost for these limited duration (LD) positions and increased nurse agency staffing is not budgeted but have been offset by position vacancy savings throughout the hospital. However, recent increases in the need for patient precautions has increased the risk that the cost of LD float staff and agency staff will exceed vacancy savings.

USDOJ/Olmstead

Per the three-year Oregon Performance Plan (OPP) that was developed by the Oregon Health Authority and approved by the United States Department of Justice, the hospital must meet the following targets:

Program Unit Narrative: Salem Campus

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 years.
   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. At the end of Year 2, OSH will discharge 90 percent of all patients who have been committed within 120 days of admission, and by the same deadline, OSH will discharge 85 percent of patients within 25 days of placement on the Ready to Transition List.

To meet these targets, OSH has identified best practices from admission to discharge. As such, the hospital considered it necessary to hire more transition assistants (currently six have been hired) with the intent to free up social workers to do more of the clinical work necessary to prepare our patients for discharge. At the same time, OSH created a Person Directed Transition Team by contracting with professionals specialized in working with patients who experience serious barriers to discharge.

Providing community outings and visits to various placement sites is essential to the hospital's ability to discharge patients within the time frames required by OPP. To help improve the ability to consistently meet this need, two security transport positions were transferred to the Social Work unit to assist with the facilitation of these visits.

Revenue sources and proposed revenue changes

- State General Fund
- Other Funds
  - Medicare
  - Third party insurance

Program Unit Narrative: Salem Campus

  - 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

Oregon State Hospital drafted Senate Bill 24 related to Aid and Assist (.370) patients assigned to OSH by the courts. The legislative concept includes several components, with those moving forward listed below:

a) The 2017 Legislature passed House Bill 2308, which gives .370 patients charged with lesser offenses credit for time they spent in jail when they are committed to OSH. But a Multnomah County judge recently interpreted that law change to apply only after OSH has sent a .370 patient back to jail. In other words, the judge found that the defendant could not get credit for time in jail before the defendant entered the hospital. The defendant's attorney has appealed this issue to the Oregon Supreme Court. This section of this LC is a placeholder if the Oregon Supreme Court opinion results in the need to amend the statute to clarify that the credit applies to time spent in jail before the OSH commitment.

b) The community mental health consult requirement is located in ORS 161.365 – not in ORS 161.370. This means that community mental health must provide a consult *before* a finding of incompetency is made and only if a .365 evaluation is ordered. Thus, the consult often does not occur and, if it does, the community mental health employee is sometimes asked to decide whether the person is competent, which the employee is not trained to do and should not do. We propose that ORS 161.365 and ORS 161.370 be amended so that the community mental health consult requirement would occur in *ORS 161.370* – when the incompetency finding is made by the court. This would be the time for the community to answer the question of whether the person may be served in the community.

c) Despite changes to ORS 161.370 made by the 2011 Legislature intended to cause courts to look to the community for restoration, courts rarely look to the community. We propose that ORS 161.370 be amended so that it more clearly requires courts to look to the community. If (b) above happens, this section of the concept is not necessary.

d) Many municipal courts send defendants to OSH for aid and assist restoration for municipal violations such as littering. This further increases the number of .370 patients at OSH. We propose that ORS 161.370 be amended so that defendants charged with only municipal violations may not be sent to OSH. Note that municipal courts often do have defendants charged with ORS violations. This proposal would not impact municipal courts sending ORS violators to OSH.

e) More than 40 percent of OSH's .370 patients have been charged with only misdemeanors. ORS 161.370 should be amended so that misdemeanant patients must be evaluated and treated in the community, unless a certified evaluator (i.e., a forensically trained doctor who focuses on risks, etc.) determines that the misdemeanant needs a hospital level of care. The middle ground placement options are something every community is seeking, and would be consistent with the USDOJ's expectations. **This component is included in OHA POP 410.**

g) Oregon State Hospital's Forensic Evaluation Service (FES) conducts forensic evaluations in response to court orders. Courts are using the following language contained in ORS 161.365 and ORS 161.315: "the court may order the defendant committed to a state institution [for] observation and examination [for] a period not to exceed 30 days." However, courts are sending many patients to OSH for hospitalization when it is unnecessary or without the authorization the hospital needs to provide services. We propose to amend 161.315 and 161.365 to make explicit that persons sent to OSH to be evaluated under 315 and 365 are to be receive a one-day evaluation. After this evaluation, *at the hospital's discretion*, they will either be returned to the sending institution (typically jail), or will be hospitalized for up to 30 days. Further, for those kept in the hospital following evaluation, we propose that the statute explicitly authorize treatment.

h) When FES and private evaluators complete their evaluations, the evaluations are filed with the court and given to the attorneys assigned to the case. However, OSH evaluators and other evaluators may not share their evaluations with community mental health. These evaluations frequently contain findings that are highly relevant to community mental health, such as diagnostic information, extensive psychiatric histories, and specific treatment recommendations. In addition, defendants at OSH with dischargeable findings (e.g., able or never-able) under 161.370 typically are quickly discharged from the hospital; community mental health providers would benefit by being notified as early as possible that OSH patients may be discharged imminently to their county. The statutes should explicitly state that any evaluation reports filed with a court must be shared with the applicable county community mental health program director or designee.

OHA is also pursuing Senate Bill 25 to improve efficiency and effectiveness of the OSH Forensic Evaluation Service. This concept has three components:

a) a) Courts do not have a standardized procedure to send orders to OSH, resulting in missed or delayed orders. This results in some defendants not being admitted or evaluated within the expected timeframe. This concept would amend 161.365 and 161.370 statutes to explicitly assign responsibility to send court orders to OSH.

b) Evaluators benefit from access to extensive records to render informed opinions. However, many organizations and people refuse to provide records to FES without a signed release of information (ROI), even when explicitly authorized by a court order. Obtaining ROIs from defendants is time-consuming and many defendants refuse to sign releases. We propose to amend the statutes to explicitly require that records be shared with the court-ordered evaluator.

c) The statutes contain either vague or outdated language regarding how the evaluations may be provided to the court and parties. ORS 161.315 is silent on the issue. ORS 161.365 states that “The report must be filed with the clerk of the court, who shall cause copies to be delivered to the district attorney and to counsel for defendant.” And ORS 161.370 states that the evaluations must be “filed with the clerk of the court and delivered to both the district attorney and the counsel for the

defendant." OSH and FES have worked out a mutually agreeable process with the Judicial Department that allows FES to file its evaluations in the Judicial Department's E-court system so that courts and parties may access the evaluations quickly and efficiently. From the FES' point of view, this is an efficient, reliable, and standardized process to communicate its reports to the court and any parties (e.g. DA, defense counsel) that have "attached" themselves to the report in the E-court system. However, because of language in the statutes, FES receives many demands from various courts and attorneys to fax, email or mail evaluations, rather than use the E-court system. This creates a workload problem for FES, which conducts over 1,400 evaluations each year. FES must handle these various "exceptions" to the usual process, which slows the filing of reports. We propose to amend the statutes to explicitly permit OSH to file its evaluations in the E-court system.

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 Funds	Pos.	FTE
Leg Approved 17-19	$6.5	$0.4	$1.9	$8.8	42	42.00
Governor's Budget 19-21	$7.1	$0.4	$2.1	$9.6	42	42.00
Difference	$0.6	$0.0	$0.1	$0.8	0	0.00
Percent Change	9%	10%	7%	9%	0%	0%

Activities, programs and issues in the program unit base budget

Pendleton Cottage is a state-operated secure residential treatment facility in Pendleton, Oregon. With the capacity to serve up to 16 people, Pendleton Cottage provides 24-hour mental health treatment services for adults in a residential setting. In 2017 the facility averaged a 97 percent occupancy rate, with an average daily population of 15.56. 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.

Background information

People served

Pendleton Cottage serves people who have been civilly committed or who are under the jurisdiction of the Psychiatric Security Review Board. Residents no longer require 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.

OREGON HEALTH AUTHORITY: OREGON STATE HOSPITAL

Program Unit Narrative: State Delivered Secure Residential Facility

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 that incorporates the resident's residential service plan, treatment care plan, and the resident's self-stated dreams, desires and goals.

Residents who are under the jurisdiction of the Psychiatric Security Review Board also must meet the expectations outlined in their conditional release 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.

Program Unit Narrative: State Delivered Secure Residential Facility

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 move 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.

Revenue sources and proposed revenue changes

Revenue sources for Pendleton Cottage include:

- 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 Unit Narrative: Junction City Campus

Expenditures by fund type, positions and full-time equivalents

	General	Other	Federal	Total Funds	Pos.	FTE
Leg Approved 17-19	$63.7	$9.5	$2.0	$75.2	357	357.00
Governor's Budget 19-21	$78.4	$10.4	$3.1	$91.9	417	386.50
Difference	$14.7	$0.9	$1.1	$16.7	60	29.50
Percent Change	23%	9%	55%	22%	17%	8%

Activities, programs and issues in the program unit base budget

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 – 79 (Daily average population for 2017)
- Square feet – 220,000

Background information

Populations Served

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

OREGON HEALTH AUTHORITY: OREGON STATE HOSPITAL

Program Unit Narrative: Junction City Campus

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, 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 pleaded Guilty Except for Insanity (GEI) for crimes related to their mental illness. These patients are under the jurisdiction of the Psychiatric Security Review Board.

Treatment program

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

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

Program Unit Narrative: Junction City Campus

Revenue sources and proposed revenue changes

Revenue sources that support the Junction City Campus include:

- 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

None.

2019-21 Oregon Health Authority Proposals/Policy Option Packages

POP #	Legislative Concept? (list LC #)	Lead Program Area	Policy Option Package Title	Description	General Fund	Other Funds	Federal Funds	Total Funds	POS	FTE	Due to OHA, SOS, Fed audit?
401	No	PHD	**Universal Family Linkages & Home Visiting System**	This policy package proposes to bring together partners to create a preventive system of care for families and deliver a universal, short-term, postnatal nurse home visiting program for all Medicaid covered/eligible infants. OHA proposes a phased-in approach over the next 3 biennia, beginning with communities of readiness.	$ 4,056,925	$ -	$ 4,675,590	$ 8,732,515	4	3.00	No
402	No	HSD-Non-Medicaid, Admin; PHD	**Expand Behavioral Health Services, including Suicide Intervention and Prevention, in Schools for Children and Youth; Develop Adult Suicide Prevention, Intervention and Postvention Plan**	Oregonians of all ages need prevention, earlier intervention, and access to services and supports to stem the rising suicide rate and ensure their behavioral health needs are met. Meeting this need requires prompt responses to crises and access to behavioral health services across the lifespan. This package would fund: the 2016-2020 priorities outlined in the Youth Suicide Intervention and Prevention Plan (YSIPP); mental health consultation and treatment services in schools; and the development of an Adult Behavioral Health Suicide Prevention and Postvention Plan. (Postvention is support for the bereaved after a suicide, because family and friends of a suicide victim may be at increased risk of suicide themselves.) Investing in earlier intervention and access to services for Oregon's elementary, middle school, and high school students would help them stay in school, improve learning outcomes, graduate, and prevent suicidal thoughts and behaviors. The YSIPP and an adult suicide prevention plan would reduce youth and family risk of suicide and improve long-term health and education outcomes.	$ 13,103,059	$ -	$ -	$ 13,103,059	3	2.64	No
403	No	HSD-Medicaid; PHD	**Intensive In-Home Behavioral Health Services**	This policy package seeks to create and expand intensive community-based behavioral health care for Oregon children. Due to a lack of intensive community-based services, many Medicaid-eligible youth are referred to residential care instead of receiving treatment in their home community. Creating and funding new intensive care opportunities in the community would increase diversity of services available to Oregon's Medicaid-eligible youth and provide alternatives to residential services.	$ 6,575,316	$ -	$ 13,064,484	$ 19,639,800	-	-	No
404	No	HPA/HP	**Office of Child Health**	Improving prenatal and early childhood health is a Governor's priority, as exemplified by the Governor's formation of the Children's Cabinet. This policy package would support the goals of the Children's Cabinet by creating the Office of Child Health within OHA. This office and staffing would improve OHA's ability to improve the social determinants of health and equity and long-term health outcomes in Oregon, with a focus on the prenatal through age 5 population.	$ 562,875	$ -	$ 358,647	$ 921,522	4	3.50	No
405	LC 390 (SB 253)	PHD	**Public Health Modernization**	In 2013 the Legislature set the state on a path to create a public health system for the future with the passage of House Bill 2348. It established the Task Force on the Future of Public Health Services, designed to develop legislative recommendations. The 2015 and 2017 legislative assemblies affirmed their commitment to a modern public health system with House Bill 3100 and House Bill 2310, which adopted a new framework for public health in Oregon. This requires state and local public health authorities to ensure that essential public health protections are in place for every person in the state through robust, outcome-driven and accountable services. This policy package creates a system of key programs in state, local and tribal public health authorities and increases accountability for health outcomes. Not funding this POP risks the progress of Oregon's nationally recognized public health modernization effort overall and challenges OHA's ability to meet HB 3100's timelines.	$ -	$ 13,600,000	$ 343,287	$ 13,943,287	6	1.50	No
409	No	HPA	**Develop Opioid Alternate Pain Education Modules & Expand Resouces for Substance Abuse Disorders Analysis**	Opioid addictions and other substance use disorders have been declared a public health crisis and priority by the Governor. This POP would address the opioid crisis by expanding training for providers pertaining to appropriate opioid prescribing and other approaches to pain management as well as additional technical resources. Specifically, this POP would: • Enable the Oregon Pain Management Commission to build, maintain and promote 4-6 pain education modules per biennium (building on their existing, nationally-recognized 2018 pain module). These modules would aim to change the risky prescribing practices contributing to the opioid use disorder emergency and promote effective approaches for pain management. In addition, they would promote up-to-date understanding of pain management strategies among patients and the public. • Enable OHA to add technical resources to perform additional analysis of prevalence, treatment and health impacts of substance use disorders and chronic pain conditions, especially opioid use disorder.	$ 312,700	$ -	$ 71,834	$ 384,534	1	0.88	No
410	LC 383 (SB 24)	HSD Non-Medicaid OSH	**Aid & Assist Misdemeanor Defendants**	More than 40 percent of Oregon State Hospital (OSH) Aid and Assist (or ".370") patients have been charged with only misdemeanors. This population has a large effect on the OSH census as the .370 population continues to rise increase. Legislative Concept 383 would amend ORS 161.370 so that misdemeanant patients must be evaluated and treated in the community, unless a certified evaluator (i.e., a forensically trained doctor who focuses on risks, etc.) determines that the misdemeanant needs a hospital level of care. To support the implementation of LC 383, this POP requests funds for more intermediate (i.e., middle ground between the hospital and living independently in the community) placement options. The middle ground placement options are sought by communities and would be consistent with the US Department of Justice's expectations.	$ 7,612,914	$ -	$ -	$ 7,612,914	-	-	No
411	LC 364 (BHH, SB 22); LC 368 (MHCAG, HB 2035)	HPA/OHIT	**Behavioral Health System Investments**	Improving the Behavioral Health system is one of the Governor's top priorities for Oregon's Coordinated Care Organization (CCO) 2.0 process. This policy package would invest in a more connected behavioral health system by providing incentives for investments in foundational technology to advance integration, adapting the primary care home model to advance integration within behavioral health settings, and improving access to evidence-based pharmaceutical treatments and practice guidelines to improve health outcomes of individuals experiencing mental illness. This POP also continues the Mental Health Clinical Advisory Group's effort to make recommendations to the Pharmacy & Therapeutics committee on treatment of mental illness including medications.	$ 5,406,573	$ -	$ 328,623	$ 5,735,196	4	3.50	No
413	No	HSD Non-Medicaid	**Behavioral Health Funding Shortfall**	Many mental health investments made over the last 4 years have been funded by tobacco taxes and Tobacco Master Settlement Agreement (TMSA) funds. Both revenue sources are forecasted to decrease in the 2019-21 biennium and will not be sufficient to support these services at the current level. To continue community mental health and substance abuse disorder services dependent on tobacco tax revenues and TMSA funds, this policy package requests General Fund to cover the shortfall.	$ 9,132,500	$ -	$ -	$ 9,132,500	-	-	No
414	No	HSD-Admin	**MOTS|COMPASS System Modernization & Completion**	The Oregon Health Authority's behavioral health data currently exists on a variety of outdated systems and platforms that are unreliable and disconnected from other agency data. These systems significantly limit the authority's ability to meet federal and state data reporting requirements, track treatment outcomes, improve service delivery, and forecast caseloads. This policy package would fund the procurement of expert contract services for the analysis, acquisition, and implementation of a standardized reporting system for behavioral health services. Once fully implemented, the reporting system would increase the agency's ability to gather data from providers; allow for the reallocation of agency information technology resources; improve collaboration between agency programs and providers; help staff identify opportunities to improve the health of Oregonians who need mental health and substance use services; bring the agency up-to-date on required state and federal reporting; and improve caseload and need forecasting.	$ 6,739,793	$ -	$ -	$ 6,739,793	2	1.76	No
415	No	HSD	**Expanding Hepatitis C Coverage**	Expand coverage for Medicaid recipients to receive Direct Acting Anti-Viral Medications in the treatment of Hepatitis C and prepare the Oregon Health Authority for innovative approaches to Hepatitis C treatment access that involve manufacturers contributing to the solution.	$ 10,000,000	$ 12,307,700	$ 85,128,200	$ 107,435,900	-	-	No
416	LC 371 (ED data, HB 2266)	HPA/CSI	**CCO 2.0**	The Oregon Health Authority (OHA) is committed to furthering health system transformation both in Coordinated Care Organizations (CCOs) and by spreading transformation to additional markets. At the direction of the Governor, OHA is undertaking a significant advancement of the coordinated care model in Medicaid (dubbed CCO 2.0). In preparation for a new procurement of CCOs in 2019 and 2020, the Governor has asked the Oregon Health Policy Board to focus on four areas to further transformation within CCO 2.0: improving the behavioral health system, increasing the use of value-based payments, controlling costs, and addressing CCO members' social determinants of health. Significant policy development work will take place over the next several years that will need to be staffed and supported by OHA, including work on prescription drug costs, long-term financing of health care, strategies for better leveraging the state's purchasing power to advance transformational efforts, maintaining access to coverage, and ensuring a stable private health insurance marketplace.	$ 1,066,092	$ -	$ 836,549	$ 1,902,641	7	6.16	No

POP #	Legislative Concept? (list LC #)	Lead Program Area	Policy Option Package Title	Description	General Fund	Other Funds	Federal Funds	Total Funds	POS	FTE	Due to OHA, SOS, Fed audit?
417	No	PHD	**State Support for Local Public Health**	State Support for Public Health (SSPH) is pass-through funding provided to local public health authorities (LPHAs) to help support basic capacity for communicable disease response. The funding for SSPH was converted from General Fund in 2015-17 to fee revenue from the Oregon Medical Marijuana Program (OMMP). Due to the implementation of recreational marijuana in Oregon, OMMP fee revenues have declined significantly and the program is no longer able to fund SSPH in addition to its own program operations. This policy package requests General Fund to maintain the current funding level for SSPH for LPHAs.	$ 5,480,601	$ -	$ -	$ 5,480,601	-	-	No
201	No	DHS / IE	**Integrated Eligibility / Medicaid Eligibility System Project**	This POP requests resources to support the continuation of the ONE Integrated Eligibility & Medicaid Eligibility (ONE IE & ME) Project from Medicaid, Shared Services, and DAS Enterprise Technology Services. The ONE system will be a single eligibility determination system for Non-MAGI Medicaid, Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, and Employment Related Day Care programs. These resources would support DHS' business needs and is related to the Legacy System Project DHS is undertaking to ensure functionality not assumed into the Integrated ONE system from legacy systems remains available for DHS business usage. The corresponding DHS POP would further the testing and implementation period for the Integrated ONE System for the purposes of Eligibility Determination work. DHS plans to pilot the system in Summer 2019 to be followed by a six-month implementation roll-out beginning early in 2020 and statewide roll-out by Summer of 2020. This POP would take advantage of enhanced federal funds across two federal agencies. Without this funding, DHS would not be able to continue its project in a timely manner, resulting in increased General Fund cost, federal audits, and modifications to Legacy systems. It also includes funding for Eligibility Transformation work that supports changes to DHS' delivery system.	$ 671,490	$ 9,589,123	$ 1,638,121	$ 11,898,734	45	31.00	No
202	No	Shared Services OIS/HSD	**Medicaid Management Information System (MMIS) Modularity**	The Centers for Medicare and Medicaid Services (CMS) requires all states to plan for and implement modular solutions supporting Medicaid using a competitive process. CMS seeks to support states in shifting away from reliance on a single solution provider and establish renewable, componentized solutions for long-term support of Medicaid. Oregon's current Medicaid Management Information System (MMIS) was implemented in 2008. The contract for the support of the MMIS with the current solution provider ends in February 2022. This policy package requests continuation of state funding to secure 90 percent federal financial participation to define Oregon's Medicaid Service Delivery strategic plan; assess other state's modularization approaches; identify options for modular solutions; understand CMS certification requirements and begin procurement activities to secure modular solution components and services to support implementation. Without this POP, the state may lose the 90 percent federal funding for planning activities in alignment with CMS requirements.	$ 547,409	$ -	$ 1,677,969	$ 2,225,378	3	3.00	No
418	LC 386 (SB 27)	PHD	**Fee Structure Revison for Drinking Water Services**	This policy package corresponds to legislative concept 386, which revises the fee authority of Drinking Water Services and increases fee revenue to support adequate regulation of all public drinking water systems. Specifically, authority to charge an inspection (sanitary survey) fee would be replaced with an annual regulatory fee based on the number of connections served by the water system, ensuring more equitable regulation of drinking water systems. With these changes, the Drinking Water program would build capacity to regulate all public water systems equitably, ensure protection of public health and maintain the public's trust in the safety of public drinking water supplies.	$ -	$ 1,853,297	$ -	$ 1,853,297	5	5.00	No
419	LC 387 (SB 28)	PHD	**Fee Changes for Food, Pool and Lodging Programs**	This policy package corresponds to legislative concept 387, which proposes changes to Food, Pool and Lodging inspection and licensing fees. These fees were last revised in 2003 and are not sufficient to cover the Oregon Health Authority's (OHA) costs to carry out the required regulatory work. Most inspections are performed by Local Public Health Authorities; however, OHA conducts inspections when a county transfers public health authority to OHA. Fee changes would cover OHA's costs of implementing regulatory programs directly or through contractors, establish a new fee for processing variances from food sanitation rules, and modify the fee structure for reviewing new pool/spa plans.	$ -	$ 64,450	$ -	$ 64,450	-	-	No
420	No	PHD	**Toxic Free Kids Program**	This policy package fulfills responsibilities described in Senate Bill 478 (2015), which requires manufacturers of children's products containing hazardous chemicals of concern for children's health to report the use of qualifying chemicals to the Oregon Health Authority and eventually remove the chemical from the product, or seek a waiver. To apply for a waiver, the manufacturer must submit an Alternatives Assessment listing a less harmful chemical substitute or an Exposure Assessment, which demonstrates the contaminant is not likely to be bioavailable to the child. This policy package would create a waiver application fee to process applications. Without this fee, the Toxic Free Kids Program will not have designated resources to review applications as required by statute.	$ -	$ 111,511	$ -	$ 111,511	-	-	No
421	No	OEBB/ PEBB	**OEBB/PEBB Benefit Management System Replacement**	The Oregon Educators Benefits Board (OEBB) provides a comprehensive selection of benefit plan options for most of Oregon's K-12 school districts, education service districts, and community college employees. It also administers benefit plan options for a number of charter schools and local government staff across the state. There are approximately 152,000 OEBB members. In 2008, OEBB implemented a Benefit Management System (BMS) to administer benefits to its members called "MyOEBB" based on the Public Employees' Benefit Board (PEBB) system called "pebb.benefits," implemented in 2003. Similarly, PEBB has approximately 139,000 members across the state. PEBB designs, contracts and administers a program of benefits for the state as the employer and state employees. The benefits include medical and dental coverage; life, accident, disability and long-term care insurance; and flexible spending accounts. PEBB also offers healthcare insurance options for retirees not eligible for Medicare and individuals in other participating groups. OEBB and PEBB share the goal of implementing a centralized, standardized, supportable, and scalable solution to replace both MyOEBB and pebb.benefits to provide easier enrollment, better coordination of benefits management, improved access to plan information, and enhanced integration with other tools that improve the overall customer and user experience. Both agencies must begin planning and analysis to implement a new solution by 2021.	$ -	$ 1,806,102	$ -	$ 1,806,102	4	4.00	No
422	No	HPA	**Statewide Pharmacy Purchasing Implementation**	This will enable the Oregon Prescription Drug Program to produce adequate analysis and oversight of existing programs and provide capacity to expand the program and adapt to the dynamic nature of pharmacy space.	$ 418,632	$ -	$ 297,498	$ 716,130	2	1.76	No
208	No	Shared Services OIS	**Centralized Abuse Management System**	House Bill 4151 requires the state of Oregon and the Department of Human Services as its agent, to standardize 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 distinct systems or data sources. Additionally, local offices have created their own one-off mechanisms for supporting 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 victims over time and between populations. This heightens the risk of not capturing all abuse allegations. This POP requests General Fund to implement ongoing maintenance and additional enhancements to build upon the capabilities of a base system implemented in the 2017-19 biennium, for an integrated solution, which meets House Bill 4151 criteria and helps protect vulnerable Oregonians. Not funding this POP will limit Oregon's ability support the system after Go-Live.	$ -	$ 446,578	$ -	$ 446,578	2	2.00	No
					$ 71,686,879	**$ 39,778,761**	**$ 108,420,802**	**$ 219,886,442**	**92**	**69.70**	

Oregon Health Authority
2019-21 Policy Package

Agency Name: Oregon Health Authority
Program Area Name: Public Health Division – Center for Prevention & Health Promotion
Program Name: Maternal and Child Health
Policy Package Title: **Universal Home Visiting for Oregon's Medicaid Population**
Policy Package Number: 401
Related Legislation: None

Summary Statement:

This policy package proposes to bring together partners to create a preventive system of care for families and deliver a universal, short-term, postnatal nurse home visiting program for all Medicaid covered/eligible infants. OHA proposes a phased-in approach over the next 3 biennia, beginning with communities of readiness.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Package Pricing:	**$4,056,925**	**$0**	**$4,675,590**	**$8,732,616**

PURPOSE

1. WHY DOES OHA PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?

A safe and healthy environment during childhood forms the foundation for a lifetime of physical and mental well-being and healthy relationships. There is an opportunity to achieve population impact by bringing together community partners to create a preventive system of care and by delivering a universal, short-term, postnatal nurse home visiting program. Population impact is achievable through universal reach, rigorous evaluation, and creating a model for sustaining funding.

Rates of maternal mortality have been on the rise in the United States and there are significant disparities by race/ethnicity. While maternal mortality rates in Oregon are typically not as high as the national average and we do not yet have a formal maternal mortality review process in place, it is likely Oregon experiences similar disparities to those experienced in other states. Washington State's Maternal Mortality Revise Panel recently included a recommendation to expand efforts to provide early and frequent home visits to prevent pregnancy-related deaths and improve maternal health care.

This universal effort would not replace more intensive targeted home visiting programs. It would identify what families need and want from local resources and provide an individualized, non-stigmatizing entry into their community's system of care. Existing home visiting programs play an integral role in preventing adverse childhood experiences (ACEs), which can harm developing brains and increase lifelong risk for many chronic diseases and other serious problems. The existing home visiting programs provide a critical service in creating a preventive system of care for families. However, these programs are long-term, intensive and don't have sufficient funding or dissemination strategies required for population change.

2. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

Local Public Health Authorities (LPHAs), with support from the Oregon Health Authority, would implement the evidence-based Family Connects Universal Home Visiting model for the Medicaid population. In

collaboration with hospitals and birth attendants, LPHAs will connect with every mother and father of a Medicaid-covered/eligible newborn shortly after birth to engage the family in services and schedule a home visit. Participation is voluntary for families. Ideally, this initial contact would be face-to-face and post-delivery. If requested, a brief home visit will be conducted by a Public Health Nurse (PHN) in the first week of life to address time-sensitive family needs such as breastfeeding, weight check, and postpartum health. A comprehensive home visit will be offered at two to three weeks after hospital discharge. The PHN will assess the physical health status of mother and child; assess unique family risks and needs; respond to immediate family needs such as feeding, weight gain, sleep, parenting stress, substance abuse and mental health; and connect the family with local community services and resources they need and want. Service referrals may include: medical and dental care, more intensive home visiting (e.g. Healthy Families Oregon, Babies First!, CaCoon, Early Head Start), WIC, TANF, childcare, parenting support, behavioral health services and housing. Up to two follow-up visits and telephone calls as needed are offered for further assessment, connections to community services, and family support. The family will be called one month after case closure to ensure customer satisfaction, quality assurance, and to confirm connections to community resources. OHA proposes a phased-in approach over the next three biennia, beginning with those communities that are prepared to implement it.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

Implementing a universal, short-term, postnatal nurse home visiting program is an "upstream" approach that furthers the agency's goal of improving the lifelong health of Oregonians. Science tells us that early childhood is a time of both great promise and considerable risk. Experiences in the earliest years of life form the foundation of brain architecture. Learning, behavior, and health across the lifespan are all built on that foundation. We know today's best programs and practices can help support child development, but too many children are left behind. By supporting all families in identifying and accessing needed resources and attending to time sensitive family needs in the first month of life, we can promote positive early childhood experiences and lay the foundation for lifelong health. Evaluation of the Family Connects Model has shown that at 6 months families have:

- More connections to community resources.
- More positive parenting behaviors with their infant (e.g., hugging, reading).

- Less clinical anxiety reported by mothers.
- Higher quality home environments (e.g., safety, books, toys, and learning materials).

In addition, this POP aims to further the agency's goals of lowering and containing health care costs. Evaluation of the Family Connects Model has shown reduced emergency medical care (hospital overnights, emergency department and emergency doctor visits) for infants at 6 months, 12 months, and 24 months. The Family Connects Model estimates that for every dollar invested in the program, there is a $3.17 savings, primarily from reduced infant emergency medical care.

Creating a preventive system of care and delivering an evidence-based, universal short-term postnatal nurse home visiting program also offers the Oregon Health Authority the opportunity to further the mission of the Early Learning Division to support all of Oregon's young children and families to learn and thrive.

While this initial investment would focus on the Medicaid population, the vision is for a private-public partnership in which commercial health plans join in this move toward universal post-natal home visiting. Building momentum and demonstrating results in the public sector would encourage the private sector to participate.

QUANTIFYING RESULTS

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 has the potential to affect a number of the metrics for Oregon's coordinated care organizations (CCOs) including: emergency department utilization; childhood immunization status; cigarette smoking prevalence; depression screening and follow-up plan; developmental screening in the first 36 months of life; effective contraceptive use among women at risk of unintended pregnancy; patient-centered primary care home enrollment; and the timeliness of postpartum care. The model's upstream approach to assessing the

needs of families and facilitating linkage to community services will further the agency's goals of supporting behavioral health needs and addressing the social determinants of health.

5. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

A lack of preventive services for families may increase numbers of children and families that need more intensive services. Existing home visiting efforts may not achieve population impact.

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGES TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No.

7. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

Implement a universal short-term, postnatal nurse home visiting program through the CCOs. Legislative changes are necessary to require this new service of CCOs. In addition, for this program to achieve measurable impact on outcomes statewide, it must be implemented to fidelity. That would require rigorous evaluation, which requires statewide oversight and coordination.

Implement a universal short-term, postnatal nurse home visiting program through Oregon's Early Learning Division. LPHAs have experience delivering nurse home visiting programs and the partnerships in place to create the preventive system of care required to support families. The current state plan amendment (SPA) to support the delivery of Targeted Case Management (TCM) by Nurse Home Visiting programs would need expansion and approval by CMS to secure federal support for the delivery of this model.

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?

Oregon has been working to build a home visiting system and is poised to capitalize on existing evidence-based and evidence-informed home visiting programs. However, the initial connection, coordination, and triage for families are missing.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

Local Public Health Authorities would be asked to implement this program, which would require additional staff and new partnerships.

The home visiting programs of the Early Learning Division would be integrated with the preventive system of care being created for families.

Families would be referred to resources and services of the Department of Human Services including TANF and ERDC.

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

Early Learning Division

11. WHAT IS YOUR EQUITY ANALYSIS?

A universal home visiting program would remove stigma and promote health equity, because unaddressed disparities during the earliest years can lead to intensified health problems and widening social, educational, and economic gaps.

12. WHAT IS THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

Statewide implementation of an evidence-based universal, short-term, postnatal nurse home visiting program for Medicaid covered/eligible population.

- 10,000 infants served in 2019-2021 biennium.
- 20,000 infants served in 2021-2023 biennium.
- 32,200 infants served in 2023-2025 biennium.

While this initial investment would focus on the Medicaid population, the vision is for a private-public partnership where commercial health plans support the delivery of this intervention of their members.

13. IS THIS POP BEING REQUESTED BECAUSE OF AN INTERNAL DHS/OHA AUDIT, OREGON SECRETARY OF STATES AUDIT, OR FEDERAL AUDIT? IF SO, PLEASE PROVIDE FURTHER INFORMATION.

No.

STAFFING AND/OR FISCAL IMPACT

14. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Replication of the Family Connects Model which includes engaging all families post-delivery, one to three PHN visits per family to conduct assessments, screenings and referrals appropriate to family needs and a post-case closure phone call. On average each family will receive two visits. Per model evidence, the cost is about $700 per family.

The target population will be all Medicaid covered/eligible newborns. Half of all births are Medicaid-supported – approximately 46,000 births in Oregon per biennium. Per model evidence, program saturation is

70 percent of the targeted population as this is a voluntary program and not all families will choose to participate. Saturation in Oregon is estimated to be 32,200 infants per biennium.

A phased-in approach, beginning with communities of readiness, with 10,000 infants served during the 2019-21 biennium.

The current Medicaid Targeted Case Management (TCM) State Plan Amendment for Nurse Home Visiting would need to be expanded and approved by CMS to access support Family Connects services. It would leverage state investment to draw down federal support — approximately 37 percent non-federal investment and 63 percent federal investment.

The current TCM reimbursement rate is $355 per visit. We are conducting a cost study for TCM, so this rate may change once the new rate has been established (~Fall 2018). This rate is inclusive of all local level costs associated with the home visit, including the actual home visit and local infrastructure support for the program.

Implementation Date(s): July 1, 2019 (service delivery to families estimated to begin March 2020)

End Date (if applicable): Ongoing

a. Based on these answers, is there a fiscal impact?
Yes.

b. Will there be new responsibilities for OHA/DHS? Specify which Program Area(s) and describe their new responsibilities.
Public Health Division would provide technical support, training and evaluation to support the successful implementation of the model.

Health Systems Division would need to submit a revised TCM State Plan Amendment (SPA) and receive CMS approval prior to claiming any federal match. The State Plan manager would begin the process to submit the SPA, which has a minimum timeline of 90 days to incorporate required Tribal consultation. Once the SPA is submitted to CMS they would have 90 days to review, ask additional questions, and deny or approve the SPA.

HSD would then provide staff support for an increase in TCM billing, rule-making, ensuring compliance with Medicaid regulations and other administrative duties such as rate setting.

Office of Information Services will need to provide minimal support to the Tracking Home Visiting Effectiveness in Oregon (THEO) data system.

c. 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.
The program needs a common data system to track family contact and referral to be successful. The Maternal and Child Health Section (MCH) is developing Tracking Home Visiting Effectiveness in Oregon (THEO), a data system that collects model specific information and can be built out to track families consistent with the Family Connects model.

d. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
This universal effort would not replace more intensive targeted home visiting programs, but referrals for more intensive home visiting would be made into eligible programs, including Healthy Families Oregon, Early Head Start, Parents as Teachers, Family Spirit, Babies First! and CaCoon. Families enrolled in home visiting programs prenatally (Nurse Family Partnership, Babies First!, Early Head Start and Healthy Families Oregon) would not receive Family Connects services.

e. 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 permanent staff would be required to provide program support and ensure the model is implemented to fidelity.

1.0 FTE Permanent Nurse Consultant (PHN2)
1.0 FTE Permanent Training and Quality Improvement Specialist (OPA3)
0.5 FTE Permanent Research Analyst 3 (RA3)
0.5 FTE Permanent Administrative Support 1 (AS1)

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?

Tracking Home Visiting Effectiveness in Oregon (THEO) development and licenses.
Training nurses and initial audits from model developers.

g. What are the ongoing costs?

- 2021-23 biennium: approximately $6 million General Fund and $9 million Federal Funds to serve 20,000 families.
- 2023-25 biennium: approximately $9.5 million General Fund and $14 million Federal Funds to serve 32,200 families.

h. What are the potential savings?

The Family Connects Model estimated a $3.02 savings by age 6 months for every dollar invested. They estimated a local average of $432 per emergency outpatient visit and $3,722 per hospital night.

2019-21 Biennium potential ROI: $24 million
2021-23 Biennium potential ROI: $45 million
2023-25 Biennium potential ROI: $71 million

TOTAL FISCAL IMPACT FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	$298,138	0	$253,619	$551,757	4	3.00
Services & Supplies	$1,158,787	0	$48,354	$1,207,141		
Special Payments	$2,600,000	0	$4,373,617	$6,973,617		
Total	**$4,056,925**	**$0**	**$4,675,590**	**$8,732,515**	**4**	**3.00**

OHA - Fiscal Impact Summary by Program Area:

	MCH	HSD	Total OHA
General Fund	$4,056,925	$0	**$4,056,925**
Other Funds	$0	$0	**$0**
Federal Funds- Ltd	$301,973	$4,373,617	**$4,675,590**
Total Funds	$4,358,898	$4,373,617	**$8,729,472**
Positions	4	0	**4**
FTE	3.00	0.00	**3.00**

i. What are the sources of funding and the funding split for each one?

Federal match revenue is available for some expenditures at various matching rates. Program administration generates a 50 percent match, while direct program costs generate a 75 percent match through Medicaid Title XIX.

Oregon Health Authority
2019-21 Policy Package

Agency Name: Oregon Health Authority
Program Area Name: Health Systems Division, Child and Family Behavioral Health
Program Name: School Based Mental Health/Suicide Prevention
Policy Package Title: **Expand Behavioral Health Services for Children & Youth in Schools and for Suicide Intervention & Prevention; Develop Adult Suicide Prevention Plan**
Policy Package Number: 402
Related Legislation: None

Summary Statement:

Oregonians of all ages need prevention, earlier intervention, and access to services and supports to stem the rising suicide rate and ensure their behavioral health needs are met. Meeting this need requires prompt responses to crises and access to behavioral health services across the lifespan. This package would fund: the 2016-2020 priorities outlined in the Youth Suicide Intervention and Prevention Plan (YSIPP); mental health consultation and treatment services in schools; and the development of an Adult Behavioral Health Suicide Prevention and Postvention Plan. (Postvention is support for the bereaved after a suicide, because family and friends of a suicide victim may be at increased risk of suicide themselves.) Investing in earlier intervention and access to services for Oregon's elementary, middle school, and high school students would help them stay in school, improve learning outcomes, graduate, and prevent suicidal thoughts and behaviors. The YSIPP and an adult suicide prevention plan would reduce youth and family risk of suicide and improve long-term health and education outcomes.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Package Pricing:	**$13,103,059**	**$0**	**$0**	**$13,103,059**

PURPOSE

1. WHY DOES OHA PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?

Suicide is one of Oregon's most persistent public health problems. The financial and emotional impacts of suicide on family members and communities are devastating and long-lasting. Meeting Oregonians' behavioral health needs in the form of prevention, earlier intervention, and access to services and supports would stem the rising suicide rate. This requires prompt responses to crises and access to behavioral health services across the lifespan.

The Health Systems Division has identified suicide prevention as an unmet-need and high priority for adults in Oregon who need behavioral health services. Adult behavioral health clients have a higher risk for suicide, and a higher completion rate, than the general population.

The State Health Improvement Plan (SHIP) places a priority on suicide prevention across the lifespan. It focuses on working with the health care system to improve the quality of suicide care for all Oregonians.

Prevention/early intervention

Schools/youth suicide: Nine Oregon counties have no existing state-funded school-based services for mental health, neither through a school-based mental health center a therapist placed by a community mental health program (CMHP). Of 78 total SBHCs with mental health services, 16 are in elementary schools. Fewer than 15 elementary schools are served through the School Based Mental Health program (SBMH), which places therapists from CMHPs in schools.

According to the Oregon Department of Education, Oregon has 1,090 schools across all grades; 660 of these are elementary schools. The overall number of schools (including middle and high schools) with counselors (apart from what is provided above) is less than 30.

Students of all ages with adverse childhood experiences (known as ACEs) are at high risk for mental health disorders, substance use and suicide. Students with ACEs need greater protection in the form of parental resilience, social connections, and concrete support in times of need. They need parents and caregivers with knowledge of parenting and child development, and who have social and emotional competence. Many Oregon students could benefit from counseling or therapy services, which can help them stay in school, improve learning, graduate, and prevent suicidal thoughts and behaviors. However, many schools in Oregon are unable to provide these services.

OHA is implementing the Oregon Youth Suicide Intervention and Prevention Plan. In OHA, the Public Health Division Injury and Violence Prevention Section's efforts to address and prevent suicide in the general population and with health care organizations are funded by the Substance Abuse and Mental health Services Administration (SAMHSA). This funding is available through September 2019. OHA has not secured funding to continue and expand this work.

But OHA does not have a comprehensive plan to address suicide for adults served through our behavioral health system. Data show that this population is at higher risk. OHA Health Systems Division is implementing adult behavioral health programs, but without formal coordination to address the concern about suicide. Barriers include:

- Statewide strategies that assist adults at risk of suicide are inadequate and lack specificity.
- OHA lacks resources to oversee community behavioral health programs that are supposed to address suicide through prevention, intervention and postvention.
- The state needs to address training gaps among behavioral health providers and community partners.

A designated position will ensure that a strategic adult behavioral health suicide prevention plan is developed and implemented. It also will ensure better outcomes through coordination of efforts across the behavioral health system and within OHA and HSD.

Access: This POP targets mental health services and supports and suicide prevention across the lifespan. It also deepens efforts to address gaps in existing outreach to youth and families and expands access to

treatment in schools. OHA anticipates that the POP will reduce youth and adult suicide in Oregon or slow its increase. It also will improve timely access to all levels of needed behavioral health services and supports.

This POP is mandated by House Bill 4124 (ORS 418.704) and the Youth Suicide Intervention and Prevention Plan 2016-2020 priorities. Oregon also critically needs expanded access to mental health services in schools, especially elementary and middle schools, according to reports from all state-funded school-based mental health programs (SBHCs and SBMHs).

This POP will affect the Public Health Division (Adolescent and School Health Programs and Injury and Violence Prevention Section) and Health Systems Division (Adult Behavioral Health and Child and Family Behavioral Health). Externally, it will affect communities throughout Oregon, schools, community behavioral health programs, private contractors supporting the work, local child fatality teams, and members of the public who are working to improve behavioral health outcomes and prevent suicide.

2. WHAT WOULD THIS POLICY PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

This policy package would streamline existing mental illness prevention and suicide prevention at the local and state levels through coordination and communication. This ensures services reach those most in need of the services, and are not duplicated.

It would expand several existing programs:

- Youth Suicide Intervention and Prevention Plan (identifies high-risk adult populations, in addition to youth).
- School Based Health Centers administered by the Public Health Division.
- Community mental health programs that place therapists in schools an SBHC, administered through the Health Systems Division.

The Health Systems Division has identified suicide prevention as an unmet need and high priority for the adult behavioral health population. Adult behavioral health clients have a higher risk for suicide, and a higher completion rate, than the general population.

The State Health Improvement Plan (SHIP) puts a priority on suicide prevention across the lifespan. The plan's proposed activities focus on working with the health care system on quality improvement related to suicide care for all Oregonians.

Prevention and early intervention: This POP will use safety planning and lethal means counseling to prevent suicide and address suicidal thoughts and behaviors through improved access to mental health services. This POP will support an increase in protective factors while decreasing risk factors (when possible), which has been shown to reduce youth and adult suicide.

Oregon's overall suicide rate increased 28.2 percent between 1999 and 2016, according to the Centers for Disease Control and Prevention (CDC)[1]. Suicide was the *second* leading cause of death among youth ages 10-24 in Oregon, the *second* leading cause of death among Oregonians ages 15 to 34 years, and the eighth leading cause of death among all Oregonians in 2012. The number of deaths from suicide annually among youth and young adults in Oregon has steadily increased since 2011. These deaths are largely preventable. Nationally, about half of completed suicides occur among people with a mental health diagnosis.

This POP seeks to improve outcomes for youth by assisting their caregivers to create a safe and nurturing environment, which is a known protective factor. Helping adults to manage their own mental health and addictions stabilizes the environmental and emotional climate for the youth in their care, also a protective factor.

Additionally, this POP will enable OHA to develop and implement the Statewide Adult Behavioral Health System Suicide Prevention and Postvention Plan. Contracted dollars would be invested to help providers and

[1] https://www.cdc.gov/vitalsigns/suicide/index.html

systems adopt best practices in preventing adult suicide. This could potentially decrease the suicide and suicide attempt rates throughout Oregon.

This plan will enable OHA to build on its efforts to:

- Integrate behavioral health and primary care through transforming healthcare delivery in Oregon.
- Identify and implement evidence-based and culturally appropriate practices that address depression and suicide among adults.
- Apply community, family and individual interventions to support successful self-management and wellness.
- Develop integrated behavioral health and primary care solutions, by expanding training in suicide intervention skills that will potentially impact populations of adults at higher risk.
- Ensure that all behavioral health providers are trained to assess and manage suicidal persons according to best practices.
- Ensure follow-up care for persons presenting with suicidal behaviors in emergency departments and inpatient psychiatric units.

Access: K-12 students in schools have a variety of immediate mental health and related needs that interfere with learning and achievement. These include factors that can heighten suicide risk: undetected or undiagnosed mental illness and substance abuse, previous suicide attempts, interpersonal or family relationship problems, recent legal or criminal problems, physical illness, chronic pain, school problems and exposure to a friend or family member's suicidal behavior. Services available in schools meet young peoples' needs in the moment and prevent crises from becoming suicide attempts or deaths.

Specific activities anticipated as part of this POP include:

Prevention and early intervention:

- Upstream resiliency programs in elementary, middle and high schools.

- Identification of and resiliency support for students with early trauma and higher adverse childhood experience (ACE) scores.
- Expanded mental health services to elementary, middle and high schools.
- School mini-grants to promote development of prevention and postvention protocols and procedures.
- Funding to update the YSIPP as mandated in legislation.
- Development and implementation of the Statewide Adult Behavioral Health System Suicide Prevention and Postvention Plan.
- Annual suicide prevention conferences to share information on access, intervention and postvention.

Access:
- Mental health providers in school settings.
- Development of online resources for youth and leadership training.
- Support for hospitals and health systems to implement system quality improvements related to safe suicide care (such as the Zero Suicide Initiative).
- Support for the Lines for Life youth peer hotline.
- Tribal mini-grants.
- LGBTQ supports.

Infrastructure support:
- Program evaluation for cost effectiveness and to guide future programs.
- Two coordinators at HSD for youth and adult suicide prevention activities (including the creation of an adult suicide prevention plan) conducted through contractually administered programs, and one for coordination and technical assistance to expanded school-based mental health services.
- A statewide system for rapid response to suicide clusters to reduce contagion risk.
- Training for members of multi-disciplinary death review teams and medical examiners.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

Prevention/early intervention:
This POP addresses the social determinants of health, incorporates and integrates mental health promotion, prevention, and earlier intervention. It supports the existing legislatively mandated Youth Suicide Intervention and Prevention Plan (YSIPP). The POP also supports the State Health Improvement Plan (SHIP), specifically:

- It is consistent with the SHIP's priority to prevent deaths from suicide.
- Key strategies of this priority include:
    - Ensure communities implement an array of services and programs to promote safe and nurturing environments.
    - Encourage health systems to adopt the organizational goal of implementing system quality improvement related to safe suicide care (such as the Zero Suicide Initiative).
    - Ensure suicide intervention and support training for physical, mental and behavioral health care professionals.

The POP also addresses several health outcomes identified in the recent OHA State Health Assessment (SHA). These areas include:

Trauma, toxic stress, and resiliency:
Early traumatic experiences influence the developing brain, and toxic stress can interrupt normal brain development. These adverse childhood experiences (ACEs) are a root cause of many social, emotional, physical, and cognitive impairments. These impairments lead to higher rates of behavioral health issues including suicide, depression, anxiety and development of mental health diagnoses.

Emotional health:
An estimated one in every five adults and youth in Oregon are coping with a mental health condition. Mental health conditions are increasing among adolescents as well. More eighth and 11th graders report being in a

depressed mood for two weeks out of the past school year[2]. Gay and bisexual youth are at significantly higher risk for several indicators of poor mental health. Transgender youth are at very high risk of suicide.

QUANTIFYING RESULTS

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 consistent with CCO metrics, specifically:

- Depression screening, risk assessment and treatment at adolescent well visits.
- Reduce hospital re-admissions through safe suicide care.
- Address issues that result in use of ADHD medications.

Prevention/early intervention:
The U.S. Department of Health and Human Services says half of all mental health problems begin by age 14[3]. Upstream prevention programs (e.g., Sources of Strength and Good Behavior Game) in schools have been shown to reduce ADHD-like disruptive behaviors, promote pro-social development, and assist in establishing peer norms. Children with ADHD are at very high risk for depression and anxiety.

These preventive measures can reduce the impact on the health care system through prevention and treatment at school. While not all suicides are related to depression, screening for depression does reach a sizeable portion of individuals before they are suicidal. Depression screening also addresses factors that can persist into adulthood if not addressed earlier in children and youth.

[2] https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/SURVEYS/OREGONHEALTHYTEENS/Documents/2017/2017_OHT_State_Report.pdf
[3] U.S. Department of Health and Human Services, Substance Abuse & Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health.

OHA will monitor the success of this POP several ways, including:

- Ongoing monitoring of the suicide rates for youth and adults.
- Oversight of access to services in an increased number of schools statewide (particularly in previously unserved areas).
- Through evaluation activities listed in the POP as a targeted action: analysis of suicide prevention, intervention and postvention activities for cost-effectiveness.

Improved school climates, reduction in risk factors and increased protective factors are longer-term outcomes better measured over a greater period of time than the biennium this POP will cover.

4. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

Inadequate access:
Continued increase in numbers of attempted and completed suicides (or no decrease); young people not getting access to needed services; disrupted learning or chronic absenteeism for young people due to mental health symptoms. Adult suicides are also increasing in some age groups (young adults, middle-age males and elder males) and there is currently no plan to address this. Adult suicides affect youth and can cause contagion among youth and young adults, who are particularly susceptible. In the past year, at least seven youth suicides in Oregon occurred after the suicide of an adult in their community.

Inadequate prevention/early intervention:
Not funding this POP will result in OHA not implementing the legislatively mandated YSIPP. Students are currently going without needed mental health services in many schools and communities. Impoverished areas in Oregon that are already lacking in adequate mental health services for young people are especially affected. Parents and caregivers are not able to get these young people to services, or may face unreasonable hardship or stigma when they do4. There is no comprehensive plan for adult suicide prevention, the rate of which is rising.

[4] Office of Rural Health, Oregon Health & Science University, *Oregon Areas of Unmet Health Care Need Report*, August 2017 retrieved from: https://www.ohsu.edu/xd/outreach/oregon-rural-health/about/news/2017-auhcn-report.cfm

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGES TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No.

7. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

These concepts were initially introduced as separate concepts (suicide prevention and school based mental health services need), but they integrate well, address a complex and disturbing issue across the lifespan, reduce silos between divisions and agencies, and represent alarming critical needs.

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?

In 2018 the Legislature allocated $950,000 of one-time funding for school-based mental health. These funds were disbursed to six impoverished counties with critical needs, counties that were already providing these services with a small number of mental health providers per 1,000 residents.

In 2017-19, the Legislature allocated $1 million of one-time funding to support the YSIPP.

The Public Health Division Injury and Violence Prevention section has also received federal funding through the SAMHSA Garrett Lee Smith Youth Suicide Prevention grant. Continued support through this grant is uncertain after September 2019. Even with continued federal support, additional funds are needed to launch comprehensive prevention programs to address the many factors that affect suicide rates.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

- The Department of Education would be affected by an increased number of schools with available mental health services. Space and time consideration for confidential services are a challenge for many districts.
- This POP provides pilot funding to schools for classroom programs as well as suicide prevention and postvention policies and procedures.
- This POP would affect schools and communities statewide by creating rapid response intervention services for schools and communities to avert contagion after a suicide. There are no services now that work in an organized or coordinated manner to prevent suicide contagion. The need is particularly acute in rural areas of Oregon.
- Local government would be affected primarily through school districts, Educational Service Districts, and community (county) mental health programs, which will be called upon to work together to coordinate and implement the services.
- This POP will bring best practices, needed services and training that will positively affect community mental health and public health programs through support and technical assistance for prevention and postvention.
- Mini-grants will be given to the tribes in Oregon for suicide prevention, intervention and postvention programs of their choosing. Reducing suicide rates among American Indians/Alaska Natives is a priority of the SHIP.
- It supports the Office of Equity and Inclusion's priority for LGBTQ Oregonians, who are at extremely high-risk of suicide, especially transgender individuals.
- DHS suicide prevention programming would be affected by the availability of technical assistance.
- Hospitals from across Oregon implementing Zero Suicide initiative for suicide-safer care would be affected. This POP will provide financial support for their efforts and improve data collection on Zero Suicide[5].

[5] https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SAFELIVING/SUICIDEPREVENTION/Pages/Program-Information.aspx

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

- Oregon School Based Health Alliance (OSBHA)
- Oregon Alliance to Prevent Suicide and its members' organizations
- Oregon School Nursing Association (OSNA)
- Confederation of School Administrators (COSA) Social-Emotional Learning workgroup
- Healthy Kids Learn Better (HKLB)
- Oregon Consumer Advisory Coalition (OCAC)
- Children's System Advisory Council
- Addictions and Mental Health Planning and Advisory Council (AMHPAC)
- Counties responsible for responding to suicides per SB 561
- Basic Rights Oregon

11. WHAT IS YOUR EQUITY ANALYSIS?

This POP prioritizes funding for activities that address populations with the highest risk.

Culturally relevant supports for tribes will address the extremely high suicide risk of tribal youth. Reducing the disparity of suicide among Native Americans is also a SHIP health equity goal. Oregon tribes receive no state funding for suicide prevention, intervention and postvention. They are in acute need of support for such programs. This funding would allow for tribes to select projects that would respond to their high suicide rate. From 2000 to 2010, Native American males aged 15 to 24 years had a suicide death rate of 51.93 per 100,000 vs. 16.9 per 100,000 among all U.S. males in that age group. Among females aged 15 to 24 years, the rate for Native Americans was 16.74 per 100,000 compared with 3.89 for the total female population.

Suicide rates are also extremely high among LGBTQ youth, with transgender youth experiencing the highest rates. *Some report that approximately 40 percent of transgender individuals attempt suicide*. Programs to reduce suicide risk among LGBTQ youth and young adults address the attempt and completion rates in these groups though family acceptance and collaboration with Basic Rights Oregon.

Adults and youth with behavioral health disabilities, are addressed though education of those who serve or treat them. Vulnerable at-risk children and youth whose parents have behavioral health disabilities will be served.

12. WHAT ARE THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

The desired long-term outcome is an increase in the ability of behavioral health providers to protect at-risk Oregonians from suicide. This will happen because there is more collaboration among the public health, behavioral health and education systems. As a result, communities will have lower risk factors for suicide and better ways to protect people of all ages from suicide.

STAFFING AND/OR FISCAL IMPACT

13. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

The Oregon Youth Suicide Intervention and Prevention Plan (YSIPP) was mandated by HB 4124 (ORS418.704) in 2014, developed by stakeholders in 2015, and adopted in 2016. Progress has been limited to activities that can be done without additional funding. Critical areas of the YSIPP need attention and funding to fully implement the vision for a suicide-safe state. In addition to the YSIPP, the State Health Improvement Plan also calls for attention to Oregon's high suicide rate, which has been increasing since 2011.

At the same time, existing school-based mental health programs lack capacity to meet existing need in the schools they serve. Beyond that, we know there are nine counties with none of these services, and very few elementary schools with any school-based mental health services. The POP is focused on (1) prevention and early intervention and the need to provide services and supports at younger ages for students, and (2) supporting adults who may be involved in the lives of young people, and who have their own behavioral health concerns that can lead to suicide.

Implementation Date(s): January 1, 2019

End Date (if applicable): Ongoing

a. Based on the following answers, is there a fiscal impact?
Yes.

b. Will there be new responsibilities for OHA/DHS? Specify which Program Area(s) and describe their new responsibilities.
Child and Family Behavioral Health
Contract management, Requests for Proposals (RFPs); coordination of the SBMH program; development of suicide prevention contracting activities; technical assistance (two permanent, full-time Operations and Policy Analyst 3 positions)

Contracts
Creating new contracts, drafting amendments and RFPs

Adult Behavioral Health
Additional staff devoted to suicide prevention, intervention and postvention policy and program development, including stakeholder outreach in development of an adult suicide prevention plan (one permanent, full-time Operations and Policy Analyst 4 position)

c. 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.
Minor facilities planning for cubicles and equipment for the three proposed positions.

d. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

There will be more access to services. Addition of elementary school therapists to existing group of therapists; all are supervised at CMHP level. The FTEs in OHA will support technical assistance for supervisors of the therapists, and help to troubleshoot programmatic issues in getting the services implemented.

e. 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 request includes three permanent, full-time positions.

- OPA 3 for Child and Family Behavioral Health to augment work of the Suicide Prevention and Intervention Coordinator in HSD.
- OPA 3 for Child and Family Behavioral Health to start up and manage additional sites with school based mental health that are not in school based health centers and oversee the SBMH program at HSD.
- OPA 4 for Adult Behavioral Health to develop and implement the statewide adult behavioral health system suicide prevention and postvention plan.

See g. below for further detail.

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?

See g. below for further detail.

g. What are the ongoing costs?

The following budget request is outlined by goals and objectives of YSIPP. All align with specific priorities of the Plan.

YSIPP Strategic Direction 1: Healthy and empowered individuals, families and communities ($250,000)

1. **Youth engagement and leadership.** Fund services to meaningfully engage youth with OHA, Oregon Alliance to Prevent Suicide and the Children's System Advisory Committee in suicide prevention, intervention and postvention. Recent experience indicates that a specific entity is needed to coordinate youth engagement and lead groups of youth stakeholders/experts to provide crucial youth and young adult input on suicide planning and activities.
2. **Develop second mandated five-year Youth Suicide Intervention and Prevention Plan**. Involve the Alliance and broad array of stakeholders and youth in developing the legislatively mandated plan update for 2021-2026**.**

YSIPP Strategic Direction 2: Clinical and community preventive services ($1,180,000)

1. **Support communities in crisis.** Fund immediate post-suicide response in communities experiencing multiple suicides or attempts. This addresses the high rate of contagion among youth. Funds will be distributed to communities that have been stressed beyond their capacity.
2. **Train communities to develop suicide response plans to reduce contagion risk.** SB 561 requires all counties to work with partners to develop and implement post-suicide response plans. This training would be offered to community members to provide knowledge and skills in postvention and increases an Oregon cadre of suicide response experts.
3. **Psychological autopsy certification.** This will allow for collaboration between medical examiners and OHA suicide prevention staff to ensure that psychological autopsies are conducted for suicide deaths. A psychological autopsy allows medical examiners to better ascertain circumstances around the suicide and improve data reporting and surveillance to better monitor the psycho-social circumstances that contributed to the suicide.
4. **Provide technical assistance and training to county Child Fatality Review Teams.** ORS 418.785 requires county multidisciplinary child abuse teams (MDTs) to establish a child fatality review team to conduct child fatality reviews, including suicides. This funding would allow a needs assessment to be conducted with county MDTs and child fatality review teams to determine what technical assistance and training are needed to support child suicide death reviews, including a focus on prevention efforts.

Once the needs assessment is completed, technical assistance and training support can be developed. This will encourage relationship building between county MDTs/child fatality review teams and state suicide prevention specialists which will provide for more valuable reports following county reviews. This can lead to county prevention successes informing state prevention efforts.

YSIPP Strategic Direction 3: Treatment and support services ($9,540,000)

This work ensures communities can implement an array of services and programs to promote safe and nurturing environments.

1. **Youth-led development of online resources for youth.** This will involve youth and suicide prevention experts working with youth to develop or identify safe online practices on social media platforms. Includes a Youth Summit to develop teams of youth to serve as prevention leaders across the state. This will encourage healthy peer relationships.
2. **Oregon suicide prevention hotline.** This will fully fund Lines for Life and YouthLine crisis response services for Oregon youth and families. The hotline currently is operating at a deficit due to drastic increases in call volume. YouthLine has never been funded by the state. Oregonians rely on this phone, chat and text service as a critical component on the continuum to prevent and intervene to de-escalate crises and guide people to the support they need.
3. **Resilience building in schools.** This will provide funding to:
    a. Implement the best practice Sources of Strength youth-led resiliency program in middle and high schools.
    b. Work with preschools and elementary schools to support pro-social development through the best-practice PAX Good Behavior Game.
    c. Provide mini-grants to pilot schools to identify or develop customized protocols and strategies to prevent suicide and provide best practice post-suicide response.
4. **Expansion of school based mental health services.** Providing funding for increased mental health services will allow for early intervention for mental health issues. Such issues may lead to poorer health and education outcomes. Adequate mental health services can lead to a reduction in suicides.
    - Counties with no existing services ($2 million) to establish school based mental health services through existing CMHP; provide technical assistance using existing mechanisms.

- For counties with clear unmet need, even with existing SBMH services ($2 million), funding mechanism to be determined, likely grant application offering to those with need as demonstrated by Oregon Healthy Teens, Office of Rural Health and other data.
- Address shortfall from 2017 SBHC Mental Health Expansion Capacity grant requests ($1.1 million) to assist SBHC sites with known unmet needs; fund through existing mechanisms.
- To develop SBMH services availability in pre-K and elementary school settings, targeting trauma and developing resilience in students who've experienced ACEs at earlier ages ($1 million); fund through grant application process.

YSIPP Strategic Direction 4: Surveillance, research and evaluation ($700,000)

1. **Evaluation on progress implementing the YSIPP.** This will continue an intergovernmental agreement between OHA and the University of Oregon to collect, evaluate and analyze data to gauge the success of programs implemented to meet the goals and objectives of YSIPP. This analysis increases the ability to determine cost/benefit of certain interventions and guide future investments.
2. **Data collection from hospitals and health systems.** This will support efforts of Oregon hospitals and medical or behavioral healthcare systems to deliver suicide-safer care. Participants also will be required to collect and submit data about their needs, challenges and program innovations they are implementing under the best practice comprehensive Zero Suicide initiative.

Infrastructure ($856,403)

1. **Support for implementation.** Hire a Child and Family Behavioral Health Specialist at the OPA 3 classification in the OHA Health Systems Division. This position would manage the data collection, grant program and start up process for additional school-based mental health settings, to amend the existing MHS 37 School Based Mental Health service element (County contractual language) and to provide oversight and technical assistance to the schools with therapists, review quarterly reports, and report to the legislature on the success of this expansion.

Hire an OHA youth suicide prevention and intervention specialist at the OPA 3 classification to coordinate and implement prevention and post-suicide intervention activities called for in the 117 action items in the YSIPP and the widening scope of youth suicide prevention activities in Oregon since 2014. ($656,403)

2. **State Health Improvement Plan: Prevent Deaths from Suicide.** Hire an adult suicide and intervention specialist at the OPA 4 classification who will coordinate efforts to:
    - Promote use of the National Suicide Prevention Lifeline.
    - Create incentives for private and public health plans and health care providers to prevent deaths from suicide
    - Establish universal screening for individuals at risk of suicide
    - Ensure training for health professionals is available to address suicide risk

    Hire an adult suicide and intervention specialist. This position will develop a statewide behavioral health system plan, and coordinate and implement activities to prevent and reduce suicides among adults within Oregon's behavioral health system. ($238,085)
3. **Hold a state suicide prevention summit and training annually.** This will encourage collaboration among communities, promote best practices, and share innovative practices from all corners of the state. ($200,000)

<u>Populations at disproportionately high risk of suicide as identified in YSIPP</u> ($600,000)

1. **LGBTQ supports**. This will expand suicide prevention efforts to the extremely high-risk LGBTQ youth in Oregon. ($100,000)
2. **Tribal mini grants.** Oregon tribes receive no state funding for suicide prevention, intervention and postvention. They are in acute need of support for such programs. This funding would allow for tribes to select projects that would respond to their high suicide rate. ($450,000)
3. **Suicide attempt and bereavement survivors.** This would fund online and other easily accessible tools to reduce suicide risk among people who previously attempted suicide and loved ones left behind after a death. ($50,000)

TOTAL: $12,926,403

h. What are the potential savings?

Improved long-term health and educational outcomes from prevention, earlier intervention, and access to behavioral health services would likely avoid costs for a variety of government programs; however, these savings are diffuse and difficult to measure.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	$548,714	0	0	$548,714	3	2.64
Services & Supplies	$1,034,345	0	0	$1,034,345		
Capital Outlay	0	0	0	0		
Special Payments	$11,520,000	0	0	$11,520,000		
Other	0	0	0	0		
Total	**$13,103,059**	**$0**	**$0**	**$13,103,059**	**3**	**2.64**

OHA - Fiscal Impact Summary by Program Area:

	HSD Non-Medicaid	HSD Admin	Total
General Fund	$11,520,000	$1,606,403	**$13,103,059**
Other Fund	$0	$0	**$0**
Federal Funds- Ltd	$0	$0	**$0**
Total Funds	$11,520,000	$1,606,403	**$13,103,059**
Positions	0	3	**3**
FTE	0.00	2.64	**2.64**

i. What are the sources of funding and the funding split for each one?

General Fund.

Oregon Health Authority
2019-21 Policy Package

Agency Name: Oregon Health Authority
Program Area Name: Health Systems Division
Program Name: Child and Family Behavioral Health
Policy Package Title: **Intensive In-home Behavioral Health Services**
Policy Package Number: 403
Related Legislation: None.

Summary Statement:

This policy package seeks to create and expand intensive community-based behavioral health care for Oregon children. Due to a lack of intensive community-based services, many Medicaid-eligible youth are referred to residential care instead of receiving treatment in their home community. Creating and funding new intensive care opportunities in the community would increase diversity of services available to Oregon's Medicaid-eligible youth and provide alternatives to residential services.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Package Pricing:	**$6,575,316**	**$0**	**$13,064,484**	**$19,639,800**

PURPOSE

1. WHY DOES OHA PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?

The primary goal for this policy package is to create a level of care in Oregon's behavioral health system that would deliver intensive community-based services to youth. OHA requires that CCOs provide for a very limited array of outpatient behavioral health services. OHA has no requirement that youth with the most intensive needs be served in their own community. While many CCOs do support and fund some form of intensive outpatient services, neither service levels nor delivery models are consistent statewide.

Many Medicaid-eligible youth are referred to residential care instead of receiving treatment in their home community, due to the lack of intensive community-based services. Creating and funding a new level of care would increase diversity of services available to Oregon's Medicaid-eligible youth and provide more alternatives to residential services. This POP would enable OHA to increase the rates paid for community-based services in a way that would encourage providers and CCOs to provide higher intensity services to more youth. Improved access to higher intensity in-home services and supports would make it possible to treat more youth without an out-of-home placement.

Eligibility for these services would be based on clinical need, as determined by the youth's treatment team and a utilization management protocol determined by the CCO.

2. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

This POP would create a community-based level of care to serve youth with intensive needs.

- Each youth receiving these services would be offered a combination of services as determined by the youth's treatment team. Services could include skills training, individual therapy, family therapy, medication management, 24-hour crisis response, peer delivered services, case management and others. These programs would emphasize providing services in the youth's home and other settings that are not office-based.

- Funds would be distributed by OHA to CCOs based on the anticipated number of youth that would receive these services in their coverage area. CCOs would have the option to deliver the services on their own or to contract with a qualified provider.
- OHA would develop Oregon Administrative Rules for programs wishing to deliver these services. OHA would certify providers to provide this level of care.
- OHA staff would provide technical assistance to ensure that providers are prepared to implement these services and to identify target populations.
- These services would be paired with OHA's ongoing work with System of Care and Wraparound to ensure consistency in the behavioral health system.

Operational costs of the program will include:

- Monthly psychiatry for medication management.
- Skills training in the community one or two times per week.
- Individual therapy in the community about one time per week.
- Family therapy in the community about one time per week.
- Peer-delivered services as needed.
- Case management services for the youth and family.
- 24-hour availability for crisis response.

Most providers will already offer these services, but higher frequency and intensity may increase costs.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

This POP would further the agency's mission by expanding services available to youth in the least restrictive environment. Serving youth in the community, as opposed to residential treatment programs, maintains youths' connections to their existing support system, which provides for stability and better overall outcomes. Further, investments in outpatient services are less costly than residential services. That means available funds go further.

Access to intensive community-based services would help to reduce strain on residential programs and provide more options for youth and their families. Residential treatment programs in Oregon are operating with very long waitlists, which create delays in needed care. Serving youth in the community would decrease the demand for beds in residential treatment programs and ensure youth admitted to residential programs have the highest level of need.

QUANTIFYING RESULTS

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 aimed at providing services to youth in the most integrated setting possible by expanding the array of services available to youth in their homes and decreasing reliance on higher levels of care.

OHA would monitor the effect these services have on assisting youth to remain in the community for treatment, and on the average length of stay for youth in residential settings. This can be accomplished by monitoring the demand for residential treatment. OHA would continue to monitor overall usage and the average length of stay in each level of care. OHA would work with CCOs to monitor the usage rate of intensive outpatient services to ensure they are fully implemented.

OHA would also continue to monitor whether fewer youth require emergency room services for behavioral health needs. Because the POP would emphasize 24-hour crisis support, it would give families and caregivers timely and intensive support that could prevent the need for emergent hospital services.

5. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

Not funding this POP would maintain the status quo. Community-based services are not adequately funded to provide in-home or community-based services to youth with intensive needs. With the strain on residential beds, we need more intensive and innovative services at the local level. This funding would allow OHA to require CCOs to cover these service, while providing adequate funding to do so.

Residential treatment is more expensive and often less effective than serving youth in community settings. Intensive in-home services would help prevent disruptions and improve communities' ability to maintain youth.

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGES TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No change to statute.

7. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

- Adding intensive community-based services to the CCO contract.
  - Since OHA is required to comply with actuarial soundness requirements under the Centers for Medicaid & Medicare Services Medicaid managed care rules 42 CFR 438.4, additional funding must be made available to cover these services in their global budgets.
  - There is no existing fee schedule for the proposed level of care. CCOs provide for differing types of intensive outpatient programs by utilizing several applicable encounter codes. This POP would enable OHA to create a daily rate and code.
- Including intensive community-based services in Oregon Administrative Rules.
  - There is no requirement or incentive for CCOs to cover these services. Instituting a new policy without a funding mechanism would be unsustainable for the CCOs.
  - Outpatient rates are not sufficient for providers to deliver services.

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?

- Technical assistance from OHA staff. This generally involves asking CCOs to go beyond traditional funding sources.

- CCOs funding single-case agreements with providers for youth who have intensive behavioral health needs.
- Most CCOs fund a version of intensive community-based services, though not with the intensity, direction, or funding mechanisms that are necessary. Further, these services have not been consolidated into a single level of care that is certified and monitored for quality by OHA. Allocating increased funding for these services would allow OHA to collaborate with CCOs and providers to develop policy and structure to implement these programs and create more consistency throughout the state.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

No negative impact for other agencies. Potential positive impacts might include:

- DHS:
  - Resources for local communities to divert youth who may otherwise stay in a hotel. The data collected on youth who are temporarily placed in a hotel suggest that most youth enter these situations after a disruption while in a foster home. This POP would provide additional in-home supports for youth in foster care with intensive needs, making it easier for homes to maintain the youth.
  - Increased support for youth in foster care, especially after school hours.

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

This concept was presented to the Children and Youth with Specialized Needs workgroup for feedback. The workgroup, which included CCO, provider, and state agency representation, supported the POP. Their recommendations have been included. They will continue to be engaged as this POP progresses.

As development continues, we will engage CCOs and providers to accurately report anticipated costs and benefits of this level of care.

DHS has shown interest in combining a form of this service with Behavior Rehabilitative Services Therapeutic Foster Care to support youth in care.

11. WHAT IS YOUR EQUITY ANALYSIS?

This POP would increase access to community-based services throughout the state. Services in a youth's community can lessen the burden on families, particularly those with very low incomes, to travel to appointments. The new funding mechanisms for community-based services could also encourage providers to develop more culturally appropriate options.

12. WHAT ARE THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

This POP would contribute to the development of a functioning system of care for youth with very intensive needs. Such a system would ensure services are available in the community, lower demand for residential services, and ensure only youth with the highest level of need are placed in residential programs.

STAFFING AND/OR FISCAL IMPACT

13. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): January 2020

End Date (if applicable): Ongoing

a. Based on the following answers, is there a fiscal impact?

Yes. There will be a fiscal impact. These funds will be distributed to CCOs as a part of their global budgets along with the expectation that they serve all members who qualify for the service.

b. Will there be new responsibilities for OHA/DHS? Specify which Program Area(s) and describe their new responsibilities.

Health Systems Division

Child and Family Behavioral Health Unit: Technical Assistance, rule writing, contracting, and ongoing consultation for sites on implementation.

Licensing and Certification: OHA will need to certify providers for these services and conduct ongoing compliance reviews.

Business Services Unit: OHA will need to make modifications to MMIS to accommodate a new level of care.

Health Policy & Analytics

Actuarial Service Unit: Setting rates for intensive in-home services.

c. 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.

d. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

This will be a change for services available to youth statewide. Caseloads may rise, but the biggest change will be in the frequency and intensity of services for youth.

Providers would likely experience increased sessions for skills training and individual therapy. There would be an increase in community-based crisis response, including more responses to the youth's home. These programs would create a more intensive delivery system which will lead to a higher frequency of services beyond what is already provided in most places. Because these services would be delivered in the community, providers could experience increased travel requirements.

e. 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.

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
None. During initial implementation, existing staff would provide intensive technical assistance, outreach, and training for service providers, as well as develop a certification process for providers.

g. What are the ongoing costs?
Payments to providers of approximately $2,204 per month, per youth for approximately 1,500 youth ages 0-18, which is approximately $3.3 million per month based on a weighted average of behavioral health procedure codes crossing CY16 and CY17. These costs would be eligible for Medicaid match per the FMAP. OHA would begin including funding for intensive in-home services in CCO rates for the 2020 contract year. Therefore, for 18 months of the 2019-21 biennium, the projected cost is $59.5 million Total Funds, which includes $19.9 million General Fund and $39.6 million Federal Funds.

h. What are the potential savings?
Investing in intensive community-based services will lead to decreased spending on higher levels of care as youth move from residential services to community-based services. Greater availability and access to in-home and community services will prevent youth from needing to access higher levels of care.

Savings would be approximately $7,383 per month, per youth, for approximately 300 youth ages 0-18 who would be diverted from requiring residential treatment. The Total Funds savings is projected to be $2.2 million per month. In 2019-21, the projected savings is $39.9 million Total Funds, $13.3 million General Fund and $26.5 million Federal Funds.

Projected Total Fund 19-21 Cost	FF	GF
$ 59,508,000	$ 39,584,991	$ 19,923,009
Projected Total Fund 19-21 Savings	**FF**	**GF**
$ 39,868,200	$ 26,520,507	$ 13,347,693
NET Projected Total Fund 19-21 Impact	**FF**	**GF**
$ 19,639,800	$ 13,064,484	$ 6,575,316

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	0	0	0	0	0	0.00
Services & Supplies	0	0	0	0		
Capital Outlay	0	0	0	0		
Special Payments	$6,575,316		$13,064,484	$19,639,800		
Other	0	0	0	0		
Total	**$6,575,316**	**$0**	**$13,064,484**	**$19,639,800**	**0**	**0.00**

OHA - Fiscal Impact Summary by Program Area:

	Behavior Health	Total
General Fund	$6,575,316	**$6,575,316**
Other Fund	$0	**$0**
Federal Funds- Ltd	$13,064,484	**$13,064,484**
Total Funds	$19,639,800	**$19,639,800**
Positions	0	**0**
FTE	0.00	**0.00**

i. What are the sources of funding and the funding split for each one?

The package includes General Fund and Federal Funds through Medicaid match. The funding splits are determined by the Federal Medical Assistance Percentages (FMAP) rate, applicable quarter, and FFY for the 2019-21 biennium. Determining which FMAP rate to apply is achieved by identifying the proportion of the 1,500 youth estimated to be eligible for intensive in-home services in each eligibility group.

Oregon Health Authority
2019-21 Policy Package

Agency Name: Oregon Health Authority
Program Area Name: Health Policy & Analytics
Program Name: Improving Prenatal and Child Health
Policy Package Title: **Office of Child Health**
Policy Package Number: 404
Related Legislation: None

Summary Statement:

Improving prenatal and early childhood health is a Governor's priority, as exemplified by the Governor's formation of the Children's Cabinet. This policy package would support the goals of the Children's Cabinet by creating the Office of Child Health within OHA. This office and staffing would improve OHA's ability to improve the social determinants of health and equity and long-term health outcomes in Oregon, with a focus on the prenatal through age 5 population.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Package Pricing:	**$562,875**	**$0**	**$358,647**	**$921,522**

PURPOSE

1. WHY DOES OHA PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?

OHA does not have a coordinated team that is focused on prenatal and child health initiatives. This limits the agency's ability to drive expanded policy strategies and improvements in children's health. Prenatal care and children's health activities have increased. They would benefit from unified agency support. OHA does not have a system in place to coordinate or lead these efforts. OHA has tremendous expertise in children's health distributed across the agency. However, OHA lacks sufficient staffing to meet current workload needs or respond to the opportunities to advance children's health. Clearly established leadership, authority, strategic focus and overall agency support and resources would significantly increase the impact of existing staff.

The Office of Child Health would support child health initiatives affecting children under age 18, with a focus on the prenatal to age 5 ("P-5") populations. Many of the child health efforts underway across the state are innovative, potentially cost-saving and move the work upstream to address the social determinants of health and equity. Examples include kindergarten readiness metric, childhood disparities data tracking, and partnerships with the Department of Education's Early Learning Division and the Department of Human Services. This work requires dedicated staff who can effectively work as a team with collective goals to drive policy, quality improvement and cross sector strategies forward. This team will be able to provide the support and resources needed for OHA to be a state leader in advancing P-5 outcomes and in building cross-sector efforts.

By improving children's health in an upstream manner and creating dedicated capacity to address child health disparities, this initiative has significant potential to reduce health care costs further down the line.

2. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

This POP would establish an Office of Child Health. It would be responsible for setting agency priorities, addressing high-level state challenges, developing policy, and participating in partnership opportunities. This office would capitalize on the current energy and investment in children's health and well-being in Oregon and nationwide by building a team in OHA dedicated to fully supporting the work. This would increase efficiency and replace the inconsistent way staff who work on children's health collaborate and share information within the agency and with external stakeholders and partners.

This POP would be implemented by establishing four new positions comprising the Office of Child Health:

- **Child Health Director** (PEMG): Responsible for leading the OHA Office of Child Health, ensuring compliance with federal and state laws, Oregon Administrative Rules, and standards, and for developing priorities and programs to meet the needs of those seeking assistance from medical insurance programs with a focus on the prenatal through age 5 population in Oregon. Also responsible for leading coordinated child health efforts within OHA (including collaboration with existing Children's Behavioral Health Team and the Maternal and Child Health Section in PHD) and with cross-sector partners.

  Guides the Office in: overseeing and aligning efforts to track, monitor, and support child health programs across OHA divisions as needed; provide support to CCOs and innovator agents on child health activities, metrics, and policies; bring together CCOs and Early Learning Hubs and other system partners for learning opportunities and technical assistance. The Child Health Director will have strong policy experience in order to provide analysis, direction, and recommendations to the leadership team related to children's health initiatives and inter-agency policy and program collaboration opportunities.

- **Children's P-5 Health Policy Analyst** (OPA4): Responsible for providing policy analysis and recommendations to the leadership team, researching and assisting with legislative concept development, coordinating and tracking child health activities and recommendations in the Oregon Health Policy Board

and OHA committees and collaborating within OHA and other agency partners on policy priorities. The policy analyst will also work closely with the Transformation Center, which has a significant role in supporting Coordinated Care Organizations in achieving better outcomes for children, including collaboration at the local level with Early Learning Hubs.

- **Children's P-5 Data Analyst** (RA4): Responsible for maternal and child health research, data analysis, report generation, and coordination with data analysis positions in other agencies regarding P-5 child and family health priorities.
- **Child Health Equity Coordinator** (OPA2): Responsible for monitoring and tracking data related to childhood disparities; identifying opportunities and strategies to improve disparities, and implementing recommendations related to improving children's health equity in Oregon.

The Office of Child Health would be in OHA's Health Policy and Analytics Division, with a streamlined reporting structure and team approach. Some of the proposed positions would have a clear relationship, i.e., "dotted line," to other offices and units. For instance, the child disparities and equity position would work closely with the Office of Equity and Inclusion to align with the expertise, opportunities and principles of OHA's broader equity work. The data analyst position would be functionally embedded in the Office of Health Analytics to ensure full access to the Health Policy and Analytics data infrastructure and expertise. It would also work closely with data analysts from Maternal and Child Health, Child and Family Behavioral Health, and others throughout OHA. The child systems coordinator would be functionally embedded in the OHA Transformation Center to leverage its structures and systems for delivering technical assistance to CCOs and primary care. This team would be structured to ensure maximum collaboration opportunities throughout the agency, ensuring connections across all of OHA's child-serving programs and divisions.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

Establishing an Office of Child Health would enable OHA to develop and advance agency priorities related to the P-5 populations. It would also allow OHA to address high-level state challenges, develop policy, and participate in partnership opportunities in alignment with the Governor's focus on creating a comprehensive, cross sector early childhood system. Establishment of this team will also prioritize data analysis to highlight

and better understand child health disparities in Oregon, as well as prioritizing implementation of recommendations and partnerships to address these disparities. This team will be able to provide the support and resources needed for OHA to be a state leader in advancing children's health and building cross-sector efforts.

QUANTIFYING RESULTS

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 the POP will be initially measured by:

- Improved collaboration and increased communication internally at OHA and with agency partners (e.g., DHS, ODE, and community organizations), including:
  - Creation of a single point of contact at OHA for children's health
  - Convening of partners to establish and support shared goals
  - Alignment of policies and programs towards shared agency goals
  - Identification of funding opportunities
- Establishment of a children's health strategic plan at the Oregon Health Authority, designed in alignment with and to support the new Early Learning strategic plan, the Public Health Division's Maternal and Child Health strategic plan, the State Health Improvement Plan, and CCO 2.0 strategies to improve health and well-being of the prenatal and child populations in Oregon. This plan will include the following:
  - How to measure, track, and reduce childhood health disparities, especially in the Medicaid population.
  - Identification of system-level challenges related to children's health (e.g., information sharing between medical and educational providers) and evidence-based and/or innovative solutions to address challenges.

- Opportunities to support continue and improve collaboration around children's health at the local level (e.g., Early Learning Hub and Coordinated Care Organization collaboration).
- Cross-sector policies to address social determinants of health and equity.

Additionally, the following OHA performance measures can be associated with the prenatal and children's population health in Oregon. While the Office of Child Health will not be directly responsible for the implementation of the programs or policies listed below, the Office will closely monitor, track and work with partners to improve these measures.

- Mental and physical health assessment for children in DHS custody
- Follow-up care for children prescribed with ADHD medication – Medicaid population
- 30-day substance use (illicit drugs & alcohol) among 6th, 8th, 11th graders – population
- Prenatal care – Population & Medicaid population
- Patient Centered Primary Care Home (PCPCH) enrollment – Medicaid (prenatal and children-only population)
- Access to care – Medicaid (prenatal and children-only populations)
- Member experience of care – Medicaid (prenatal and children-only populations)
- Member health status – Medicaid (prenatal and children-only populations)
- Rate of tobacco use – Prenatal and children-only populations
- Rate of obesity – Prenatal and children-only populations
- Effective contraceptive use – Under 18 population
- Child immunization rates – Population & Medicaid population OHA customer satisfaction

5. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

Without the Office of Child Health proposed by this POP, OHA will not be in an effective position to implement the Governor's vision for a comprehensive cross-sector early childhood system and will not have the dedicated capacity to address early childhood disparities impacting population health. OHA will not have

the capacity to effectively coordinate child health priorities and partnerships within OHA and with state agency and other partners.

Currently, the OHA does not have a coordinated team focused on child health initiatives, which limits the agency's ability to provide statewide leadership, support cross-divisional collaboration and external partnerships (e.g., with other agencies or stakeholders) that can drive expanded improvements in children's health. There has been a significant increase in the number of activities related to children's health that require or would benefit from unified agency support and we don't currently have a system in place to coordinate or lead these efforts.

Furthermore, the Public Health Division's focus around children's health is focused on leading public health programs, and it does not have the capacity or resources available to identify and establish cross-agency or cross-sector improvements to the children's health care system, children's health care access, or other policy improvements and innovations related to children's health.

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGES TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No.

7. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

The primary alternative is to absorb the work into existing positions/staffing. However, due to insufficient capacity within existing positions and units, this would mean de-prioritizing other critical work or not providing sufficient focus on the P-5 population. Additionally, no alternative reporting and coordination

structure has been identified that could serve to create an efficient agency-wide approach to child health work without taking away from existing positions.

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?

Existing positions within the agency are currently stretching to accommodate the recent increase in child health work and prioritization and are not able to meet the need. A single, limited duration position exists within the OHA Transformation Center to coordinate this work but is not able to serve the variety of functions and roles necessary to ensure an agency-wide coordinated approach to child health and cross-system partnerships.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

- Early Learning Division of the Oregon Department of Education
- Oregon Department of Education
- Oregon Department of Human Services
- Oregon's nine federally recognized tribes
- Local public health authorities and tribal health authorities
- Coordinated Care Organizations
- Early Learning Hubs

In particular, the Early Learning Division and Department of Human Services would be affected by the creation of an OHA Office of Child Health. These agencies serve the same priority population as the Office of Child Health and it is anticipated they would benefit from having a unified team at OHA addressing this population and helping coordinate work child health across OHA and its partners. Local partner organizations, including Oregon's Early Learning Hubs, have indicated a need for more distinction and dedication from the OHA for collaboration and partnership on child health. Additionally, increased capacity

at OHA in for providing access to child health data and addressing child health disparities will serve to advance the wellbeing of children throughout Oregon and ensure collective impact of the work of all partners within the Oregon's child serving systems.

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

- Maternal and Child Health Section of PHD
- Child and Family Behavioral Health team in HSD
- External partners (e.g., Early Learning Division, CCOs, Early Learning Hubs, etc.) have indicated a need for more distinction and dedication from the OHA for collaboration and partnership.

11. WHAT IS YOUR EQUITY ANALYSIS?

Part of the overall problem is OHA does not have the dedicated staff or resources to better understand what the disparities are within Oregon's child population. We have some indicators that provide glimpses (e.g., developmental screening completion in CCOs, immunization rates in CCOs) but we don't understand and haven't been able to track overall disparities related to children's' race, ethnicity, gender, sexuality, geographic location, or disability. This is a major shortfall considering how vulnerable this population is and how impactful it would be to address disparities as early in life as possible. The additional capacity requested in this POP would address this issue in multiple ways, including 1) Increased capacity for data analysis to understand disparities among Oregon's youngest children, and 2) Dedicated capacity to work with partners and implement recommendations to address these disparities.

12. WHAT ARE THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

As the Governor's Children's Cabinet works to develop a cross-system multi-biennium early childhood strategy, the OHA Office of Child Health will be a key partner in implementing this strategy. Ultimately,

long-term outcomes would include strong and sustainable cross-sector partnerships with other child-serving sectors; higher quality collaborative service delivery to children due to technical assistance and supports across sectors; and increased focus, momentum and cross-sector strategies for addressing disparities within Oregon's child population.

Long-term desired outcomes include improved child and adult health outcomes, improved experience of care including care coordination and meeting families' needs and reducing costs to the health system through earlier and more impactful, upstream investments.

13. IS THIS PP BEING REQUESTED BECAUSE OF AN INTERNAL DHS/OHA AUDIT, OREGON SECRETARY OF STATE AUDIT, OR FEDERAL AUDIT? IF SO, PLEASE PROVIDE FURTHER INFORMATION.

No.

STAFFING AND/OR FISCAL IMPACT

14. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): October 1, 2019

End Date (if applicable): Ongoing

a. Based on the following answers, is there a fiscal impact?
Yes.

b. Will there be new responsibilities for OHA/DHS? Specify which Program Area(s) and describe their new responsibilities.
See response to question #2.

c. 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.

d. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
No.

e. 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, four permanent, full-time positions:

- one Child Health Director, PEMG position
- one Operations and Policy Analyst 4 positions
- one Research Analyst 4 position
- one Operations and Policy Analyst 2 position

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
None.

g. What are the ongoing costs?
Permanent positions.

h. What are the potential savings?

The following impacts would likely result in long-term savings across state and local governments; however, because savings would be diffuse and difficult to quantify they are not included in the pricing of this POP.

- Improved longer-term health outcomes through upstream intervention during the most sensitive periods of development.
- Increased care coordination and integration with physical, behavioral and oral health.
- Increased data analysis and reporting efficiencies, accuracy and compliance for the P-5 population.
- Increased cross-sector coordination, improved strategies to address the social determinants of health and equity, and improved referrals.
- Increased potential for maternal and child-focused value-based purchasing arrangements.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	475,151	0	303,791	$778,942	4	3.50
Services & Supplies	87,724	0	54,856	$142,580		
Capital Outlay	0	0	0	0		
Special Payments	0	0	0	0		
Other	0	0	0	0		
Total	**$562,875**	**$0**	**$358,647**	**$921,522**	**4**	**3.50**

OHA - Fiscal Impact Summary by Program Area:

	Health Policy	**Total**
General Fund	$562,875	**$562,875**
Other Funds	$0	**$0**
Federal Funds- Ltd	$358,547	**$358,647**
Total Funds	$921,522	**$921,522**
Positions	4	**4**
FTE	3.50	**3.50**

i. What are the sources of funding and the funding split for each one?

The fund split is 61 percent General Fund and 39 percent Federal Funds from Medicaid match for all positions.

Oregon Health Authority
2019-21 Policy Package

Agency Name: Oregon Health Authority
Program Area Name: Public Health Division – Office of the State Public Health Director
Program Name: Office of the State Public Health Director
Policy Package Title: **Public Health Modernization Implementation**
Policy Package Number: 405
Related Legislation: LC 390; House Bill 2348 (2013); House Bill 3100 (2015); House Bill 2310 (2017)

Summary Statement:

In 2013 the Legislature set the state on a path to create a public health system for the future with the passage of House Bill 2348. It established the Task Force on the Future of Public Health Services, designed to develop legislative recommendations. The 2015 and 2017 legislative assemblies affirmed their commitment to a modern public health system with House Bill 3100 and House Bill 2310, which adopted a new framework for public health in Oregon. This requires state and local public health authorities to ensure that essential public health protections are in place for every person in the state through robust, outcome-driven and accountable services. This policy package creates a system of key programs in state, local and tribal public health authorities and increases accountability for health outcomes. Not funding this POP risks the progress of Oregon's nationally recognized public health modernization effort overall and challenges OHA's ability to meet HB 3100's timelines.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Package Pricing:	$0	$13,600,000	$343,450	$13,943,450

PURPOSE

1. WHY DOES OHA PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?

The way that we live, travel, work and recreate has created a series of new and increasingly complex public health issues. Examples include increasing international travel, which escalates opportunities for the spread of disease outbreaks like Zika and West Nile Virus. At the same time changes in Oregon's climate make the state more susceptible to acute and communicable disease threats such as cyanotoxins that were previously not a significant health issue in Oregon. And across Oregon, certain groups continue to experience a disproportionate burden of death and disease. The demands on Oregon's public health system have increased as the rate of public health investment, particularly in environmental health, has decreased or remained flat. This has strained the public health system's ability to respond to disease outbreaks and plan for the changes needed to better manage emerging public health threats as a result of climate change.

While public health threats have changed in type and grown in complexity, Oregon's health system transformation has created a key opportunity for the public health system to refocus on population-wide interventions to protect and improve health, working in tandem with the health care system. Investments in public health have been proven to drive down health care costs. It passed House Bill 3100 which tasks Oregon's public health system with: ensuring that basic public health protections are in place for every person in Oregon; being accountable for improvements in health outcomes; and ensuring that the public health system is as effective and efficient as possible in order to deliver on its mission.

In 2016 all state and local public health authorities completed an assessment of their capacity to implement foundational public health programs. As a part of that assessment, significant gaps were found in the state's ability to respond to new communicable disease outbreaks, ensure that public health benefits apply equally to subpopulations experiencing health disparities, and collect and report public health data to solve new public health problems. The 2016 public health modernization assessment also found that state and local public health authorities need $210 million more per biennium to fully accomplish statutory responsibilities. This POP supports partial implementation of the key public health priorities selected by the Oregon Public Health Advisory Board for the 2019-21 biennium.

2. WHAT WOULD THIS POLICY PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

This POP invests in state, local and tribal public health authorities to:

- Build on the public health system improvements created by the 2017-19 legislative investment.
- Improve health equity by engaging with communities and tribes in public health interventions and begin filling the 55 percent health equity service gap found in the 2019 assessment of state and local public health.
- Modernize how state public health collects and reports data on public health problems to inform timely and fact-based decision-making.
- Make progress toward filling the 37 percent service gap in communicable disease investigation from the 2016 public health assessment: use data to mount timely responses to emerging public health issues.
- Reduce disease transmission by increasing immunization rates among young children, adolescents and adults.
- Curb the marked increase in sexually transmitted infections and viral hepatitis among Oregon's most vulnerable populations.
- Work across sectors to identify and respond to acute threats to human health.
- Improve linkages across data sets to identify public health issues more quickly and develop comprehensive solutions to emerging public health problems.
- Ensure state funds investment has the intended impact and leads directly to improved health outcomes.
- Mitigate health disparities and ensure the entire population benefits from public health services.

This POP would be managed by the Oregon Health Authority Public Health Division (OHA-PHD) and implemented by the staff this POP funds as well as existing fully funded OHA-PHD positions. Specific work included in this POP is:

- OHA-PHD: Manage local and tribal public health authority contracts; perform regular fiscal reviews; provide technical assistance to local and tribal grantees to support the execution of contractually required deliverables; maintain and annually report on public health accountability measures; collect

and report population health data for the public health system and its partners; and coordinate acute and communicable disease outbreak investigations.

- Local public health authorities: Train clinic staff in evidence-based quality improvement activities to increase immunization rates; track cases of sexually transmitted infections and other communicable diseases in order to ensure affected individuals and their partners receive treatment to curb the spread of disease; involve communities experiencing health disparities in the development and execution of health-related interventions; implement health equity plans developed during the 2017-2019 biennium to reduce communicable disease disparities; and implement performance management systems to ensure the work of the local public health authority is continuously improved to drive towards population health outcomes.
- Tribal public health authorities and the Native American Rehabilitation Association (NARA): Conduct modernization assessments and develop and implement tribal public health modernization action plans; develop and strengthen existing regional partnerships with local public health authorities and other entities; share tribal best practices for a modern tribal public health system.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

OHA's mission is to help people and communities achieve optimal physical, mental and social well-being through partnerships, prevention, and access to quality, affordable health care. A robust public health system that is equipped to weather new challenges is essential to OHA's mission. Public health modernization has been a leading priority for OHA since 2015.

This POP supports Governor Brown's Health Care Agenda by advancing development of a 21st century public health system to handle 21st century public health challenges. It does so by increasing capacity in the public health system to reduce communicable disease risks and increase immunization rates and doing so in a way that promotes enduring partnerships with tribal and local public health authorities and promotes equity and fairness for everyone across Oregon; ensuring that children are healthy and ready to learn and remain in school; and providing communities with critical public health infrastructure that keeps residents safe and connected to resources.

The 2018 Health Care for All: Sustaining the Oregon Model of Health Care Coverage, Quality and Cost Management plan calls for a modernized public health system for the entire state. A modern public health system sets the foundation for the success of coordinated care organizations (CCOs) in improving health outcomes, reducing costs and improving quality by preventing disease and keeping individuals healthy. An investment in the prevention of disease and disability is proven to yield significant savings to Medicaid and other payers. Indeed, just a 10 percent increase in per capita public health spending in Oregon would:

- Lower infant mortality rates from 5.0/1,000 to 4.6/1,000.
- Lower diabetes death rates from 24.1/100,000 to 23.8/100,000.
- Lower heart disease death rates from 132.9/100,000 to 128.6/100,000.
- Lower cancer death rates from 167.3/100,000 to 165.4/100,000.

QUANTIFYING RESULTS

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 would support the achievement of the following OHA-PHD's Key Performance Measures that are also tied to Oregon's 2015-2019 State Health Improvement Plan:

- Child immunization rates.
- Flu vaccinations.
- Effective contraceptive use, through the implementation of interventions to control sexually transmitted infections.

This POP would also support achievement of public health accountability metrics for communicable disease control. Based on advice from the Oregon Public Health Advisory Board, this POP would not allow OHA-PHD to "turn on" incentive payments to local public health authorities based on their achievement of process measures for communicable disease control. However, OHA-PHD will track and report on these measures annually.

This POP also includes resources to enable OHA-PHD and local and tribal public health authorities to identify the public health system's successes and where it can improve service delivery for greater efficiency and accountability.

5. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

Should this POP not be funded, we can expect Oregon's governmental public health system to struggle to address ongoing and emerging needs, including protection from communicable diseases and clusters of illness related to acute exposures, and lose the momentum achieved through the 2017-19 legislative investment in public health modernization. It is possible that communities could be exposed to life-threatening diseases and conditions without a public health system that can protect them in a timely and comprehensive fashion.

An even greater disparity in the level of public health service provided across the state could be expected, particularly as local government budgets struggle to keep up with budget shortfalls. This would mean some Oregonians would lack certain public health protections based on where they live.

Health disparities across population groups would increase, since the public health system would not have the capacity to engage communities to improve equity, nor would communities have the population data they need to know where to focus their resources.

The current focus on gaining efficiencies and improving effectiveness in public health service delivery would subside because there would be little incentive to continue working regionally. Recent transitions in local public health service delivery have shown that without resources, local governments are more likely to cut or privatize public health activities or transfer their authority to OHA-PHD, rather than to work regionally.

Finally, OHA's ability to foster its relationship with federally recognized tribes would be hindered by a lack of investment in tribal public health capacity.

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGES TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

The work included in this POP is fully authorized in ORS 431.131 and ORS 431.141.

OHA-PHD also has Legislative Concept 390 for any additional changes that need to be made to statute to support this work. OHA-PHD is in the process of managing an unprecedented situation in which an Oregon county has adopted an ordinance to transfer its public health authority to OHA-PHD. This places responsibility for statutorily required public health functions on OHA-PHD for that county. The legislative concept will allow for minor changes needed to ORS 431.045 and ORS 431.382 in order to improve on the process of a local public health authority transfer in the future.

7. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

OHA-PHD has explored whether federal funding might be available for this POP. Based on the way Congress appropriates federal public health funds, OHA does not have an immediate option for federal funding for the level of investment needed to implement public health modernization in Oregon. Furthermore, federal investments in the areas funded by this POP have continued to decline or remain flat over time. Outside of this POP request, OHA will continue to align its funding streams to further support public health modernization to the extent possible, given federal funding restrictions.

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?

In the 2017-19 biennium, OHA-PHD leveraged federal grants and restructured existing positions to the extent possible to augment the programs implemented with the initial $5 million legislative investment in public health modernization. However, this investment's impact is expected to be proportional to its size. The Legislature expects the public health system to fully implement its statutory responsibilities, and the $5 million investment will not support expansion of the work needed in communicable disease control, health

equity and cultural responsiveness, and assessment and epidemiology. The $13.6 million investment requested in this POP is a small portion of the $210 million in total need per biennium identified in 2016 for state and local public health authorities.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

This POP's investments in local and tribal public health authorities primarily would allow them to carry out their public health responsibilities related to communicable disease control, health equity and cultural responsiveness, and assessment and epidemiology. Within OHA, PHD will collaborate with the Office of Equity and Inclusion to ensure alignment and mutual benefit of health equity and cultural responsiveness initiatives. OHA-PHD will continue to work with the Health Policy and Analytics Division to align public health accountability metrics with those identified by the Health Plan Quality Metrics Committee and selected for CCO incentive measures by the Metrics and Scoring Committee. OHA-PHD will partner with the Health Policy and Analytics and the Health Systems divisions to ensure that the public health system fully supports the implementation of CCO 2.0, and that CCOs strategically partner with local public health authorities on shared population health goals. To ensure the success of the work funded in this POP, OHA-PHD will collaborate closely with several state agencies. This includes the Department of Education with whom OHA-PHD has established a formal partnership with in a signed memorandum of understanding.

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

This POP's direction is being guided by the Oregon Health Policy Board and the Public Health Advisory Board. Local public health authorities have been engaged through the Conference of Local Health Officials, and federally-recognized tribes will be engaged through the Senate Bill 770 Health Cluster meeting and, if requested, formal tribal consultation.

11. WHAT IS YOUR EQUITY ANALYSIS?

The 2016 statewide public health modernization assessment identified the system's ability to address health equity as the most significant gap across state and local public health authorities. In addition, OHA-PHD

analyzes population health indicators by race and ethnicity, and has reported public health accountability measures by race, ethnicity and county. These data find that health outcomes vary across racial and ethnic groups. OHA-PHD and local and tribal public health authorities can use the data to determine where to target interventions to eliminate health disparities.

This POP will, for the first time, direct public health modernization funding to Oregon's federally-recognized tribes. Funding will strengthen each tribe's capacity to provide foundational public health programs and services to tribal members and will set Oregon on a course toward stronger systems for communicable disease control across the governmental public health system.

At this funding level, all LPHAs will receive a floor amount of funding, with the majority of funds distributed through grants for LPHA partnerships. In 2017-19 public health modernization funding supported LPHA partnerships to conduct a health equity assessment and develop a health equity action plan. This POP would provide funding to implement action plans and meaningfully engage populations experiencing health disparities in the identification of leading health issues and the development and implementation of culturally specific interventions to address them.

12. WHAT ARE THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

The desired outcomes are: To ensure that basic public health services are in place for every person in Oregon; to improve health outcomes across the population; and to build a public health system that is effective and efficient in order to meet these goals. Specifically, OHA-PHD anticipates the following long-term outcomes for the work completed in this biennium:

- Improved immunization rates for young children, adolescents and adults.
- Decreased rates of communicable diseases, including sexually transmitted infections and viral hepatitis; and
- Improved equity in health outcomes among Oregon's most vulnerable populations.

This POP prioritizes a subset of public health programmatic work based on recommendations from the Public Health Advisory Board. The overall goal of OHA-PHD and its partners is to phase in statewide access to all foundational capabilities and programs for governmental public health over the next several biennia, with the expectation that the public health system eventually meets all statutory requirements included in ORS 431.131 and ORS 431.141. Local public health authorities are required to submit their plans for implementing all foundational capabilities and programs by December 2023.

13. IS THIS POP BEING REQUESTED BECAUSE OF AN INTERNAL DHS/OHA AUDIT, OREGON SECRETARY OF STATES AUDIT, OR FEDERAL AUDIT? IF SO, PLEASE PROVIDE FURTHER INFORMATION.

No.

STAFFING AND/OR FISCAL IMPACT

13. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): January 1, 2021
End Date (if applicable): N/A

a. Based on the following answers, is there a fiscal impact?

Yes.

b. Will there be new responsibilities for OHA/DHS? Specify which Program Area(s) and describe their new responsibilities.

Office of Information Services

The Office of Information Services will be responsible for implementing public health data system upgrades that are essential for the public health system to collect and report data to local and tribal public health authorities and other partners so that data can be used for program and policy decision-making.

c. 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.
This POP includes funding and new positions for the Office of Information Services (OIS). OIS has been consulted throughout the development of this POP.

d. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
Yes, it is anticipated this POP will provide an additional level of public health service to all residents in the state through improvements in state, local and tribal public health authorities.

e. 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 the following positions:

- Operations and Policy Analyst 3: (2) permanent position, 6 months
- Operations and Policy Analyst 3, MMN: (1) permanent position, 6 months
- Operations and Policy Analyst 3: (1) permanent position, 6 months, .10 FTE Other Fund
- Epidemiologist 3: (1) permanent position, 6 months
- OIS Information Systems Specialist 7: (1) permanent position, 6 months, .30 FTE Other Fund

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
The epidemiologist position will require statistical analysis software.

g. What are the ongoing costs?
Ongoing costs are associated with personal services and contracts.

h. What are the potential savings?

This POP has the potential to save Medicaid, PEBB, OEBB and other insurers by preventing and controlling the spread of acute and communicable diseases. This POP could also avoid unnecessary health care costs associated with health disparities by focusing on the delivery of culturally specific interventions with communities at greatest risk for disease and disability.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	0	245,693	71,801	317,494	6	1.50
Services & Supplies	0	2,754,307	271,649	3,025,956		
Special Payments	0	10,600,000	0	10,600,000		
Total	**$0**	**$13,600,000**	**$343,450**	**$13,943,450**	**6**	**1.50**

OHA - Fiscal Impact Summary by Program Area:

	OSPHD	EPH	ACDP	OIS	Total
General Fund	**$0**	**$0**	**$0**	**$0**	**$0**
Other Funds	**$13,381,429**	**$67,267**	**$71,407**	**$79,897**	**$13,600,000**
Federal Funds- Ltd	**$343,450**	**$0**	**$0**	**$0**	**$343,450**
Total Funds	**$13,724,879**	**$67,267**	**$71,407**	**$79,897**	**$13,943,450**
Positions	**3**	**1**	**1**	**1**	**6**
FTE	**0.75**	**0.25**	**0.25**	**0.25**	**1.50**

i. What are the sources of funding and the funding split for each one?

This POP would be primarily funded by Tobacco Tax revenue, while some positions would be cost-allocated as part of an allocation plan.

Oregon Health Authority
2019-21 Policy Package

Agency Name: Oregon Health Authority
Program Area Name: Health Policy and Analytics
Program Name: Clinical Systems Improvement/Health Evidence Review Commission
Policy Package Title: **Opioid Alternatives Pain Education Modules/Addictions analysis**
Policy Package Number: 409
Related Legislation: Senate Bill 608 (2015), Senate Bill 855 (2001), House Bill 2100 (2011)

Summary Statement:

Opioid addictions and other substance use disorders have been declared a public health crisis and priority by the Governor. This POP would address the opioid crisis by expanding training for providers pertaining to appropriate opioid prescribing and other approaches to pain management as well as additional technical resources. Specifically, this POP would:

- Enable the Oregon Pain Management Commission to build, maintain and promote 4-6 pain education modules per biennium (building on their existing, nationally-recognized 2018 pain module). These modules would aim to change the risky prescribing practices contributing to the opioid use disorder emergency and promote effective approaches for pain management. In addition, they would promote up-to-date understanding of pain management strategies among patients and the public.
- Enable OHA to add technical resources to perform additional analysis of prevalence, treatment and health impacts of substance use disorders and chronic pain conditions, especially opioid use disorder.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Package Pricing:	**$312,700**		**$71,834**	**$384,534**

PURPOSE

1. WHY DOES OHA PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?

Opioid addictions and other substance use disorders have been declared a public health crisis and priority by the Governor. This POP would address the opioid crisis by expanding training for providers pertaining to appropriate opioid prescribing and alternative approaches to pain management as well as additional technical resources. Specifically, this POP would:

1. Enable the Pain Management Commission to develop, update and promote additional pain education modules and educational materials to provide high-quality continuing education for healthcare providers and patients. The goal is to promote an up-to-date understanding of chronic pain, thereby improving pain treatment, reduce risky prescribing and improve patient knowledge about effective pain treatment strategies. The Pain Management Commission would create (or update) and promote four to six modules per biennium.
2. Enable Health Analytics to increase capacity to analyze data related to patients with chronic pain and substance use disorders, including information about prevalence, patient characteristics and services delivered, especially related to opioid medication use.

2. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

With this proposal, Health Policy and Analytics (HPA) would hire a permanent full-time research analyst. Half of this position would allow the Pain Management Coordinator to dedicate time currently spent on Health Evidence Review Commission (HERC) work to the Pain Management Commission's educational efforts. The other half of the position would increase Health Analytics capacity to analyze prevalence, treatment and health impacts associated with substance use disorders, especially those focused on opioid addictions.

In addition, HPA would contract for technical production, maintenance and promotion of the online pain education modules themselves, using up to $200,000 for the 2019-21 biennium, with an ongoing amount in future biennia approaching $100,000 or less as the work transitions from the creation of new modules to updates of existing modules.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

In March 2018, Governor Brown declared addiction and substance abuse as a public health crisis in Oregon. The educational modules created by the Pain Management Commission are designed to encourage safer approaches to pain treatment, including fewer initiations of opioid therapy and encouragement of effective other pain management techniques and treatments. Many healthcare professionals practicing in Oregon received their education in a time when liberal opioid prescribing was generally encouraged without sufficient emphasis on the risks of these medications. In addition, researchers have an improved understanding of the biological, psychological and social factors contributing to pain which can be addressed without reliance on risky opioids. Developing and promoting engaging educational materials and packaging them to meet continuing education requirements for various professions will encourage safer, better care for Oregonians experiencing pain.

The increased capacity in Health Analytics would increase the division's capacity to analyze prevalence, treatment and health impacts associated with substance use disorders, especially those focused on opioid use disorder. Connecting the dedicated analyst with OHA public health data analysts will lead to a wholistic view of the opioid crisis through prevention, utilization and vital statistics data sets.

QUANTIFYING RESULTS

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 ties to the 2019-2021 Oregon Statewide Performance Improvement Project (PIP) on Opioid Safety: Acute Prescribing Practices of Oregon. In addition, the impending current Statewide PIP on

Reducing Prescribing of High Morphine Equivalent Doses can be further analyzed post calendar year 2018 for an assessment on sustained improvements. The modules and analysis would provide education indirectly supporting the goals of this PIP as well as other statewide efforts around opioids and substance use disorders.

OHA will report on the modules developed and number of persons taking each module to management and the Legislature upon request.

In addition, the added capacity would allow for focused research activities to produce PIP metrics and facilitate deeper dives into successes for sharing, while rooting out continued barriers.

5. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

Oregon providers and members of the public would have less access to high-quality pain education materials and analysis related to substance use disorders.

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGES TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No.

7. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

Another alternative that would allow completion of at least some pain education modules would be to reduce the HERC's work on Evidence-based Reports to allow for the Pain Management Coordinator to devote more time to the Pain Management Commission's creation of additional modules. This option was rejected because of the value of promoting evidence-based coverage policy in Oregon and because it would not solve the need for a contractor to create/maintain these modules.

Without this POP, the Health Analytics will continue to analyze and study issues related to pain treatment and substance use disorders on an ad-hoc basis for many requests, as there is not the current ability to dedicate resources.

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?

A previous pain management coordinator worked many extra hours to complete the first pain module in addition to her other job duties. Management believes this overwork was a major reason she left her position.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

Improvements in pain education that reduces inappropriate prescribing would disproportionally benefit tribal members. Tribal members experience higher-than-average levels of opioid prescribing, dependence and opioid use disorders. Preventing the loss of function as well as the addiction, crime, family and foster care issues would benefit many areas of state and local government including law enforcement, education and corrections.

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

None**.**

11. WHAT IS YOUR EQUITY ANALYSIS?

These modules would improve care by educating providers who serve patients who have or are at risk for chronic pain and opioid dependence. Many risk factors for these conditions are based on or associated with social determinants of poor health including trauma, stress from discrimination and marginalization.

12. WHAT ARE THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

Ensuring up-to-date pain education materials (by producing/updating 4 to 6 pain education modules per biennium) would allow patients across the state to benefit from being served by providers with the most current knowledge on pain and pain management.

Reducing unnecessary opioid prescribing for patients who have never received opioids would reduce the epidemic for future generations; providing optimal pain management for patients already on chronic opioids.

Improving public understanding of up-to-date science related to chronic pain would increase awareness of non-opioid strategies for treating chronic pain and understanding about efforts to reduce opioid prescribing.

Improving treatment network adequacy with regular, ongoing, analytics to determine gaps in network and utilization patterns for policy development and better resource allocation across Oregon SUD networks.

Integrated data reporting across OHA for quality monitoring and policy development on opioid, chronic pain and SUD.

13. IS THIS POP BEING REQUESTED BECAUSE OF AN INTERNAL DHS/OHA AUDIT, OREGON SECRETARY OF STATE AUDIT, OR FEDERAL AUDIT? IF SO, PLEASE PROVIDE FURTHER INFORMATION.

No.

STAFFING AND/OR FISCAL IMPACT

14. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): October 1, 2019 for new staff

End Date (if applicable): Ongoing

a. Based on the following answers, is there a fiscal impact?
Yes.

b. Will there be new responsibilities for OHA/DHS? Specify which Program Area(s) and describe their new responsibilities.
Pain Management Commission

Produce and update 4 to 6 pain education modules per biennium

Health Analytics

- Track metrics associated with opioid PIP
- Integrated dashboard to monitor progress
- Coordinate with other OHA analytics staff to for best practice of sharing data to drive improvements and policy development

c. 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.

d. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
No.

e. 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.
One new permanent, full-time Research Analyst 3 position, 21 months in 2019-21 and 24 months in 2021-23.

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
None.

g. What are the ongoing costs?
Staffing and $100,000 per biennium for a contractor to create, support and update the pain education modules.

h. What are the potential savings?
Long-term savings in health, education and corrections are likely from improved opioid policy but would be difficult to tie to this specific initiative.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	90,903	0	58,120	$149,023	1	0.88
Services & Supplies	221,797	0	13,714	$235,511		
Capital Outlay	0	0	0	0		
Special Payments	0	0	0	0		
Other	0	0	0	0		
Total	**$312,700**	**$0**	**$71,834**	**$384,534**	**1**	**0.88**

OHA - Fiscal Impact Summary by Program Area:

	Health Policy	Total
General Fund	**$312,700**	**$312,700**
Other Fund	**$0**	**$0**
Federal Funds- Ltd	**$71,834**	**$71,834**
Total Funds	**$384,534**	**$384,534**
Positions	**1**	**1**
FTE	**0.88**	**0.88**

i. **What are the sources of funding and the funding split for each one?**

- 61 percent General Fund and 39 percent Federal Funds (Medicaid match) for Permanent Research Analyst 3 for HERC and Health Analytics
- $200,000 General Fund for the 2019-21 biennium to create and update Pain Management modules (reduce to $100,000 in future biennia)

Oregon Health Authority
2019-21 Policy Package

Agency Name: Oregon Health Authority
Program Area Name: Health Systems Division and Oregon State Hospital
Program Name: Community Mental Health
Policy Package Title: **Aid & Assist Misdemeanor Defendants**
Policy Package Number: 410
Related Legislation: Senate Bill 24 (Legislative Concept 383)

Summary Statement:

More than 40 percent of Oregon State Hospital (OSH) Aid and Assist (or ".370") patients have been charged with only misdemeanors. This population has a large effect on the OSH census as the .370 population continues to rise increase. Senate Bill 24 (Legislative Concept 383) would amend ORS 161.370 so that misdemeanant patients must be evaluated and treated in the community, unless a certified evaluator (i.e., a forensically trained doctor who focuses on risks, etc.) determines that the misdemeanant needs a hospital level of care.

To support the implementation of Senate Bill 24 (Legislative Concept 383), this POP requests funds for more intermediate (i.e., middle ground between the hospital and living independently in the community) placement options. The middle ground placement options are sought by communities and would be consistent with the US Department of Justice's expectations.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Package Pricing:	**$7,612,914**	**$0**	**$0**	**$7,612,914**

PURPOSE

1. WHY DOES OHA PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?

The Aid and Assist (or ".370") census continues to increase at OSH at an unsustainable rate. The Oregon Health Authority (OHA) is proposing this POP to assist in having individuals served in the most appropriate level of care and reduce the number of individuals sent to OSH for restoration services.

2. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

OHA is proposing this POP to work in conjunction with Senate Bill 24 (Legislative Concept 383). This POP would fund intermediate placements for individuals who have been deemed unfit to proceed and require a secure residential setting, but not a hospital level of care. This would allow individuals to receive the services that they need in the most appropriate setting, while decreasing the number of misdemeanants at OSH for Aid and Assist services.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

Funding this POP would further the agency's mission by increasing the number of individuals served in the most appropriate level of care, reducing costs by providing care in less costly placements, and having individuals provided services in the community that they come from.

QUANTIFYING RESULTS

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?

Success will be measured by tracking and analyzing the number of individuals who are being provided services in the intermediate level of care funded through this POP, instead of receiving services at OSH as a default placement.

5. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

If the number of .370 individuals at OSH continues to rise, this will have a negative impact on OSH's ability to admit other population groups to OSH, especially those under civil commitment. This backlog could increase the length of the OSH waitlist and could have negative impacts on Oregon's US Department of Justice agreement.

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGES TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

This POP is designed to correspond to Senate Bill 24 (Legislative Concept 383), which would modify ORS 161.370 by amending the statute so that misdemeanant patients must be evaluated and treated in the community, unless a certified forensic evaluator (i.e., a forensically trained doctor who focuses on risks, etc.) determines that the misdemeanant needs a hospital level of care.

7. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

Several other legislative concepts were considered in association with this legislative concept and POP. Some of those legislative concepts are still moving forward and others have been determined to not continue on to the next legislative session.

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?

OHA has previously put forward legislative concepts for .370 changes, instituted community consultations in .365, and worked with counties, courts, and other stakeholders to assist in getting individuals who need restoration services served in the most appropriate level of care. However, the .370 population at OSH continues to increase.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

Counties and courts would have access to an intermediate level of care for individuals who require restoration services. Having individuals remain in their community would allow increased engagement with local services provides that will assist both the individual and provider when the person is released from custody.

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

OHA coordinated with OSH on this POP and associated legislative concept. Counties have requested other options for providing restoration services that are not limited to only OSH or an outpatient level of care.

11. WHAT IS YOUR EQUITY ANALYSIS?

Admissions to OSH for Aid and Assist show that several racial groups are either disproportionately represented or under-represented in Aid and Assist admissions compared to the Oregon population.

2/2008-5/2018

Race			
Race	**Admissions (#)**	**Admissions (%)**	**Oregon (%)***
White / Caucasian	2981	64.6%	87.4%
Black / African American	409	8.9%	2.1%
American Indian / Alaskan Native	69	1.5%	1.8%
Asian	60	1.3%	4.5%
Hawaiian / Pacific Islander	27	0.6%	0.4%
Unknown / Other / Declined	1069	23.2%	N/A
Two or More Races	N/A	N/A	3.8%
Total	**4615**	**100.0%**	**100.0%**
Hispanic / Latino	309	6.7%	12.8%
White/Caucasian (Non-Hispanic/Latino)	3219	69.8%	76.4%
* - www.census.gov			

12. WHAT ARE THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

The long-term outcomes for the POP are to fund an intermediate level of care for individuals who require restoration services. The desired outcome of this intermediate level of care is for individuals to be served in the most appropriate level of care and to decrease the amount of people sent to OSH for restoration services associated with fitness to proceed.

STAFFING AND/OR FISCAL IMPACT

13. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): July 1, 2019

End Date (if applicable): Not Applicable

a. Based on the following answers, is there a fiscal impact?

Yes.

b. Will there be new responsibilities for OHA/DHS? Specify which Program Area(s) and describe their new responsibilities.

None at OHA or DHS.

c. 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.

d. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

If Senate Bill 24 (Legislative Concept 383) becomes law, the Aid and Assist client caseload could be reduced as more misdemeanants are serviced in the community. As this occurs, OSH would see an increase in the number of Civil Commitment clients served at OSH. Both Aid and Assist and Civil Commitment clients are forecasted caseloads and any attained changes would be accounted for in those forecasts.

e. 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 are needed.

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?

There would not be any startup costs, new systems, or new materials. HSD and OSH would need to provide outreach and training how to provide community restoration services to providers who agree serve this population. Providers also would need to bill for residential services if not medically necessary.

g. What are the ongoing costs?

Costs will include residential service payments, services that are not Medicaid billable, room and board, and personal incidental funds.

h. What are the potential savings?

A potential reduction in Oregon State Hospital census could allow individuals who have been civilly committed, but who are on the waitlist to be placed at OSH, to move from being served in Acute Psychiatric Care Hospitals to OSH.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	0	0	0	0	0	0.00
Services & Supplies	0	0	0	0		
Capital Outlay	0	0	0	0		
Special Payments	0	0	0	0		
Capital Construction	$7,612,914	0	0	$7,612,914		
Total	**$7,612,914**	**$0**	**$0**	**$7,612,914**	**0**	**0.00**

OHA - Fiscal Impact Summary by Program Area:

	HSD Non-Medicaid CMH	Total
General Fund	**$7,612,914**	**$7,612,914**
Other Fund	**$0**	**$0**
Federal Funds- Ltd	**$0**	**$0**
Total Funds	**$7,612,914**	**$7,612,914**
Positions	**0**	**0**
FTE	**0.00**	**0.00**

i. What are the sources of funding and the funding split for each one?
General Fund only.

Oregon Health Authority
2019-21 Policy Package

Agency Name: Oregon Health Authority
Program Area Name: Health Policy & Analytics
Program Name: Health Information Technology, Behavioral Health, and Pharmacy
Policy Package Title: **Advancing Behavioral Health Integration and Improvements**
Policy Package Number: 411
Related Legislation: House Bill 2300 (2017), Senate Bill 22 (Legislative Concept 364) and House Bill 2035 (Legislative Concept 368)

Summary Statement:

Improving the Behavioral Health system is one of the Governor's top priorities for Oregon's Coordinated Care Organization (CCO) 2.0 process. This policy package would invest in a more connected behavioral health system by providing incentives for investments in foundational technology to advance integration, adapting the primary care home model to advance integration within behavioral health settings, and improving access to evidence-based pharmaceutical treatments and practice guidelines to improve health outcomes of individuals experiencing mental illness. This POP also continues the Mental Health Clinical Advisory Group's effort to make recommendations to the Pharmacy & Therapeutics committee on treatment of mental illness including medications.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Package Pricing:	**$5,406,573**	**$0**	**$328,623**	**$5,735,196**

PURPOSE

1. WHY DOES OHA PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?

Improving the Behavioral Health system is one of the Governor's top priorities for Oregon's Coordinated Care Organization (CCO) 2.0 process. This POP would provide funding for three objectives that support this priority:

1. Invest in a more connected behavioral health system by providing incentives for investments in foundational technology to advance integration.
    - This POP would create the Behavioral Health Electronic Health Record (EHR) Incentive Program to support & incentivize behavioral health (BH) agencies' investments in EHRs. This would help reduce the disparity between BH & physical health; care coordination; health information exchange (HIE); electronic reporting; patient care; & value-based payments.
2. Adapt the primary care home model to advance integration within behavioral health settings.
    - This POP would enable the Oregon Health Authority (OHA) to conduct reviews & provide technical assistance to recognize Behavioral Health Homes. This would integrate primary care services into BH service settings.
3. Improve access to evidence-based pharmaceutical treatments to improve health outcomes of individuals experiencing mental illness.
    - This POP would continue the Mental Health Clinical Advisory Group's effort to make recommendations to the Pharmacy & Therapeutics committee on treatment of mental illness including medications.

<u>Behavioral Health Electronic Health Record Incentive Program</u>

The OHA's Office of Health Information Technology (HIT) conducted a scan (including an online survey and in-depth interviews) of BH agencies to better understand their HIT and HIE adoption, use, needs, and challenges. Scan results confirmed that Oregon's BH agencies need improved HIT, specifically EHRs. Benefiting both providers and patients, EHRs provide the ability to retrieve and meaningfully use patient health information as well as provide the basis to share this information electronically.

BH agencies increasingly need high-functioning EHRs, HIE opportunities, and the ability to effectively meet reporting requirements and analyze client data. However, not all EHRs have the functionality necessary for achieving these goals. Certified EHR technology (CEHRT) adheres to established federal standards and is more likely to include the necessary functionality to maintain health information confidentially and exchange it with other HIT/HIE systems. However, many BH agencies have non-certified EHRs, partially-implemented EHR systems, or no system at all (meaning paper records are still being used). In some cases, an agency has a CEHRT, but it must be significantly modified to meet reporting needs. In other cases, an EHR designed for physical health providers is used and must be modified to serve BH workflows.

Without sufficient EHR technology, BH agencies are less able to communicate electronically with each other and with physical and oral health providers, inhibiting their ability to provide the highest quality of care. Health information is often exchanged through less efficient and secure means, such as fax or mail. With high functioning EHRs, the BH agency would have better access to health information at the point of care. Although adoption of high-functioning EHRs would not guarantee the interoperable exchange of health information, it would increase the likelihood that the agency has an EHR with standards-based functionality that would support the exchange.

Unfortunately, financing is an obstacle. BH agencies are not eligible to participate in the federally-funded EHR incentive programs benefiting many other providers. In the BH scan, financial costs, lack of staff resources, and/or technical infrastructure were repeatedly cited as significant barriers to adopting an EHR. Further, agencies interviewed strongly desired data analytics technology to improve quality, manage client

populations, demonstrate return on investment, and engage in value-based payment arrangements – all of which could be supported through an investment in high functioning EHRs.

OHA proposes establishing a four-year incentive program to support licensed BH agencies' investments in high functioning EHRs and related HIT to shrink the "digital divide" between physical, oral, and behavioral health.

Behavioral Health Homes

The 2015 Legislature passed Senate Bill 832 which directed OHA to establish behavioral health home (BHH) standards and to encourage CCOs to utilize BHHs. In the negotiations around this bill there was a desire to remove any fiscal impact. Therefore, there was a decision to remove any requirement that OHA establish a process to "identify" clinics (as is the case for PCPCHs) that meet BHH standards. OHA worked with the PCPCH Standards Advisory Committee and developed standards for BHH, but there is no provision to identify clinics who meet those standards.

Access to Evidence-Based Medications for BH

In the Mental Health Clinical Advisory Group (MHCAG) significant progress is underway. The group is addressing schizophrenia presently and will then proceed to address depression. Creating a sustainable path forward for continuing this meaningful work would assist the agency in developing and maintaining effective evidence and evidence-based practice algorithms. These algorithms could help OHA move away from the existing mental health drugs carve-out.

2. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

BH EHR Incentive Program

This POP would allow OHA to establish a four-year BH EHR Incentive Program to encourage and support licensed BH agencies' investments in EHRs and other-related HIT. Financial incentives would be available to support BH agencies adopting, upgrading, or configuring/customizing EHRs. This investment provides BH agencies the basis for enabling appropriate consent and connecting to physical/oral providers through

HIE efforts and establishing electronic reporting to state systems. This program is intended to support BH agencies that serve Oregon's vulnerable populations, including Medicaid. Through the BH EHR Incentive Program, participating BH agencies would be able to better capture, track, and monitor patient health information, and more easily facilitate referrals needed to address to complex care issues.

The incentives will either be a one-time payment per organization, or milestone-based payments for each organization. The incentives will help participating BH agencies positively affect the care of their patients by eliminating a substantial barrier to coordinating and integrating with physical and oral health and exchanging health information. Recipients of the incentive payments would be able to purchase a new EHR, upgrade or enhance an existing EHR, or potentially acquire an add-on HIT component such as an analytics or population management tool or patient portal application.

The BH EHR Incentive Program would be developed and operated out of the Office of Health Information Technology within the Health Policy & Analytics Division of OHA, which also operates the federally-funded Medicaid EHR Incentive Program. One full time staff member would manage the operations of the program.

More work is underway to assess the availability and investment needed to adequately support BH agencies' EHR adoption or upgrade efforts.

Behavioral Health Homes

This POP would provide the necessary staff and resources to conduct reviews of programs in accordance with BHH standards. Clinics that meet the standards will receive formal recognition as meeting those standards. It would also provide funds to contract with subject matter experts to provide technical assistance. This program will be modeled after the very successful Patient Centered Primary Care Homes program.

Access to Evidence-Based Medications for BH

This option would be a continuation of the Operations and Policy Analyst 1's duties and responsibilities on a permanent basis. As there are always changes to drug pricing, and innovations in practices and treatments, this body of work should truly be an ongoing effort to ensure OHA has the best possible treatment resources positioned to address mental health issues and illness.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

BH EHR Incentive Program

OHA is committed to the triple aim of better health, better care, and lower costs through system transformation. By helping BH agencies catch up to their physical and oral health peers in terms of HIT and exchange, we will not only provide the building blocks for physical, oral, and BH integration, but also help move our health care systems towards patient-centered care coordination and value-based payments. These goals cannot be met if behavioral health organizations do not have adequate tools and resources.

Similar to the increased rate of EHR adoption among physical and oral health providers that resulted from the Medicaid and Medicare EHR Incentive Programs, it is expected that adoption and utilization of EHR technology among BH providers will increase as a result of the BH EHR incentive program. This will contribute to:

- Improved care delivery and efficiency and reduction of BH disparities
- Increased care coordination and support for integrated physical, behavioral and oral care
- Improved billing processes and greater potential for participation in value-based payment arrangements
- Increased rate of and improved data analytics
- Increased rate of HIE, including supporting improved referrals
- Improved privacy and security of protected health information (PHI)
- Increased patient participation with their health information
- Increased reporting efficiencies, accuracy and compliance, including for OHA required reporting to the Measures and Outcomes Tracking System (MOTS)

Behavioral Health Homes
The BHH initiative addresses the goal to integrate physical, behavioral and oral care to meet the Triple Aim.

Access to Evidence-Based Medications for BH
It aligns with the mission of the agency, treating all people suffering from mental illness in a uniform manner according to a minimum standard. Ultimately, it will help people and communities achieve optimum physical, mental and social well-being. It is also important to note that mental illness is often linked to shortened life expectancy, with timely and effective treatment fostered by the implementation and sharing of the MHCAG's algorithms people's lives could be lengthened and improved.

QUANTIFYING RESULTS

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?

BH EHR Incentive Program
The proposed BH EHR Incentive Program is not tied to a specific OHA performance measure. OHA will initially measure success of the program by evaluating the number of participating BH agencies adopting/upgrading high functioning EHRs. OHA will then obtain feedback from participating BH agencies on improvements demonstrated in patient participation, health information exchange, data analytics, and patient outcomes.

Behavioral Health Homes
This is not tied to a specific OHA performance measure, OHA will track the number of BHH that receive recognition. After initial work to recognize programs OHA will determine a target number of BHHs.

Access to Evidence-Based Medications for BH

First, success would be measured via number of published algorithms. Growth of list would indicate progress in establishing a community standard of practice/care. Second, outcomes for patients should be monitored to establish reduction on emergency care utilization and adherence to treatment.

5. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

BH EHR Incentive Program

If the proposed program is not developed, BH agencies will continue to experience significant challenges to adopting high-functioning EHRs, and therefore the current "digital divide" between the physical health and BH realms will continue to widen, likely resulting in:

- Continued care coordination challenges
- Limited care integration – continued siloes
- Lack of health information exchange participation and disconnected patient care
- Limited ability to participate in value-based payment arrangements
- Reporting challenges and administrative burden
- Limited patient participation
- Continued risk to patient confidentiality through use of non-secure information exchange methods

Behavioral Health Homes

Oregon would continue to struggle to advance primary care integration into behavioral health settings.

Access to Evidence-Based Medications for BH

Discontinuing this work would have significant negative impacts to people suffering from mental illness. Establishing a community standard would fail and fragmentation of mental health services would continue.

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGES TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

BH EHR Incentive Program

This program does not require any statute changes.

Behavioral Health Homes

Senate Bill 22 (Legislative Concept 364) regarding BHH recognition has been submitted.

Access to Evidence-Based Medications for BH

House Bill 2035 (Legislative Concept 368) includes additional tribal representation for the MHCAG and reduces the overall size of the group to ensure a more efficient and adequately supported process.

7. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

BH EHR Incentive Program

Consideration has been given to have CCOs support BH clinics in adoption and technical assistance of certified EHRs, and at least one CCO has invested in EHR costs for a BH agency. However, CCOs would potentially bear significant costs for each agency to acquire a high-functioning EHR.

Behavioral Health Homes

OHA considered incorporating the BHH process into the PCPCH program, but the resources were not available without negatively impacting the PCPCH program.

Access to Evidence-Based Medications for BH

Carve-out of mental health drugs has been in place for over a decade. No alternatives are available or considered.

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?

BH EHR Incentive Program

OHA has been able to support some access to HIE tools for BH agencies – but very little support has been available for EHR costs. In the past, OHA hosted an EHR for BH agencies, called "OWITS" – the Oregon instance of WITS (an open source certified EHR). OWITS was not robust enough for many agencies' use and there was little uptake. Several agencies chose to use OWITs rather than rely on paper records, but had such low levels of resources that they had no other EHR options. The OWITS system required significant funds to maintain current certification, and OHA ultimately stopped supporting OWITS. Federal incentive payments are available to "eligible providers" but these have largely left out BH agencies, since only specific provider types are eligible (e.g., physician, nurse practitioner, dentist, physician assistant in certain setting). Congress has made multiple attempts to introduce legislation for EHR incentives to BH agencies, and up until recently all have failed. On October 24, 2018, President Trump signed the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, which contains legislation authorizing the Center for Medicare and Medicaid Innovation (CMMI) to create a demonstration project to incentivize the adoption and use of CEHRT for BH care providers. Timing of project implementation and award recipients are unknown, so it is unclear if Oregon BH agencies will benefit from the demonstration project.

Behavioral Health Homes

OHA has submitted BHH legislatively concepts in previous sessions without success.

Access to Evidence-Based Medications for BH

We have implemented MHCAG and seated 15 members to the group. They have begun their work and attendance to these meetings has been very high.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

BH EHR Incentive Program

Tribal Governments and County mental health agencies would be affected in that BH programs they operate could be eligible to apply for the incentives.

Behavioral Health Homes

The BHH portion of this POP would not affect other agencies or governments.

Access to Evidence-Based Medications for BH

Tribal population is impacted but not represented.

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

BH EHR Incentive Program

The Office of Health Information Technology within the Health Policy & Analytics Division, is collaborating with Behavioral Health Policy and Pharmacy to align BH concepts.

Behavioral Health Homes

The PCPCH program have collaborated on the BHH proposal.

Access to Evidence-Based Medications for BH

HPA and HSD

11. WHAT IS YOUR EQUITY ANALYSIS?

BH EHR Incentive Program

Individuals who have severe and persistent mental illness face significant disparities in health outcomes as well as challenges in accessing services; this is also true for the Medicaid population. The agencies involved

in treating and supporting these individuals are well-suited to identify social determinants of health issues which can help address disparities and improve outcomes.

Through the BH EHR Incentive Program, participating BH agencies would be able to better capture, track, and monitor patient health information, and more easily facilitate needed referrals to address complex care issues. As a program requirement, OHA proposes requiring participants to use EHRs as a BH promotion and prevention tool, with the goal of improving access to BH services for all Oregonians, as well as promoting the coordinated health care system envisioned by Oregon's Behavioral Health Collaborative.

Behavioral Health Homes

The BHH proposal will finalize the standards for BHH and include standards that address health equity. The advancement can provide further access to primary care services for underserved populations. Of course, there will need to be further work in the behavioral health system to address health equity.

Access to Evidence-Based Medications for BH

Bringing this algorithm approach to the mental health treatment space will enhance the system's ability to uphold a holistic and encompassing standard of care for all people suffering from mental health illness, including individuals who have severe and persistent mental illness and face disparities in health outcomes and access to services.

12. WHAT ARE THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

BH EHR Incentive Program

To promote improved use of patient information by equipping BH agencies with the tools and resources that would allow the electronic capture of patient information. This would provide the basis for participating in HIE with other health care providers and support reporting to OHA. These changes would improve care coordination among providers, but it ultimately leads to better care for patients.

Behavioral Health Homes
Studies have shown individuals with a serious mental illness die at on average 25 years younger than the general population. Increasing access to primary care through the BHH proposal will address help ensure adults with serious mental illness will live longer and more fully.

Access to Evidence-Based Medications for BH
Improve access and best practices for consumers seeking and receiving treatment for mental health illness across the state.

13. IS THIS POP BEING REQUESTED BECAUSE OF AN INTERNAL DHS/OHA AUDIT, OREGON SECRETARY OF STATE AUDIT, OR FEDERAL AUDIT? IF SO, PLEASE PROVIDE FURTHER INFORMATION.
No.

STAFFING AND/OR FISCAL IMPACT

14. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): BH EHR Incentive Program: January 1, 2020
Behavioral Health Homes: Effective July 1, 2019, with positions and technical assistance funding effective October 1, 2019

End Date (if applicable): BH EHR Incentive Program: December 31, 2023
Behavioral Health Homes]: Ongoing

a. Based on the following answers, is there a fiscal impact?
Yes.

b. Will there be new responsibilities for OHA/DHS? Specify which Program Area(s) and describe their new responsibilities.

Office of Health Information Technology

Manage the operations of the BH EHR Incentive Program, which includes managing the technical assistance contract, developing outreach materials, and ensuring the appropriate payment of financial incentives to qualifying BH agencies.

Transformation Center PCPCH Program

Support identification of Behavioral Health Homes

c. 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.

d. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

e. 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.

BH EHR Incentive Program

- One permanent, full-time Operations and Policy Analyst 4 position through December 31, 2023 (21 months in 2019-21 biennium and 24 months in following biennia)

Behavioral Health Homes

- One permanent, full-time Program Analyst 3 position (21 months in 2019-21 biennium and 24 months in following biennia);

- One permanent, full-time Compliance Specialist 3 position (21 months in 2019-21 biennium and 24 months in following biennia)

Access to Evidence-Based Medications for BH

- One permanent, full-time Operations and Policy Analyst 1 (21 months in 2019-21 biennium and 24 months in following biennia)

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?

None.

g. What are the ongoing costs?

BH EHR Incentive Program costs

- $238,085 wages, benefits and supplies for Operations and Policy Analyst 4 position
- $250,000 for technical assistance contractor for BH EHR Incentive Program
  - Additional $250,000 for the 2021-23 biennium
- $4,500,000 for incentive payments to Behavioral Health organizations
  - At approximately $75,000 in incentive payments per organization, this would support 60 BH organizations.
  - Funding would need to be adjusted in future biennia to disburse $9,000,000 total over four-year program (January 2020 to December 2023) to support a total of 120 BH organizations.
  - To qualify for an incentive, a BH organization would submit a request for proposal or application and OHA would approve funding amount based on the organization's size and need.

Behavioral Health Homes

Staff costs and contract for technical assistance.

Access to Evidence-Based Medications for BH
Staff costs and committee costs for meetings and consultant as needed.

h. What are the potential savings?

BH EHR Incentive Program
Providing financial support for BH agency adoption of CEHRTs will likely result in the following gains:

- Improved patient care and outcomes through more efficient use of patient information and EHRs
- Increased care coordination and integration with physical and oral health
- Increased reporting efficiencies, accuracy and compliance, including for OHA MOTS reporting
- Increased potential for HIE participation, and improved referrals
- Increased potential for BH agency participation in VBP arrangements

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	$475,163	0	$196,731	$668,894	4	3.50
Services & Supplies	$434,410	0	$131,892	$5,101,861		
Capital Outlay	0	0	0	0		
Special Payments	$4,500,000	0	0	0		
Other	0	0	0	0		
Total	**$5,406,573**	**$0**	**$328,623**	**$5,735,196**	**4**	**3.50**

OHA - Fiscal Impact Summary by Program Area:

	Health Policy	Health Information Technology	Total
General Fund	**$418,488**	**$4,988,085**	**$5,406,573**
Other Fund	**$0**	**$0**	**$0**
Federal Funds- Ltd	**$328,623**	**$0**	**$328,623**
Total Funds	**$747,111**	**$4,988,085**	**$5,735,196**
Positions	**3**	**1**	**4**
FTE	**2.62**	**0.88**	**3.50**

i. What are the sources of funding and the funding split for each one?

All Federal Funds are Medicaid match.
One Operations and Policy Analyst 4 (100% GF)
One Operations and Policy Analyst 1 (50% GF/ 50% FF)
Program Analyst 3 (61% GF/ 39% FF)
Compliance Specialist 3 (61% GF/ 39% FF)
$60,000 contract with Oregon Health & Sciences University. (50% GF/ 50% FF)
$96,000 contract for Clinical Transformation Consultant. (50% GF/ 50% FF)
$4,500,000 for incentive payments to Behavioral Health organizations. (100% GF)
$250,000 for technical assistance contractor (100% GF)
$17,771 for meeting and travel costs associated with the advisory group (50% GF 50% FF)

Oregon Health Authority
2019-21 Policy Package

Agency Name: Oregon Health Authority
Program Area Name: Behavioral Health
Program Name:
Policy Package Title: **Behavioral Health Funding Shortfall**
Policy Package Number: 413
Related Legislation: None

Summary Statement:

Many mental health investments made over the last 4 years have been funded by tobacco taxes and Tobacco Master Settlement Agreement (TMSA) funds. Both revenue sources are forecasted to decrease in the 2019-21 biennium and will not be sufficient to support these services at the current level. To continue community mental health and substance abuse disorder services dependent on tobacco tax revenues and TMSA funds, this policy package requests General Fund to cover the shortfall.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Package Pricing:	**$9,132,500**			**$9,132,500**

PURPOSE

1. **WHY DOES OHA PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?**
   Many mental health investments made over the last 4 years have been funded by tobacco taxes and Tobacco Master Settlement Agreement (TMSA) funds. These services include rental assistance, mobile crisis services and outpatient substance use disorder (SUD) services for unfunded individuals. Tobacco tax revenues and TMSA funds are both forecasted to decrease in the 2019-21 biennium and will not be sufficient to support these services at the current level. To continue community mental health and substance abuse disorder services dependent on tobacco tax revenues and TMSA funds, this policy package requests General Fund to cover the shortfall.

2. **WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?**
   General Fund would be used to cover the shortfall related to tobacco tax revenues and TMSA funds and vital behavioral health services would continue without a reduction.

3. **HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?**
   These services provide services and supports for individuals with mental illness to live successfully in the community.

QUANTIFYING RESULTS

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**?
   Not specifically. This request will permit vital behavioral health services to enable individuals to get the right service at right place at the right time.

5. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?
OHA would need to reduce community mental health and substance use disorder services dependent on these funds. Individuals would be at risk of losing housing and having reduced access to SUD services.

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGES TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.
No.

7. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?
Reducing these services. OHA did not pursue this alternative due to the unacceptable negative consequences for individuals who need these services.

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?
Attempted to resolve this through other budget building mechanisms.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?
None.

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?
None.

11. WHAT IS YOUR EQUITY ANALYSIS?

These funds would support community mental health and SUD services provided to underserved populations, including undocumented individuals in need of behavioral health services.

12. WHAT ARE THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

Individuals receiving services and supports that enable more people with behavioral health disorders to live successfully in the community

STAFFING AND/OR FISCAL IMPACT

13. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): July 1, 2019

End Date (if applicable): Ongoing

a. Based on the following answers, is there a fiscal impact?

Yes.

b. Will there be new responsibilities for OHA/DHS? Specify which Program Area(s) and describe their new responsibilities.

No.

c. 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.

d. **Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.**
No. This request would support the continuation of behavioral health services.

e. 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.

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
None.

g. What are the ongoing costs?
None.

h. What are the potential savings?
None.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	0	0	0	0		
Services & Supplies	0	0	0	0		
Capital Outlay	0	0	0	0		
Special Payments	$9,132,500	0	0	$9,132,500		
Other	0	0	0	0		
Total	**$9,132,500**	**$0**	**$0**	**$9,132,500**	**0**	**0.00**

OHA - Fiscal Impact Summary by Program Area:

	HSD Non-Medicaid	Total
General Fund	$9,132,500	**$9,132,500**
Other Fund	$0	**$0**
Federal Funds- Ltd	$0	**$0**
Total Funds	$9,132,500	**$9,132,500**
Positions	0	**0**
FTE	0.00	**0.00**

i. What are the sources of funding and the funding split for each one?
General Fund only.

Oregon Health Authority
2019-21 Policy Package

Agency Name: Oregon Health Authority
Program Area Name: COMPASS
Program Name: Health Policy & Analytics, Health Systems Division: Behavioral Health Programs
Policy Package Title: **MOTS|COMPASS System Modernization & Completion**
Policy Package Number: 414
Related Legislation: None

Summary Statement:

The Oregon Health Authority's behavioral health data currently exists on a variety of outdated systems and platforms that are unreliable and disconnected from other agency data. These systems significantly limit OHA's ability to meet federal and state data reporting requirements, track treatment outcomes, improve service delivery, and forecast caseloads. This policy package would fund the procurement of expert contract services for the analysis, acquisition, and implementation of a standardized reporting system for behavioral health services. Once fully implemented, the reporting system would increase the agency's ability to gather data from providers; allow for the reallocation of agency information technology resources; improve collaboration between agency programs and providers; help staff identify opportunities to improve the health of Oregonians who need mental health and substance use services; bring the agency up-to-date on required state and federal reporting; and improve caseload and need forecasting.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Package Pricing:	**$6,739,793**	**$0**	**$0**	**$6,739,793**

PURPOSE

1. WHY DOES OHA PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?

The Oregon Health Authority's (OHA) behavioral health data currently exists on a variety of outdated systems and platforms. The data in those systems is unreliable and no existing technology integrates agency data. Because OHA is using old, disconnected systems, OHA is unable to adequately perform many of the tasks required by state and federal officials, such as meeting data reporting requirements, tracking treatment outcomes, improving service delivery, and forecasting caseloads.

OHA requires complete and accurate data to meet mandatory reporting requirements at the federal and state level. The agency is required to make available information related to:

- Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant
- Oregon State Police reporting to the National Instant Criminal Background Check System (NICS) database
- Treatment Episode Data Set (TEDS), including National Outcome Measures (NOMs)

OHA has been unable to comply with the monthly data submissions required by SAMHSA since 2014 due to changing funding models and the implementation of data systems that were not designed to meet either the needs of the funding model nor fully assessed to meet the business need for integrated data. Continued noncompliance with this requirement places millions of dollars for mental health and addictions services at risk.

Due to the lack of integrated data and information systems, OHA cannot easily track treatment and outcomes for Oregonians suffering from mental health and substance use issues. Currently, OHA cannot easily track when entities required to report data are failing to report to the agency. This is due in part to a lack of integrated contract data that would allow the agency to practicably hold contractors accountable for required reporting and include reporting as a contract deliverable supporting payment. Because of the complexity of reporting, few non-mandated reporters are willing to provide behavioral health and

substance use data to the agency. This prevents the agency from providing state officials with accurate state-wide data and inhibits accurate assessments of need and financial forecasting.

A comprehensive analysis of the agency's business need is required to create and implement a flexible system that aligns with the enterprise technology vision. By aligning business processes and data, the system would facilitate cooperation and collaboration between stakeholders and improve reporting of, and access to contract and encounter information. It would also ensure information is shared securely and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and federal regulations. Ultimately, this work would create efficiencies for providers, agency program staff and OIS staff, who will no longer need to maintain the expensive and outdated systems. It would also allow the agency to meet state and federal requirements to maintain funding and improve both service delivery and budget forecasting.

2. WHAT WOULD THIS POLICY PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

The project and resulting system will provide a variety of business support functions:

- Compliance with Personally Identifiable Information (PII) Privacy Act;
- Compliance with Health Insurance Portability and Accountability Act (HIPAA);
- Compliance with Health Information Technology for Economic and Clinical Health (HITECH) Act;
- Reduce silos around system maintenance in OHA's OIS team;
- Increase the agency's ability to tie reporting responsibilities to payment;
- Improve the standardization of data in the agency;
- Increase the agency's ability to measure behavioral health outcomes;
- Reduce the administrative burden on contracting providers and staff;
- Create integrated and adjustable reports that meet federal reporting requirements;

- Simplify the ability to meet routine change and upgrade requirements for federal and state legislation, rules, and business needs;
- Migrate data from multiple data collection systems;
- Streamline and update business processes;
- Provide ongoing maintenance and support;
- Support required functionality for 5 – 10 years;
- Align with the agency's long-term IT strategies.

To achieve these goals, the agency anticipates contracting with a vendor of business analyst services to manage the identification of business needs, and acquisition (or construction) and implementation of a technology solution for behavioral health and substance use reporting. This would include:

- Meeting with Behavioral Health leadership to understand the future vision for behavioral health services to promote and align systems work with business vision.
- Collaborating with business teams on business process improvement and documentation of processes related to contracting and reporting.
- Collaborating with Behavioral Health teams to define data reporting requirements for evaluating contract fulfillment and agency metrics around successful client outcomes.
- Collaborating with HPA and HSD teams to define reporting requirements for SAMHSA, TEDS and the Oregon Performance Plan.
- Collaborating with teams in HPA and HSD to standardize data field definition for entry into the data warehouse and aligning those with contract specifications.
- Assessing existing "out-of-the-box" systems for suitability for agency use and making recommendations.
- Assisting with the creation of a Request for Proposal (RFP) and scoring model or project plan for procurement of resources if custom build.
- Assisting with procurement of goods or services to complete project.

- Assisting with the development of internal and external training resources for successful launch of the new system and business processes.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

The COMPASS modernization project supports the following missions and strategic technology plan.

- Governor's Executive Order 18-01: Building Oregon's commitment to addiction prevention, treatment, and recovery priorities, and setting deadlines for statutory requirements, and declaring a public health crisis.

- Health and Human Services Agencies Information Resource Management 2017-2019, Governor Brown's Strategic Initiatives for Healthy, Safe Oregonians:
    - Ensure that every Oregonian who needs alcohol and other drug treatment or mental health services can easily get it.
    - Ensure all Oregonians have equitable and appropriate access to affordable, high quality health care.
    - Keep communities safe through mindful law enforcement and using data and analytics to balance accountability, reformation and treatment in order to reduce recidivism and prevent future victimization.

- OHA Mission: Helping people and communities achieve optimum physical, mental, and social well-being through partnerships, prevention and access to quality, affordable health care.

- DHS/OHA Strategic Technology Plan:
    - Provide Trusted Services for accurate health care outcomes data by effectively collecting, maintaining, and organizing information to enable informed decision-making and support internal and external data sharing.

- Enable Business Automation via workflows and business rules, reducing manual, paper-based processes while increasing effectiveness.
- Enable Connectivity Anytime, Anywhere, in Multiple Ways by providing self-service, role-based capabilities with remote access to information meeting the diverse needs of staff and partners.
- Use Dynamic Services Supporting Dynamic Needs by supporting provider modular, common services and capabilities, which promote agility, reuse, and best practices leveraging enterprise capabilities.

QUANTIFYING RESULTS

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**?

There are currently no Key Performance Measures (KPMs) tied to behavioral health work outside of Coordinated Care Organization (CCO) metrics. The COMPASS modernization project does support many of the key goals outlined on the OHA Fundamentals Map: An Engaged and Supported Workforce, Effective Partnerships, Operational Excellence, Better Health, Better Care, and Lower Cost.

5. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

OHA could lose federal funding for a wide range of behavioral health programs due to its inability to adequately meet federal reporting requirements. Aside from funding impacts, the inability to track and measure the outcomes of contracting and care could have a devastating impact for one of Oregon's most vulnerable populations, due to:

- Poor care coordination between facilities and providers.
- Delay or failure to provide Oregonians with treatment or services.
- Increased length of hospital commitment.
- Potential civil rights violations.

Additional challenges to the state and its external partners will continue to compound in the following areas:

- Increased administrative burden for behavioral health providers and CCOs.
- Lack of compliance with legal and federal requirements.
- Lack of IT staff resources to support outdated and ineffective data systems.
- Loss of public trust.
- Less effective behavioral health and substance use care
- OHA and the state will be unable to track care outcomes and promote those options that provide better outcomes and cost efficiency.
- Increased cost of care for Oregonians with mental health and substance use.

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGES TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No. However, statue changes may be required following an analysis of the COMPASS system to ensure appropriate data reporting.

7. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

1. Continue running the current systems until they are unsupportable.
   The applications are aging, running on outdated hardware and software and will ultimately fail. Since these applications were developed separately and are not connected, the data they contain is duplicative, aging and difficult to maintain. Most of the databases' business rules are enforced by external applications, making them hard to understand on their own. As the system becomes increasingly unsustainable there are fewer people available with the skills to maintain it.

Without this policy package, COMPASS applications will continue to consume a disproportionate amount of resources both in the agency's IT services section and from staff required to do time-consuming and costly workarounds. System failure, inefficiency and the inability to hold service providers accountable will compromise the agency's ability to support the triple aim of better health, better care and lower costs. This is not an acceptable alternative for the administration of OHA services.

2. Transition outdated systems to more modern platforms without integrating the systems and the data. The basic work of gathering systems requirements for each system, determining whether to buy or build a system and the transition of work would remain. Costs are likely similar to the current proposal, but without the long-term benefit of business and system integration. This approach runs the risk of leaving existing business and reporting gaps intact.

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?

The agency has attempted to integrate the current systems on an existing platform and performs on-going maintenance, operations and fixes. The agency is reviewing options for transitioning of one of the oldest data platforms in COMPASS to either a different, existing platform or building a system that could be expanded. The possibility of moving other aging platforms will continue to be reviewed.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

Primary stakeholders include, but are not limited to:

- Federal partners: Substance Abuse and Mental Health Services Administration (SAMHSA) and U.S. Department of Justice (USDOJ)
- Oregon State Police
- Department of Administrative Services/State Financial management Application

- Oregon Department of Corrections
- Oregon Youth Authority
- Oregon county mental health and substance use providers
- Electronic Health Record (EHR) and other software providers
- Providers of behavioral health services, including Oregon Tribes
- Clients receiving behavioral health services, including Oregon Tribal members
- Providers of substance use treatment services, including Oregon Tribes
- Clients receiving substance use treatment services, including Oregon Tribal members

Partners providing data will be impacted by simplified administrative tasks. Partners receiving reporting will be able to better assess their service provision and future needs. DAS will be impacted by OHA's improved ability to perform required transaction reporting. Internal stakeholders will be impacted by improved business processes and reporting and simplified administrative tasks.

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

The following internal partners participated in conversations about the future of data, data analytics, data use and information reporting related to behavioral health programs and will be involved in the COMPASS modernization project.

- Behavioral health teams,
- Health Systems Division contracting unit,
- Staff who work with CCOs and on CCO policy,
- MMIS,
- Health Policy and Analytics Division,
- COMPASS team, and
- Office of Information Services.

The agency expects to begin meeting with external stakeholders in coming days. The agency will engage with a wide number of mandated and non-mandated data providers, including Tribes, in the development of the system.

11. WHAT IS YOUR EQUITY ANALYSIS?

This project would allow the agency to assess data collected by mental health and substance use programs, including the feasibility of incorporating REAL-D data collection. Improving the agency's ability to track service delivery across the continuum of care and evaluate outcomes would help the agency address behavioral health outcome disparities.

12. WHAT ARE THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

OHA envisions a data system for behavioral health service outcomes that can hold millions of individual records, directly interface with a variety of internal and external data systems and electronic health records systems, and provide multi-functional reporting to support state and federal requirements. The new system should support required functionality for 5 – 10 years and will bring the behavioral health information systems into alignment with OHA's long-term IT strategy.

Additionally, the work is expected to support improved treatment outcomes for Oregonians through the exchange, analysis and reporting of data; support improved business practices and reduced administrative burden for OHA through the ability to better analyze and forecast outcomes and need; and support improved customer service and reduce administrative burden to providers.

13. IS THIS POP BEING REQUESTED BECAUSE OF AN INTERNAL DHS/OHA AUDIT, OREGON SECRETARY OF STATE AUDIT, OR FEDERAL AUDIT? IF SO, PLEASE PROVIDE FURTHER INFORMATION?

No.

STAFFING AND/OR FISCAL IMPACT

14. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): July 1, 2019

End Date (if applicable): June 30, 2021

a. Based on the following answers, is there a fiscal impact?
Yes.

b. Will there be new responsibilities for OHA/DHS? Specify which Program Area(s) and describe their new responsibilities.
For the COMPASS team, improved data reporting and the demand for more customized data by internal program staff and external providers would result in increased workload.

c. 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.
Office of Information Services – additional resources to consult on project development, build (if an agency constructed solution is determined to be the best option), test the application, and transition users (system access/service desk); contractor access to systems, services and equipment. If the project becomes an agency build, additional equipment may be required for short term staff. Implementation will require on-going service to new users, for password resets, access etc.

Office of Budget and Forecasting – consultation through the course of development and implementation, training needed

Office of Contracts and Procurement – consultation through the course of development and implementation, training needed

Office of Facilities Services – contractor access to facilities, services and equipment. If the project becomes an agency build, additional facilities space may be required for short term staff.

d. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Desktop access for appropriate user levels should streamline client care and facilitate the prompt and appropriate transitioning of clients to the least restrictive care environment (USDOJ directive) and maintain client civil rights (Olmstead). Improved provision of services and the ability to more accurately access services are expected to result in increased caseloads for those providing behavioral health services.

e. 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 request includes two permanent, full-time Operations and Policy Analyst 3 (OPA) positions (21 months) to support project development and implementation and the anticipated increased workload after system implementation.

Existing COMPASS staff will provide on-going project support in their areas of expertise. They will also serve as liaisons with existing users for outreach, transition support, and training. Some modification of roles is anticipated; best practice would call for an HR evaluation of changes in position responsibilities and workload when the project is complete.

The COMPASS team's ISS7 and ISS 8 and the OIS technical team supporting COMPASS would contribute to the project while maintaining their current workload. These teams may require additional resources, especially if the new system becomes a custom build. If the new system is developed in-house, additional programming resources would be required. The current team is dedicated to maintenance and operations of existing systems, which cannot be put on hold because many of these systems are fragile. The team would also need to assist with transitioning data to the new system. If the system is not developed in-house, members of the OIS team would need to collaborate closely on the project to ensure that stakeholder needs are met and the project aligns with OHA's long-term IT strategy. An IT project manager will be assigned.

Existing OPA 3 and Business Analyst positions would allocate a significant amount of time to this work, but would continue to support and maintain current systems, improve data integrity in current systems, and alter current systems to streamline the transition of data into the new systems.

Existing program staff would provide expert guidance to help determine new system requirements. Since this work is temporary and intermittent there is no expectation that the agency would hire additional program staff.

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?

The request includes funds for contracting with a vendor for an individual or team to provide business analyst services, and project manage the acquisition (or construction) and implementation of a technology solution for behavioral health reporting. This would include:

- Project management services.
- Meeting with Behavioral Health leadership to understand the future vision for behavioral health services to promote and align systems work with business vision.
- Collaborating with business teams on business process improvement and documentation of processes related to contracting and reporting.

- Collaborating with Behavioral Health teams to define required reporting data for evaluation of contract fulfillment and agency metrics around successful service recipient outcomes.
- Collaborating with Health Policy & Analytics (HPA), Health Systems Division (HSD) and Central Operations teams to define reporting requirements for SAMHSA and NICS.
- Collaborating with teams in HPA, HSD and Central Operations to standardize data field definition for entry into the data warehouse and aligning those with contract and reporting specifications.
- Technical consulting services.
- Assessing existing "out-of-the-box" systems for suitability for agency use and making recommendations.
- Assisting with the creation of RFP and scoring model or project plan for procurement of resources if custom build.
- Assisting with procurement of goods or services to complete project.
- Test management services.
- Assisting with the development of internal and external training resources for successful launch of the new system and business processes.

g. What are the ongoing costs?

Ongoing costs would need to be evaluated after project completion, however there would be on-going IT costs around systems maintenance and changes, including those routinely required by the Legislature and federal reporting requirements.

h. What are the potential savings?

Savings are anticipated from the decommissioning of existing systems.

- $30,000/month by moving OPRCS data off mainframe
- Eliminating use of AIX servers (data center cost)
- Using existing state vendors
- Streamlining business processes and eliminating time-consuming work-arounds

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Positions	FTE
Personal Services	$346,618	0	0	$346,618	2	1.76
Services & Supplies	$6,393,175	0	0	$6,393,175		
Capital Outlay	0	0	0	0		
Special Payments	0	0	0	0		
Other	0	0	0	0		
Total	**$6,739,793**	**$0**	**$0**	**$6,739,793**	**2**	**1.76**

OHA - Fiscal Impact Summary by Program Area:

	HSD Admin	Total
General Fund	**$6,739,793**	**$6,739,793**
Other Fund	**$0**	**$0**
Federal Funds- Ltd	**$0**	**$0**
Total Funds	**$6,739,793**	**$6,739,793**
Positions	**2**	**2**
FTE	**1.76**	**1.76**

i. What are the sources of funding and the funding split for each one?

State General Fund.

Oregon Health Authority
2019-21 Policy Package

Agency Name: Oregon Health Authority
Program Area Name: Health Systems Division
Program Name: Oregon Health Plan Pharmacy & Medical Services Programs
Policy Package Title: **Hepatitis C Treatment Expansion**
Policy Package Number: 415
Related Legislation: Not Applicable

Summary Statement:

Expand coverage for Medicaid recipients to receive Direct Acting Anti-Viral Medications in the treatment of Hepatitis C and prepare the Oregon Health Authority (OHA) for innovative approaches to Hepatitis C treatment access that involve manufacturers contributing to the solution.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Package Pricing:	**$10,000,000**	**$12,307,700**	**$85,128,200**	**$107,435,900**

PURPOSE

1. WHY DOES OHA PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?

To expand coverage for Medicaid recipients to receive Direct Acting Anti-Viral (DAA) medications in the treatment of Hepatitis C. In addition, it will prepare OHA for innovative approaches to Hepatitis C treatment access that involve manufacturers contributing to the solution. This could mean making screening and case management part of the services a manufacturer provides for a contract period that offers the manufacturer some exclusivity. This could be a way to navigate around best price and expand screening, access and monitoring of DAA delivery and success.

2. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

Funding would be available for Health Systems Division to expand coverage criteria for treatment of people with Hepatitis C. This would be implemented through existing structure or by implementing an innovative solution as described above.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

Treating everyone with Hepatitis C infection would help people and communities achieve optimum physical, mental and social well-being. It is also important to note that Hepatitis C relates to the opioid crisis, and failure to treat acutely infected individuals could perpetuate Hepatitis C incidence rates.

QUANTIFYING RESULTS

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?

Success would be monitored through ongoing risk corridor and data analysis that would demonstrate an increase in individuals identified and treated. Data analysis and reporting mechanisms are currently in place.

5. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?
Hepatitis C would be allowed to maintain its foothold and the long-term costs could exceed the immediate cost of treating the population affected now.

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGES TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.
No.

7. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?
No alternatives are available. Direct acting anti-viral agents are new and the evidence suggests they are an effective treatment.

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?
OHA requested funding during the 2017 legislative session and received funding for half of the projected costs.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?
Tribal members could be favorably impacted, with access to treatment being expanded. There are other opportunities that could be leveraged with other agencies if an innovative strategy were deployed, this could include the Public Health Division, Department of Corrections and Oregon Youth Authority.

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

A memorandum of understanding (MOU) has been in place since early 2017 with the Oregon Law Center, who is advocating for the expansion of treatment criteria for Hepatitis C.

11. WHAT IS YOUR EQUITY ANALYSIS?

Expansion of treatment criteria for Hepatitis C will improve eligibility/access to treatment for many vulnerable populations. These include tribal members with Hepatitis C and other populations that actively suffer from substance use disorders and at risk of acquiring or spreading the disease without treatment.

12. WHAT ARE THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

Hepatitis C Elimination plan is more than a purchasing vehicle that is designed to contain the costs for the medications that are effective in treating this disease.

An elimination plan is a longer term set of strategies:

- that promote screening efforts to better identify magnitude of crisis in Oregon;
- that target the incidence (i.e. - new infection rate) of HCV;
- that preserve and expand access to effective treatment, and
- that leverage synergistic efforts that work towards infected populations achieving optimum physical, mental and social well-being.

13. IS THIS POP BEING REQUESTED BECAUSE OF AN INTERNAL DHS/OHA AUDIT, OREGON SECRETARY OF STATE AUDIT, OR FEDERAL AUDIT? IF SO, PLEASE PROVIDE FURTHER INFORMATION.

No.

STAFFING AND/OR FISCAL IMPACT

14. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Pricing of medications are not stable and recent price decreases have been noticed.

Implementation Date(s): January 1, 2020

End Date (if applicable): Ongoing

a. Based on the following answers, is there a fiscal impact?
Yes.

b. Will there be new responsibilities for OHA/DHS? Specify which Program Area(s) and describe their new responsibilities.
None.

c. 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.

d. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
Yes. An increase in the number of Medicaid recipients eligible to access and receive treatment.

e. 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.

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
None.

g. What are the ongoing costs?

The costs of the medications, which could fluctuate over time.

h. What are the potential savings?

The cost avoidance associated with these efforts will generate some immediate and likely more appreciable long-term savings. Potential savings include cost avoidance of very expensive procedures and complications such as cancer treatment, treatment for liver failure, and chronic supportive care for patients with Hepatitis C.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	0	0	0	0	0	0.00
Services & Supplies	0	0	0	0		
Capital Outlay	0	0	0	0		
Special Payments	$10,000,000	$12,307,700	$85,128,200	$107,435,900		
Other	0	0	0	0		
Total	**$10,000,000**	**$12,307,700**	**$85,128,200**	**$107,435,900**	**0**	**0.00**

OHA - Fiscal Impact Summary by Program Area:

	HSD	Total
General Fund	$10,000,000	**$10,000,000**
Other Fund	$12,307,700	**$12,307,700**
Federal Funds- Ltd	$85,128,200	**$85,128,200**
Total Funds	$107,435,900	**$107,435,900**
Positions	0	**0**
FTE	0.00	**0.00**

i. What are the sources of funding and the funding split for each one?

There would be federal matching funds for Drug expenditures and there would be rebates available as well. Remember that the expansion population will receive slightly higher match rate than general Medicaid population.

Oregon Health Authority
2019-21 Policy Package

Agency Name: Oregon Health Authority
Program Area Name: Health Policy and Analytics Division
Program Name: CCO 2.0
Policy Package Title: **CCO 2.0**
Policy Package Number: 416
Related Legislation: **House Bill 2266 (**Legislative Concept 371)

Summary Statement:

The Oregon Health Authority (OHA) is committed to furthering health system transformation both in Coordinated Care Organizations (CCOs) and by spreading transformation to additional markets. At the direction of the Governor, OHA is undertaking a significant advancement of the coordinated care model in Medicaid (dubbed CCO 2.0). In preparation for a new procurement of CCOs in 2019 and 2020, the Governor asked the Oregon Health Policy Board to focus on four areas to further transformation within CCO 2.0: improving the behavioral health system, increasing the use of value-based payments, controlling costs, and addressing CCO members' social determinants of health/health equity. Significant policy development and implementation work will take place over the next several years that will need to be staffed and supported by OHA, including the four CCO 2.0 topic areas complementary areas related to prescription drug costs, long-term financing of health care, strategies for better leveraging the state's purchasing power to advance transformational efforts, maintaining access to coverage, and ensuring a stable private health insurance marketplace.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Package Pricing:	**$1,066,092**	**$0**	**$836,549**	**$1,902,641**

PURPOSE

1. **WHY DOES OHA PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?**
   At the direction of the Governor, the Oregon Health Authority (OHA) is undertaking a significant advancement of the coordinated care model in Medicaid (dubbed CCO 2.0). In preparation for a new procurement of Coordinated Care Organizations (CCOs) in 2019 and 2020, the Governor has asked the Oregon Health Policy Board to focus on four areas to further transformation within CCO 2.0:
   1. improving the behavioral health system,
   2. increasing the use of value-based payments,
   3. controlling costs, and
   4. addressing CCO members' social determinants of health.

   Significant policy development and implementation work will take place over the next several years that will require staffing and support from OHA, including the four CCO 2.0 topic areas and complementary areas related to prescription drug costs, long-term financing of health care, strategies for better leveraging the state's purchasing power to advance transformational efforts, maintaining access to coverage, and ensuring a stable private health insurance marketplace.

   This POP would advance health system transformation by increasing capacity in several areas expected to improve transparency and accountability, advance improvements in quality and outcomes and result in lower and more sustainable health care costs.
   - Ensuring adequate business intelligence tools and infrastructure would improve OHA's ability to track health system performance and allow for more thorough tracking and analysis of Oregon's progress on transformation goals, including CCO 2.0 goals. This would result in making more data on health care quality and costs publicly available, which would assist in identifying opportunities for efficiency within the health system and provide better data to inform stakeholders, policymakers and the public about trends within the health system.
   - Advancing payment reform and moving more of the health system toward paying for value of care rather than volume of services to improve quality and lower costs (in CCOs and other markets).

- Advancing the focus on, and support for, addressing social determinants of health — issues recognized to have a bigger impact on health outcomes and costs – which will help reduce disparities and ensure a health next generation of Oregonians.
- Ensure adequate resources to develop policy options and understand the economic implications of policy options under consideration by policy makers. Policy topics include strategies to sustain and finance health care coverage and opportunities to better align transformation efforts across markets.

Specifically, OHA requests:

- Two positions within the Transformation Center: A Value-based Payment Transformation Analyst (OPA 4) and Social Determinants of Health Transformation Analyst (OPA 4)
- The infrastructure necessary to weave together various data and health information technology efforts to maximize the use of available and future data sources.
- Four positions within the Office of Health Analytics: Business Intelligence (BI) Portfolio Manager (PEM F), BI Platform Developer (ISS 6), BI Systems Integration (RA 4), BI Project Support (RA 2).
- One position within Health Policy: An economic and policy analyst (OPA 4)

Component 1: Social Determinants of Health: As health systems move further upstream to address the root causes of health conditions and health inequities, there is a growing focus on the social determinants of health (SDOH), which are the factors outside of the medical care system, such as housing and food that impact short- and long-term health outcomes. This focus on addressing the SDOH as a key part of health system transformation has emerged as a priority for OHA, exemplified by the fact that one of Governor Brown's priorities for CCO 2.0 is to enhance CCOs' support for their members' SDOH and health equity needs. The CCO 2.0 contract and corollary requirements related to House Bill 4018 (2018) will put in place new CCO SDOH spending requirements to address SDOH and health disparities in their service areas.

More broadly, OHA is engaging and exploring various cross-agency partnerships to drive health system collaboration with other sectors, such as housing (which is identified as a statewide priority related to CCO 2.0 policies), education, self-sufficiency programs (e.g. food stamps), and transportation. OHA lacks a dedicated staff person to oversee the SDOH body of work related to health system transformation or, specifically, provide support and monitoring necessary to ensure CCOs satisfy the new requirements.

Adding an SDOH Transformation Analyst, housed within the Transformation Center, would provide the necessary expertise and capacity within OHA to ensure the agency can adequately coordinate, track, and monitor CCO compliance with SDOH requirements, as well as coordinate, develop and execute an agency-wide SDOH strategy for health systems.

Component 2: Value-based Payment: One of the Oregon's health system transformation goals is to move the health system away from paying providers using volume-based, fee-for-service payments toward the adoption of value-based payment (VBP) models that reward providers for a combination of high-quality care, positive member health outcomes and cost savings. This is a key element of the CCO model and a key area of focus to better leverage the state's purchasing power to lower costs in the Public Employees Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB), as directed by Senate Bill 1067 (2017 Regular Session). Significant progress in this area was not achieved during CCOs' first five years. Consequently, Oregon's 1115 Waiver, renewed in 2017, requires OHA to develop a "plan describing how the State, CCOs and their network providers will achieve a set target of VBP by June 30, 2022." In addition, Governor Brown identified CCOs' increased use of VBP as one of the four CCO 2.0 focus areas, and specific VBP requirements will be included in CCO 2.0 contracts. Further, OHA leadership has indicated a desire to leverage increased CCO adoption of VBPs to accelerate VBP adoption in the commercial market.

OHA lacks a dedicated staff member to oversee the substantial body of VBP policy work. A VBP Transformation Analyst would be housed within the Transformation Center and direct the Center's VBP Program. They would provide the requisite internal VBP expertise to oversee all strategic planning, oversight, and monitoring necessary to ensure CCOs satisfy their waiver and contractual VBP requirements. The VBP Transformation Analyst would also manage the cross- and intra-agency coordination necessary to align CCOs' VBP expectations with PEBB, OEBB, and the commercial health insurance market. Specifically, this staff member role would ensure payment reform efforts are coordinated, supported, tracked, monitored and evaluated across public health plans and commercial markets.

Component 3: Robust Business Intelligence and Master Data Management to Improve Transparency and Accountability: The work associated with VBP, SDOH, and health system transformation, in general, requires the collection, evaluation, and sharing of data. OHA should be leading the effort to use modern health care technology resources to tap into its vast array of data and information. While OHA should be

held to the same standards we expect of our providers, the agency currently lacks the ability to efficiently develop insights and track performance of the health care system. This is despite efforts to implement changes within the resources currently held by OHA. OHA possesses many of tools necessary to catch up; however, we need to plan the overall architecture to bring the efforts and resources together effectively to better leverage data to improve transparency and accountability in the health system.

OHA would consolidate efforts across various ongoing data and health information technology infrastructure endeavors in the Office of Health Information Technology and the Office of Health Analytics to maximize the use of available and future data sources. Data sources include the All Payers All Claims (APAC) database, health analytics library (Medicaid and health care survey data), Provider Directory, the clinical quality metrics registry, Emergency Department Information Exchange (EDIE), and more. More efficient use of these data sources would allow OHA to track:

- Investments and risks associated with social determinants of health and equity
- Behavioral health integration
- Health-related service use
- True value and cost of services
- Provider data management
- Strategic implementation of policies and interventions impacting the health care system

As a result, OHA would be better able to identify opportunities to improve the quality of care and lower costs, as well as foster accountability and transparency by making more data and analysis publicly available.

Component 4: Economic Policy Analyst: To fully realize health system transformation goals, OHA will require an Economic Policy Analyst to provide the economic and fiscal analysis necessary to develop and analyze proposals regarding maintaining access to health care coverage, financing of health care programs, and alignment of transformation efforts across markets. For example, future recommendations from the health care cost legislative task force created by Senate Bill 419 (2017 Regular Session) could require OHA to develop and analyze policies related to creating sustainable health care inflation targets, advancing multi-payer accountable care organization models, moving toward multi-payer provider-level global budgets, and seeking additional federal waivers to advance Oregon's health care goals. The continuing refinement of the CCO model will require ever increasing sophistication of agency analyzes on the intersection of access,

quality and cost containment. As OHA moves into the implementation phase of policies developed in CCO 2.0 and continues to examine their effect on health care transformation, the agency will need to monitor the outcomes of these policies and provide robust analysis on internal decisions, as well as emerging options from internal and external sources. This position would also allow the Health Policy and Analytics Division to explore alignment of CCO policies with PEBB and OEBB, collaborate with the Department of Consumer and Business Services and other entities, and anticipate how current policies will be impacted by federal trends.

2. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

The purpose of this POP is to take a more strategic approach to enhancing OHA's capacity to support of CCO 2.0 and health system transformation more broadly. Integrating OHA's approach to supporting health system transformation requires an integrated set of resources.

This POP would allow OHA to properly resource a business intelligence suite to mine the data sources made available through consolidation and make information more accessible to planning, evaluation, and decision-making efforts. This would be achieved by creating:

- Roadmap for data integration and analytics: investing now for the development of a plan that can show incremental investments over time and can lay the foundation for connecting to MMIS enhanced match. OHA would hire a consultant to assist and advise on developing an MMIS Advanced Planned Document. This would capitalize on the 90 percent federal match available for a planning effort.

- Business Intelligence (BI) suite and unit: providing business rigor to internal leadership and datamart access to data sets and interactive data displays to external stakeholders, freeing up staff time from running ad hoc reports for stakeholders and legislators. Four positions are requested: BI Portfolio Manager (PEM F), BI Platform Developer (ISS 6), BI Systems Integration (RA 4), BI Project Support (RA 2).

- Provider data management: Leverage the Provider Directory to attribute program and characteristics to providers and facilities; i.e., one place to identify Patient-centered Primary Care Home, Certified Community Behavioral Health Clinics, Health Information Exchange participation, etc. and the ability to analyze how effectively the delivery system is participating and achieving OHA's expectations. The POP would support modifying existing data collection points to enhance data collected. For example, by adding the National Provider Identifier to every data set OHA could match providers and facilities across data sets.

- Master person management and attribution: OHA seeks to leverage Integrated Client Services client matching where possible. Attributing patients to providers would also help align and integrate claims and clinical data and hospital discharge data, for a variety of purposes. For example, OHA could determine whether patients with psychiatric emergency department boarding experiences are connected to primary care and behavioral health services.

The above data infrastructure enhancements would improve OHA's ability understand the impact of SDOH on the health of those served by OHA. To complement this work, OHA proposes adding a Social Determinants of Health Transformation Analyst position (OPA 4) to address a lack of staff expertise and capacity to manage OHA's SDOH work within health system transformation. The SDOH Transformation Analyst, who would serve as the point person for all OHA's SDOH work, would focus on CCO 2.0 policy implementation and the broader agency strategy related to SDOH. With the data infrastructure enhancements described above the individual in this position would be more effective and efficient.

In addition, OHA would add a VBP Transformation Analyst position (OPA 4) to address the current lack of VBP staff capacity and expertise to oversee the comprehensive body of emerging VBP work within the agency. The VBP Transformation Analyst would serve as OHA's VBP lead, with a focus on CCO 2.0 policy implementation and longer-term strategic planning, including VBP alignment with other payers. Again, the effectiveness of the position would be greatly bolstered by having information at their fingertips, as provided by an enhanced approach to data management and reporting.

OHA also requests the addition of an Economic Policy Analyst (OPA 4) to support the broad range of emerging SDOH and VBP policy work as well as the controlling costs and behavioral health areas under CCO 2.0. An Economic Policy Analyst would, among other things, contribute to strategic and planning discussions around health system transformation, and provide fiscal and economic analysis to allow the agency to better understand the financial impact of its health system transformation strategies.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

Component 1: Social Determinants of Health: OHA's vision ("A healthy Oregon") and mission ("Helping people and communities achieve optimum physical, mental and social well-being.…") cannot be fully realized if the SDOH—which contribute to over half of the populations' long-term health outcomes—are not prioritized, through an accountable lead, within the agency's work. VBP analysts would complement this work.

Component 2: Value-based Payment: Since VBP offers incentives for providers to deliver high-quality care, positive member health outcomes and cost savings, VBP is a primary strategy for achieving OHA's mission of "Helping people and communities…access… quality, affordable health care."

Component 3: Master Data Management: Appropriate data management is again the backbone of supporting these activities, as we need to demonstrate responsible use of resources by having the sophistication necessary to utilize all our data resources. Without this infrastructure it is difficult to know if we are truly achieving our goals.

Component 4: Economic Policy Analysis: The mission of OHA is helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to high-quality, affordable health care. An Economic Policy Analyst would provide much-needed staff capacity to conduct fiscal and economic analyses of the agency's health system transformation goals, ensuring the goal of high-quality, affordable health care is achieved.

QUANTIFYING RESULTS

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?

Component 1: Social Determinants of Health

The OHA Performance Measures are not relevant to this component. OHA will measure the success of this POP via the following measures:

- A common understanding of SDOH between OHA and partner agencies, and a set of shared priorities and desired outcomes for addressing SDOH through health system/cross-agency collaboration.
- An increase in health care provider capacity to identify and address SDOH needs of patients.
- An increase in CCOs' partnerships with, and financial support of, community-based organizations to address SDOH needs of CCOs' members.
- An increase in the percent of Oregon Health Plan (OHP) members served by CCOs whose SDOH needs are addressed.
- Increased data availability and cross-agency data sharing to understand the SDOH factors experienced by Oregonians.
- Savings to the health care, self-sufficiency, justice, and other state systems as health improves and Oregonians experience increasing economic and social stability.

Component 2: Value-Based Payment

The OHA Performance Measures are not relevant to this component. OHA will measure the success of this POP via the following measures:

- Increased quality of care for CCO members due to the additional flexibility VBPs offer their network providers to meet the needs of their patients.

- Improved health outcomes for CCO members given providers' ability to offer care not strictly reimbursed based on volume of services.
- Improved provider satisfaction within an aligned system not driven by the volume of health care services provided.
- Increased alignment across CCOs and, eventually, PEBB, OEBB, and the commercial market in the targets and metrics they incorporate into their VBP models.
- Savings to OHA's budget due to VBP incentives to deliver cost-effective care.

Component 3: Master Data Management
This component will be incorporated in to all manner of performance measurement at OHA, including the tracking of OHA Performance Measures. In addition, it will provide means to share the results of analyses associated with the performance measures for OHA, CCOs, and the broader health care system.

Component 4: Economic Policy Analysis
The OHA Performance Measures are not relevant to this component, however the Governor's goal of furthering cost containment in the health care system is highly relevant. The position will strengthen OHA's ability to run cost models on policy proposals and track the impact of current policies regarding VBP and SDOH.

5. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

Component 1: Social Determinants of Health
Without the requested funding and resources, OHA would not fully realize its goal of "a healthy Oregon." The over one million OHP members in Oregon include those disproportionately impacted by SDOH factors. Given that health outcomes are driven by SDOH factors—even more so than by clinical care—it is critical that health system transformation direct and prioritize funding and resources toward these factors. However, without an agency SDOH lead, there would be missed opportunities in building the cross-agency partnerships and statewide strategy necessary for this transformation. Without this position, the agency would lack sufficient staff expertise and capacity to track and facilitate CCO innovation related to addressing their members' SDOH, which would limit the statewide impact of the work and could adversely affect health inequities.

Over the first five years of the CCOs, there was very limited accountability for CCOs addressing SDOH, and minimal OHA capacity to provide support to CCOs for this work. As a result, while innovations occurred across the state, the degree to which CCOs have engaged in SDOH interventions has varied significantly, and the impact of the work has not been adequately measured. To drive a strategic and effective approach in CCO 2.0, it is critical OHA have the staff capacity to support this work.

Component 2: Value-Based Payment

Without the requested resources, OHA would not be able to fully realize its goal of shifting Medicaid reimbursement strategies away from a system that pays for volume—or fee-for-service—to one that rewards quality and improved health. Without this position, the agency would lack sufficient staff expertise and capacity to support, track and facilitate CCO VBP innovation, which would limit the statewide impact of OHA's VBP work. To drive a strategic and effective approach in CCO 2.0, it is critical OHA have the staff capacity to support this work. In addition, without this position, OHA would not have the capacity to serve as a VBP "change agent" within the larger health care delivery system to support widespread VBP adoption and broad-based health system transformation.

Specifically, not funding this POP would have wide-ranging adverse impacts

- **CCO services and programs**, which would lack adequate support and technical assistance from OHA to implement evidence-based VBP models with their providers and transform operations and strategically address the SDOH needs of their members.
- **OHP members**, whose care would not be delivered by providers who have greater ability to deliver high-quality care supported through VBPs and who may receive fewer SDOH-focused services, and whose access to these services may depend on where they live and the degree to which their CCO prioritizes SDOH
- **OEBB, PEBB and other commercial payers**, who would not have a dedicated OHA VBP point-person with whom to coordinate their VBP work
- **Community-based organizations, equity-focused organizations, and public health agencies**, whose work significantly improves the health of OHP members and others in the community, but who may not be adequately resourced to do this work.

- **OHA and other state agencies, such as** Oregon Housing and Community Services, the Early Learning Division, the Department of Human Services, and others, due to the lack of capacity to establish meaningful collaboration to drive system-to-system partnerships to address SDOH.
- **The health of Oregonians and Oregon's budget**, due to the missed opportunities of cross-agency collaboration to reduce health costs and other system costs (such as those for justice-involved individuals), and the lack of a strategic approach to addressing SDOH through the health system.
- **Providers who see patients covered by Medicaid and, eventually, commercial payers,** whose VBPs from payers across Oregon will not be aligned to the degree they could be

Component 3: Master Data Management

OHA will continue to collect information without realizing its value in any strategic holistic form. This is costly in terms of resources and wasted potential, especially as OHA continues to advance its health system transformation goals.

Without a better approach to data management, OHA is perpetuating the stereotype that government is inefficient. Meanwhile, stakeholders, legislators, and partners are clamoring for information and turning to organizations outside of government. This is not helpful as OHA continues to provide and strive for common goals and messaging. Ensuring that state data is transparently and flexibly available when needed is a core component of proper stewardship of state resources. Without additional rigor in developing a roadmap and modest investments in infrastructure and staff, OHA is at risk for neglecting its stewardship role and creating artificial markets where research organizations compete for information.

Component 4: Economic Policy Analysis

Without adequate resources to efficiently and thoroughly assess the economic impact of so many intersecting and policies related to OHA's health system transformation goals, OHA will be unable to truly understand the financial implications of the transformation it is championing. One of the intrinsic elements of the CCO model is continuing to bend the cost curve and champion cost containment. Without adequate economic policy analysis, this essential goal is difficult to meet.

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGES TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No.

7. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

Components 1 and 2: Social Determinants of Health and Value-based Payment: Repurposing existing staff within the Transformation Center and Office of Health Policy to become the VBP and SDOH Transformation Analysts was considered. However, current staff within these offices are at capacity with ongoing work requirements and would not be able to take on this body of work. In addition, the VBP goals established under CCO 2.0 will require additional staff capacity beyond the time currently dedicated to developing CCO 2.0 VBP policy; there will be significant technical assistance and data tracking necessary to ensure CCOs' VBP adoption and progress meets OHA's expectations.

Component 3: Master Data Analysis: OHA has been working to develop its capacity associated with Business Intelligence for the past several years and has made good progress, however it has been slow. The work has been added to existing activities and activated by existing staff. It has become clear that to move faster and become more sophisticated OHA needs resources focused on these activities.

In addition, OHA has been working to develop a much stronger infrastructure associated with health information technology which has been very successful. Many of these accomplishments greatly benefit the provider system and could have a big impact on OHA's internal data structure. That internal aspect and the data provided by the new HIT structure needs to be appropriately utilized by OHA. The proposed funding to support strategy development is greatly needed otherwise it will be a wasted opportunity.

Component 4: Economic Policy Analysis: Without this position, the work would continue to be absorbed by current staff, though many of the staff do not have the economic analysis training required to sufficiently perform the economic and fiscal analysis necessary for vast amount of emerging CCO 2.0 implementation work.

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?

A current Transformation Center staff member manages the development of the CCO 2.0 VBP policy, with a substantial amount of assistance from the Transformation Center Director. However, the increased amount of VBP work that will be required to manage the CCO 2.0 VBP implementation will far exceed the capacity of these current staff.

In addition, while the oversight of CCO 2.0 health equity policy implementation is housed within the Office of Equity and Inclusion, OHA currently lacks the corollary staff expertise and resources to oversee the CCO 2.0 SDOH policy options and strategy for the agency over the long term. One staff member from the Office of Health Policy has served as the lead staff for the SDOH work during the CCO 2.0 policy option development period. However, the SDOH work responsibilities required to manage CCO 2.0 SDOH implementation, including necessary support for CCOs, will far exceed those this staff member would be able to manage on a permanent basis.

For data management, OHA has positioned itself to take greater advantage of its data resources by developing and utilizing efficient management of data warehouse resources and training to utilize reporting tools. This work has made it clear OHA needs dedicated resources to avoid falling behind the broader health care field.

For economic policy analysis, OHA has attempted to absorb the work into current analytics and policy staff, however demand for economic policy analysis support already exceeds the capacity of the current Economic Policy Advisor, and the need for economic analysis support will only continue to grow under CCO 2.0.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

Components 1: Social Determinants of Health
Adequately supporting an OHA-led statewide strategy to integrate SDOH and health system transformation will require cross-agency collaboration with partners such as the Department of Human Services, Oregon Housing and Community Services, and the Department of Education. It will also require coordination with Tribal governments to ensure Tribal health clinics are adequately engaged to address SDOH, and Tribal OHP members' unique needs are addressed. This strategy will also require effectively strengthening partnerships between OHA and other state agencies and local governments. The SDOH Transformation Analyst would ensure this coordination occurs and results in a more aligned focus toward support of a healthier Oregon.

Component 2: Value-Based Payment
Adequately supporting an OHA-led statewide strategy to increase the use of VBPs and health system transformation will require close collaboration with the Department of Consumer and Business Services. The strategy will also require coordination with Tribal governments to ensure Tribal health clinics are adequately engaged in the state's VBP activities and Tribal OHP members' unique needs are addressed. The VBP Transformation Analyst would ensure this coordination occurs.

Component 4: Economic Policy Analysis
Adequately supporting an OHA-led statewide strategy to increase cost containment will require close collaboration with the Department of Consumer and Business Services, as well as frequent contact with other agencies, such as Department of Human Services, Oregon Housing and Community Services, and the Governor's Office.

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

N/A

11. WHAT IS YOUR EQUITY ANALYSIS?

Component 1: Social Determinants of Health

An OHA SDOH Transformation Analyst would ensure the agency strategy to address SDOH through health system transformation is designed to impact SDOH with a focus on underserved communities. SDOH are not fairly distributed in communities. Instead, factors such as institutional racism, sexism, ableism, and others – also called the social determinants of health equity – predispose certain groups to more SDOH challenges than others. For example, Oregon's legacy of discriminatory laws, such as housing discrimination and laws barring blacks from residing in the state, have resulted in significant racial and ethnic inequities with regard to housing insecurity, and access to critical resources such as healthy food, transportation, credit and banking, and others.

The proposed CCO 2.0 SDOH and health equity policy options are designed with a focus on improving health equity and advancing culturally and linguistically appropriate care, including policies aimed at increasing utilization of Traditional Health Workers and requiring spending on SDOH and health disparities. Implementation of these strategies will require close coordination between an SDOH Transformation Analyst and the Office of Equity and Inclusion, including the capacity to work with the Oregon Health Policy Board's Health Equity Committee and the Traditional Health Worker Commission. Additionally, the SDOH Transformation Analyst would be responsible for coordinating with community-based entities, such as Regional Health Equity Coalitions, to bridge partnerships with CCOs and other health system partners. Finally, the SDOH Transformation Analyst would be responsible for tracking and monitoring how the CCOs' SDOH initiatives are designed to address health disparities, and to further facilitate evaluation of the CCO-level and statewide impact on health equity from these initiatives.

Component 2: Value-Based Payment

A core principle of the CCO VBP Roadmap is to ensure health disparities are considered within CCOs' VBP activities. The flexibility that comes with VBPs could support providers offering the necessary care or supports to address their patients' health disparities, such as traditional health workers. The VBP Transformation Analyst would oversees the CCO VBP reporting process, which would allow OHA to ensure CCOs consider strategies to support health equity in their VBP models. In addition, the VBP Transformation

Analyst would manage the Transformation Center's VBP technical assistance (TA) for CCOs, which will include TA on VBP models that address health equity.

Component 3: Master Data Management
OHA's approach to equity analysis would be greatly strengthened by giving better access to data. Currently, this is often considered "extra" analysis, whereas BI resources would essentially have it built into reporting process.

Component 4: Economic Policy Analysis
This component is requested to support goals suggested above, without economic stability we cannot guarantee sustained resources for the efforts described above.

12. WHAT ARE THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

Component 1: Social Determinants of Health
Over the long-term, the SDOH Transformation Analyst would support broader statewide strategy to integrate SDOH and health system transformation, ensuring that CCOs are maximizing their potential to address SDOH in collaboration with community partners. Additionally, the SDOH Transformation Analyst would ensure stronger cross-agency partnerships to address SDOH with the long-term goal of statewide, cross-sectoral priorities and formalized agency partnerships. Outcome indicators include:

- An increase in health care provider capacity to identify and address SDOH needs of patients
- An increase in CCOs' partnerships with, and financial support of, community-based organizations to address SDOH needs of CCOs' members
- An increase in the percent of OHP members served by CCOs whose SDOH needs are addressed
- A common understanding of SDOH between OHA and partner agencies, and a set of shared priorities and desired outcomes for addressing SDOH through health system/cross-agency collaboration
- Increased data availability and cross-agency data sharing to understand the SDOH factors experienced by Oregonians
- Savings to the health care, self-sufficiency, justice, and other state systems as health improves and Oregonians experience increasing economic and social stability

Component 2: Value-Based Payments

Over the long-term, the VBP Transformation Analyst will continue to support CCOs' increased adoption of VBPs, providing them with the necessary guidance, technical assistance, and data to ensure they have the capacity to meet their annual VBP growth targets in support of the statewide CCO VBP goal. The VBP Transformation Analyst will also work to increase and align VBP implementation beyond CCOs, focusing on PEBB, OEBB and the commercial insurance market to maximize impact and further transformation of the health care delivery system. Outcome indicators include:

- Increased quality of care for CCO members due to the additional flexibility VBPs offer their network providers to meet the needs of their patients
- Improved health outcomes for CCO members given providers' ability to offer care not strictly reimbursed based on volume of services
- Alignment between CCOs, PEBB, OEBB, and the commercial market in their VBP targets and goals
- Improved provider satisfaction within an aligned system not driven exclusively by volume of health care services provided
- Increased alignment across CCOs and, eventually, PEBB, OEBB, and the commercial market in the metrics they incorporate into their VBP models
- Savings to OHA's budget given VBP incentives to deliver cost-effective care through VBP

Component 3: Master Data Management

The long-term goals associated with this process are to become and more data driven and transparent organizations. Moving to tools that greatly increase the access to OHA's vast data resources both internally and externally to various stakeholders will enrich discussion associated with the health care system and allow for more informed discussions to occur.

Component 4: Economic Policy Analysis

Greater understanding of the economic impact of OHAs policies will also increase and facilitate the discussion that will continue to occur, as OHA and stakeholders look to continuously improve the health care system and manage costs.

13. IS THIS POP BEING REQUESTED BECAUSE OF AN INTERNAL DHS/OHA AUDIT, OREGON SECRETARY OF STATE AUDIT, OR FEDERAL AUDIT? IF SO, PLEASE PROVIDE FURTHER INFORMATION.

No.

STAFFING AND/OR FISCAL IMPACT

14. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): July 1, 2019

End Date (if applicable): Ongoing

a. Based on the following answers, is there a fiscal impact?
Yes (all components).

b. Will there be new responsibilities for OHA/DHS? Specify which Program Area(s) and describe their new responsibilities.
N/A

c. 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.

d. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
No (all components).

e. 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.

Component 1: Social Determinants of Health
New staff member (permanent): Operations and Policy Analyst 4 position, 21 months

Component 2: Value-Based Payments
New staff member (permanent): Operations and Policy Analyst 4 position, 21 months

Component 3: Master Data Management
Four new staff members (permanent): PEM F, RA4, RA2, ISS6 – 21 months

Component 4: Economic Policy Analysis
New staff member (permanent) Operations and Policy Analyst 4 position, 21 months

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
N/A

g. What are the ongoing costs?
Permanent Positions and $150,000 to support a contract for hospital emergency department discharge data delivery.

h. What are the potential savings?
OHA may realize long-term savings in OHP expenditures due to more cost-effective, high-quality care being delivered to OHP members, which is the goal of VBP.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	$750,650	0	$552,822	$1,303,472	7	6.16
Services & Supplies	$315,442	0	$283,727	$599,169		
Capital Outlay	0	0	0	0		
Special Payments	0	0	0	0		
Other	0	0	0	0		
Total	**$1,066,092**	**$0**	**$836,549**	**$1,902,641**	**7**	**6.16**

OHA - Fiscal Impact Summary by Program Area:

	Health Policy	Office of Health Analytics	Total
General Fund	$238,098	$827,994	**$1,066,092**
Other Fund	$0	$0	**$0**
Federal Funds- Ltd	$237,254	$599,295	**$836,549**
Total Funds	$475,352	$1,427,289	**$1,902,641**
Positions	2	5	**7**
FTE	1.76	4.40	**6.16**

i. What are the sources of funding and the funding split for each one?

All Federal funding from Medicaid match.
Positions:
2 – Operation and Policy Analyst 4s (50% GF/50% FF)
1 – Operation and Policy Analyst 4 (61% GF/39% FF)
1 – Information System Specialist 6 (61% GF/39% FF)

1 – Principle Executive Manager F (61% GF/39% FF)
1 – Research Analyst 2 (61% GF/39% FF)
1 – Research Analyst 4 (61% GF/39% FF)

$200,000 (10% GF/90% FF) to fund a contracted consultant to assist/advise on developing MMIS Planning APD.
$150,000 (100% GF) to support a contract for hospital emergency department discharge data delivery.

Oregon Health Authority
2019-21 Policy Package

Agency Name: Oregon Health Authority
Program Area Name: Public Health Division – Office of the State Public Health Director
Program Name: State Support for Local Public Health
Policy Package Title: **State Support for Local Public Health**
Policy Package Number: 417
Related Legislation: None

Summary Statement:

State Support for Public Health (SSPH) is pass-through funding provided to local public health authorities (LPHAs) to help support basic capacity for communicable disease response. The funding for SSPH was converted from General Fund in 2015-17 to fee revenue from the Oregon Medical Marijuana Program (OMMP). Due to the implementation of recreational marijuana in Oregon, OMMP fee revenues have declined significantly and the program is no longer able to fund SSPH in addition to its own program operations. This policy package requests General Fund to maintain the current funding level for SSPH for LPHAs.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Package Pricing:	**$5,480,601**	**$0**	**$0**	**$5,480,601**

PURPOSE

1. WHY DOES OHA PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?

The Oregon Health Authority (OHA) Public Health Division is making this request because of decreasing OMMP revenues, which are no longer sufficient to support public health programs in 2019-21 in addition to OMMP operations. The 2015-17 Legislatively Adopted Budget replaced by OMMP revenues with General Fund, resulting in a reduction to the Public Health Division General Fund appropriation.

The implementation of recreational marijuana has significantly impacted the OMMP. The revenues generated by the program have decreased by 34 percent since 2016 and are no longer available to support public health services outside of OMPP operations. This package will allow OHA to continue current funding levels to LPHAs for 2019-21.

This funding source is critical to LPHA program operations and there is no other available funding source for this work.

2. WHAT WOULD THIS POLICY PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

The Public Health Division provides resources to LPHAs through **a** Financial Assistance Agreement with each LPHA. This package ensures LPHAs receive the current level of funding to operate basic communicable disease control programs in each jurisdiction.

- Report, monitor and control communicable diseases.
- Provide diagnostic and consultative communicable disease services.
- Conduct early detection, education, and prevention activities to reduce the morbidity and mortality of reportable communicable diseases.
- Ensure appropriate immunizations for human and animal target populations to control and reduce the incidence of communicable diseases.
- Collect and analyze of communicable disease and other health hazard data for program planning and management.

The Public Health Division provides technical assistance to LPHAs and coordination of outbreak investigations through staff funded through other sources.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

OHA's mission is to help people and communities achieve optimal physical, mental and social well-being through partnerships, prevention, and access to quality, affordable health care. Control of communicable diseases is a primary statutory responsibility of governmental public health and leads to significant cost savings and reduced burden to the health care delivery system by preventing the spread of disease. Much of the work of LPHAs funded by SSPH involved direct interface with health care providers in the LPHA's jurisdiction.

Communicable diseases affect the health of individuals and communities throughout Oregon. LPHAs are responsible for routine communicable disease investigation and control, as well as urgent responses to communicable disease outbreaks and related investigations. Examples of communicable diseases include tuberculosis, pertussis, hepatitis A, hepatitis B, salmonella, E. Coli, listeriosis, HIV, gonorrhea, chlamydia and syphilis.

QUANTIFYING RESULTS

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?

Through interface with local health care providers, this POP supports the achievement of Public Health Division's Key Performance Measures that are also tied to Oregon's 2015-2019 State Health Improvement Plan:

- Child immunization rates; and
- Flu shots.

The success of this POP will be measured by continued capacity to support existing local communicable disease programs at a base level. During a triennial review, each LPHA currently is measured on the following:

- Proportion of contacts with appropriate treatment for certain communicable diseases to prevent further transmission;
- Proportion of case investigations completed within specified timeframes;
- Timely reporting to OHA of immediately notifiable diseases and outbreaks;
- Timely initiation of outbreak initiations; and
- Proportion of cases in which data collection is complete.

5. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

Without this POP, LPHAs would receive only 24 percent of their current SSPH allocations, resulting in a cut in excess of 75 percent. This would put core capacity for local communicable disease response in jeopardy and harm the communicable disease control system throughout Oregon. As a result, LPHAs would be severely limited in their ability to protect individuals in their jurisdiction from communicable diseases.

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGES TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No changes are required.

7. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

The only alternative to this POP is to reduce the distribution of funds to the LPHAs. This was rejected due to state and local statutory requirements for communicable disease control, which would not be met without continued funding at the current level.

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?

OHA does not have funding available to continue providing SSPH at the current level, which would be the only way to resolve this issue.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

All LPHAs across Oregon would be affected by the loss of funding. LPHA capacity to perform epidemiological investigations that report, monitor and control communicable diseases would be eliminated, or drastically reduced, leaving communities around the state at risk for infectious disease outbreaks. According to the 2016 public health modernization assessment of LPHA communicable disease control capacity and expertise, one in four people in Oregon, or 1 million people, lives in an area that cannot fully identify, prevent and control a disease outbreak. Without SSPH funding, this gap will widen even further and OHA does not have the capacity to perform communicable disease investigations in lieu of LPHAs.

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

LPHAs and the Conference of Local Health Officials have a stake in this POP being funded.

The work supported by this POP benefits local health care providers by providing them with information and support needed to control the spread of communicable diseases.

11. WHAT IS YOUR EQUITY ANALYSIS?

SSPH provides a modest base level funding to address communicable disease control in each LPHA service area across Oregon. There are vast differences in local support for public health across the state. Some LPHAs are able to invest additional County General Fund into communicable disease programs and others do not receive any additional resources to support communicable disease control in their jurisdictions. This creates inequities in access to services in areas where supplemental funding not available. In addition, some communicable diseases, including but not limited to HIV, Viral Hepatitis, and tuberculosis disproportionately impact some populations more than others.

12. WHAT IS THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

The long-term outcome is stable funding for base communicable disease control programs across all service areas in Oregon.

13. IS THIS POP BEING REQUESTED BECAUSE OF AN INTERNAL DHS/OHA AUDIT, OREGON SECRETARY OF STATES AUDIT, OR FEDERAL AUDIT? IF SO, PLEASE PROVIDE FURTHER INFORMATION.

Not applicable.

STAFFING AND/OR FISCAL IMPACT

14. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): July 1, 2019

End Date (if applicable): N/A

a. Based on these answers, is there a fiscal impact?

Yes

b. Will there be new responsibilities for OHA/DHS? Specify which Program Area(s) and describe their new responsibilities.

There are no additional responsibilities associated with this POP.

c. 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.
There will be no impact to Shared Services.

d. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
There will be no changes to client caseloads or services.

e. 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.
There are no positions associated with this POP.

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
None.

g. What are the ongoing costs?
The ongoing cost is the financial support to local programs.

h. What are the potential savings?
This POP has the potential to save Medicaid, PEBB, OEBB and other insurers by preventing disease and supporting early access to necessary preventive treatment.

TOTAL FISCAL IMPACT FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	0	0	0	0	0	0.00
Services & Supplies	0	0	0	0		
Capital Outlay	0	0	0	0		
Special Payments	$5,480,601	0	0	$5,480,601		
Other	0	0	0	0		
Total	**$5,480,601**	**$0**	**$0**	**$5,480,601**	**0**	**0.00**

OHA - Fiscal Impact Summary by Program Area:

	OSPHD	Total OHA
General Fund	$5,480,601	**$5,480,601**
Other Funds	$0	**$0**
Federal Funds- Ltd	$0	**$0**
Total Funds	$5,480,601	**$5,480,601**
Positions	0	**0**
FTE	0.00	**0.00**

i. What are the sources of funding and the funding split for each one?
State General Funds.

Oregon Health Authority
2019-21 Policy Package

Agency Name: Department of Human Services and Oregon Health Authority
Program Area Name: Integrated Eligibility Project Office
Program Name: DHS Central Services
Policy Package Title: **Integrated Eligibility / Medicaid Eligibility System Project**
Policy Package Number: 201
Related Legislation: N/A

Summary Statement:

This POP requests resources to support the continuation of the ONE Integrated Eligibility & Medicaid Eligibility (ONE IE & ME) Project from Medicaid, Shared Services, and DAS Enterprise Technology Services. The ONE system will be a single eligibility determination system for Non-MAGI Medicaid, Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, and Employment Related Day Care programs. These resources would support DHS' business needs and is related to the Legacy System Project DHS is undertaking to ensure functionality not assumed into the Integrated ONE system from legacy systems remains available for DHS business usage.

The corresponding DHS POP would further the testing and implementation period for the Integrated ONE System for the purposes of Eligibility Determination work. DHS plans to pilot the system in Summer 2019 to be followed by a six-month implementation roll-out beginning early in 2020 and statewide roll-out by Summer of 2020. This POP would take advantage of enhanced federal funds across two federal agencies. Without this funding, DHS would not be able to continue its project in a timely manner, resulting in increased General Fund cost, federal audits, and modifications to Legacy systems. It also includes funding for Eligibility Transformation work that supports changes to DHS' delivery system.

	General Fund	Other Funds	Federal Funds	Total Funds
OHA Policy Package Pricing:	**$671,490**	**$9,589,123**	**$1,638,121**	**$11,895,734**
DHS Policy Package Pricing:	**$18,320,972**	**$39,247,563**	**$121,950,843**	**$179,519,378**

PURPOSE

1. WHY DOES DHS PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?

Today, when an individual wants to apply for public benefits in Oregon, they must submit multiple applications to multiple agencies and offices, with different options for submitting the information depending on location or programs being applied for. Our Legacy computer systems do not communicate effectively with each other or in many cases, not at all. While the individual processing time for a single program in a Legacy system may be less today than projected during the initial rollout of an integrated solution, the total amount of time multiple workers must interact with multiple systems to process all these programs coupled with the time applicants need to spend with different agencies on the phone or in person is significant and demonstrates an inefficient level of infrastructure. At the center of our work are the individuals we serve and we believe these changes will allow Oregonians to move towards a true "no-wrong-door" system. An integrated system provides an electronic portal for individual applications, unifies Medicaid programs for greater coordination and accuracy of benefits, creates automation opportunities to improve on data and utilizing metrics in our decision making, and provides future avenues for improved service delivery. Ultimately, an integrated system provides the customer-focused direction that the agency has continued to strive towards and that the Legislature has encouraged us to pursue.

Oregon also has one of the larger Legacy system networks among states that have utilized Deloitte to implement an integrated eligibility system. When discussing implementation options with other states, many

only need to modify between 4 and 8 Legacy systems to keep ongoing work and support the Data Conversion to a new system. In Oregon, there are over 33 Legacy systems being modified through this integrative project. While many of these systems are currently stable, the ability to recruit and retain knowledgeable staff who can work in these older programming languages while simultaneously maintaining so many Legacy systems is an ongoing risk for Oregon. The historical risk is currently being mitigated by the consistently overtasked Legacy staff resources of the Office of Information Services and bringing on costly contractors to supplement staffing resources.

Oregon is also at a time where our service delivery model needs to be transformed. According to various studies, over half of all US adults bank online and 79 percent of US adults shop online, an increase from just 22 percent in the year 2000. This online shift has been seen with the federal government creating the Federal Exchange for Healthcare and has become commonplace in private industry. However, Oregon's eligibility process has limited system functionality for individuals in Oregon to apply for benefits online. These benefits again are not coordinated, leaving Oregonians to have to work with multiple divisions, multiple systems, and multiple responses. DHS is leading change through an effort called Eligibility Transformation. The goal is to move Oregon along the Human Services Value Curve, a concept that came out of Harvard's Kennedy Center for Public Management, which defines four levels of business models with the most basic being regulative, then collaborative, integrative, and generative. Each looking to increase in efficiency and effectiveness, which has balancing properties. While DHS has parts of our systems that could be close to all those models, we operate in a regulative model. Eligibility Transformation, hopes to break down barriers and develop models that shift from the regulations and programs and focus on the whole-person and family centric service design. This is a large change for workers and Oregonians moving from a system that processes the person based on one program at a time, to a system that allows Oregonians to apply for benefits in ways that work for them and focuses on their needs.

2. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

The corresponding DHS POP would 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 ONE IE & ME Project and its transition into maintenance and operations.

DHS has engaged with a 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 within which Oregonians can apply for and receive benefits from DHS for Medical Programs, SNAP, including SEBTC, TANF, and ERDC program areas.

DHS has gone through the Stage Gate process, completed a Fit-Gap analysis in 15-17, and by the end of 17-19 biennium will have completed Design and two Design Addendums, Unit Testing, System Integration Testing, as well as entered into and be near completion of the User Acceptance Testing for the upgraded ONE system. OIS will have completed design, development, and testing of over 33 Legacy systems, with modifications being made to keep functionality for programs and requirements within the system once these programs have been removed. The intent is to be able to sunset 4 Legacy systems at the stable completion of this project. This POP also requests funding for ongoing M&O support for Legacy systems. OIS previously received 21 permanent positions, which have 7 individuals supporting current ONE and 14 focused on IE design and development. The DHS POP requests additional positions to support legacy systems based on the Gartner Assessment, which called out a methodology that identified for every 10,000 hours of modifications to an integrated system the need for 3,000 hours of modifications to legacy systems. To engage with changes and coordinate as well as support ongoing maintenance of these legacy systems, this investment provides the support to allow these activities to continue. The DHS POP is also requesting staff support for JV, a mainframe system that has been modified to include additional functionality that the Office of Financial Services requested to better coordinate financing of programs.

The DHS POP would continue these efforts and provides funding for a 5-month Pilot which slated for the Summer of 2019 in Jackson and Josephine counties. The system would then be rolled out following a waved format, moving geographically across counties per federal requirements. Full implementation would be complete by the Summer of 2020. The DHS and OHA POPs also request funding for ongoing M&O support for business needs. The OHA POP includes additional positions for training of non-eligibility staff to meet legislative and operational needs, staffing for HSD to have oversight and coordination from the Medicaid agency for ongoing builds, and structure for triage and support for the new Virtual Eligibility Center (VEC). The OHA POP also adds funding for implementation support, including Eligibility Transformation work.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

The project would assist Oregonians to achieve well-being and independence by providing timely and efficient eligibility determinations. It would allow a self-service option for Oregonians to apply through the applicant portal at times that are convenient for them, which in turn, would minimize the amount of time needed in DHS field offices to complete the application process. The system would also generate notices in seven languages and five alternate formats, helping to reduce barriers for traditionally underserved populations. Ultimately, this is a project about people. Today, individuals applying for these programs have to provide their information to as many as three different offices. Some interactions can be in person, others must be over the phone or online, and Oregonians must provide the same or similar documentation multiple times while staff input their information into multiple systems that communicate with each other. In our current state, an Oregonian can turn in their information to one office, assuming that it will apply to all programs and unfortunately today, only the specific offices that work in those programs can update or make decisions on the individual's case. This leads to confusion for Oregonians and potential errors on cases. This project brings the disparate IT systems together, provides previously unavailable opportunities for service delivery improvements and moves the agency closer towards a no-wrong-door approach.

QUANTIFYING RESULTS

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. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

Failure to fund the DHS and OHA POPs would result in the ONE IE & ME project coming to a halt; and increased General Fund cost to bring it to its eventual completion. Oregonians would be negatively affected, efficiencies would be lost, and potential issues with accuracy and capitation would continue placing Oregonians and our Federal Funding at risk. Ultimately, Oregonians would be forced to apply through multiple avenues, coordination of benefits would bring continued risk to Medicaid, and the opportunities for federal funding and additional support would be greatly diminished.

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGE(S) TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No.

7. 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.

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?

These policy packages are the continuation of an effort to complete this essential work. Oregon has been engaging with other states, leading national calls on states attempting to do similar work, and partnering with Office of the State Chief Information Officer (OSCIO), DOJ, and Federal Partners to ensure that we understand the decisions we are making and bringing the best opportunity for success through this package.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

DHS is impacted because POP enhances their current systems and Eligibility Transformation work.
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.
DOC is impacted as they apply for benefits for individuals moving towards release from an institutional setting.
Area Agencies on Aging (AAA) who process eligibility will transition to this new system.
Tribal and other partners will use the system in accessing benefits.

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

DHS.

11. 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. REAL+D questions will be within the application as allowable by Federal regulations. This will provide additional avenues for communicating with various communities and update our out-of-date and often less than culturally appropriate correspondence. An additional question capturing gender identity have been added to the system as well.

12. WHAT ARE THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

DHS is committed to a bringing about an integrated electronic system and complementary business practices that allow Oregonians to apply online, over the phone, through the mail, or in-person for multiple programs. We anticipate outcomes which will include greater efficiency after the initial implementation and adjustment period as Oregonians will not have to visit multiple locations and staff will not have to enter information into

multiple systems for multiple programs. We believe this project will provide for increased accuracy in our benefit determinations as program information, notification of changes, Federal and State interfaces, automation logic and a rules engine will standardize practices across multiple programs. DHS will to be able to determine eligibility for programs cumulatively rather than spread across multiple systems and based upon information that is dependent on where and how it is reported.

Ultimately, this investment allows DHS to scrutinize and improve our delivery model and determine means for better community interactions. DHS's service delivery can evolve in a more contemporary technological setting while maximizing our ability to have meaningful insight into the data as stewards of State funds. This investment will also move the Department's eligibility from Legacy systems, which while currently stable, have had past issues including losing data and authorization errors when being modified. Many of these Legacy systems are 20-30 years old. Simply finding qualified staff to maintain them and build an enterprise architecture, was not something in the original vision or subsequent planning. Hence, the large number of systems that have interactions with this project. This investment will create a modular platform within which the Department can continue to modernize and improve our systems.

STAFFING AND/OR FISCAL IMPACT

13. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): DDI began in 2016

End Date (if applicable): Implementation of DDI ending July 2020, M&O ongoing after that.

a. Based on these answers, is there a fiscal impact?
Yes.

b. Will there be new responsibilities for DHS/OHA? Specify which Program Area(s) and describe their new responsibilities.

☒ Aging & People with Disabilities (APD)	☐
☒ Self-Sufficiency Programs (SSP)	☐
☒ OBIS	☐
☒ OIS	☐
☐	☐

APD (including Type B transfer AAAs) and SSP will be responsible for utilizing the new system in determining eligibility for Medical (mainly Medicaid), SNAP, TANF, and ERDC. This is a change from today where APD/AAA will do eligibility for part of Medicaid and SNAP, SSP does SNAP, TANF, and ERDC in local offices, and SSP now does eligibility for part of Medicaid with the branch (5503) that was transferred from OHA.

OBIS is the Office of Business and Information Supports, this unit will have the Business Analysts and support for the ONE system when it is complete. They will coordinate the business requirements for the system and represent DHS in ownership of the system which will be supported by an M&O vendor and OIS.

OIS will retire 4 systems and start to engage in the ONE system infrastructure, with the intent of learning more about the system and how it interacts with other Legacy systems.

c. 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.
While the system affects the origins of financial and budget information comes from, OIS has the largest shared service impact. Other changes related to facilities and infrastructure are being

determined through eligibility transformation. This POP contains any known impacts identified by organizations.

d. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

The number of individuals in each caseload is expected to not be significantly adjusted based on these changes. Programmatic changes identified to align with federal policy or the transfer solution, should have minimal impacts.

e. 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.

There are several distinct position groups for this project. The following is a table of the positions within each of the groups. The positions are marked with DHS, OHA, and OHA/OIS based on where the funding and authority would be directed for the group's associated work. For DHS there are 29 LD positions, 127 funding only positions (to use for rotations or temps), 21 new permanent positions, and 8 reclassed positions. For OHA there are 4 permanent positions for HSD and 4 LD positions for HSD, 21 new permanent positions for OIS, 20 LD positions for OIS, and 33 funding only positions for OIS.

DHS LD or Funding Only			
Qty	Class Title	Role	# of months
15	Training and Development Spec 2	Implementation and Roll-out training	13
2	Principal Executive Manager G	Business Directors for SSP and APD	18
1	Public Affairs Specialist 3	Communications Specialist	18
17	Operations and Policy Analyst 3	Functional and Policy leads	15
1	Office Manager 2	Manage office operations	24
1	Administrative Specialist 1	Project Support	18
1	Administrative Specialist 2	BD Support	24
51	Human Services Specialist 4	Roll out support and change leads	13
6	Operations and Policy Analyst 3	Legacy Business Analysts	12
5	Operations and Policy Analyst 2	Business and People Readiness Staff	13
1	Principal Executive Manager H	IE Project Director	18
1	Principal Executive Manager E	Business Transition Manager	18
4	Operations and Policy Analyst 2	LD Triage Support	24
1	Executive Support Specialist 2	Executive Leadership Support	18

OHA/OIS LD or Funding Only			
Qty	Class Title	Role	# of months
3	Info Systems Specialist 6	Development	12
11	Info Systems Specialist 8	Development	12
1	Info Systems Specialist 4	Development	12
4	Administrative Specialist 2	Project Scheduling and Support	2 x 12 2 x 18
1	Project Manager 1	Project Management Support	12
6	Project Manager 2	Project Management	12
6	Project Manager 3	Senior Project Management	3 x 12 3 x 18

DHS Permanents (existing-funding only or updating classification)			
Qty	Class Title	Role	# of months
1	Principal Executive Manager E	OBIS and ONE Manager	24
6	Operations and Policy Analyst 3	OBIS BAs for ONE	24
1	Operations and Policy Analyst 4	OBIS BA Lead for ONE	24
8	Operations and Policy Analyst 1	UAT and Data Integrity	24

OHA/OIS Perm (existing-funding only)			
Qty	Class Title	Role	# of months
13	Info Systems Specialist 8	Development	24
2	Info Systems Specialist 7	Development	24
2	Operations and Policy Analyst 4	Contract and Operational Leads	24
2	Principal Executive Manager E	Management	24

1	Administrative Specialist 1	OBIS and ONE support	24
1	Office Specialist 2	ONE support	24
1	Program Analyst 2	UAT Test	24
2	Training and Development Spec 2	ONE Eligibility Training Leads	24
4	Training and Development Spec 1	ONE Eligibility Trainers	24

DHS Permanents (New)			
Qty	Class Title	Role	# of months
1	Principal Executive Manager D	UAT Manager	24
4	Operations and Policy Analyst 2	ONE Triage	24
2	Training and Development Spec 2	ONE APD Coordination Leads	24
2	Training and Development Spec 1	ONE APD Community Trainers	24
3	Principal Executive Manager C	VEC Queue Managers	24
4	Human Services Specialist 4	LTC Coordinators and Resource Coordinators	24

DHS Eligibility Transformation (Funding Only or LD)			
Qty	Class Title	Role	# of months
10	Operations and Policy Analyst 3	Process Consultants	14
1	Principal Executive Manager E	ET Change Manager	14
2	Project Manager 3	ET Project Managers	14
18	Operations and Policy Analyst 3	Change Guides	14
1	Public Affairs Specialist 3	ET Communications (LD)	14
1	Administrative Specialist 1	ET Support	14

1	Information Systems Specialist 2	Development	24
1	Information Systems Specialist 6	Development	24

OHA (HSD) Perm and Funding Only			
Qty	Class Title	Role	# of months
1	Principal Executive Manager G	Business Directors of OHA (PERM)	24
3	Operations and Policy Analyst 3	Medicaid Eligibility Policy (PERM)	24
4	Operations and Policy Analyst 3	Medicaid Policy	24

OHA/OIS Perm (New)			
Qty	Class Title	Role	# of months
1	Principal Executive Manager E	M&O Management	24
8	Information Systems Specialist 8	M&O Development	5 x 12 3 x 24
6	Information Systems Specialist 7	M&O Development	3 x 12 3 x 24
3	Information Systems Specialist 6	M&O Development	1 x 12 2 x 24
2	Administrative Specialist 2	M&O Development	1 x 12 1 x 24
1	Project Manager 2	M&O Development	24

This biennium there are two distinct bodies of work from a position ask, with sub-sections of the work within these areas. The first body of work is finishing Design, Development, and Implementation. This project work for 2019-21 has a couple of months of UAT, then Pilot, Statewide Rollout, and close out of the project. Within this work are positions needed for DHS business, OHA business, and OIS. Then there is the ongoing M&O of the ONE system. This work will involve ongoing testing and support, maintenance and operation builds, access, security, enhancements, and day-to-day operations of the system. This POP has funding for Deloitte to continue to support the system as the M&O vendor, a procurement for ongoing M&O services will be done during this timeframe as well. Within this work are positions needed for DHS and OHA business, as well as OIS, to support Deloitte, the system, and infrastructure within the ONE system and connected to it that is necessary to provide Oregonians with the benefits and services that they are eligible for.

For M&O the below diagram (image1) shows the M&O structure and position authority for the business portion of this work. There are five funding areas that provided or are being requested to create this structure. There are Perm. Positions from 17-19, Perm Positions from 17-19 that we are requesting to reclass based on updated knowledge of the work they need to perform, 19-21 Perm Position request, OHP BA Transfer Positions, and Modernization Positions. The following is an overview of the work and requests by section.

OHA-HSD: OHA is the single-State Medicaid Agency, with responsibility to provide oversight and decision over the Medicaid Programs. As the ONE system goes live, the work that has been happening from OHA since 2015 needs to continue. This has been supported with limited duration positions and funding. This POP makes permanent the positions necessary to meet federal funding expectations of oversight and policy interactions between OHA and DHS, and with regards to supporting the ONE system from OHA-HSD. These 4 positions are new asks in 2019-21 based on knowledge of the design at this time.

DHS-APD: APD has historically performed financial eligibility for non-MAGI and SNAP within local APD and AAA offices. After statewide rollout, they will perform eligibility for all programs within the ONE system. The training associated with that work will be done by SSP, based on DHS internal agreements. However, APD will still need to train county and community partners on areas around financial eligibility and system access for long-term care and Older American Act programs. This is essential training, that doesn't exist today, but is foundational to acceptance and ongoing support for a system and programs that cover the State. The initial scope for the ONE system did not include long-term care (LTC) and asset verification. To avoid additional delays, business processes were put into place to coordinate LTC benefits with county developmental disability programs, county mental health programs, and APD long-term care. There are positions being added to this POP to allow us to comply with federal regulations and meet this need. There are also positions associated with resource coordination and the work to coordinate asset verification for the stand-alone system that APD is having to implement. This standalone system was required since 2008 and must be implemented by the end of 2018. Coordination across the systems require manual intervention until at least 2023 when Oregon may be able to create an interface to integrate the processes. These 8 positions are new asks in 2019-21 based on current knowledge of the design.

DHS-SSP: SSP has historically performed financial eligibility for SNAP, TANF, and ERDC programs within SSP offices. In 2017-19 OHA transferred OHP processing for MAGI eligibility to DHS and within SSP. When Statewide rollout is complete SSP offices will perform financial eligibility for all programs within scope. SSP will lead training, coordinating with policy and operations from OHA and APD, for eligibility workers. Six positions focused on training were funded in the 17-19 POP. DHS will also be standing up a Virtual Eligibility Center (VEC) as part of the implementation of this work. The VEC will connect all the processing centers within SSP and staff working on MAGI eligibility today. This model is creating jobs in rural areas and allows Oregon to position ourselves for a transformation on how we provide eligibility and services to Oregonians. This POP requests 3 positions in 2019-21 to manage the statewide queue and resourcing of the statewide VEC. This is based on industry best practices and work required to ensure that priority work happens and continue to move business towards the same-day, next-day model.

DHS-OBIS: The Office of Business Information Supports (OBIS) is the organizational area that is responsible for the business support of systems that cross multiple divisions. This area also is responsible for utilizing modernization positions for the ongoing support of modernization activities. The structure in image1 shows each of the funding areas and where the positions for ongoing M&O support as well as modernization funding are going. DHS has 14 modernization positions, 12 positions from the 17-19 POP, 8 positions that we are requesting to reclass from the original classification in the 17-19 POP to align with where the workload need materialized. 4 new positions in the 2019-21 POP based on current analysis and missed items from the 2017-19 POP, and finally, 4 positions that were moved from SSP as it relates to work that came from OHA for the OHP processing center positions.

Beyond this, to better delineate the work, we are including image 2. Image2 shows the same OBIS breakout but separates the work into three bucketed areas. First, there is ONE Testing and Operational Support. This has the staff that are permanently supporting UAT, Data correction, and Triage. This has a permanent lead from Modernization that supports UAT work for shared areas and modernization activities. Next, there is ONE Business Analysts. These are the BAs who will permanently support the ONE system, update business requirements, and work on future enhancements and M&O builds. Finally, there are the modernization positions. There is the Director position, and then there are the modernization BAs. These BAs are assigned to projects where the Department is working to modernize our systems. Currently they are supporting the work of projects such as IE, PTC, AVS, CAM, DD modernization, and other efforts. With MMIS modularization, completing PTC, the need for updating and modernizing our family coaching and case management systems, and updating licensing databases, there is an ongoing need for these positions to support the cross divisional work of ensuring that we have systems that are up-to-date and meeting the ever-changing landscape and requirements associated with IT.

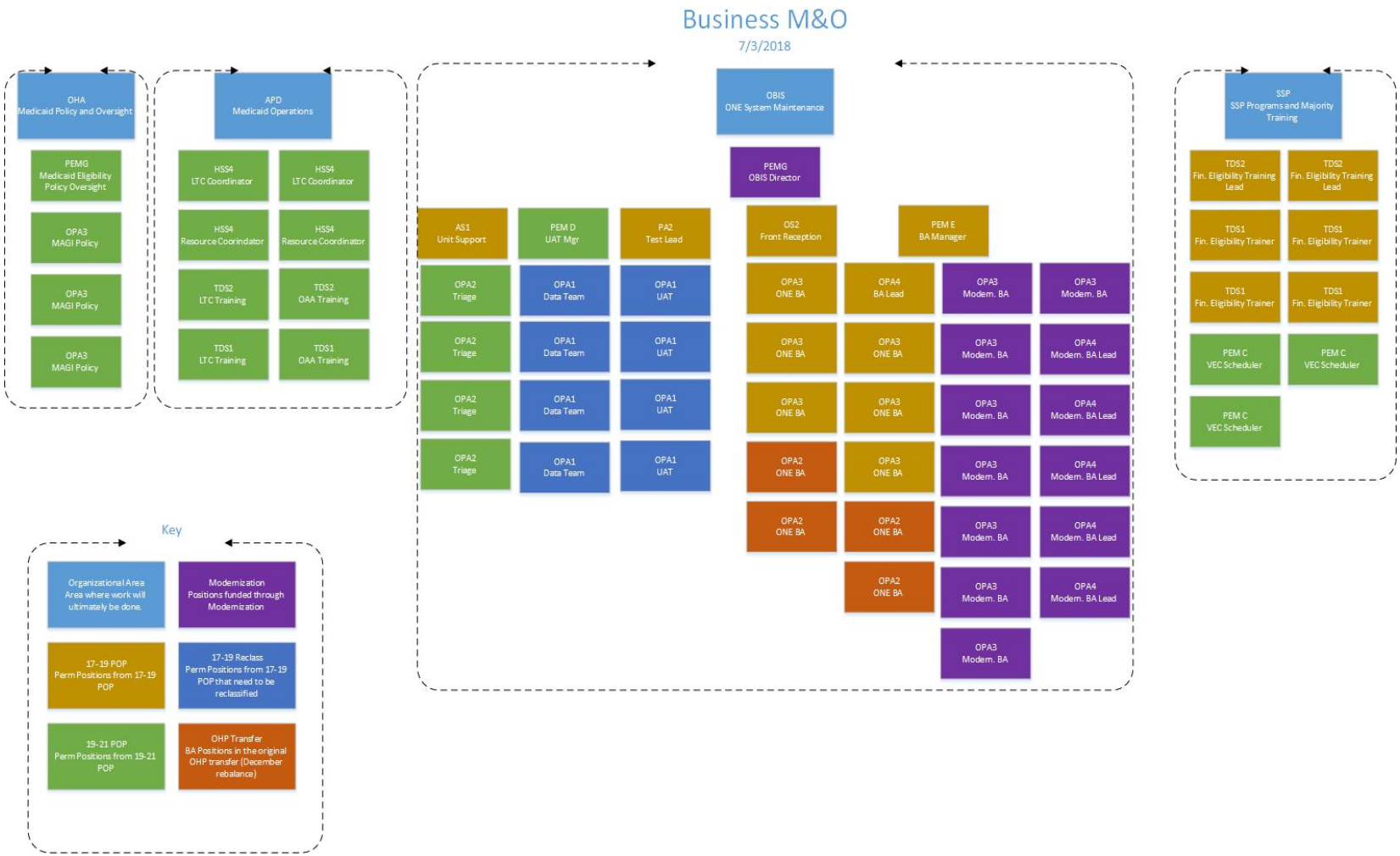

Business M&O
7/3/2018
OHA
Medicaid Policy and Oversight
PEMG
Medicaid Eligibility Policy Oversight
OPA3
MAGI Policy
OPA3
MAGI Policy
OPA3
MAGI Policy
APD
Medicaid Operations
HSS4
LTC Coordinator
HSS4
LTC Coordinator
HSS4
Resource Coorindator
HSS4
Resource Coordinator
TDS2
LTC Training
TDS2
OAA Training
TDS1
LTC Training
TDS1
OAA Training
OBIS
ONE System Maintenance
PEMG
OBIS Director
AS1
Unit Support
PEM D
UAT Mgr
PA2
Test Lead
OS2
Front Reception
PEM E
BA Manager
OPA2
Triage
OPA1
Data Team
OPA1
UAT
OPA3
ONE BA
OPA4
BA Lead
OPA3
Modern. BA
OPA3
Modern. BA
OPA2
Triage
OPA1
Data Team
OPA1
UAT
OPA3
ONE BA
OPA3
ONE BA
OPA3
Modern. BA
OPA4
Modern. BA Lead
OPA2
Triage
OPA1
Data Team
OPA1
UAT
OPA3
ONE BA
OPA3
ONE BA
OPA3
Modern. BA
OPA4
Modern. BA Lead
OPA2
Triage
OPA1
Data Team
OPA1
UAT
OPA2
ONE BA
OPA3
ONE BA
OPA3
Modern. BA
OPA4
Modern. BA Lead
OPA2
ONE BA
OPA2
ONE BA
OPA3
Modern. BA
OPA4
Modern. BA Lead
OPA2
ONE BA
OPA3
Modern. BA
OPA4
Modern. BA Lead
OPA3
Modern. BA
SSP
SSP Programs and Majority Training
TDS2
Fin. Eligibility Training Lead
TDS2
Fin. Eligibility Training Lead
TDS1
Fin. Eligibility Trainer
TDS1
Fin. Eligibility Trainer
TDS1
Fin. Eligibility Trainer
TDS1
Fin. Eligibility Trainer
PEM C
VEC Scheduler
PEM C
VEC Scheduler
PEM C
VEC Scheduler
Key
Organizational Area
Area where work will ultimately be done.
Modernization
Positions funded through Modernization
17-19 POP
Perm Positions from 17-19 POP
17-19 Reclass
Perm Positions from 17-19 POP that need to be reclassified
19-21 POP
Perm Positions from 19-21 POP
OHP Transfer
BA Positions in the original OHP transfer (December rebalance)

Image1

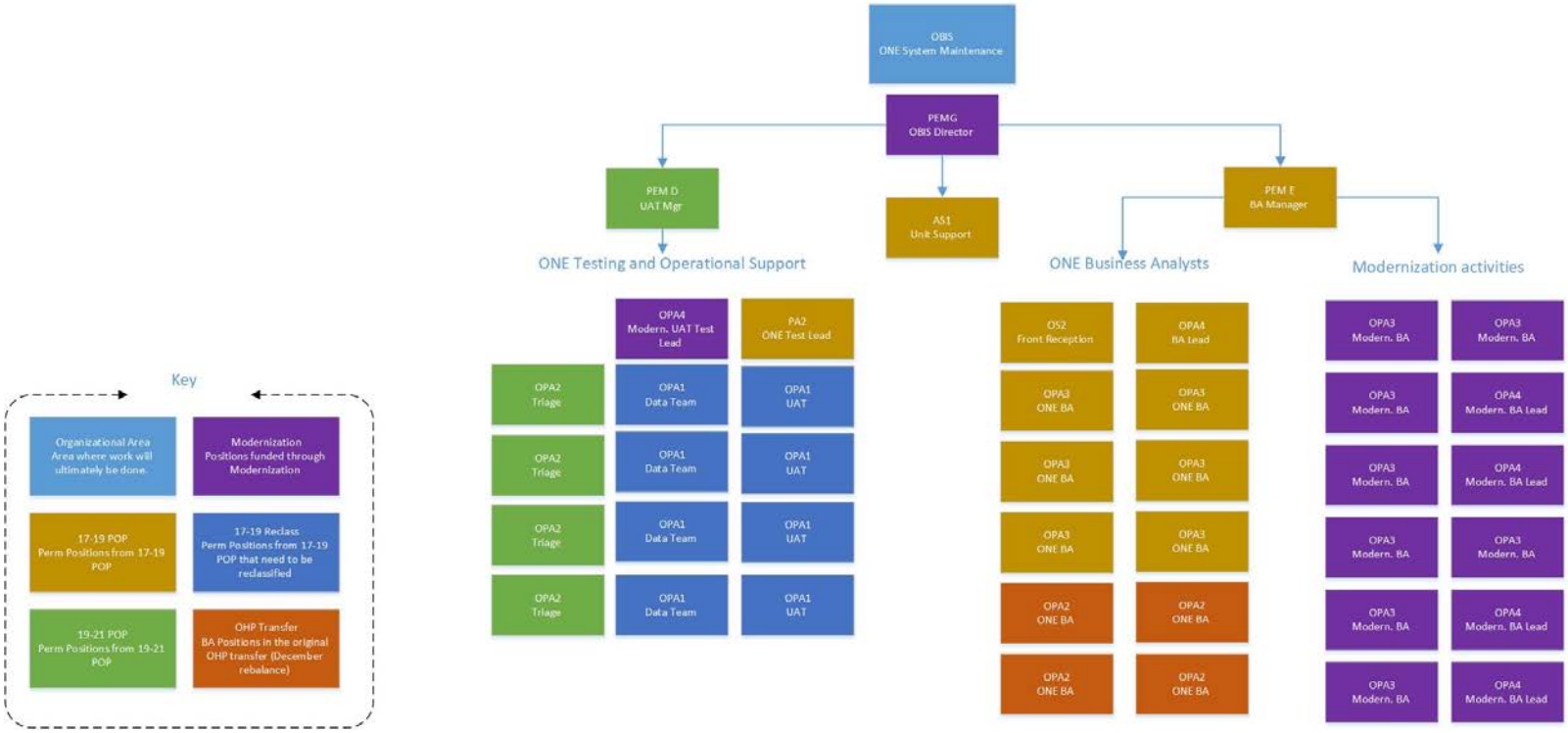


Image2

OHA-OIS: OIS is responsible for supporting the Legacy systems associated with these programs and supporting the technical knowledge for the system integrator. OIS does not plan on taking on the maintenance and operations of the ONE system from a system integrator in the near future. OIS received positions to support the ONE system and is requesting additional support for legacy systems to support future enhancements of ONE and the subsequent effects on legacy systems as well as supporting the JV system, which was built out to meet needs and requests from the Office of Financial Services.

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?

There are additional infrastructure costs such as building rent and server costs, these are developed and included in the cost projections for this POP.

g. What are the ongoing costs?

There are ongoing costs associated with the maintenance and operations of the system, which are included in the cost projections.

h. What are the potential savings?

None.

TOTAL DHS FISCAL IMPACT FOR THIS PACKAGE

Category	GF	OF	FF	TF	Positions	FTE
Personal Services	$2,056,865	$4,116,202	$9,895,218	$16,068,285	33	25.26
Services & Supplies	10,961,912	34,163,448	111,506,719	156,632,079		
Special Payments	0	292,913	548,906	841,819		
Other	0	0	0	0		
Total	**$13,018,777**	**$38,572,563**	**$121,950,843**	**$173,542,183**	**33**	**25.26**

Fiscal Impact Summary by Program Area:

	DHS	OHA OIS	OHA HSD	Total IE/ME
General Fund	$13,018,777	$0	$671,490	**$19,924,560**
Other Funds	$39,852,563	$9,589,123	$0	**$49,441,686**
Federal Funds- Ltd	$121,950,843	$0	$1,638,121	**$123,588,964**
Total Funds	$173,542,183	$9,589,123	$2,309,611	**$192,955,210**
Positions	33	41	4	**78**
FTE	25.26	27.00	4.00	**56.26**

i. What are the sources of funding and the funding split for each one?

There are federal funds and state funds. Federal funds come from CMS and FNS. Federal funding makes up 86 percent of funding through December 31, 2018 and then 74 percent of federal funding January 2019 through the end of DDI. These costs are cost allocated and part of the annual submission of advanced planning documentation. During DDI most of state funds are bonds (both taxable and non-taxable), with general funds for non-bondable activities. In M&O state funds become general fund based.

Oregon Health Authority
2019-21 Policy Package

Agency Name: Oregon Health Authority & Department of Human Services
Program Area Name: DHS|OHA Shared Services - Office of Information Services
Program Name: DHS Central Services
Policy Package Title: **Medicaid Management Information System (MMIS) Modularity**
Policy Package Number: 202
Related Legislation: None

Summary Statement:

The Centers for Medicare and Medicaid Services (CMS) requires all states to plan for and implement modular solutions supporting Medicaid using a competitive process. CMS seeks to support states in shifting away from reliance on a single solution provider and establishing renewable, componentized solutions for long-term support of Medicaid. Oregon's current Medicaid Management Information System (MMIS) was implemented in 2008. The contract for the support of the MMIS with the current solution provider ends in February 2022.

This policy package requests continuation of state funding to secure 90 percent federal financial participation to define Oregon's Medicaid Service Delivery strategic plan; assess other state's modularization approaches; identify options for modular solutions; and begin procurement activities to secure modular solution components and services to comply with CMS certification requirements. Without this POP, the state may risk losing 90 percent federal funding for planning activities to align with CMS requirements.

	General Fund	Other Funds	Federal Funds	Total Funds
OHA Policy Package Pricing:	**$547,409**	**$0**	**$1,638,121**	**$2,225,378**
DHS Policy Package Pricing:	**$277,922**	**$0**	**$276,444**	**$554,366**

PURPOSE

1. WHY DOES OHA PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?

Oregon's current Medicaid Management Information System (MMIS) is a monolithic system implemented in 2008. The Centers for Medicare and Medicaid Services (CMS) has indicated eligibility for continued federal funding is dependent on compliance with CMS mandates and evidence states are committed to a thorough planning effort supporting a modular future state. The goal of the proposed program is to support the Department of Human Services (DHS) and the Oregon Health Authority (OHA) in crucial planning activities to achieve compliance with CMS requirements and improve interoperability and sustainability of the technology solutions supporting Medicaid service delivery. The Office of Information Services (OIS) will support initiation and planning activities and procure a Strategic Advisor (SA) that will be tasked with updating Medicaid Information Technology Architecture (MITA) State Self-Assessment (SS-A), development of the strategic modernization roadmap eventually leading to the creation of an architectural blueprint, Concept of Operations and procurement activities to solicit for and acquire services of IV&V, Quality Assurance (QA) and System Integrator (SI) vendors in the modularization effort.

The role of the Strategic Advisor will involve assistance with the following activities:

- Helping leadership define Oregon's Medicaid Service Delivery Strategy.
- Defining functional requirements, capturing operational business needs, defining and refining business processes, and optimizing workflows.
- Sharing industry best practices, other states' approaches and lessons learned with recommendations and guidance to help create the best solution acquisition strategy and approach for the State of Oregon.
- Updating Oregon's MITA plan in accordance with CMS requirements.
- Incorporating CMS certification requirements into Medicaid solution alternative requirements to ensure compliance with certification criteria.
- Defining an overall technical architecture that ensures modular components will work together to support Medicaid business operations.

- Creating an acquisition approach, roadmap and detailed plan recommending the optimal sequence for procuring and implementing components to achieve modularity for Oregon.
- Developing the Request for Proposal (RFP) to solicit modular solutions and RFP to solicit System Integrator services to support implementation of modular components meeting Oregon and CMS requirements.
- Providing Quality Assurance throughout the planning and implementation lifecycle to manage program risk.

2. WHAT WOULD THIS POLICY PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

This POP would provide the state funds necessary to secure 90 percent enhanced federal funding from CMS to support the essential strategic planning, creation of the roadmaps and ultimately implementation of system changes supporting Oregon's Medicaid service delivery.

Rigorous planning is required to ensure Oregon's roadmap meets CMS requirements, supports continued stability of the mission-critical current MMIS solution during the journey to the future state, and supports health care transformation for the State of Oregon. Subsequent implementation efforts will require funding in future biennia to continue Oregon's eligibility for 90 percent enhanced federal funding.

It is essential OHA and DHS begin planning efforts now as the current contract with the existing MMIS solution provider will expire by 2022. Oregon needs to have a solid plan for its future Medicaid solution set to sustain CMS enhanced funding support for ongoing maintenance and operations and enhanced funding support for modular component implementation.

Specifically, DHS and OHA would *each* hire three additional positions (one Principle Executive Manager F (PEMF) and two Operations and Policy Analyst 4s (OPA)) for a *combined total of six* to support the modularity modernization effort. The PEMF positions would work with executive leaders and subject matter experts within various business areas and manage analysts. These positions would require a solid understanding of Medicaid, eligibility rules and any other business areas impacted by MMIS. The OPA4

positions would provide critical subject matter expertise required for the analysis of the current processes, business requirement definition and identification of improvement opportunities to enable creation of modular systems to meet future business and systems requirements.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

Oregon made numerous enhancements to MMIS since its original implementation in 2008. These changes impact 1,800 state users, 17,000 provider users, and over 1 million Oregonians receiving health care services. Despite various improvements, large sections of the Medicaid enterprise system are from legacy technologies. To continue supporting its business mission, OHA needs to transform its business operations and modernize its IT ecosystem to align with rapid changes in the health care delivery system. Based on federal regulations, OHA completed its first MITA SS-A a few years ago to review existing capabilities and determine future needs. In the early stages of the MITA SS-A, it was determined that even the current MMIS installed in 2008 is unlikely to meet future business needs of OHA and needs to be updated with modular functionality to eliminate redundancy, duplication of effort and waste of IT assets.

QUANTIFYING RESULTS

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 ties to Key Performance Measure (KPM) #31, OHA's triple aim measure.

5. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

- Lost opportunity to develop a modern, sustainable and scalable solution environment supporting Medicaid for Oregon.

- Lost opportunity to leverage enhanced 90 percent federal funding for future replacement of existing aging Medicaid supporting technology. By the end of the 2019-21 biennium, the current MMIS solution will be 13 years old and will be past end of life. The typical cost to replace MMIS systems is roughly $110 to $150 million. Without enhanced funding the state share of a replacement would be $55 to $75 million, compared to $11 to $15 million with enhanced funding.
- Lost opportunity to negotiate competitive maintenance and operations vendor support because of increased competition. The current contract with HPE for maintenance and operations increases by 2 percent annually.
- 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 enhanced funding increases federal financial participation from 50 percent to 75 percent. Without CMS enhanced funding, Oregon's state funds need for annual maintenance and operations would increase between $5 million and $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 and $20 million. CMS currently pays 75 percent of the cost of system change requests and 90 percent of the cost of major enhancements. Federal financial participation would fall to 50 percent without enhanced funding and would increase Oregon's typical change request and enhancement projects state funds cost from under $4 million to over $11 million per year.

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGES TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No.

7. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

Oregon could consider two alternatives:

1. Do nothing – continue to extend the existing support contract with DXC.
   - The current MMIS was implemented in 2008 and existing M&O contract will expire in 2022, so Oregon needs to execute a modularization plan by that time.
   - Oregon needs to demonstrate a commitment to plan and execute a renewed Medicaid solution environment in compliance with CMS mandates to avoid significant negative financial consequences, including loss of enhanced federal funding for enhancements of the system & potential doubling of state fund need for current M&O expenditures.
   - Several Medicaid sub-systems in OHA and DHS are not currently integrated with the core MMIS[1]. Maintaining the current state will leave Oregon with siloed Medicaid systems and miss a unique opportunity to update and streamline the Medicaid Enterprise System.

2. Develop and issue a procurement RFP *without* the support and planning efforts outlined above
   Oregon could choose adopting the planning approach of another state, leveraging its planning outcomes and RFPs to procure new modular solutions. While this approach might lead to some inconsequential financial savings, choosing that approach may result in a lack of a cohesive roadmap and executable plan to meet Oregon's unique needs and increase program risk. In addition, solutions used by another state may require substantial customization to address Oregon-specific requirements and may require significant business process and operational workflow reengineering.

[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).

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?

This POP addresses a new CMS mandate. Under the authority of Section 1903 of the Social Security Act, CMS issued the Modularity Standard as one of the Standards and Conditions for Medicaid IT with which state systems must comply to receive enhanced federal financial participation.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

This POP would positively impact Coordinated Care Organizations (CCOs) as modular solutions would be better suited to supporting a capitation model versus a fee-for-service model, which the original system was built for. There would be system enhancements for Tribal providers who use the system to submit claims to OHA for payment.

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

Stakeholders involved in this effort include OHA, DHS, CCOs, Tribal Providers and the Oregon State Hospital. These entities are current MMIS users and would benefit tremendously from modularization of the Medicaid solution environment. This POP requests position authority for DHS and OHA to have focused subject matter experts and business leadership with the capacity to fully engage in the essential long-term efforts around modernizing systems and services supporting both agencies.

11. WHAT IS YOUR EQUITY ANALYSIS?

OHA and DHS would engage all interested stakeholders in preparing for the modularity planning effort, including the OHA Office of Equity and Inclusion and the DHS Office of Multicultural Services.

12. WHAT ARE THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

CMS Final rule "Federal Funding for Medicaid Eligibility Determination and Enrollment Activities" provided for a temporary enhancement to the federal financial participation (FFP) rate to support the design, development, and installation (DDI) and maintenance and operations (M&O) of Medicaid Eligibility and Enrollment (E&E) systems that are streamlined and interoperable with other systems and that provide a consumer-friendly experience. The broadened definition was also refined to support an enterprise approach where individual processes, modules, sub-systems, and systems are interoperable and work together seamlessly to support a unified Medicaid enterprise.

The Medicaid Enterprise includes: (1) An E&E system used to process Medicaid enrollment applications, as well as change in circumstance updates and renewals. The E&E system might be implemented as the core of an integrated eligibility system that also supports eligibility for other human services programs; and (2) An MMIS used to process claims for Medicaid payment from providers of medical care and services furnished to beneficiaries under the medical assistance program, including review of managed care encounter data, and to perform other functions necessary for economic and efficient operations, management, monitoring, and administration of the Medicaid program. To receive enhanced federal funding for development, maintenance and operations, the Medicaid E&E systems and the MMIS must meet all applicable standards and conditions, including modularity, along with associated provisions such as the role of independent verification and validation (IV&V).

Oregon is in the process of replacing its E&E system using a modern SOA technology framework. In addition, Oregon made numerous enhancements to its MMIS in 2008. Despite various improvements, large portions of the Medicaid enterprise system are still based on legacy technologies. To continue supporting its business mission, OHA needs to transform its business operations and modernize its IT ecosystem to align to rapidly evolving changes in the health care delivery system. OHA completed its first MITA SS-A a few years ago to review existing capabilities and determine future needs. In the early stages of the MITA SS-A, it was determined that even the current MMIS (installed in 2008) is unlikely to meet future business needs of

OHA and must be updated with modular functionality to streamline IT operations and eliminate unnecessary duplication of effort.

13. IS THIS PP BEING REQUESTED BECAUSE OF AN INTERNAL DHS/OHA AUDIT, OREGON SECRETARY OF STATE AUDIT, OR FEDERAL AUDIT? IF SO, PLEASE PROVIDE FURTHER INFORMATION.

No.

STAFFING AND/OR FISCAL IMPACT

14. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): July 1, 2019 (planning phase only), implementation TBD

End Date (if applicable): N/A

a. Based on the following answers, is there a fiscal impact?

Yes.

b. Will there be new responsibilities for OHA/DHS? Specify which Program Area(s) and describe their new responsibilities.

No.

c. 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.

This package includes 3 permanent, full time positions in the Office of Information Services.

d. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
No.

e. 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.
To support the modularity modernization effort, this POP requests 3 permanent full-time positions in OIS.

- 1 Principle Executive Manager F position
- 2 Operations and Policy Analyst 4 positions

In addition, to support this effort, the DHS companion POP requests 3 permanent full-time positions in DHS.

- 1 Principle Executive Manager F position
- 2 Operations and Policy Analyst 4 positions

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
There are no anticipated start-up costs in the 2019-21 biennium; previously approved CMS funds are targeted for planning efforts only.

g. What are the ongoing costs?
This project is in the early planning stages and the future ongoing costs cannot be determined until the planning effort is complete.

h. What are the potential savings?

Federal government will support funding of modularization planning activities at an enhanced 90/10 match rate. This level of federal support translates into substantial financial savings for Oregon to transform its existing Medicaid system to provide sustainable foundation into the future. Access to enhanced funding will allow Oregon to incrementally implement modular solutions over the next 5 to 7 years while shouldering only 10 percent of the primary costs.

OHA TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	$346,442	0	$346,452	$1,046,262	3	3.00
Services & Supplies	$200,967	0	$1,331,517	$1,532,484		
Capital Outlay	0	0	0	0		
Special Payments	0	0	0	0		
Other	0	0	0	0		
Total	**$547,409**	**$0**	**$1,677,969**	**$2,225,378**	**3**	**3.00**

Fiscal Impact Summary by Agency:

	DHS	OHA HSD	Total
General Fund	$277,922	$547,409	**$825,331**
Other Fund	$0	$0	**$0**
Federal Funds- Ltd	$276,444	$1,677,969	**$1,954,413**
Total Funds	$554,366	$2,225,378	**$2,779,744**
Positions	2	3	**5**
FTE	2.00	3.00	**5.00**

i. What are the sources of funding and the funding split for each one?
This POP requests 3 permanent positions for OIS. CMS will fund 90 percent of positions and consulting during planning and implementation and 75 percent for ongoing maintenance.

Oregon Health Authority
2019-21 Policy Package

Agency Name: Oregon Health Authority
Program Area Name: Public Health Division – Center for Health Protection
Program Name: Drinking Water Services
Policy Package Title: **Fee Structure Revision for Drinking Water Services**
Policy Package Number: 418
Related Legislation: Senate Bill 27 (Legislative Concept 386)

Summary Statement:

This policy package corresponds to Senate Bill 27 (Legislative Concept 386), which revises the fee authority of Drinking Water Services and increases fee revenue to support adequate regulation of all public drinking water systems. Specifically, authority to charge an inspection (sanitary survey) fee would be replaced with an annual regulatory fee based on the number of connections served by the water system, ensuring more equitable regulation of drinking water systems. With these changes, the Drinking Water program would build capacity to regulate all public water systems equitably, ensure protection of public health and maintain the public's trust in the safety of public drinking water supplies.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Package Pricing:	**$0**	**$1,853,297**	**$0**	**$1,853,297**

PURPOSE

1. WHY DOES OHA PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?

The mission of the Drinking Water program is to ensure public water systems provide safe drinking water. The program has primacy to implement federal requirements under the Safe Drinking Water Act (SDWA), which includes regulation of approximately 2,500 federally defined public water systems serving at least 25 people or 15 service connections. In addition, the Drinking Water program is mandated by Oregon statute to regulate public water systems to a lower state-defined threshold that includes systems serving at least 10 people or 4 or more connections. Due to flat federal funding and rising personnel costs, program staffing and capacity has eroded over the past several years jeopardizing the program's ability to fully meet its mission and statutory mandates. Impacts of declining resources include periodic compliance data processing backlogs, limited capacity for technical assistance and emergency preparedness and an inability to adequately regulate approximately 900 very small water systems that fall between the federal and State lower thresholds. Although the total population served by these very small state regulated systems is only 15,000 people, many of these systems serve highly vulnerable populations, including children in schools and daycares and economically disadvantaged renters.

By broadening fee authority and generating additional revenue, the Drinking Water program would be able to build the capacity to regulate all public water systems equitably. Additional technical staff would expand the program's ability to provide technical assistance to small systems and more comprehensive technical review of large systems. Additional compliance and data management staff would eliminate compliance data backlogs, improve the proportion of systems providing timely monitoring data to ensure safe water and enable data analysis to target resources toward the greatest risks and vulnerable populations. Providing additional support to local public health authorities—that perform many of the inspections and respond to local contaminant detections—would help resolve drinking water issues quickly and improve compliance.

The overall purpose is to expand capacity to ensure protection of public health and maintain the public's trust in the safety of public drinking water supplies.

2. WHAT WOULD THIS POLICY PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

Senate Bill 27 (Legislative Concept 386) would revise statutory fee authority for the Drinking Water program to enable adoption of a fee rate structure in rule that would result in an increase in fee revenue sufficient to support adequate regulation of all public drinking water systems. Additional revenue would enable the program to add needed positions and increase support for local public health agencies that perform drinking water work under contract. The additional program support would ensure all public water systems are adequately regulated to ensure protection of public health.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

The Drinking Water program is a foundational program within the Public Health Division and critical to protection of public health. Developing foundational capacity to implement the program in concert with local public health partners aligns with efforts to modernize public health programs statewide.

QUANTIFYING RESULTS

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?

Yes. A fundamental measure used is "The percentage of Community Water Systems that meet all health based standards." This is a performance measure used nationally by States and EPA, reporting on compliance of Community Water Systems, which is a category of system that serves much of the population but a subset of the larger universe of Public Water Systems. In addition, since one program objective is to ensure Public Water Systems comply with water monitoring and reporting requirements, we track "The percentage of Public Water Systems that meet all health based standards and monitoring requirements."

5. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

Continued erosion of Drinking Water Services program capacity, which will necessitate prioritization of work and reducing the level of regulatory service provided. Failing to adequately fund local public health agency partners may result in some counties being unwilling to provide local drinking water services. Reduced regulatory service threatens the safety of drinking water systems, particularly very small systems.

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGES TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

Yes, it requires amendment to ORS 448.150. These changes are proposed in Senate Bill 27 (Legislative Concept 386).

7. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

1. No action and deregulation of very small water systems.
   Taking no action to adjust Drinking Water fees would result in continued erosion of the program and potential threats to public health. If the State changed the definition of Public Water System to not regulate systems below the federal Safe Drinking Water threshold, it would result in a health equity issue where residents served by very small water systems are at greater risk because the systems are unregulated and not required to monitor water quality and report results to ensure water is safe.

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?

The Drinking Water program has prioritized its workload and looked for improvements in program efficiency. In 2017, the program formed a work group with local public health agency partners to identify and implement measures to improve efficiency. Two temporary employees performing data entry have assisted in reducing the data entry and compliance backlog. Although the program lacks capacity to fully

regulate very small water systems, it sent a letter to these systems reminding them of their obligations to monitor water quality and submit results.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

Local public health agencies and the Department of Agriculture receive funding to perform inspections of public water systems and to respond to contaminant detections. This POP would increase the level of support for this work to account for increased costs of providing services.

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

Drinking Water Services has convened a ten member Stakeholder Group that includes representatives of cities, special districts, large and small water systems and local health officials. In addition, the proposal has been reviewed with the Drinking Water Advisory Committee, a statutorily created 15 member panel that includes diverse representation from water systems, local government, environmental laboratories, consultants, and environmental groups.

11. WHAT IS YOUR EQUITY ANALYSIS?

A primary intention of this POP is to obtain the resources to adequately regulate small and very small water systems serving vulnerable and disadvantaged communities. Urban areas served by larger public water systems enjoy drinking water that is managed and treated by trained professionals and these systems are highly regulated. Owners of small systems often lack capacity to maintain and safely operate their systems. For many small systems, providing water is not their primary business or purpose. In addition, some owners are unwilling to invest in necessary treatment, maintenance, or monitoring to ensure safe water. Along with technical and financial assistance, adequate regulation of these systems is imperative to protecting public health for everyone.

12. WHAT ARE THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

Increase the stability and reliability of program funding sources to prevent potential threats to public health created by loss of services. A more balanced portfolio of federal, state and fee revenue would better enable the program to weather economic downturns without the significant staff reductions of the past several years.

13. IS THIS POP BEING REQUESTED BECAUSE OF AN INTERNAL DHS/OHA AUDIT, OREGON SECRETARY OF STATES AUDIT, OR FEDERAL AUDIT? IF SO, PLEASE PROVIDE FURTHER INFORMATION.

No.

STAFFING AND/OR FISCAL IMPACT

14. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

It is assumed that the level of General Fund support provided to the Drinking Water program will continue at the same level and that federal grant funding will remain flat over time.

Implementation Date(s): July 1, 2019

End Date (if applicable): Ongoing

a. Based on these answers, is there a fiscal impact?

Yes.

b. Will there be new responsibilities for OHA/DHS? Specify which Program Area(s) and describe their new responsibilities.

No.

c. 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.

d. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
In general, fee changes will not affect services or population groups. There is no caseload change in Drinking Water Services.

e. 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.

- C8503, Natural Resource Specialist 3, 24 months, permanent
- C8503, Natural Resource Specialist 3, 24 months, permanent
- C8503, Natural Resource Specialist 3, 24 months, permanent
- C5247, Compliance Specialist 2, 24 months, permanent
- C1115, Research Analyst 1, 24 months, permanent.

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
Staff will require computers and desks.

g. What are the ongoing costs?
The ongoing costs are related to staffing and program operations.

h. What are the potential savings?
Adding permanent staff will eliminate the need for temporary positions.

TOTAL FISCAL IMPACT FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	0	$826,734	0	$826,734	5	5.00
Services & Supplies	0	$196,563	0	$196,563		
Special Payments	0	$830,000	0	$830,000		
Total	**$0**	**$1,853,297**	**$0**	**$1,853,297**	**5**	**5.00**

OHA - Fiscal Impact Summary by Program Area:

	Center for Health Protection	Total OHA
General Fund	$0	**$0**
Other Funds	$1,853,297	**$1,853,297**
Federal Funds- Ltd	$0	**$0**
Total Funds	$1,853,297	**$1,853,297**
Positions	5	**5**
FTE	5.00	**5.00**

i. What are the sources of funding and the funding split for each one?
Other Funds fee revenue.

Oregon Health Authority
2019-21 Policy Package

Agency Name: Oregon Health Authority
Program Area Name: Public Health Division – Center for Health Protection
Program Name: Drinking Water Services
Policy Package Title: **Fee Changes for Food, Pool, and Lodging Programs**
Policy Package Number: 419
Related Legislation: Senate Bill 28 (Legislative Concept 387)

Summary Statement:

This policy package corresponds to Senate Bill 28 (Legislative Concept 387), which proposes changes to Food, Pool and Lodging inspection and licensing fees. These fees were last revised in 2003 and are not sufficient to cover the Oregon Health Authority's (OHA) costs to carry out the required regulatory work. Most inspections are performed by local public health authorities; however, OHA conducts inspections when a county transfers public health authority to OHA. Fee changes would cover OHA's costs of implementing regulatory programs directly or through contractors, establish a new fee for processing variances from food sanitation rules, and modify the fee structure for reviewing new pool/spa plans.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Package Pricing:	**$0**	**$64,450**	**$0**	**$64,450**

PURPOSE

1. WHY DOES OHA PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?

Food, Pool and Lodging Inspections

It is imperative to increase the statutorily set fees for the Food, Pool and Lodging Programs to cover the current costs of performing required regulatory work. Licensing fees for food service facilities, public pools/spas, and tourist accommodations are listed in Oregon Revised Statute (ORS). The applicable ORSs also include fees for public pool/spa plan review, variance requests, and a construction permit. These fees were last revised in 2003 and are no longer sufficient to cover the costs for OHA to provide the required inspections and public health oversight of these facilities. Generally, OHA delegates the authority to license and inspect these facilities to local public health authorities (LPHAs). State law permits LPHAs to raise or lower their fees from the amount listed in statute. All LPHAs have increased their restaurant licensing fees above the amount listed in statute to cover their regulatory costs. Any fee that is 20 percent above or below this amount requires approval from OHA. Increasing fees in statute would realign fees with the current cost of doing business and decrease the frequency by which LPHA's must develop justification requests for increasing fees.

Recent adoption of Oregon Administrative Rules (OARs) define parameters for LPHAs to transfer authority to OHA under certain conditions. Wallowa County recently voted to transfer its public health authority to OHA. As of May 1, 2018, OHA is responsible for regulating health and safety in Wallowa County food, pool and lodging facilities. OHA is required to charge these regulated entities the licensing fees listed in statute, however the current fee structure is not sufficient for OHA to cover the costs associated with licensing and inspecting these facilities. Douglas County has also recently adopted an ordinance to return its authority back to the state in 2019.

Food Sanitation Variances

Oregon Administrative Rule (OAR) allows OHA to grant variances from food sanitation rule requirements if specific criteria are met. Currently, there is no statutory fee authority to cover the costs of processing

variance request, which can be time consuming and involves collaboration with food scientists and specialists. OHA proposes to establish a fee to cover the costs of processing these variance requests.

Swimming Pool Plan Review

Under current statute, OHA collects a $100 plan review fee and a $200 construction permit fee for the review and approval of plans for new public pools and spas. The plan review fee is insufficient to cover the costs of reviewing such plans. The construction permit fee requires OHA to issue a building permit upon approval of a plan review. Issuing construction permits is not in alignment with typical duties performed within the agency. Increasing the plan review fee to cover review costs and eliminating the requirement to issue a construction permit would streamline this process. OHA could then provide written plan review approval, allowing construction to begin.

2. WHAT WOULD THIS POLICY PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

This POP would increase state licensing fees, plan review fees, and establish a variance request fee. It would allow OHA and LPHAs to cover the actual costs of doing business. It would decrease the need for LPHAs to submit exception requests to OHA when they raise their fees 20 percent above the fee currently listed in statute. Increasing fees would also reimburse OHA for the costs associated with implementing required regulatory programs when a LPHA transfers their public health authority to the state.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

The Food, Pool and Lodging Programs work to protect the health and safety of Oregonians by ensuring that the food establishments we eat in, pools and spas we soak in and lodging facilities we rest in are operating in a manner that protects the public from disease and infection. Preventing disease is part of OHA's mission.

QUANTIFYING RESULTS

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?

There are no specific OHA performance measures for food, pool, and lodging. The success of this measure will be measured by the budget solvency of the OHA food, pool and lodging program. It will also be measured by the decrease in number of fee exception requests from counties received and reviewed.

5. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

For food, pool and lodging programs, if a LPHA were to return public health duties to the state, OHA would be required to use the licensing fees listed in statute, which are not sufficient to cover the costs of implementing the programs. If plan review and variance request fees remain the same, the programs will not be able to recoup the cost of providing these services from our regulated community. This could result in request for General Fund to cover the shortfall incurred to meet statutory requirements.

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGES TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

Yes, it requires amendments to ORS 624.490, 624.630, 448.030, 448.035, 448.037, 446.321. These changes are proposed in Senate Bill 28 (Legislative Concept 387).

7. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

1. No action.

If no changes are made to the food, pool and lodging fees, the programs will not collect enough revenue to cover costs to support environmental health services in a county that returns public health authority to the state. Alternate funding sources will need to be located to provide these statutorily required services.

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?

OHA has analyzed OHA's costs related to food, pool and lodging regulation if an LPHA transfers its public health authority to OHA. These analyses show OHA will need to either raise fees or request General Fund to cover the costs of fulfilling statutory responsibilities.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

LPHAs would be directly affected by any licensing and plan review increase. The vast majority of LPHAs have already increased their licensing fees well above those currently listed in statute. LPHAs have the ability to increase or decrease their fees to cover program costs by submitting a request and justification to OHA. If fees are increased in statute, LPHAs will be required to charge the new fee or request a variance if required by statute.

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

LPHAs support increasing the state licensing fees to more closely align with today's cost of doing business.

11. WHAT IS YOUR EQUITY ANALYSIS?

This POP would ensure populations in all parts of the state benefit from safe food, tourist accommodations, and recreational pool facilities. The bill adjusts statutory fees and does not include new policies. There is flexibility in rulemaking to address equity concerns, such as better calibrating the level of fees to the complexity of the food service; for example, exempting very small mobile food operations serving a limited menu of low-risk foods. Statutory action is not needed to advance such goals.

12. WHAT ARE THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

Increase the stability and reliability of program funding sources to prevent potential threats to public health created by loss of services.

13. IS THIS POP BEING REQUESTED BECAUSE OF AN INTERNAL DHS/OHA AUDIT, OREGON SECRETARY OF STATES AUDIT, OR FEDERAL AUDIT? IF SO, PLEASE PROVIDE FURTHER INFORMATION.

No.

STAFFING AND/OR FISCAL IMPACT

14. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Food, Pool and Lodging, fees have been developed as an average mean of fees currently being collected by LPHAs around the state. This gives a basis of what the average cost is to provide food, pool and lodging health and safety services.

Implementation Date(s): July 1, 2019

End Date (if applicable): Ongoing

a. Based on these answers, is there a fiscal impact?

Yes.

b. Will there be new responsibilities for OHA/DHS? Specify which Program Area(s) and describe their new responsibilities.

No.

c. 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.

d. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
In general, fee changes will not affect services or population groups. However, Wallowa County has transferred their public health responsibilities to OHA, which took effect on May 1, 2018. OHA is now providing licensing and inspection services to food, pool and lodging facilities in Wallowa County. There are around 100 licensed facilities in Wallowa County, about 50 food establishments, 50 lodging facilities and two pool facilities. Existing fees are not sufficient to cover the costs of providing these services.

e. 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.
None.

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
None.

g. What are the ongoing costs?
The ongoing costs are related to program operations.

h. What are the potential savings?
None known.

TOTAL FISCAL IMPACT FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services		$19,425		$19,425	5	5.00
Services & Supplies		$45,025		$45,025		
Special Payments		$0		$0		
Total	**$0**	**$64,450**	**$0**	**$64,450**	**5**	**5.00**

OHA - Fiscal Impact Summary by Program Area:

	Center for Health Protection	Total OHA
General Fund	$0	**$0**
Other Funds	$64,450	**$64,450**
Federal Funds- Ltd	$0	**$0**
Total Funds	$64,450	**$64,450**
Positions	5	**5**
FTE	5.00	**5.00**

i. What are the sources of funding and the funding split for each one?
Other Fund fee revenue.

Oregon Health Authority
2019-21 Policy Package

Agency Name: Oregon Health Authority
Program Area Name: Public Health Division – Center for Health Protection
Program Name: Environmental Public Health
Policy Package Title: **Toxic Free Kids Program**
Policy Package Number: 420
Related Legislation: Senate Bill 478 (2015 Regular Session)

Summary Statement:

This policy package fulfills responsibilities described in Senate Bill 478 (2015 Regular Session), which requires manufacturers of children's products containing hazardous chemicals of concern for children's health to report the use of qualifying chemicals to the Oregon Health Authority (OHA) and eventually remove the chemical from the product or seek a waiver. To apply for a waiver, the manufacturer must submit an Alternatives Assessment listing a less harmful chemical substitute or an Exposure Assessment, which demonstrates the contaminant is not likely to be bioavailable to the child. This policy package would create a waiver application fee to process applications. Without this fee, the Toxic Free Kids program will not have designated resources to review applications as required by statute.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Package Pricing:	**$0**	**$111,511**	**$0**	**$111,511**

PURPOSE

1. WHY DOES OHA PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?

This policy package will create fees for the Toxic Free Kids (TFK) Program, specifically for the review of Waiver Applications. The TFK Program was created by Senate Bill 478 (2015 Regular Session), which requires manufacturers of children's products to notify OHA if any of their products contain certain high priority chemicals of concern for children's health. Manufacturers are then required to remove the chemicals from their products or substitute them with a less hazardous chemical by January 1, 2022. This POP would create an application fee and a $200 hourly consultant fee to process waiver applications. The processing fee of $1,500 would be retained by OHA and used to support the cost of processing and reviewing the waiver application. The hourly consultant fee would be paid directly to an outside consultant and OHA would not retain any of this revenue for program use.

2. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

This POP would create an application fee to cover the cost of reviewing and processing waiver applications and create a $200 per hour consultant fee for an independent consultant to provide technical review of Alternative and Exposure Assessments.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

The TFK Program protects one of our most vulnerable populations from exposure to harmful chemicals in commercial products. Preventing children from exposure to these chemicals prevents potential disease and improves the overall health of children in Oregon.

QUANTIFYING RESULTS

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. OHA will measure the effectiveness of this POP by tracking the costs of processing waiver applications. This POP would be successful if OHA generates sufficient funds to cover staff time to effectively and efficiently process applications.

5. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

The Legislature gave OHA the authority to collect fees to cover the cost of implementing the TFK program. Receiving and reviewing waiver applications is a program requirement and is necessary to implement the program. If the TFK program is not able to collect fees to cover the cost of processing and reviewing waiver applications, OHA will need to request additional General Fund to comply with the ORS.

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGES TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No.

7. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

The Department of Environmental Quality may have the expertise to review waiver applications for the TFK Program. However, funding to support DEQ's efforts would not be available without the ability to collect fees.

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?

N/A.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

N/A.

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

N/A.

11. WHAT IS YOUR EQUITY ANALYSIS?

Fees for applications and review of waivers would be paid by manufacturers that gross over $5 million in sales annually. The fees would only apply to manufacturers utilizing high priority chemicals of concern for children's health in children's products and choose not to remove the chemical of concern or substitute it with another less harmful chemical. Manufacturers are not required to apply for a waiver, and have the option to remove the chemical by January 1, 2022. Children are more sensitive than adults to chemical exposure because they are growing rapidly, and put fingers and objects in their mouths, among other reasons. Children in low income families and communities of color experience a disproportionately high burden of exposure to toxics from multiple sources. Reducing toxins in toys can help reduce this disproportionate exposure.

12. WHAT IS THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

Fees generated through this POP will cover the costs of receiving and processing waiver applications.

13. IS THIS POP BEING REQUESTED BECAUSE OF AN INTERNAL DHS/OHA AUDIT, OREGON SECRETARY OF STATES AUDIT, OR FEDERAL AUDIT? IF SO, PLEASE PROVIDE FURTHER INFORMATION.

No.

STAFFING AND/OR FISCAL IMPACT

14. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

The $1,500 application fee and the $200 consultation fee proposed here are equal to the fees for the TFK Program's Manufacturing Control Program application and consultation fee which is already in Rule. OHA estimates the costs to be the same.

Implementation Date(s): January 1, 2020

End Date (if applicable): Ongoing

a. Based on these answers, is there a fiscal impact?

Yes. OHA will incur staffing costs for processing the applications as well as contractual costs to secure the required expertise and consultation to determine the appropriateness of the chemical substitution.

b. Will there be new responsibilities for OHA/DHS? Specify which Program Area(s) and describe their new responsibilities.

No.

c. 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.

d. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
No.

e. 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.

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
N/A.

g. What are the ongoing costs?
The ongoing costs are staff time to process and review waiver applications and consultant fees.

h. What are the potential savings?
N/A.

TOTAL FISCAL IMPACT FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	0	$31,511	0	$31,511	0	0.00
Services & Supplies	0	$80,000	0	$80,000		
Special Payments	0	$0	0	$0		
Total	**$0**	**$111,511**	**$0**	**$111,511**	**0**	**0.00**

OHA - Fiscal Impact Summary by Program Area:

	EPH	Total OHA
General Fund	$0	**$0**
Other Funds	$111,511	**$111,511**
Federal Funds- Ltd	$0	**$0**
Total Funds	$111,511	**$111,511**
Positions	0	**0**
FTE	0.00	**0.00**

i. What are the sources of funding and the funding split for each one?
Other Fund fee revenue.

Oregon Health Authority
2019-21 Policy Package

Agency Name: Oregon Health Authority
Program Area Name: Health Policy and Analytics
Program Name: Public Employees' Benefit Board / Oregon Educators Benefit Board
Policy Package Title: **OEBB and PEBB Benefit Management System Replacement**
Policy Package Number: 421
Related Legislation: None

Summary Statement:

The Oregon Educators Benefits Board (OEBB) provides a comprehensive selection of benefit plan options for most of Oregon's K-12 school districts, education service districts, and community college employees. It also administers benefit plan options for a number of charter schools and local government staff across the state. There are approximately 152,000 OEBB members. In 2008, OEBB implemented a Benefit Management System (BMS) to administer benefits to its members called "MyOEBB" based on the Public Employees' Benefit Board (PEBB) system called "pebb.benefits," implemented in 2003.

Similarly, the Public Employees' Benefit Board (PEBB) has approximately 139,000 members across the state. PEBB designs, contracts and administers a program of benefits for the state as the employer and state employees. The benefits include medical and dental coverage; life, accident, disability and long-term care insurance; and flexible spending accounts. PEBB also offers healthcare insurance options for retirees not eligible for Medicare and individuals in other participating groups.

OEBB and PEBB share the goal of implementing a centralized, standardized, supportable, and scalable solution to replace both MyOEBB and pebb.benefits to provide easier enrollment, better coordination of benefits management, improved access to plan information, and enhanced integration with other tools that improve the overall customer and user experience. Both agencies must begin planning and analysis to implement a new solution by 2021.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Package Pricing:	**$0**	**$1,806,102**	**$0**	**$1,806,102**

PURPOSE

1. WHY DOES OHA PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?

MyOEBB and pebb.benefits are not meeting all current business needs, which have grown since their original implementations in 2008 and 2003 respectively. OEBB and PEBB seek to have more processes integrated into a new single solution that accommodates the administrative and organizational changes subsequent to Senate Bill 1067 (2017 Regular Session), while improving care for and user experiences for all OEBB and PEBB members.

The current OEBB and PEBB benefit management systems were built on antiquated legacy technology that now presents significant risks to properly maintain. The systems are costly and cumbersome to support due to the age and custom nature of the code upon which they were built. High turnover with contractor contracted staff compounds this problem, as it takes new staff much longer to understand the systems well enough to address identified issues.

Although the vendor name has changed several times, OEBB and PEBB have contracted with essentially the same vendor from initial build to current maintenance and operations. This continued contractual relationship results in increased dependence on the contractor due to the age, high degree of customization, and complexity of the systems, while remaining responsible for managing the tendency for accruing technical debt inherent to a custom solution. It is also cumbersome and costly to transition to a new vendor to support its maintenance and operations. High turnover with vendor staff compounds this problem, as it takes new vendor staff much longer to understand the systems well enough to address issues. Special procurement authority for the current contract ends in 2021.

The Oregon Health Authority's (OHA) 2015 Benefit Management System Technical Assessment Report noted both systems are nearing the end of their life cycles and are currently being supported with obsolete technologies. The report recommends implementing system upgrades in the short term, and replacing the entire system within the next several years to allow OEBB and PEBB to meet their statutory responsibilities.

2. WHAT WOULD THIS POLICY PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

The policy package for exploring solutions for the replacement of the MyOEBB and pebb.benefits systems requires significant business resources. The estimates provided herein would cover a significant workload in preparation of the expected project to implement the yet to be determined solution. To lay the groundwork for such a project, the Office of Information Services (OIS) has engaged with OEBB and PEBB at this point of the project's concept origination phase and explored further requirements and alternatives. This effort would include the development of a high-level business case, a risk assessment, and overall project plan, all required to obtain both internal and external approval (i.e., the Department of Administrative Services' Office of the State Chief Information Officer).

A new combined system would allow OEBB and PEBB to modernize all its members' and administrators' user experience. Among the top modernization goals:

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

Once this level of approval is achieved, OIS resources would work in partnership with OEBB and PEBB staff to create the detailed business case, project charter, detailed risk assessment, and fully developed project plans communicating how the project's intended scope, schedule, and budget will be managed. Business, functional, technical, security, and other requirements will need to be documented, that would establish the foundation for a Request for Proposals (RFP) to solicit potential

solution providers. Project management resources would also be identified and assigned in this timeframe, as well as other necessary project team members to support initiation.

With these efforts in mind, OIS estimates a duration of 8 to 12 months, and an overall cost of $560,000 to $705,000 to adequately cover this initial phase of project preparation prior to vendor/solution identification and implementation. At that point, new estimates would be developed to forecast the time and budget required for project execution, solution implementation, close out, and transitioning to operations & maintenance.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

The goals of PEBB and OEBB are the same – provide a modernized, centralized, standardized, supportable, and scalable solution to replace both OEBB's and PEBB's benefit management systems for public employees, with the ability to accommodate the administrative and organizational changes subsequent to Senate Bill 1067 (2017 Regular Session), while implementing and maintaining more rigorous security best practices.

- Alignment with the DHS|OHA Strategic Technology Plan (STP) Initiatives

  - **Business Automation**
    While the current BMS solutions have provided significant efficiency gains, the multitude of options now available provide greater functionality and capability to further automate and streamline essential business processes, including support of dependent eligibility verification.

  - **Dynamic Needs Supported by Seamless Technology Services**
    OEBB and PEBB's existing systems have been continuously enhanced to meet the needs of the member populations served, and the program staff responsible for overseeing benefits administration; replacement solutions will be reviewed and assessed for additional capabilities including modularity, agility, reusability, and incorporation of best practices in benefit administration.

- **Enables Connectivity Anytime, Anywhere, in Multiple Ways**
  The current solutions provide connection capability via multiple interfaces, but alternatives solutions offer expanded capabilities to better meet member, staff, and partner needs through inclusion of mobile devices.

- **Trusted Source for Health & Human Service Data**
  The member information collected in the existing systems is organized in such a way as to allow searching and reporting capabilities, but lacks the capacity to provide predictive analytics, which may be available with modern solutions.

QUANTIFYING RESULTS

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 tied to Goal 3 of the PEBB business plan approved by PEBB's previous agency – the Department of Administrative Services: Efficient and Effective Government Infrastructure. Provide appropriate oversight and cost containment processes by maintaining and modifying enterprise processes for use by staff, agencies, universities, school districts and other entities and their covered employees.

5. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

The lifecycle of the current systems have expired. Approximately 300,000 covered lives could have their benefits impacted, or worse their personal information compromised.

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGES TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No.

7. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

Status quo was considered. However, the current OEBB and PEBB benefit management systems were built on antiquated legacy technology that now presents significant security risks. The systems are costly and cumbersome to support, due to the age of the code upon which they were built. High turnover with contractor contracted staff compounds this problem, as it takes new staff a much longer period of time to understand the systems well enough to address identified issues.

OEBB and PEBB have contracted with the same vendor from initial build to current maintenance and operations. This continued contractual relationship results in increased dependence on the contractor due to the age, customization and complexity of the systems. It is also cumbersome and costly to transition to a new vendor to support its maintenance and operations.

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?

PEBB and OEBB have sought advice from technical experts with OIS and within OSCIO. OEBB and PEBB have continued to contract, with little negotiating leverage, for maintenance and operations support to maintain basic system functions. OEBB and PEBB staff must either rule out or be very selective about enhancements to the systems as new functionality adds to the custom-made complexity of each system and could introduce new security risks. PEBB and OEBB recently contracted to have a security scan to identify risks since the last scan was done approximately four years ago. Other recommendations were followed, including implementing hardware and software system upgrades to remedy issues identified in the report, and to allow OEBB and PEBB to continue meeting their statutory responsibilities until the replacement solution would be implemented.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

All the benefit and payroll processes of state agencies, universities, school districts, education service districts and community colleges would be impacted: either by benefiting from a new benefit management

or adversely impacted if the benefit systems are not maintained because costs become unsustainable due to the reliance on a single vendor, or the systems are no longer viable.

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

None. OEBB and PEBB are in the planning stages and have received endorsements from the Boards. Other agencies, programs, and stakeholders will be involved with any implementation of a new system.

11. WHAT IS YOUR EQUITY ANALYSIS?

This policy package assumes equity of benefit enrollment and management services across geographic areas and opportunities to ensure those services are provided equitably, including considerations of language differences and alternative formats. Additionally, REaL+D demographic data is provided to carriers during the enrollment process, which grants healthcare providers better information in rendering services to OEBB and PEBB members, as well as their covered dependents. Strategic planning activities commenced by both Boards and their representatives will better allow OEBB and PEBB to include all stakeholders in the planning for the replacement, including the Office of Equity and Inclusion.

12. WHAT ARE THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

Replace the existing systems with a modernized, centralized, sustainable, and scalable benefits management solution, supporting the unified PEBB and OEBB business practice with features that include, but are not limited to:

- Role-based access for internal OEBB and PEBB access, as well as for external groups including:
  - Plan carriers
  - Members
  - Entity admins
  - Wellness vendors
  - Other state and local government agencies
- Compliance with federal and state security and privacy requirements

- Reporting (e.g. canned, ad hoc, and self-service for carriers, entities, school districts, and other state agencies)
- Contact management (e.g. comments, chat, integration with phone system, member profile, appeals, dependent eligibility verification, tracking of communications, help desk ticketing, etc.)
- Online Help for OEBB and PEBB staff, members, carriers, and other vendors
- Self-service administrative capabilities (e.g. OEBB and PEBB would have the ability to manage history of changes to qualifying events, etc.)
- Expanded automated error checking and data validation
- Compatibility with commonly used browsers, devices, mobile applications, and operating systems
- Ability to import data into and export data from solution, in multiple formats
- Financial management including invoicing to entity-customers, individual subscribers, COBRA benefits administrator, and other third parties
    - Solution allows OEBB and PEBB to reconcile back to carrier payments
- Notifications (e.g. COBRA, reminders for those who haven't enrolled during open enrollment, and other required notices, etc.)
- Dependent eligibility verifications among and between OEBB and PEBB member groups
- Integrated appeals process
- Open enrollment support tools
    - Plan comparison tool integrated into solution for OEBB and PEBB to show premium amounts, plan benefits, and other items required for Open Enrollment
    - Provider searches
    - Medical home searches
    - Health assessments
    - Premium quotes
- Trainings and webinars integrated into solution for OEBB and PEBB
- Integrated reference pricing (information based on plan for services)

STAFFING AND/OR FISCAL IMPACT

13. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Pricing for this POP assumes 4.00 FTE and a Strategic Advisor hired at the beginning of the biennium and continuing their work beyond the initial planning stage.

Implementation Date(s): July 1, 2019

End Date (if applicable): N/A

a. Based on the following answers, is there a fiscal impact?

Yes.

b. Will there be new responsibilities for OHA/DHS? Specify which Program Area(s) and describe their new responsibilities.

No.

c. 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.

Two positions in OIS would be dedicated and funded by OEBB and PEBB funds.

d. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

e. 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.

Phase 1 Planning

- One Operations and Policy Analyst 3 position "Business Analyst", 1.00 FTE
- One Operations and Policy Analyst 4 position "Project Manager", 1.00 FTE
- Additional position resources allocated to OIS for project dedicated services:
    - Information Services Specialist 8 "Technical Project Manager"
    - Information Services Specialist 7 "Business Systems Analyst"

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?

Since this POP would fund the planning of a replacement system, there will be no significant modifications to computer systems during the 2019-21 biennium. This request includes $750,000 Other Funds expenditure limitation for a contract IT Strategic Advisor.

g. What are the ongoing costs?

Costs are for positions listed above and a contracted IT Strategic Advisor. Planning will include a recommended replacement system and in addition to state approval, there will also be approvals necessary from the OEBB Board, the PEBB Board, and the legislature. Cost for the 2021-23 biennium will be based on the recommendation put forth by the contracted IT Strategic Advisor.

h. What are the potential savings?

OEBB and PEBB would expect to realize cost efficiencies with lower maintenance and operations costs for a new combined system. Program efficiencies anticipate full integration with finance and budgeting, COBRA administration, wellness program administration, and other business functions that are not currently integrated. A new system would also reduce duplication between programs and the use of "one-off" systems. Soliciting for a new, consolidated system would enable OEBB and PEBB to establish a strong on-going support contract with terms favorable to the State and position the agency to better manage the technical debt associated with a benefits solution.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	0	$897,784	0	$897,784	4	4.00
Services & Supplies	0	$908,318	0	$908,318		
Capital Outlay	0	0	0	0		
Special Payments	0	0	0	0		
Other	0	0	0	0		
Total	**$0**	**$1,806,102**	**$0**	**$1,806,102**	**4**	**4.00**

OHA - Fiscal Impact Summary by Program Area:

	PEBB	OEBB	Total
General Fund	$0	$0	**$0**
Other Fund	$908,395	$897,707	**$1,806,102**
Federal Funds- Ltd	$0	$0	**$0**
Total Funds	$0	$0	**$0**
Positions	2	2	**4**
FTE	2.00	2.00	**4.00**

i. What are the sources of funding and the funding split for each one?
100% Other Funds. OEBB and PEBB administrative fee revenue.

Oregon Health Authority
2019-21 Policy Package

Agency Name: Oregon Health Authority
Program Area Name: Health Policy & Analytics Division
Program Name: Oregon Health Plan Pharmacy & Medical Services Programs
Policy Package Title: **Statewide Pharmacy Purchasing Implementation**
Policy Package Number: 422
Related Legislation: Not Applicable

Summary Statement: This will enable the Oregon Prescription Drug Program to produce adequate analysis and oversight of existing programs and provide capacity to expand the program and adapt to the dynamic nature of pharmacy space.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Package Pricing:	**$418,632**	**$0**	**$297,498**	**$716,130**

PURPOSE

1. WHY DOES OHA PROPOSE THIS POP (WHAT ISSUE ARE YOU TRYING TO FIX/SOLVE)?

The Oregon Health Authority (OHA) currently lacks adequate staff capacity to work at the policy and operational level to implement large-scale organizational improvement work through the Oregon Prescription Drug Program (OPDP). OHA requires additional staff to adapt to the dynamic pharmacy marketplace and effectively administer all pharmacy-related programs, including but not limited to, Medicaid and the Oregon Prescription Drug Program. A Statewide purchasing model is something that should be leveraged in order to align and leverage our state's purchasing power by all levels of government and willing private sector participation.

2. WHAT WOULD THIS POLICY PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

This policy package requests two permanent positions: a Pharmacy Manager 2 and an Operations and Policy Analyst 4 to equip OHA with clinical and non-clinical expertise to ensure value and mitigate waste through sound program oversight and marketplace monitoring. With these positions, OHA would be able to adequately develop programs that suit context of eligible entity's needs, respond to program needs, including contractor oversight. Additionally, these staff members would help determine how OPDP works with and impacts other programs within OHA and throughout the state. With this capacity enhancement, Oregon could lead the growth of the Northwest Prescription Drug Consortium and expansion to other states who are expressing interest.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

This POP furthers OHA's mission to help people achieve optimum physical, mental, and social well-being through partnership, prevention and access to quality, affordable health care. It would contribute toward lowering and containing costs of medications and increasing access to medications to improve the lifelong health of Oregonians. Equipping the agency with resources as described would allow OHA to effectively administer the ODPD in concert with the NW Prescription Drug Consortium. It would also assist in the alignment of the OHA programs and other entities statewide conducting pharmacy purchasing and the

policies supporting this work. The POP places OHA in a better position to improve and innovate the delivery systems in place to ensure medication access, security and continuity as Oregonians transition between jurisdictional settings.

QUANTIFYING RESULTS

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?

Success will be monitored through enrollments of new groups and sustaining and servicing the current groups, measured in lives and savings to the people of the state of Oregon. There are existing data analysis and multiple reporting mechanisms currently in place, which are monitored on a monthly and quarterly basis. One of these is an Impact Summary, which details how much Oregonians have saved by using the OPDP prescription discount card. Since program inception, this total is $136,021,791. This savings is tracked monthly by OPDP staff. Another reporting mechanism tracks the groups throughout Oregon served by OPDP (including SAIF, the Oregon Educators Benefit Board, and the Public Employees' Benefit Board). With a negotiation of administrative fees at the request of OPDP staff during Oct. 2018, $2,221,720 in savings will be recognized during 2019 for these groups. The number of claims for each group are tracked monthly by OPDP and a yearly competitive marketplace assessment is conducted to ensure that the program's rates and guarantees are favorable. It is also important to recognize that the OPDP Discount card program saves individual Oregonians an average monthly total of $1 million on drug purchased through the discount card program. Success will also be monitored by the contractor performing and meeting their deliverables. Growing the consortium in terms of state partners is also a metric of success. Successful engagement of state agencies that work with our facility purchasing program will be an additional metric.

5. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

There would be continued limited ability to develop effective programming to control costs and drive savings in a statewide manner, not allowing the program to grow to its full potential. The long-term costs could exceed the immediate cost of adding this position. This would provide clinical, analytic, and program

direction to the pharmacy programs and clinical committees overseen by the Pharmacy Purchasing and OPDP Director and provide clinical oversight over contractors. This oversight is paramount in program growth and retention of current participating groups. The key to understanding the need is this: Pharmacy purchasing is not a "one and done solution" purchasers face a complex set of vehicles and strategies designed by various players in the pharmacy supply chain keeping interests of each player protected. Navigating changes in these complex dynamics is critical to ensure Oregon and our partner states retain the best purchasing strategy. This cannot be achieved without adequate staffing.

HOW ACHIEVED

6. DOES THIS POP REQUIRE ANY CHANGES TO EXISTING STATUTE(S) OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No.

7. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

No alternatives are available. The program has been operating with two staff: the Pharmacy Purchasing and Oregon Prescription Drug Program Director and an Operations Manager (Operations and Policy Analyst 3) position. The program is below minimum staff level required to sustain and grow the program. Other staff support the Pharmacy Team in a Medicaid role and providing support services, but do not work directly on OPDP tasks or innovative policy solutions that span the delivery systems and agencies within our state.

8. WHAT ACTIONS HAVE OCCURRED TO RESOLVE THE ISSUE PRIOR TO REQUESTING A POLICY PACKAGE?

OHA has previously asked for funding during the 2018 legislative session as part of House Bill 4151, but was not granted the request as the bill failed to move forward.

9. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

There are many opportunities that could be leveraged with other agencies if an innovative strategy were deployed, this could include savings to the Public Health Division, Department of Corrections, and Oregon Youth Authority among other local government entities throughout the state. Statewide Pharmacy Purchasing that is aligned and not fragmented would improve Oregon's leverage and purchasing strategies in the pharmacy space for public and private entities or individuals. DAS also currently facilitates a statewide purchasing agreement in the pharmacy space, looking to ensure this is aligned inside of OPDP as a statewide pharmacy purchasing solution would take large steps towards defragmentation of the state's pharmacy purchasing power.

10. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

None at this time.

11. WHAT IS YOUR EQUITY ANALYSIS?

Expansion of the program will increase savings to not only within OHA, but to other government entities throughout the state. This savings translates into preserved and increased access to medicines to all Oregonians.

12. WHAT ARE THE LONG-TERM DESIRED OUTCOMES (LONGER THAN THE UPCOMING BIENNIUM)?

To add participating groups to the NW Prescription Drug Consortium, which will increase savings on prescriptions for Oregonians belonging to these groups. These savings would also be recognized by OHA, the OR Department of Corrections, and the Oregon Youth Authority, should they choose to join the OPDP. Cost savings programs that would adapt to changes in the pharmacy marketplace and ensure the best value for the Oregon taxpayer. Concurrent to these efforts OPDP should be in a better position to queue state agencies in conducting a collaborative analysis to determine the best strategy for pharmacy purchasing. OPDP could also offer consultative services around pharmacy programs to ensure waste is mitigated and

appropriate oversight is in place to ensure medicines are safely delivered to Oregonians served inside our facilities and programs.

13. IS THIS POP BEING REQUESTED BECAUSE OF AN INTERNAL DHS/OHA AUDIT, OREGON SECRETARY OF STATE AUDIT, OR FEDERAL AUDIT? IF SO, PLEASE PROVIDE FURTHER INFORMATION.

No.

STAFFING AND/OR FISCAL IMPACT

14. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Positions and a surcharge. If the surcharge is implemented, the funding will be supplemented with Other Funds.

Implementation Date(s): October 1, 2019

End Date (if applicable): Ongoing

a. Based on the following answers, is there a fiscal impact?

Yes.

b. Will there be new responsibilities for OHA/DHS? Specify which Program Area(s) and describe their new responsibilities.

No.

c. 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.

d. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
The number of groups could grow as more join the OPDP. This would require sound program oversight and marketplace monitoring.

e. 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. This will require two permanent, full time positions: a Pharmacy Manager 2 and an Operations and Policy Analyst 4 position. This policy packaged includes 18 months of funding for 2019-21, but these positions will work 24 months during future biennia.

f. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
None.

g. What are the ongoing costs?
The salary and benefits for the position and $120,000 set aside per biennium to ensure any third party consultant needs are available when agencies or participating program desires outside evaluation to verify OHA analytics or OPDP director determines there is a need for additional program audits for oversight an improvement to ensure the best possible pricing is being offered. If the surcharge is implemented, the funding will be supplemented with Other Funds.

h. What are the potential savings?

To add groups to the NW Prescription Drug Consortium which will increase savings on prescriptions for Oregonians belonging to these groups. These savings would also be recognized by OHA, the OR Department of Corrections, and the Oregon Youth Authority, should they choose to join the OPDP.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	262,342	0	262,342	$524,684	2	1.76
Services & Supplies	156,290	0	35,156	$191,446		
Capital Outlay	0	0	0	0		
Special Payments	0	0	0	0		
Other	0	0	0	0		
Total	**$418,632**	**0**	**$297,498**	**$716,130**	**2**	**1.76**

OHA - Fiscal Impact Summary by Program Area:

	Health Policy	Total
General Fund	**$418,632**	**$418,632**
Other Fund	**$0**	**$0**
Federal Funds- Ltd	**$297,498**	**$297,498**
Total Funds	**$716,130**	**$716,130**
Positions	**2**	**2**
FTE	**1.76**	**1.76**

i. What are the sources of funding and the funding split for each one?

All Federal Funds are Medicaid match

Staffing: 1 – Pharmacy Manager 2 (50/50 GF/FF) and 1 – Operations and Policy Analyst 4 (50/50 GF/FF)

$120,000 (100% GF) third party consultant

Oregon Health Authority/Department of Human Services
2019-21 Policy Package

Agency Name:	**Oregon Health Authority/Department of Human Services (DHS)**
Program Area Name:	**OHA/DHS Shared Services**
Program Name:	**Office of Business Information Systems (OBIS)**
Policy Package Initiative:	**N/A**
Policy Package Title:	**Maintenance & Operations of Centralized Abuse Management (CAM) System**
Policy Package Number:	**POP 208**
Related Legislation:	**N/A**
Program Funding Team:	**Safer, Healthier Communities**

Summary Statement:

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 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.

This POP requests general funds to implement ongoing maintenance and additional enhancements that will build upon the capabilities of a base system implemented in the 2017-19 biennium, for an integrated solution, which meets HB 4151 criteria and helps protect vulnerable Oregonians. Not funding this POP will limit Oregon's ability support the system after Go-Live.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Package Pricing:	**3,512,949**			**3,512,949**

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

This POP supports multiple DHS programs by funding the Operations and Maintenance of an integrated solution for tracking, reporting and supporting investigations of adult abuse. Program areas include: Aging and People with Disabilities (APD), Developmental Disabilities (DD), and Mental Health (OHA/MH).

Funding will support the Operations and Maintenance of the system, which will realize efficiencies by training to CAM, maintaining a robust change management process, and providing a continuous review and revision of business process and policies.

Activities this POP will fund include:

- Operations and Maintenance costs for the CAM system including all program and support areas (DD, DDI, OHA, APD, OIS, OBIS, OTIS) for the full 2019-2021 biennium
- Software/platform/hosting licensing costs for the full 2019-2021 biennium

2. WHY DOES DHS/OHA PROPOSE THIS POP?

This POP provides the funding necessary to complete Operations and Maintenance to centralized abuse management system post implementation and funds software licensing through the full 2019-21 biennium.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS? HOW DOES THIS FURTHER THE PROGRAM FUNDING TEAM OUTCOMES OR STRATEGIES?

In 2014, almost 750,000 Oregonians belonged to one of the nine Oregon populations supported by OAAPI and its program partners that receive and process reports of abuse. During that same year OAAPI and its program partners received more than 38,000[1] allegations of abuse of these individuals, resulting in 18,185[1] investigations.

According to the 2014 OAAPI Annual Report dated July 2015, "In 2014, there was a 10% overall increase in the number of investigations conducted (compared to 2013)." During the next 10 years the number of allegations received and screened by OAAPI and its program partners is expected to increase nearly 60%. This assessment increases the projected 50,414 allegations in 2015 to more than 78,500 allegations in 2024, based on current and predicted growth of vulnerable populations. OAAPI is

[1] OAAPI Annual Report 2014 – Published July 2015.

projecting 30,800 investigations by 2024, a nearly 63% increase from the 2015 level of 19,000 investigations. This growth in the number of abuse referrals and investigations, typical of previous years, is one of the reasons that OAAPI was formed, to ensure a coordinated and consistent response to an increasing number of abuse referrals across all vulnerable populations. Abuse can't be undone. Abuse carries with it lifelong impacts to a person's life in regard to health, emotional well-being and a person's ability to benefit from available services.

The need for a stable Centralized Abuse Management System becomes ever more critical as Oregon faces an aging population, a significant annual increase in abuse referrals and an increased need for services across all demographics.

An improved system for abuse data collection, from the time of screening through investigation, case closure and referral, is essential to better protect vulnerable Oregonians and to more accurately and efficiently produce meaningful abuse data and outcomes to the Legislature, DHS leadership and the public. This system must be focused on abuse across programs, not simply added on to the various existing, disconnected program databases.

The full implementation of such a system would directly contribute to the DHS Policy Outcome of "Improving our Human Services Systems" by addressing a long-standing gap in data collection and analysis and leading to a more efficient and effective state response to the reported abuse of vulnerable Oregonians.

Additionally, the implementation of a Centralized Abuse Management System is in alignment with the DHS/OHA Strategic Technology Plan (STP) including progress in pursuit of automating business workflows, decision-making, and business rules while reducing manual, paper-based processes. A Centralized Management System moves the state closer to providing a comprehensive view of a client and makes progress towards the goal of a "360-degree view of a person." The project will provide workers connectivity to a real-time system to perform their work anytime and anywhere. Through the reduction of data duplications and entry into multiple systems, CAM will make advancements in providing a trusted source for abuse and investigation data. The implementation of a SaaS (software as a service) solution will allow responsiveness to quickly evolving business needs.

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?

Yes, this POP is directly tied to the following process measures and outcome measures outlined on the DHS Fundamentals Map:

"Protection and Intervention" (OP1) Process Measures:

- % of completed investigations coded "unable to determine" or "inconclusive"

- % of calls assigned for field contact that meet policy timelines
- % of investigation reports completed within policy timelines

"Safety" (O1) Outcome Measures:

- Re-abuse rate
- Abuse rate

As of the fourth quarter of 2015, DHS and OHA were not meeting most of the Adult Abuse Quarterly Business Review (QBR) – Key Performance Metrics (KPMs) for Adult Abuse.

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, this POP supports HB 4151.

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

Oregon considered three alternatives:

1. Maintain the status quo
   Under this alternative there would be no additional investment in abuse tracking system automation. Improvements to current processes would be limited to those that arise naturally through the Department's continuous improvement program.
   - The department would continue with ineffective, disconnected automated and manual systems that are difficult to oversee and analyze.
   - The requirements and recommendations made by HB 4151, SB 1515, and various reports and audits would not be met in the foreseeable future.

2. Implement a Custom Build Solution
   Under this alternative the department would design, develop, test and deploy a custom solution built from the ground up for Centralized Abuse Management needs. This alternative would allow a tailor-made solution that would meet all the functional, technical and organization requirements.

- The costs to develop a custom system are substantially higher than procuring the Salesforce CRM, with commensurate risks and a timeline that is more than a year longer to implement compared to implementing a Salesforce solution.

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

- Unpaid, licensing costs would deprive the State of its investment in CAM.
- Unstaffed, poor operations and maintenance of the system would curtail the benefits of the system and increase workloads.
- DHS would be out of compliance with HB 4151.

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

Other agencies affected by this POP include OAAPI's Program Partners and those with a business need for abuse data or investigation reports, such as:

- Background Check Unit (BCU)
- DHS Abuse Case Management (APD & DD)
- Safety, Oversight and Quality (SOQ)
- The Oregon Health Authority / Mental Health

These agencies would experience a change in how they receive abuse data and reports from OAAPI and from community programs. Agencies access to abuse data would be based on business need and enforced using a role-based security protocol.

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

Oregon Adult Abuse Prevention and Investigations (OAAPI), on behalf of the Department of Human Services, Aging and People with Disabilities, Developmental Disabilities, and OHA's Mental Health program and multiple county partners including Multnomah County, champion this POP. All these entities are stakeholders in protecting vulnerable Oregonians and will benefit from full implementation of an integrated tracking and reporting solution for adult abuse.

10. WHAT IS YOUR EQUITY ANALYSIS?

Abuse data systems currently in use do not capture the racial and ethnic identifiers needed for an analysis of service equity in the abuse investigation process. As a result, it is currently impossible to analyze the service equity in the provision of abuse response and investigation. The fully-implemented CAM system will incorporate such identifiers and allow for in-depth analysis of service equity in the delivery of abuse investigations and protective services.

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s):

The implementation for the base system, supporting APD and all support agencies will begin on July 9, 2018. Additional regional deployments will occur during calendar year 2018. An enhanced version of the system will deploy in early 2019 that supports DD and OHA. The system will enter Operations and Maintenance beginning with the 2019-21 biennium.

End Date (if applicable):

Not applicable.

a. Will there be new responsibilities for DHS? Specify which Program Area(s) and describe their new responsibilities.

DHS will add the CAM Operations and Maintenance team to their existing OBIS support organization. We have allocated 3 new FTE for OBIS.

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.

The Office of Information Systems (OIS) will supply infrastructure support, service desk support, and Salesforce development support. We have allocated 2 new FTE for OIS.

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 Positions	Months in 19-21 Biennium	Type of Position
OPA-3 (OBIS)	24	Permanent
OPA-3 (OBIS)	24	Permanent

OPA-4 (OBIS)	24	Permanent
ISS6 (OIS)	24	Permanent
ISS3 (OIS)	24	Permanent

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?

No additional start-up costs are anticipated.

f. What are the ongoing costs?

Ongoing costs include licensing fees estimated at approximately at $781,538 in 2020 and $828,430 in 2021 and vendor operation and maintenance fees estimated at $400,000 a year.

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 utilization of the technical staff who support those systems to be leveraged in support of the new systems.

h. Based on these answers, is there a fiscal impact?

Yes.

TOTAL FOR THIS PACKAGE

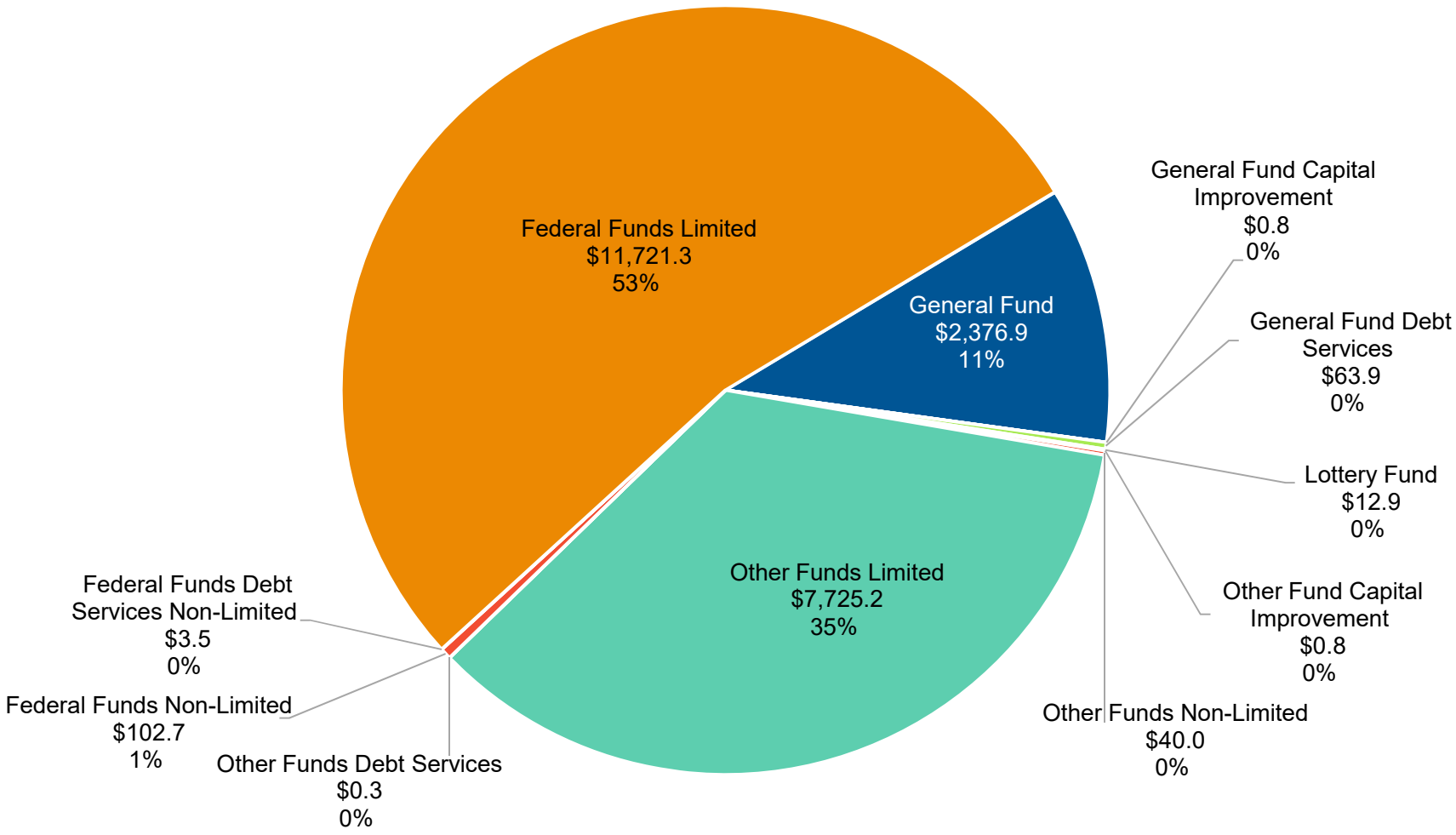
Category	GF	OF	FF	TF	Position	FTE
Personal Services	$548,714	0	0	$548,714	3	2.64
Services & Supplies	2,889,564	0	0	2,889,564		
Special Payments	74,602	0	0	74,602		
Total	**$3,512,949**	**0**	**0**	**$3,512,949**	**3**	**2.64**

DHS - Fiscal Impact Summary by Program Area:

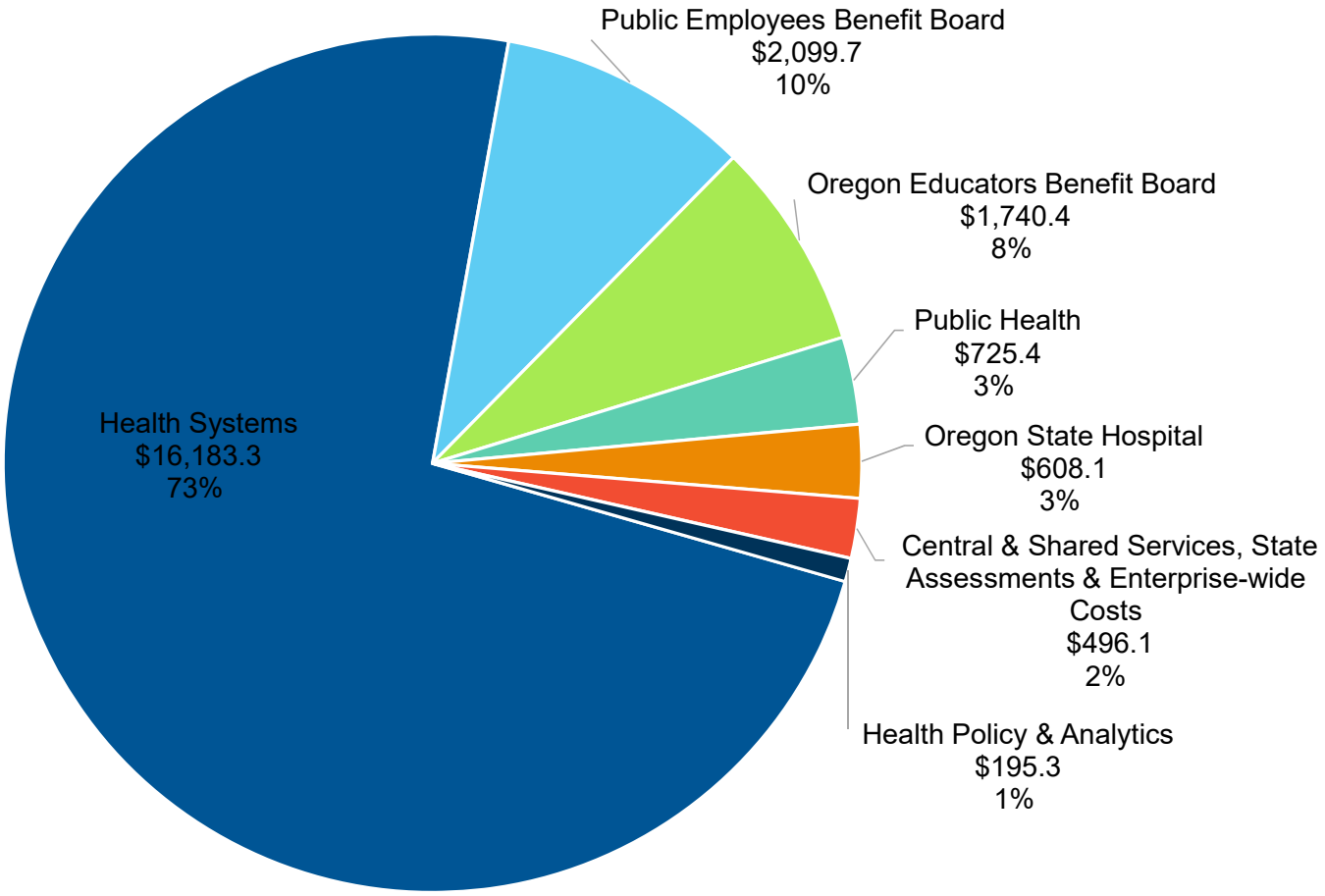
	OBIS	Total
General Fund	**3,512,949**	**3,512,949**
Other Fund	**0**	**0**
Federal Funds- Ltd	**$0**	**$0**
Total Funds	**3,512,949**	**3,512,949**
Positions	**3**	**3**
FTE	**2.64**	**2.64**

What are the sources of funding and the funding split for each one?

Oregon Health Authority
2019-21 Governor's Budget by Fund Type
$22,048.2 Total Funds



Oregon Health Authority
2019-21 Governor's Budget by Program Area in millions
$22,048.2 Total Funds



Summary of 2019-21 Biennium Budget

Oregon Health Authority | **Governor's Budget**
Oregon Health Authority | **Cross Reference Number: 44300-000-00-00-00000**
2019-21 Biennium

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2017-19 Leg Adopted Budget	4,646	4,591.03	19,912,013,086	2,185,935,679	12,457,116	6,653,688,309	10,913,483,621	40,000,000	106,448,361
2017-19 Emergency Boards	(465)	(314.99)	299,458,204	(22,247,320)	41,793	77,977,659	243,686,072	-	-
2017-19 Leg Approved Budget	**4,181**	**4,276.04**	**20,211,471,290**	**2,163,688,359**	**12,498,909**	**6,731,665,968**	11,157,169,693	**40,000,000**	**106,448,361**
2019-21 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(85)	(193.87)	13,129,164	19,867,270	58,043	2,599,355	(9,395,504)	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			(4,028,449)	(2,405,056)	-	(1,371,293)	-	-	(252,100)
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2019-21 Base Budget	**4,096**	**4,082.17**	**20,220,572,005**	**2,181,150,573**	**12,556,952**	**6,732,894,030**	11,147,774,189	**40,000,000**	**106,196,261**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	13,673,711	4,292,307	(3,681)	4,229,631	5,155,454	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	4,790,938	4,032,263	8,526	697,222	52,927	-	-
Subtotal	**-**	**-**	**18,464,649**	**8,324,570**	**4,845**	**4,926,853**	5,208,381	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	25	14.30	540,816,083	16,110,149	-	152,296,638	372,409,296	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(292,015,893)	(7,562,980)	-	(75,805,774)	(208,647,139)	-	-
Subtotal	**25**	**14.30**	**248,800,190**	**8,547,169**	**-**	**76,490,864**	163,762,157	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	1,181,753,228	94,447,790	474,012	413,133,259	673,698,167	-	-
State Gov"t & Services Charges Increase/(Decrease)			18,686,669	12,887,221	-	720,233	5,079,215	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal	**-**	**-**	**1,200,439,897**	**107,335,011**	**474,012**	**413,853,492**	678,777,382	**-**	**-**
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	129,801,443	22,037,272	-	(20,077,406)	127,841,577	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	849,583,537	-	(335,106,722)	(514,476,815)	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	-	-	-	-	-	-	-
Subtotal: 2019-21 Current Service Level	**4,121**	**4,096.47**	**21,818,078,184**	**3,176,978,132**	**13,035,809**	**6,872,981,111**	11,608,886,871	**40,000,000**	**106,196,261**

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2019-21 Current Service Level	**4,121**	**4,096.47**	**21,818,078,184**	**3,176,978,132**	**13,035,809**	**6,872,981,111**	11,608,886,871	**40,000,000**	**106,196,261**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	(13,876,365)	-	-	(11,442,182)	(2,434,183)	-	-
Modified 2019-21 Current Service Level	**4,121**	**4,096.47**	**21,804,201,819**	**3,176,978,132**	**13,035,809**	**6,861,538,929**	11,606,452,688	**40,000,000**	**106,196,261**
080 - E-Boards									
080 - May 2018 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2018 Emergency Board	1	1.00	245,621	245,621	-	-	-	-	-
090 - Analyst Adjustments	64	33.50	(38,070,001)	(806,170,565)	(109,953)	804,729,636	(36,519,119)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(4,255,554)	(2,574,530)	-	(756,855)	(924,169)	-	-
092 - Statewide AG Adjustment	-	-	(511,701)	(180,268)	(87)	(211,204)	(120,142)	-	-
095 - December 2018 Rebalance	19	20.50	66,744,897	1,552,391	-	21,176,379	44,016,127	-	-
201 - Integratd Eligibility/Medicaid Eligibility	45	31.00	11,898,734	671,490	-	9,589,123	1,638,121	-	-
202 - Medicaid Modularity	3	3.00	2,225,378	547,409	-	-	1,677,969	-	-
203 - Overpmt Writing & Recovery Proc Right-Sizing	-	-	-	-	-	-	-	-	-
204 - Interstate Benefit ID (PARIS) Proc Resourcing	-	-	-	-	-	-	-	-	-
205 - Protect, Modernize, Strengthen	-	-	-	-	-	-	-	-	-
206 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
207 - Provider Time Capture	-	-	-	-	-	-	-	-	-
208 - M & O of Centralized Abuse Management	2	2.00	446,578	-	-	446,578	-	-	-
209 - Bldg Cap & Tools for Intagy Data & GIS Dvit	-	-	-	-	-	-	-	-	-
210 - Health, Safety & Wellness	-	-	-	-	-	-	-	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
301 - Oregon Buys	-	-	-	-	-	-	-	-	-
302 - Deferred Maintenance	-	-	-	-	-	-	-	-	-
401 - Universal Family Linkages & Home Visiting Sys	4	3.00	8,732,515	4,056,925	-	-	4,675,590	-	-
402 - Prev'n, Interv'n & Access thru Lifespan	3	2.64	13,103,059	13,103,059	-	-	-	-	-
403 - Intensive In-Home Behavioral Health Services	-	-	19,639,800	6,575,316	-	-	13,064,484	-	-
404 - Office of Child Health	4	3.50	921,522	562,875	-	-	358,647	-	-
405 - Public Health Modernization	6	1.50	13,943,287	-	-	13,600,000	343,287	-	-
406 - Increase the Price of Tobacco Products	-	-	-	-	-	-	-	-	-
407 - Increase Taxes for Beer, Wine and Cider	-	-	-	-	-	-	-	-	-
408 - Continuation of Mental Health Funding	-	-	-	-	-	-	-	-	-
409 - Opioid Alt Pain Ed Modules/Addictions	1	0.88	384,534	312,700	-	-	71,834	-	-
410 - Misdemeanor Defenders	-	-	7,612,914	7,612,914	-	-	-	-	-
411 - Behavioral Health	4	3.50	5,735,196	5,406,573	-	-	328,623	-	-
412 - Safety, Patient Care & Regulatory Compliance	-	-	-	-	-	-	-	-	-
413 - Behavioral Health Funding Shortfall	-	-	9,132,500	9,132,500	-	-	-	-	-
414 - MOTS/COMPASS Modernization & Completion	2	1.76	6,739,793	6,739,793	-	-	-	-	-
415 - Expanding Hepatitis C Coverage	-	-	107,435,900	10,000,000	-	12,307,700	85,128,200	-	-
416 - CCO 2.0	7	6.16	1,902,641	1,066,092	-	-	836,549	-	-
417 - State Support for Local Public Health	-	-	5,480,601	5,480,601	-	-	-	-	-
418 - Fee Structure Rev for Drinking Water Svcs	5	5.00	1,853,297	-	-	1,853,297	-	-	-
419 - Fee Chgs for the Food, Pool and Lodging Pgms	-	-	64,450	-	-	64,450	-	-	-
420 - Toxic Free Kids Program	-	-	111,511	-	-	111,511	-	-	-
421 - OEBB/PEBB Benefit Management Sys Replacement	4	4.00	1,806,102	-	-	1,806,102	-	-	-
422 - Statewide Pharmacy Purchasing Implmtn Group	2	1.76	716,130	418,632	-	-	297,498	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal Policy Packages	**176**	**124.70**	**244,039,704**	**(735,440,472)**	**(110,040)**	**864,716,717**	114,873,499	**-**	**-**
Total 2019-21 Governor's Budget	**4,297**	**4,221.17**	**22,048,241,523**	**2,441,537,660**	**12,925,769**	**7,726,255,646**	11,721,326,187	**40,000,000**	**106,196,261**
Percentage Change From 2017-19 Leg Approved Budget	2.77%	-1.28%	9.09%	12.84%	3.42%	14.77%	5.06%	-	-0.24%
Percentage Change From 2019-21 Current Service Level	4.27%	3.04%	1.05%	-23.15%	-0.84%	12.41%	0.97%	-	-

Oregon Health Authority | **Governor's Budget**
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Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2017-19 Leg Adopted Budget	644	632.45	474,419,678	216,010,088	231,570	189,915,900	64,542,810	-	3,719,310
2017-19 Emergency Boards	2	1.50	874,080	501,457	-	4,658,900	(4,286,277)	-	-
2017-19 Leg Approved Budget	**646**	**633.95**	**475,293,758**	**216,511,545**	**231,570**	**194,574,800**	60,256,533	**-**	**3,719,310**
2019-21 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(37)	(25.84)	(74,346)	920,728	-	(1,160,512)	165,438	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			(4,028,449)	(2,405,056)	-	(1,371,293)	-	-	(252,100)
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2019-21 Base Budget	**609**	**608.11**	**471,190,963**	**215,027,217**	**231,570**	**192,042,995**	60,421,971	**-**	**3,467,210**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	2,791,387	639,648	-	1,858,213	293,526	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	457,636	240,038	5,062	168,954	43,582	-	-
Subtotal	**-**	**-**	**3,249,023**	**879,686**	**5,062**	**2,027,167**	337,108	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	-	-	2,311,146	1,562,724	-	457,616	290,806	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(8,651,165)	(2,013,649)	-	(1,923,340)	(4,714,176)	-	-
Subtotal	**-**	**-**	**(6,340,019)**	**(450,925)**	**-**	**(1,465,724)**	(4,423,370)	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	12,110,497	6,880,033	11,677	2,661,955	2,556,832	-	-
State Gov"t & Services Charges Increase/(Decrease)			18,686,669	12,887,221	-	720,233	5,079,215	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal	**-**	**-**	**30,797,166**	**19,767,254**	**11,677**	**3,382,188**	7,636,047	**-**	**-**
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	-	-	-	-	-	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	8,025,581	-	1,638,103	(9,663,684)	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	320,470	144,761	-	149,512	26,197	-	-
Subtotal: 2019-21 Current Service Level	**609**	**608.11**	**499,217,603**	**243,393,574**	**248,309**	**197,774,241**	54,334,269	**-**	**3,467,210**

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2019-21 Current Service Level	**609**	**608.11**	**499,217,603**	**243,393,574**	**248,309**	**197,774,241**	54,334,269	**-**	**3,467,210**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	(5,085,418)	-	-	(2,651,235)	(2,434,183)	-	-
Modified 2019-21 Current Service Level	**609**	**608.11**	**494,132,185**	**243,393,574**	**248,309**	**195,123,006**	51,900,086	**-**	**3,467,210**
080 - E-Boards									
080 - May 2018 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2018 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	-	-	(5,288,452)	(3,680,208)	(4,734)	(457,459)	(1,146,051)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(3,757,820)	(2,477,022)	-	(542,206)	(738,592)	-	-
092 - Statewide AG Adjustment	-	-	(52,069)	(40,903)	-	(4,456)	(6,710)	-	-
095 - December 2018 Rebalance	5	5.00	1,027,644	515,458	-	327,164	185,022	-	-
201 - Integratd Eligibility/Medicaid Eligibility	41	27.00	9,589,123	-	-	9,589,123	-	-	-
202 - Medicaid Modularity	-	-	-	-	-	-	-	-	-
203 - Overpmt Writing & Recovery Proc Right-Sizing	-	-	-	-	-	-	-	-	-
204 - Interstate Benefit ID (PARIS) Proc Resourcing	-	-	-	-	-	-	-	-	-
205 - Protect, Modernize, Strengthen	-	-	-	-	-	-	-	-	-
206 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
207 - Provider Time Capture	-	-	-	-	-	-	-	-	-
208 - M & O of Centralized Abuse Management	2	2.00	446,578	-	-	446,578	-	-	-
209 - Bldg Cap & Tools for Intagy Data & GIS Dvit	-	-	-	-	-	-	-	-	-
210 - Health, Safety & Wellness	-	-	-	-	-	-	-	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
301 - Oregon Buys	-	-	-	-	-	-	-	-	-
302 - Deferred Maintenance	-	-	-	-	-	-	-	-	-
401 - Universal Family Linkages & Home Visiting Sys	-	-	-	-	-	-	-	-	-
402 - Prev'n, Interv'n & Access thru Lifespan	-	-	-	-	-	-	-	-	-
403 - Intensive In-Home Behavioral Health Services	-	-	-	-	-	-	-	-	-
404 - Office of Child Health	-	-	-	-	-	-	-	-	-
405 - Public Health Modernization	-	-	-	-	-	-	-	-	-
406 - Increase the Price of Tobacco Products	-	-	-	-	-	-	-	-	-
407 - Increase Taxes for Beer, Wine and Cider	-	-	-	-	-	-	-	-	-
408 - Continuation of Mental Health Funding	-	-	-	-	-	-	-	-	-
409 - Opioid Alt Pain Ed Modules/Addictions	-	-	-	-	-	-	-	-	-
410 - Misdemeanor Defenders	-	-	-	-	-	-	-	-	-
411 - Behavioral Health	-	-	-	-	-	-	-	-	-
412 - Safety, Patient Care & Regulatory Compliance	-	-	-	-	-	-	-	-	-
413 - Behavioral Health Funding Shortfall	-	-	-	-	-	-	-	-	-
414 - MOTS/COMPASS Modernization & Completion	-	-	-	-	-	-	-	-	-
415 - Expanding Hepatitis C Coverage	-	-	-	-	-	-	-	-	-
416 - CCO 2.0	-	-	-	-	-	-	-	-	-
417 - State Support for Local Public Health	-	-	-	-	-	-	-	-	-
418 - Fee Structure Rev for Drinking Water Svcs	-	-	-	-	-	-	-	-	-
419 - Fee Chgs for the Food, Pool and Lodging Pgms	-	-	-	-	-	-	-	-	-
420 - Toxic Free Kids Program	-	-	-	-	-	-	-	-	-
421 - OEBB/PEBB Benefit Management Sys Replacement	-	-	-	-	-	-	-	-	-
422 - Statewide Pharmacy Purchasing Implmtn Group	-	-	-	-	-	-	-	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal Policy Packages	**48**	**34.00**	**1,965,004**	**(5,682,675)**	**(4,734)**	**9,358,744**	(1,706,331)	**-**	**-**
Total 2019-21 Governor's Budget	**657**	**642.11**	**496,097,189**	**237,710,899**	**243,575**	**204,481,750**	50,193,755	**-**	**3,467,210**
Percentage Change From 2017-19 Leg Approved Budget	1.70%	1.29%	4.38%	9.79%	5.18%	5.09%	-16.70%	-	-6.78%
Percentage Change From 2019-21 Current Service Level	7.88%	5.59%	-0.63%	-2.33%	-1.91%	3.39%	-7.62%	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2017-19 Leg Adopted Budget	105	104.11	35,758,612	23,526,866	31,570	2,557,616	9,642,560	-	-
2017-19 Emergency Boards	2	1.50	904,590	1,129,938	-	(25,422)	(199,926)	-	-
2017-19 Leg Approved Budget	**107**	**105.61**	**36,663,202**	**24,656,804**	**31,570**	**2,532,194**	9,442,634	**-**	**-**
2019-21 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	1	1.50	1,524,529	920,728	-	438,363	165,438	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2019-21 Base Budget	**108**	**107.11**	**38,187,731**	**25,577,532**	**31,570**	**2,970,557**	9,608,072	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	989,730	639,648	-	56,556	293,526	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	139,706	81,977	-	18,637	39,092	-	-
Subtotal	**-**	**-**	**1,129,436**	**721,625**	**-**	**75,193**	332,618	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	-	-	6,704	6,704	-	-	-	-	-
022 - Phase-out Pgm & One-time Costs	-	-	-	-	-	-	-	-	-
Subtotal	**-**	**-**	**6,704**	**6,704**	**-**	**-**	-	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	1,233,729	850,597	1,199	96,508	285,425	-	-
Subtotal	**-**	**-**	**1,233,729**	**850,597**	**1,199**	**96,508**	285,425	**-**	**-**

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	-	-	-	3,901,989	-	(527,707)	(3,374,282)	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	(3,707,000)	(2,582,057)	-	(274,337)	(850,606)	-	-
Subtotal: 2019-21 Current Service Level	**108**	**107.11**	**36,850,600**	**28,476,390**	**32,769**	**2,340,214**	6,001,227	**-**	**-**

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2019-21 Current Service Level	**108**	**107.11**	**36,850,600**	**28,476,390**	**32,769**	**2,340,214**	6,001,227	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2019-21 Current Service Level	**108**	**107.11**	**36,850,600**	**28,476,390**	**32,769**	**2,340,214**	6,001,227	**-**	**-**
080 - E-Boards									
080 - May 2018 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2018 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	-	-	(812,857)	(722,196)	-	(24,155)	(66,506)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(1,341)	(1,109)	-	(88)	(144)	-	-
092 - Statewide AG Adjustment	-	-	(51,014)	(40,811)	-	(3,571)	(6,632)	-	-
095 - December 2018 Rebalance	5	5.00	887,153	535,588	-	92,116	259,449	-	-
201 - Integratd Eligibility/Medicaid Eligibility	-	-	-	-	-	-	-	-	-
202 - Medicaid Modularity	-	-	-	-	-	-	-	-	-
203 - Overpmt Writing & Recovery Proc Right-Sizing	-	-	-	-	-	-	-	-	-
204 - Interstate Benefit ID (PARIS) Proc Resourcing	-	-	-	-	-	-	-	-	-
205 - Protect, Modernize, Strengthen	-	-	-	-	-	-	-	-	-
206 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
207 - Provider Time Capture	-	-	-	-	-	-	-	-	-
208 - M & O of Centralized Abuse Management	-	-	-	-	-	-	-	-	-
209 - Bldg Cap & Tools for Intagy Data & GIS Dvit	-	-	-	-	-	-	-	-	-
210 - Health, Safety & Wellness	-	-	-	-	-	-	-	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
301 - Oregon Buys	-	-	-	-	-	-	-	-	-
302 - Deferred Maintenance	-	-	-	-	-	-	-	-	-
401 - Universal Family Linkages & Home Visiting Sys	-	-	-	-	-	-	-	-	-
402 - Prev'n, Interv'n & Access thru Lifespan	-	-	-	-	-	-	-	-	-
403 - Intensive In-Home Behavioral Health Services	-	-	-	-	-	-	-	-	-
404 - Office of Child Health	-	-	-	-	-	-	-	-	-
405 - Public Health Modernization	-	-	-	-	-	-	-	-	-
406 - Increase the Price of Tobacco Products	-	-	-	-	-	-	-	-	-
407 - Increase Taxes for Beer, Wine and Cider	-	-	-	-	-	-	-	-	-
408 - Continuation of Mental Health Funding	-	-	-	-	-	-	-	-	-
409 - Opioid Alt Pain Ed Modules/Addictions	-	-	-	-	-	-	-	-	-
410 - Misdemeanor Defenders	-	-	-	-	-	-	-	-	-
411 - Behavioral Health	-	-	-	-	-	-	-	-	-
412 - Safety, Patient Care & Regulatory Compliance	-	-	-	-	-	-	-	-	-
413 - Behavioral Health Funding Shortfall	-	-	-	-	-	-	-	-	-
414 - MOTS/COMPASS Modernization & Completion	-	-	-	-	-	-	-	-	-
415 - Expanding Hepatitis C Coverage	-	-	-	-	-	-	-	-	-
416 - CCO 2.0	-	-	-	-	-	-	-	-	-
417 - State Support for Local Public Health	-	-	-	-	-	-	-	-	-
418 - Fee Structure Rev for Drinking Water Svcs	-	-	-	-	-	-	-	-	-
419 - Fee Chgs for the Food, Pool and Lodging Pgms	-	-	-	-	-	-	-	-	-
420 - Toxic Free Kids Program	-	-	-	-	-	-	-	-	-
421 - OEBB/PEBB Benefit Management Sys Replacement	-	-	-	-	-	-	-	-	-
422 - Statewide Pharmacy Purchasing Implmtn Group	-	-	-	-	-	-	-	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal Policy Packages	**5**	**5.00**	**21,941**	**(228,528)**	**-**	**64,302**	186,167	**-**	**-**
Total 2019-21 Governor's Budget	**113**	**112.11**	**36,872,541**	**28,247,862**	**32,769**	**2,404,516**	6,187,394	**-**	**-**
Percentage Change From 2017-19 Leg Approved Budget	5.61%	6.15%	0.57%	14.56%	3.80%	-5.04%	-34.47%	-	-
Percentage Change From 2019-21 Current Service Level	4.63%	4.67%	0.06%	-0.80%	-	2.75%	3.10%	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2017-19 Leg Adopted Budget	539	528.34	162,731,801	-	-	162,731,801	-	-	-
2017-19 Emergency Boards	-	-	3,775,678	-	-	3,775,678	-	-	-
2017-19 Leg Approved Budget	**539**	**528.34**	**166,507,479**	**-**	**-**	**166,507,479**	-	**-**	**-**
2019-21 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(38)	(27.34)	(1,598,875)	-	-	(1,598,875)	-	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2019-21 Base Budget	**501**	**501.00**	**164,908,604**	**-**	**-**	**164,908,604**	-	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	1,801,657	-	-	1,801,657	-	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	27,815	-	-	27,815	-	-	-
Subtotal	**-**	**-**	**1,829,472**	**-**	**-**	**1,829,472**	-	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	-	-	316,180	-	-	316,180	-	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(1,878,122)	-	-	(1,878,122)	-	-	-
Subtotal	**-**	**-**	**(1,561,942)**	**-**	**-**	**(1,561,942)**	-	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	1,373,417	-	-	1,373,417	-	-	-
Subtotal	**-**	**-**	**1,373,417**	**-**	**-**	**1,373,417**	-	**-**	**-**

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: 2019-21 Current Service Level	**501**	**501.00**	**166,549,551**	**-**	**-**	**166,549,551**	-	**-**	**-**

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2019-21 Current Service Level	**501**	**501.00**	**166,549,551**	**-**	**-**	**166,549,551**	-	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2019-21 Current Service Level	**501**	**501.00**	**166,549,551**	**-**	**-**	**166,549,551**	-	**-**	**-**
080 - E-Boards									
080 - May 2018 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2018 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	-	-	-	-	-	-	-	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(23,231)	-	-	(23,231)	-	-	-
092 - Statewide AG Adjustment	-	-	(862)	-	-	(862)	-	-	-
095 - December 2018 Rebalance	-	-	-	-	-	-	-	-	-
201 - Integratd Eligibility/Medicaid Eligibility	41	27.00	9,589,123	-	-	9,589,123	-	-	-
202 - Medicaid Modularity	-	-	-	-	-	-	-	-	-
203 - Overpmt Writing & Recovery Proc Right-Sizing	-	-	-	-	-	-	-	-	-
204 - Interstate Benefit ID (PARIS) Proc Resourcing	-	-	-	-	-	-	-	-	-
205 - Protect, Modernize, Strengthen	-	-	-	-	-	-	-	-	-
206 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
207 - Provider Time Capture	-	-	-	-	-	-	-	-	-
208 - M & O of Centralized Abuse Management	2	2.00	446,578	-	-	446,578	-	-	-
209 - Bldg Cap & Tools for Intagy Data & GIS Dvit	-	-	-	-	-	-	-	-	-
210 - Health, Safety & Wellness	-	-	-	-	-	-	-	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
301 - Oregon Buys	-	-	-	-	-	-	-	-	-
302 - Deferred Maintenance	-	-	-	-	-	-	-	-	-
401 - Universal Family Linkages & Home Visiting Sys	-	-	-	-	-	-	-	-	-
402 - Prev'n, Interv'n & Access thru Lifespan	-	-	-	-	-	-	-	-	-
403 - Intensive In-Home Behavioral Health Services	-	-	-	-	-	-	-	-	-
404 - Office of Child Health	-	-	-	-	-	-	-	-	-
405 - Public Health Modernization	-	-	-	-	-	-	-	-	-
406 - Increase the Price of Tobacco Products	-	-	-	-	-	-	-	-	-
407 - Increase Taxes for Beer, Wine and Cider	-	-	-	-	-	-	-	-	-
408 - Continuation of Mental Health Funding	-	-	-	-	-	-	-	-	-
409 - Opioid Alt Pain Ed Modules/Addictions	-	-	-	-	-	-	-	-	-
410 - Misdemeanor Defenders	-	-	-	-	-	-	-	-	-
411 - Behavioral Health	-	-	-	-	-	-	-	-	-
412 - Safety, Patient Care & Regulatory Compliance	-	-	-	-	-	-	-	-	-
413 - Behavioral Health Funding Shortfall	-	-	-	-	-	-	-	-	-
414 - MOTS/COMPASS Modernization & Completion	-	-	-	-	-	-	-	-	-
415 - Expanding Hepatitis C Coverage	-	-	-	-	-	-	-	-	-
416 - CCO 2.0	-	-	-	-	-	-	-	-	-
417 - State Support for Local Public Health	-	-	-	-	-	-	-	-	-
418 - Fee Structure Rev for Drinking Water Svcs	-	-	-	-	-	-	-	-	-
419 - Fee Chgs for the Food, Pool and Lodging Pgms	-	-	-	-	-	-	-	-	-
420 - Toxic Free Kids Program	-	-	-	-	-	-	-	-	-
421 - OEBB/PEBB Benefit Management Sys Replacement	-	-	-	-	-	-	-	-	-
422 - Statewide Pharmacy Purchasing Implmtn Group	-	-	-	-	-	-	-	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal Policy Packages	**43**	**29.00**	**10,011,608**	**-**	**-**	**10,011,608**	-	**-**	**-**
Total 2019-21 Governor's Budget	**544**	**530.00**	**176,561,159**	**-**	**-**	**176,561,159**	-	**-**	**-**
Percentage Change From 2017-19 Leg Approved Budget	0.93%	0.31%	6.04%	-	-	6.04%	-	-	-
Percentage Change From 2019-21 Current Service Level	8.58%	5.79%	6.01%	-	-	6.01%	-	-	-

Oregon Health Authority | **Governor's Budget**
State Assessments and Enterprise-wide Costs | **Cross Reference Number: 44300-010-50-00-00000**
2019-21 Biennium

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2017-19 Leg Adopted Budget	-	-	275,929,265	192,483,222	200,000	24,626,483	54,900,250	-	3,719,310
2017-19 Emergency Boards	-	-	(3,806,188)	(628,481)	-	908,644	(4,086,351)	-	-
2017-19 Leg Approved Budget	**-**	**-**	**272,123,077**	**191,854,741**	**200,000**	**25,535,127**	50,813,899	**-**	**3,719,310**
2019-21 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	-	-	-	-	-	-	-	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			(4,028,449)	(2,405,056)	-	(1,371,293)	-	-	(252,100)
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2019-21 Base Budget	**-**	**-**	**268,094,628**	**189,449,685**	**200,000**	**24,163,834**	50,813,899	**-**	**3,467,210**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Non-PICS Personal Service Increase/(Decrease)	-	-	290,115	158,061	5,062	122,502	4,490	-	-
Subtotal	**-**	**-**	**290,115**	**158,061**	**5,062**	**122,502**	4,490	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	-	-	1,988,262	1,556,020	-	141,436	290,806	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(6,773,043)	(2,013,649)	-	(45,218)	(4,714,176)	-	-
Subtotal	**-**	**-**	**(4,784,781)**	**(457,629)**	**-**	**96,218**	(4,423,370)	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	9,503,351	6,029,436	10,478	1,192,030	2,271,407	-	-
State Gov"t & Services Charges Increase/(Decrease)			18,686,669	12,887,221	-	720,233	5,079,215	-	-
Subtotal	**-**	**-**	**28,190,020**	**18,916,657**	**10,478**	**1,912,263**	7,350,622	**-**	**-**

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	-	-	-	4,123,592	-	2,165,810	(6,289,402)	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	4,027,470	2,726,818	-	423,849	876,803	-	-
Subtotal: 2019-21 Current Service Level	**-**	**-**	**295,817,452**	**214,917,184**	**215,540**	**28,884,476**	48,333,042	**-**	**3,467,210**

Oregon Health Authority | **Governor's Budget**
State Assessments and Enterprise-wide Costs | **Cross Reference Number: 44300-010-50-00-00000**
2019-21 Biennium

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2019-21 Current Service Level	**-**	**-**	**295,817,452**	**214,917,184**	**215,540**	**28,884,476**	48,333,042	**-**	**3,467,210**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	(5,085,418)	-	-	(2,651,235)	(2,434,183)	-	-
Modified 2019-21 Current Service Level	**-**	**-**	**290,732,034**	**214,917,184**	**215,540**	**26,233,241**	45,898,859	**-**	**3,467,210**
080 - E-Boards									
080 - May 2018 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2018 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	-	-	(4,475,595)	(2,958,012)	(4,734)	(433,304)	(1,079,545)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(3,733,248)	(2,475,913)	-	(518,887)	(738,448)	-	-
092 - Statewide AG Adjustment	-	-	(193)	(92)	-	(23)	(78)	-	-
095 - December 2018 Rebalance	-	-	140,491	(20,130)	-	235,048	(74,427)	-	-
201 - Integratd Eligibility/Medicaid Eligibility	-	-	-	-	-	-	-	-	-
202 - Medicaid Modularity	-	-	-	-	-	-	-	-	-
203 - Overpmt Writing & Recovery Proc Right-Sizing	-	-	-	-	-	-	-	-	-
204 - Interstate Benefit ID (PARIS) Proc Resourcing	-	-	-	-	-	-	-	-	-
205 - Protect, Modernize, Strengthen	-	-	-	-	-	-	-	-	-
206 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
207 - Provider Time Capture	-	-	-	-	-	-	-	-	-
208 - M & O of Centralized Abuse Management	-	-	-	-	-	-	-	-	-
209 - Bldg Cap & Tools for Intagy Data & GIS Dvit	-	-	-	-	-	-	-	-	-
210 - Health, Safety & Wellness	-	-	-	-	-	-	-	-	-

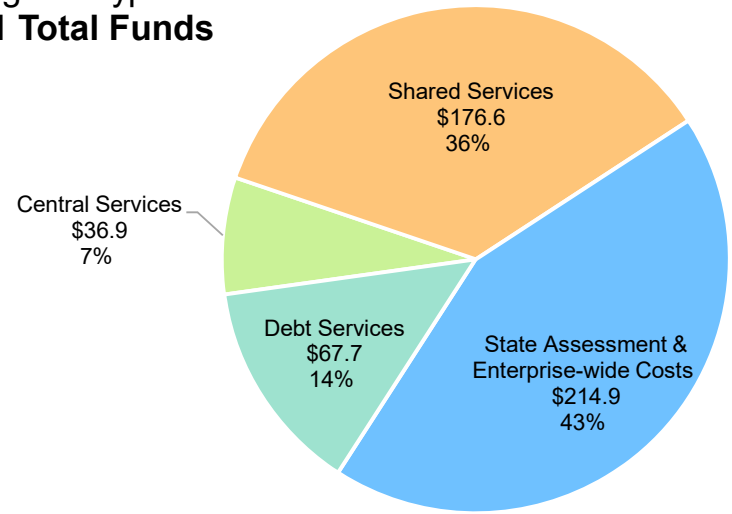
Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
301 - Oregon Buys	-	-	-	-	-	-	-	-	-
302 - Deferred Maintenance	-	-	-	-	-	-	-	-	-
401 - Universal Family Linkages & Home Visiting Sys	-	-	-	-	-	-	-	-	-
402 - Prev'n, Interv'n & Access thru Lifespan	-	-	-	-	-	-	-	-	-
403 - Intensive In-Home Behavioral Health Services	-	-	-	-	-	-	-	-	-
404 - Office of Child Health	-	-	-	-	-	-	-	-	-
405 - Public Health Modernization	-	-	-	-	-	-	-	-	-
406 - Increase the Price of Tobacco Products	-	-	-	-	-	-	-	-	-
407 - Increase Taxes for Beer, Wine and Cider	-	-	-	-	-	-	-	-	-
408 - Continuation of Mental Health Funding	-	-	-	-	-	-	-	-	-
409 - Opioid Alt Pain Ed Modules/Addictions	-	-	-	-	-	-	-	-	-
410 - Misdemeanor Defenders	-	-	-	-	-	-	-	-	-
411 - Behavioral Health	-	-	-	-	-	-	-	-	-
412 - Safety, Patient Care & Regulatory Compliance	-	-	-	-	-	-	-	-	-
413 - Behavioral Health Funding Shortfall	-	-	-	-	-	-	-	-	-
414 - MOTS/COMPASS Modernization & Completion	-	-	-	-	-	-	-	-	-
415 - Expanding Hepatitis C Coverage	-	-	-	-	-	-	-	-	-
416 - CCO 2.0	-	-	-	-	-	-	-	-	-
417 - State Support for Local Public Health	-	-	-	-	-	-	-	-	-
418 - Fee Structure Rev for Drinking Water Svcs	-	-	-	-	-	-	-	-	-
419 - Fee Chgs for the Food, Pool and Lodging Pgms	-	-	-	-	-	-	-	-	-
420 - Toxic Free Kids Program	-	-	-	-	-	-	-	-	-
421 - OEBB/PEBB Benefit Management Sys Replacement	-	-	-	-	-	-	-	-	-
422 - Statewide Pharmacy Purchasing Implmtn Group	-	-	-	-	-	-	-	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal Policy Packages	**-**	**-**	**(8,068,545)**	**(5,454,147)**	**(4,734)**	**(717,166)**	(1,892,498)	**-**	**-**
Total 2019-21 Governor's Budget	**-**	**-**	**282,663,489**	**209,463,037**	**210,806**	**25,516,075**	44,006,361	**-**	**3,467,210**
Percentage Change From 2017-19 Leg Approved Budget	-	-	3.87%	9.18%	5.40%	-0.07%	-13.40%	-	-6.78%
Percentage Change From 2019-21 Current Service Level	-	-	-4.45%	-2.54%	-2.20%	-11.66%	-8.95%	-	-

Oregon Health Authority
2019-21 Governor's Budget

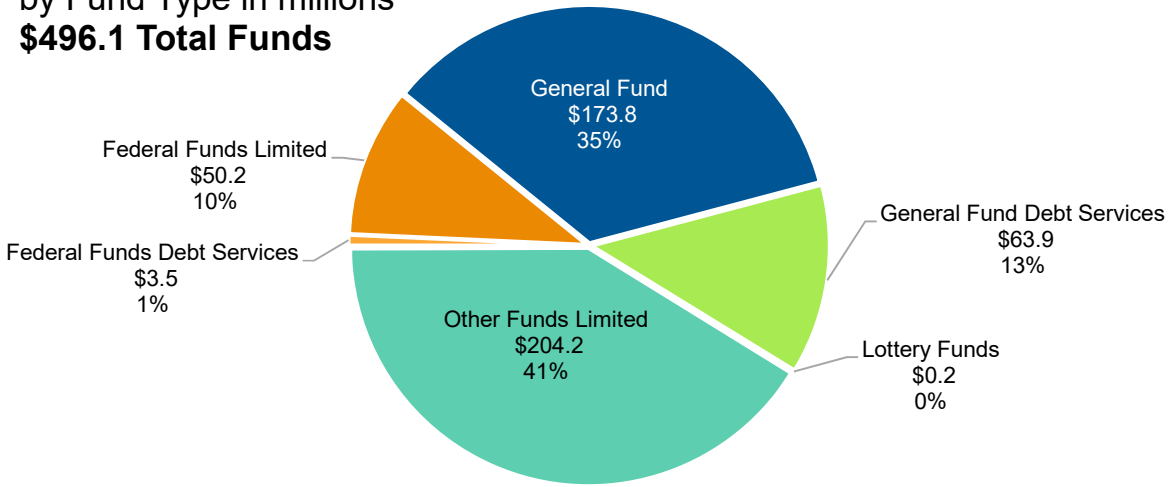
Central & Shared Services, State Assessments & Enterprise-wide Costs by Program Type in millions

$496.1 Total Funds



Central & Shared Services, State Assessments & Enterprise-Wide Costs by Fund Type in millions

$496.1 Total Funds



Oregon Health Authority | **Governor's Budget**
OHA Central & Shared Services | **Cross Reference Number: 44300-010-00-00-00000**
2019-21 Biennium

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2017-19 Leg Adopted Budget	644	632.45	474,419,678	216,010,088	231,570	189,915,900	64,542,810	-	3,719,310
2017-19 Emergency Boards	2	1.50	874,080	501,457	-	4,658,900	(4,286,277)	-	-
2017-19 Leg Approved Budget	**646**	**633.95**	**475,293,758**	**216,511,545**	**231,570**	**194,574,800**	60,256,533	**-**	**3,719,310**
2019-21 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(37)	(25.84)	(74,346)	920,728	-	(1,160,512)	165,438	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			(4,028,449)	(2,405,056)	-	(1,371,293)	-	-	(252,100)
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2019-21 Base Budget	**609**	**608.11**	**471,190,963**	**215,027,217**	**231,570**	**192,042,995**	60,421,971	**-**	**3,467,210**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	2,791,387	639,648	-	1,858,213	293,526	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	457,636	240,038	5,062	168,954	43,582	-	-
Subtotal	**-**	**-**	**3,249,023**	**879,686**	**5,062**	**2,027,167**	337,108	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	-	-	2,311,146	1,562,724	-	457,616	290,806	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(8,651,165)	(2,013,649)	-	(1,923,340)	(4,714,176)	-	-
Subtotal	**-**	**-**	**(6,340,019)**	**(450,925)**	**-**	**(1,465,724)**	(4,423,370)	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	12,110,497	6,880,033	11,677	2,661,955	2,556,832	-	-
State Gov"t & Services Charges Increase/(Decrease)			18,686,669	12,887,221	-	720,233	5,079,215	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal	**-**	**-**	**30,797,166**	**19,767,254**	**11,677**	**3,382,188**	7,636,047	**-**	**-**
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	-	-	-	-	-	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	8,025,581	-	1,638,103	(9,663,684)	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	320,470	144,761	-	149,512	26,197	-	-
Subtotal: 2019-21 Current Service Level	**609**	**608.11**	**499,217,603**	**243,393,574**	**248,309**	**197,774,241**	54,334,269	**-**	**3,467,210**

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2019-21 Current Service Level	**609**	**608.11**	**499,217,603**	**243,393,574**	**248,309**	**197,774,241**	54,334,269	**-**	**3,467,210**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	(5,085,418)	-	-	(2,651,235)	(2,434,183)	-	-
Modified 2019-21 Current Service Level	**609**	**608.11**	**494,132,185**	**243,393,574**	**248,309**	**195,123,006**	51,900,086	**-**	**3,467,210**
080 - E-Boards									
080 - May 2018 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2018 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	-	-	(5,288,452)	(3,680,208)	(4,734)	(457,459)	(1,146,051)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(3,757,820)	(2,477,022)	-	(542,206)	(738,592)	-	-
092 - Statewide AG Adjustment	-	-	(52,069)	(40,903)	-	(4,456)	(6,710)	-	-
095 - December 2018 Rebalance	5	5.00	1,027,644	515,458	-	327,164	185,022	-	-
201 - Integratd Eligibility/Medicaid Eligibility	41	27.00	9,589,123	-	-	9,589,123	-	-	-
202 - Medicaid Modularity	-	-	-	-	-	-	-	-	-
203 - Overpmt Writing & Recovery Proc Right-Sizing	-	-	-	-	-	-	-	-	-
204 - Interstate Benefit ID (PARIS) Proc Resourcing	-	-	-	-	-	-	-	-	-
205 - Protect, Modernize, Strengthen	-	-	-	-	-	-	-	-	-
206 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
207 - Provider Time Capture	-	-	-	-	-	-	-	-	-
208 - M & O of Centralized Abuse Management	2	2.00	446,578	-	-	446,578	-	-	-
209 - Bldg Cap & Tools for Intagy Data & GIS Dvit	-	-	-	-	-	-	-	-	-
210 - Health, Safety & Wellness	-	-	-	-	-	-	-	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
301 - Oregon Buys	-	-	-	-	-	-	-	-	-
302 - Deferred Maintenance	-	-	-	-	-	-	-	-	-
401 - Universal Family Linkages & Home Visiting Sys	-	-	-	-	-	-	-	-	-
402 - Prev'n, Interv'n & Access thru Lifespan	-	-	-	-	-	-	-	-	-
403 - Intensive In-Home Behavioral Health Services	-	-	-	-	-	-	-	-	-
404 - Office of Child Health	-	-	-	-	-	-	-	-	-
405 - Public Health Modernization	-	-	-	-	-	-	-	-	-
406 - Increase the Price of Tobacco Products	-	-	-	-	-	-	-	-	-
407 - Increase Taxes for Beer, Wine and Cider	-	-	-	-	-	-	-	-	-
408 - Continuation of Mental Health Funding	-	-	-	-	-	-	-	-	-
409 - Opioid Alt Pain Ed Modules/Addictions	-	-	-	-	-	-	-	-	-
410 - Misdemeanor Defenders	-	-	-	-	-	-	-	-	-
411 - Behavioral Health	-	-	-	-	-	-	-	-	-
412 - Safety, Patient Care & Regulatory Compliance	-	-	-	-	-	-	-	-	-
413 - Behavioral Health Funding Shortfall	-	-	-	-	-	-	-	-	-
414 - MOTS/COMPASS Modernization & Completion	-	-	-	-	-	-	-	-	-
415 - Expanding Hepatitis C Coverage	-	-	-	-	-	-	-	-	-
416 - CCO 2.0	-	-	-	-	-	-	-	-	-
417 - State Support for Local Public Health	-	-	-	-	-	-	-	-	-
418 - Fee Structure Rev for Drinking Water Svcs	-	-	-	-	-	-	-	-	-
419 - Fee Chgs for the Food, Pool and Lodging Pgms	-	-	-	-	-	-	-	-	-
420 - Toxic Free Kids Program	-	-	-	-	-	-	-	-	-
421 - OEBB/PEBB Benefit Management Sys Replacement	-	-	-	-	-	-	-	-	-
422 - Statewide Pharmacy Purchasing Implmtn Group	-	-	-	-	-	-	-	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal Policy Packages	**48**	**34.00**	**1,965,004**	**(5,682,675)**	**(4,734)**	**9,358,744**	(1,706,331)	**-**	**-**
Total 2019-21 Governor's Budget	**657**	**642.11**	**496,097,189**	**237,710,899**	**243,575**	**204,481,750**	50,193,755	**-**	**3,467,210**
Percentage Change From 2017-19 Leg Approved Budget	1.70%	1.29%	4.38%	9.79%	5.18%	5.09%	-16.70%	-	-6.78%
Percentage Change From 2019-21 Current Service Level	7.88%	5.59%	-0.63%	-2.33%	-1.91%	3.39%	-7.62%	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2017-19 Leg Adopted Budget	105	104.11	35,758,612	23,526,866	31,570	2,557,616	9,642,560	-	-
2017-19 Emergency Boards	2	1.50	904,590	1,129,938	-	(25,422)	(199,926)	-	-
2017-19 Leg Approved Budget	**107**	**105.61**	**36,663,202**	**24,656,804**	**31,570**	**2,532,194**	9,442,634	**-**	**-**
2019-21 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	1	1.50	1,524,529	920,728	-	438,363	165,438	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2019-21 Base Budget	**108**	**107.11**	**38,187,731**	**25,577,532**	**31,570**	**2,970,557**	9,608,072	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	989,730	639,648	-	56,556	293,526	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	139,706	81,977	-	18,637	39,092	-	-
Subtotal	**-**	**-**	**1,129,436**	**721,625**	**-**	**75,193**	332,618	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	-	-	6,704	6,704	-	-	-	-	-
022 - Phase-out Pgm & One-time Costs	-	-	-	-	-	-	-	-	-
Subtotal	**-**	**-**	**6,704**	**6,704**	**-**	**-**	-	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	1,233,729	850,597	1,199	96,508	285,425	-	-
Subtotal	**-**	**-**	**1,233,729**	**850,597**	**1,199**	**96,508**	285,425	**-**	**-**

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	-	-	-	3,901,989	-	(527,707)	(3,374,282)	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	(3,707,000)	(2,582,057)	-	(274,337)	(850,606)	-	-
Subtotal: 2019-21 Current Service Level	**108**	**107.11**	**36,850,600**	**28,476,390**	**32,769**	**2,340,214**	6,001,227	**-**	**-**

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2019-21 Current Service Level	**108**	**107.11**	**36,850,600**	**28,476,390**	**32,769**	**2,340,214**	6,001,227	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2019-21 Current Service Level	**108**	**107.11**	**36,850,600**	**28,476,390**	**32,769**	**2,340,214**	6,001,227	**-**	**-**
080 - E-Boards									
080 - May 2018 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2018 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	-	-	(812,857)	(722,196)	-	(24,155)	(66,506)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(1,341)	(1,109)	-	(88)	(144)	-	-
092 - Statewide AG Adjustment	-	-	(51,014)	(40,811)	-	(3,571)	(6,632)	-	-
095 - December 2018 Rebalance	5	5.00	887,153	535,588	-	92,116	259,449	-	-
201 - Integratd Eligibility/Medicaid Eligibility	-	-	-	-	-	-	-	-	-
202 - Medicaid Modularity	-	-	-	-	-	-	-	-	-
203 - Overpmt Writing & Recovery Proc Right-Sizing	-	-	-	-	-	-	-	-	-
204 - Interstate Benefit ID (PARIS) Proc Resourcing	-	-	-	-	-	-	-	-	-
205 - Protect, Modernize, Strengthen	-	-	-	-	-	-	-	-	-
206 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
207 - Provider Time Capture	-	-	-	-	-	-	-	-	-
208 - M & O of Centralized Abuse Management	-	-	-	-	-	-	-	-	-
209 - Bldg Cap & Tools for Intagy Data & GIS Dvit	-	-	-	-	-	-	-	-	-
210 - Health, Safety & Wellness	-	-	-	-	-	-	-	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
301 - Oregon Buys	-	-	-	-	-	-	-	-	-
302 - Deferred Maintenance	-	-	-	-	-	-	-	-	-
401 - Universal Family Linkages & Home Visiting Sys	-	-	-	-	-	-	-	-	-
402 - Prev'n, Interv'n & Access thru Lifespan	-	-	-	-	-	-	-	-	-
403 - Intensive In-Home Behavioral Health Services	-	-	-	-	-	-	-	-	-
404 - Office of Child Health	-	-	-	-	-	-	-	-	-
405 - Public Health Modernization	-	-	-	-	-	-	-	-	-
406 - Increase the Price of Tobacco Products	-	-	-	-	-	-	-	-	-
407 - Increase Taxes for Beer, Wine and Cider	-	-	-	-	-	-	-	-	-
408 - Continuation of Mental Health Funding	-	-	-	-	-	-	-	-	-
409 - Opioid Alt Pain Ed Modules/Addictions	-	-	-	-	-	-	-	-	-
410 - Misdemeanor Defenders	-	-	-	-	-	-	-	-	-
411 - Behavioral Health	-	-	-	-	-	-	-	-	-
412 - Safety, Patient Care & Regulatory Compliance	-	-	-	-	-	-	-	-	-
413 - Behavioral Health Funding Shortfall	-	-	-	-	-	-	-	-	-
414 - MOTS/COMPASS Modernization & Completion	-	-	-	-	-	-	-	-	-
415 - Expanding Hepatitis C Coverage	-	-	-	-	-	-	-	-	-
416 - CCO 2.0	-	-	-	-	-	-	-	-	-
417 - State Support for Local Public Health	-	-	-	-	-	-	-	-	-
418 - Fee Structure Rev for Drinking Water Svcs	-	-	-	-	-	-	-	-	-
419 - Fee Chgs for the Food, Pool and Lodging Pgms	-	-	-	-	-	-	-	-	-
420 - Toxic Free Kids Program	-	-	-	-	-	-	-	-	-
421 - OEBB/PEBB Benefit Management Sys Replacement	-	-	-	-	-	-	-	-	-
422 - Statewide Pharmacy Purchasing Implmtn Group	-	-	-	-	-	-	-	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal Policy Packages	**5**	**5.00**	**21,941**	**(228,528)**	**-**	**64,302**	186,167	**-**	**-**
Total 2019-21 Governor's Budget	**113**	**112.11**	**36,872,541**	**28,247,862**	**32,769**	**2,404,516**	6,187,394	**-**	**-**
Percentage Change From 2017-19 Leg Approved Budget	5.61%	6.15%	0.57%	14.56%	3.80%	-5.04%	-34.47%	-	-
Percentage Change From 2019-21 Current Service Level	4.63%	4.67%	0.06%	-0.80%	-	2.75%	3.10%	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2017-19 Leg Adopted Budget	539	528.34	162,731,801	-	-	162,731,801	-	-	-
2017-19 Emergency Boards	-	-	3,775,678	-	-	3,775,678	-	-	-
2017-19 Leg Approved Budget	**539**	**528.34**	**166,507,479**	**-**	**-**	**166,507,479**	-	**-**	**-**
2019-21 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(38)	(27.34)	(1,598,875)	-	-	(1,598,875)	-	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2019-21 Base Budget	**501**	**501.00**	**164,908,604**	**-**	**-**	**164,908,604**	-	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	1,801,657	-	-	1,801,657	-	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	27,815	-	-	27,815	-	-	-
Subtotal	**-**	**-**	**1,829,472**	**-**	**-**	**1,829,472**	-	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	-	-	316,180	-	-	316,180	-	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(1,878,122)	-	-	(1,878,122)	-	-	-
Subtotal	**-**	**-**	**(1,561,942)**	**-**	**-**	**(1,561,942)**	-	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	1,373,417	-	-	1,373,417	-	-	-
Subtotal	**-**	**-**	**1,373,417**	**-**	**-**	**1,373,417**	-	**-**	**-**

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: 2019-21 Current Service Level	**501**	**501.00**	**166,549,551**	**-**	**-**	**166,549,551**	-	**-**	**-**

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2019-21 Current Service Level	**501**	**501.00**	**166,549,551**	**-**	**-**	**166,549,551**	-	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2019-21 Current Service Level	**501**	**501.00**	**166,549,551**	**-**	**-**	**166,549,551**	-	**-**	**-**
080 - E-Boards									
080 - May 2018 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2018 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	-	-	-	-	-	-	-	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(23,231)	-	-	(23,231)	-	-	-
092 - Statewide AG Adjustment	-	-	(862)	-	-	(862)	-	-	-
095 - December 2018 Rebalance	-	-	-	-	-	-	-	-	-
201 - Integratd Eligibility/Medicaid Eligibility	41	27.00	9,589,123	-	-	9,589,123	-	-	-
202 - Medicaid Modularity	-	-	-	-	-	-	-	-	-
203 - Overpmt Writing & Recovery Proc Right-Sizing	-	-	-	-	-	-	-	-	-
204 - Interstate Benefit ID (PARIS) Proc Resourcing	-	-	-	-	-	-	-	-	-
205 - Protect, Modernize, Strengthen	-	-	-	-	-	-	-	-	-
206 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
207 - Provider Time Capture	-	-	-	-	-	-	-	-	-
208 - M & O of Centralized Abuse Management	2	2.00	446,578	-	-	446,578	-	-	-
209 - Bldg Cap & Tools for Intagy Data & GIS Dvit	-	-	-	-	-	-	-	-	-
210 - Health, Safety & Wellness	-	-	-	-	-	-	-	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
301 - Oregon Buys	-	-	-	-	-	-	-	-	-
302 - Deferred Maintenance	-	-	-	-	-	-	-	-	-
401 - Universal Family Linkages & Home Visiting Sys	-	-	-	-	-	-	-	-	-
402 - Prev'n, Interv'n & Access thru Lifespan	-	-	-	-	-	-	-	-	-
403 - Intensive In-Home Behavioral Health Services	-	-	-	-	-	-	-	-	-
404 - Office of Child Health	-	-	-	-	-	-	-	-	-
405 - Public Health Modernization	-	-	-	-	-	-	-	-	-
406 - Increase the Price of Tobacco Products	-	-	-	-	-	-	-	-	-
407 - Increase Taxes for Beer, Wine and Cider	-	-	-	-	-	-	-	-	-
408 - Continuation of Mental Health Funding	-	-	-	-	-	-	-	-	-
409 - Opioid Alt Pain Ed Modules/Addictions	-	-	-	-	-	-	-	-	-
410 - Misdemeanor Defenders	-	-	-	-	-	-	-	-	-
411 - Behavioral Health	-	-	-	-	-	-	-	-	-
412 - Safety, Patient Care & Regulatory Compliance	-	-	-	-	-	-	-	-	-
413 - Behavioral Health Funding Shortfall	-	-	-	-	-	-	-	-	-
414 - MOTS/COMPASS Modernization & Completion	-	-	-	-	-	-	-	-	-
415 - Expanding Hepatitis C Coverage	-	-	-	-	-	-	-	-	-
416 - CCO 2.0	-	-	-	-	-	-	-	-	-
417 - State Support for Local Public Health	-	-	-	-	-	-	-	-	-
418 - Fee Structure Rev for Drinking Water Svcs	-	-	-	-	-	-	-	-	-
419 - Fee Chgs for the Food, Pool and Lodging Pgms	-	-	-	-	-	-	-	-	-
420 - Toxic Free Kids Program	-	-	-	-	-	-	-	-	-
421 - OEBB/PEBB Benefit Management Sys Replacement	-	-	-	-	-	-	-	-	-
422 - Statewide Pharmacy Purchasing Implmtn Group	-	-	-	-	-	-	-	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal Policy Packages	**43**	**29.00**	**10,011,608**	**-**	**-**	**10,011,608**	-	**-**	**-**
Total 2019-21 Governor's Budget	**544**	**530.00**	**176,561,159**	**-**	**-**	**176,561,159**	-	**-**	**-**
Percentage Change From 2017-19 Leg Approved Budget	0.93%	0.31%	6.04%	-	-	6.04%	-	-	-
Percentage Change From 2019-21 Current Service Level	8.58%	5.79%	6.01%	-	-	6.01%	-	-	-

Oregon Health Authority | **Governor's Budget**
State Assessments and Enterprise-wide Costs | **Cross Reference Number: 44300-010-50-00-00000**
2019-21 Biennium

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2017-19 Leg Adopted Budget	-	-	275,929,265	192,483,222	200,000	24,626,483	54,900,250	-	3,719,310
2017-19 Emergency Boards	-	-	(3,806,188)	(628,481)	-	908,644	(4,086,351)	-	-
2017-19 Leg Approved Budget	**-**	**-**	**272,123,077**	**191,854,741**	**200,000**	**25,535,127**	50,813,899	**-**	**3,719,310**
2019-21 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	-	-	-	-	-	-	-	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			(4,028,449)	(2,405,056)	-	(1,371,293)	-	-	(252,100)
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2019-21 Base Budget	**-**	**-**	**268,094,628**	**189,449,685**	**200,000**	**24,163,834**	50,813,899	**-**	**3,467,210**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Non-PICS Personal Service Increase/(Decrease)	-	-	290,115	158,061	5,062	122,502	4,490	-	-
Subtotal	**-**	**-**	**290,115**	**158,061**	**5,062**	**122,502**	4,490	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	-	-	1,988,262	1,556,020	-	141,436	290,806	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(6,773,043)	(2,013,649)	-	(45,218)	(4,714,176)	-	-
Subtotal	**-**	**-**	**(4,784,781)**	**(457,629)**	**-**	**96,218**	(4,423,370)	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	9,503,351	6,029,436	10,478	1,192,030	2,271,407	-	-
State Gov"t & Services Charges Increase/(Decrease)			18,686,669	12,887,221	-	720,233	5,079,215	-	-
Subtotal	**-**	**-**	**28,190,020**	**18,916,657**	**10,478**	**1,912,263**	7,350,622	**-**	**-**

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	-	-	-	4,123,592	-	2,165,810	(6,289,402)	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	4,027,470	2,726,818	-	423,849	876,803	-	-
Subtotal: 2019-21 Current Service Level	**-**	**-**	**295,817,452**	**214,917,184**	**215,540**	**28,884,476**	48,333,042	**-**	**3,467,210**

Oregon Health Authority | **Governor's Budget**
State Assessments and Enterprise-wide Costs | **Cross Reference Number: 44300-010-50-00-00000**
2019-21 Biennium

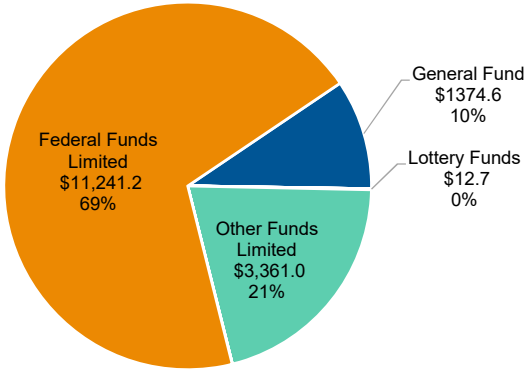
Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2019-21 Current Service Level	**-**	**-**	**295,817,452**	**214,917,184**	**215,540**	**28,884,476**	48,333,042	**-**	**3,467,210**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	(5,085,418)	-	-	(2,651,235)	(2,434,183)	-	-
Modified 2019-21 Current Service Level	**-**	**-**	**290,732,034**	**214,917,184**	**215,540**	**26,233,241**	45,898,859	**-**	**3,467,210**
080 - E-Boards									
080 - May 2018 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2018 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	-	-	(4,475,595)	(2,958,012)	(4,734)	(433,304)	(1,079,545)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(3,733,248)	(2,475,913)	-	(518,887)	(738,448)	-	-
092 - Statewide AG Adjustment	-	-	(193)	(92)	-	(23)	(78)	-	-
095 - December 2018 Rebalance	-	-	140,491	(20,130)	-	235,048	(74,427)	-	-
201 - Integratd Eligibility/Medicaid Eligibility	-	-	-	-	-	-	-	-	-
202 - Medicaid Modularity	-	-	-	-	-	-	-	-	-
203 - Overpmt Writing & Recovery Proc Right-Sizing	-	-	-	-	-	-	-	-	-
204 - Interstate Benefit ID (PARIS) Proc Resourcing	-	-	-	-	-	-	-	-	-
205 - Protect, Modernize, Strengthen	-	-	-	-	-	-	-	-	-
206 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
207 - Provider Time Capture	-	-	-	-	-	-	-	-	-
208 - M & O of Centralized Abuse Management	-	-	-	-	-	-	-	-	-
209 - Bldg Cap & Tools for Intagy Data & GIS Dvit	-	-	-	-	-	-	-	-	-
210 - Health, Safety & Wellness	-	-	-	-	-	-	-	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
301 - Oregon Buys	-	-	-	-	-	-	-	-	-
302 - Deferred Maintenance	-	-	-	-	-	-	-	-	-
401 - Universal Family Linkages & Home Visiting Sys	-	-	-	-	-	-	-	-	-
402 - Prev'n, Interv'n & Access thru Lifespan	-	-	-	-	-	-	-	-	-
403 - Intensive In-Home Behavioral Health Services	-	-	-	-	-	-	-	-	-
404 - Office of Child Health	-	-	-	-	-	-	-	-	-
405 - Public Health Modernization	-	-	-	-	-	-	-	-	-
406 - Increase the Price of Tobacco Products	-	-	-	-	-	-	-	-	-
407 - Increase Taxes for Beer, Wine and Cider	-	-	-	-	-	-	-	-	-
408 - Continuation of Mental Health Funding	-	-	-	-	-	-	-	-	-
409 - Opioid Alt Pain Ed Modules/Addictions	-	-	-	-	-	-	-	-	-
410 - Misdemeanor Defenders	-	-	-	-	-	-	-	-	-
411 - Behavioral Health	-	-	-	-	-	-	-	-	-
412 - Safety, Patient Care & Regulatory Compliance	-	-	-	-	-	-	-	-	-
413 - Behavioral Health Funding Shortfall	-	-	-	-	-	-	-	-	-
414 - MOTS/COMPASS Modernization & Completion	-	-	-	-	-	-	-	-	-
415 - Expanding Hepatitis C Coverage	-	-	-	-	-	-	-	-	-
416 - CCO 2.0	-	-	-	-	-	-	-	-	-
417 - State Support for Local Public Health	-	-	-	-	-	-	-	-	-
418 - Fee Structure Rev for Drinking Water Svcs	-	-	-	-	-	-	-	-	-
419 - Fee Chgs for the Food, Pool and Lodging Pgms	-	-	-	-	-	-	-	-	-
420 - Toxic Free Kids Program	-	-	-	-	-	-	-	-	-
421 - OEBB/PEBB Benefit Management Sys Replacement	-	-	-	-	-	-	-	-	-
422 - Statewide Pharmacy Purchasing Implmtn Group	-	-	-	-	-	-	-	-	-

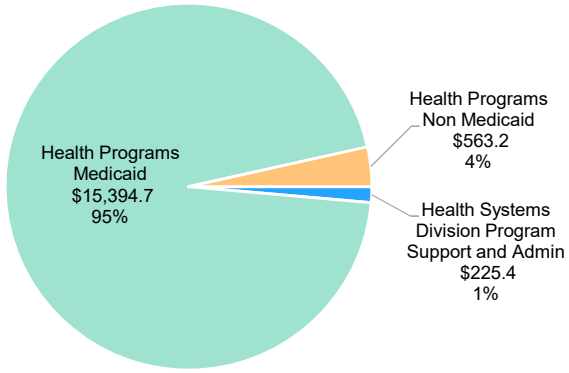
Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal Policy Packages	**-**	**-**	**(8,068,545)**	**(5,454,147)**	**(4,734)**	**(717,166)**	(1,892,498)	**-**	**-**
Total 2019-21 Governor's Budget	**-**	**-**	**282,663,489**	**209,463,037**	**210,806**	**25,516,075**	44,006,361	**-**	**3,467,210**
Percentage Change From 2017-19 Leg Approved Budget	-	-	3.87%	9.18%	5.40%	-0.07%	-13.40%	-	-6.78%
Percentage Change From 2019-21 Current Service Level	-	-	-4.45%	-2.54%	-2.20%	-11.66%	-8.95%	-	-

Oregon Health Authority
2019-21 Governor's Budget

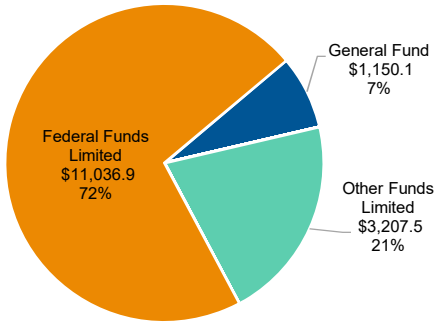
Health Systems Division by Fund Type in millions
$16,183.2 Total Funds



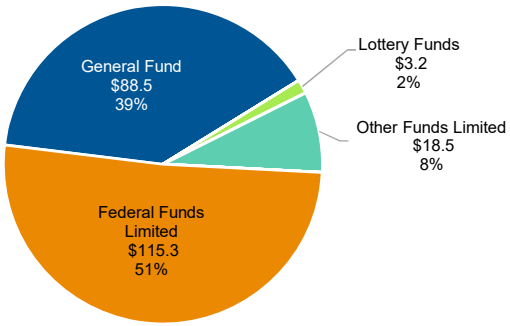
Health Systems Division by Program in millions
$16,183.2 Total Funds



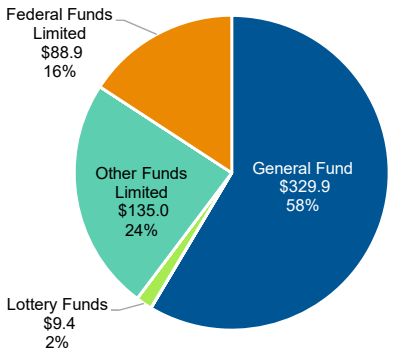
Health Programs Medicaid in millions
$15,394.7 Total Funds



Health Systems Program Support &
Administration in millions
$225.4 Total Funds



Health Programs Non-Medicaid in millions
$563.2 Total Funds



Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2017-19 Leg Adopted Budget	4,002	3,958.58	19,437,593,408	1,969,925,591	12,225,546	6,463,772,409	10,848,940,811	40,000,000	102,729,051
2017-19 Emergency Boards	(467)	(316.49)	298,584,124	(22,748,777)	41,793	73,318,759	247,972,349	-	-
2017-19 Leg Approved Budget	**3,535**	**3,642.09**	**19,736,177,532**	**1,947,176,814**	**12,267,339**	**6,537,091,168**	11,096,913,160	**40,000,000**	**102,729,051**
2019-21 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(48)	(168.03)	13,203,510	18,946,542	58,043	3,759,867	(9,560,942)	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2019-21 Base Budget	**3,487**	**3,474.06**	**19,749,381,042**	**1,966,123,356**	**12,325,382**	**6,540,851,035**	11,087,352,218	**40,000,000**	**102,729,051**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	10,882,324	3,652,659	(3,681)	2,371,418	4,861,928	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	4,333,302	3,792,225	3,464	528,268	9,345	-	-
Subtotal	**-**	**-**	**15,215,626**	**7,444,884**	**(217)**	**2,899,686**	4,871,273	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	25	14.30	538,504,937	14,547,425	-	151,839,022	372,118,490	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(283,364,728)	(5,549,331)	-	(73,882,434)	(203,932,963)	-	-
Subtotal	**25**	**14.30**	**255,140,209**	**8,998,094**	**-**	**77,956,588**	168,185,527	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	1,169,642,731	87,567,757	462,335	410,471,304	671,141,335	-	-
Subtotal	**-**	**-**	**1,169,642,731**	**87,567,757**	**462,335**	**410,471,304**	671,141,335	**-**	**-**

Oregon Health Authority
Health Systems Programs
2019-21 Biennium

Governor's Budget
Cross Reference Number: 44300-030-00-00-00000

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	-	-	129,801,443	22,037,272	-	(20,077,406)	127,841,577	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	841,557,956	-	(336,744,825)	(504,813,131)	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	(320,470)	(144,761)	-	(149,512)	(26,197)	-	-
Subtotal: 2019-21 Current Service Level	**3,512**	**3,488.36**	**21,318,860,581**	**2,933,584,558**	**12,787,500**	**6,675,206,870**	11,554,552,602	**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: 2019-21 Current Service Level	**3,512**	**3,488.36**	**21,318,860,581**	**2,933,584,558**	**12,787,500**	**6,675,206,870**	11,554,552,602	**40,000,000**	**102,729,051**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	(8,790,947)	-	-	(8,790,947)	-	-	-
Modified 2019-21 Current Service Level	**3,512**	**3,488.36**	**21,310,069,634**	**2,933,584,558**	**12,787,500**	**6,666,415,923**	11,554,552,602	**40,000,000**	**102,729,051**
080 - E-Boards									
080 - May 2018 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2018 Emergency Board	1	1.00	245,621	245,621	-	-	-	-	-
090 - Analyst Adjustments	64	33.50	(32,781,549)	(802,490,357)	(105,219)	805,187,095	(35,373,068)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(497,734)	(97,508)	-	(214,649)	(185,577)	-	-
092 - Statewide AG Adjustment	-	-	(459,632)	(139,365)	(87)	(206,748)	(113,432)	-	-
095 - December 2018 Rebalance	14	15.50	65,717,253	1,036,933	-	20,849,215	43,831,105	-	-
201 - Integratd Eligibility/Medicaid Eligibility	4	4.00	2,309,611	671,490	-	-	1,638,121	-	-
202 - Medicaid Modularity	3	3.00	2,225,378	547,409	-	-	1,677,969	-	-
203 - Overpmt Writing & Recovery Proc Right-Sizing	-	-	-	-	-	-	-	-	-
204 - Interstate Benefit ID (PARIS) Proc Resourcing	-	-	-	-	-	-	-	-	-
205 - Protect, Modernize, Strengthen	-	-	-	-	-	-	-	-	-
206 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
207 - Provider Time Capture	-	-	-	-	-	-	-	-	-
208 - M & O of Centralized Abuse Management	-	-	-	-	-	-	-	-	-
209 - Bldg Cap & Tools for Intagy Data & GIS Dvit	-	-	-	-	-	-	-	-	-
210 - Health, Safety & Wellness	-	-	-	-	-	-	-	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
301 - Oregon Buys	-	-	-	-	-	-	-	-	-
302 - Deferred Maintenance	-	-	-	-	-	-	-	-	-
401 - Universal Family Linkages & Home Visiting Sys	4	3.00	8,732,515	4,056,925	-	-	4,675,590	-	-
402 - Prev'n, Interv'n & Access thru Lifespan	3	2.64	13,103,059	13,103,059	-	-	-	-	-
403 - Intensive In-Home Behavioral Health Services	-	-	19,639,800	6,575,316	-	-	13,064,484	-	-
404 - Office of Child Health	4	3.50	921,522	562,875	-	-	358,647	-	-
405 - Public Health Modernization	6	1.50	13,943,287	-	-	13,600,000	343,287	-	-
406 - Increase the Price of Tobacco Products	-	-	-	-	-	-	-	-	-
407 - Increase Taxes for Beer, Wine and Cider	-	-	-	-	-	-	-	-	-
408 - Continuation of Mental Health Funding	-	-	-	-	-	-	-	-	-
409 - Opioid Alt Pain Ed Modules/Addictions	1	0.88	384,534	312,700	-	-	71,834	-	-
410 - Misdemeanor Defenders	-	-	7,612,914	7,612,914	-	-	-	-	-
411 - Behavioral Health	4	3.50	5,735,196	5,406,573	-	-	328,623	-	-
412 - Safety, Patient Care & Regulatory Compliance	-	-	-	-	-	-	-	-	-
413 - Behavioral Health Funding Shortfall	-	-	9,132,500	9,132,500	-	-	-	-	-
414 - MOTS/COMPASS Modernization & Completion	2	1.76	6,739,793	6,739,793	-	-	-	-	-
415 - Expanding Hepatitis C Coverage	-	-	107,435,900	10,000,000	-	12,307,700	85,128,200	-	-
416 - CCO 2.0	7	6.16	1,902,641	1,066,092	-	-	836,549	-	-
417 - State Support for Local Public Health	-	-	5,480,601	5,480,601	-	-	-	-	-
418 - Fee Structure Rev for Drinking Water Svcs	5	5.00	1,853,297	-	-	1,853,297	-	-	-
419 - Fee Chgs for the Food, Pool and Lodging Pgms	-	-	64,450	-	-	64,450	-	-	-
420 - Toxic Free Kids Program	-	-	111,511	-	-	111,511	-	-	-
421 - OEBB/PEBB Benefit Management Sys Replacement	4	4.00	1,806,102	-	-	1,806,102	-	-	-
422 - Statewide Pharmacy Purchasing Implmtn Group	2	1.76	716,130	418,632	-	-	297,498	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal Policy Packages	**128**	**90.70**	**242,074,700**	**(729,757,797)**	**(105,306)**	**855,357,973**	116,579,830	**-**	**-**
Total 2019-21 Governor's Budget	**3,640**	**3,579.06**	**21,552,144,334**	**2,203,826,761**	**12,682,194**	**7,521,773,896**	11,671,132,432	**40,000,000**	**102,729,051**
Percentage Change From 2017-19 Leg Approved Budget	2.97%	-1.73%	9.20%	13.18%	3.38%	15.06%	5.17%	-	-
Percentage Change From 2019-21 Current Service Level	3.64%	2.60%	1.09%	-24.88%	-0.82%	12.68%	1.01%	-	-

Oregon Health Authority
Health Systems Division
2019-21 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
2017-19 Leg Adopted Budget	776	764.56	14,541,553,701	1,422,175,819	12,225,546	2,633,695,924	10,473,456,412	-	-
2017-19 Emergency Boards	(475)	(320.86)	243,631,516	(47,509,081)	17,793	44,496,349	246,626,455	-	-
2017-19 Leg Approved Budget	**301**	**443.70**	**14,785,185,217**	**1,374,666,738**	**12,243,339**	**2,678,192,273**	10,720,082,867	**-**	**-**
2019-21 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(8)	(157.07)	(22,530,082)	(7,630,943)	58,043	55,393	(15,012,575)	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2019-21 Base Budget	**293**	**286.63**	**14,762,655,135**	**1,367,035,795**	**12,301,382**	**2,678,247,666**	10,705,070,292	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	1,829,005	1,174,635	(3,681)	256,047	402,004	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	(396,451)	(69,622)	3,464	6,424	(336,717)	-	-
Subtotal	**-**	**-**	**1,432,554**	**1,105,013**	**(217)**	**262,471**	65,287	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	4	3.00	487,951,653	4,542,991	-	129,831,689	353,576,973	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(281,084,728)	(3,998,450)	-	(73,153,315)	(203,932,963)	-	-
Subtotal	**4**	**3.00**	**206,866,925**	**544,541**	**-**	**56,678,374**	149,644,010	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	905,898,678	83,376,051	461,423	160,796,530	661,264,674	-	-
Subtotal	**-**	**-**	**905,898,678**	**83,376,051**	**461,423**	**160,796,530**	661,264,674	**-**	**-**

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	-	-	129,801,443	22,037,272	-	(20,077,406)	127,841,577	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	841,557,956	-	(336,744,825)	(504,813,131)	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	1,936,644	2,194,577	-	-	(257,933)	-	-
Subtotal: 2019-21 Current Service Level	**297**	**289.63**	**16,008,591,379**	**2,317,851,205**	**12,762,588**	**2,539,162,810**	11,138,814,776	**-**	**-**

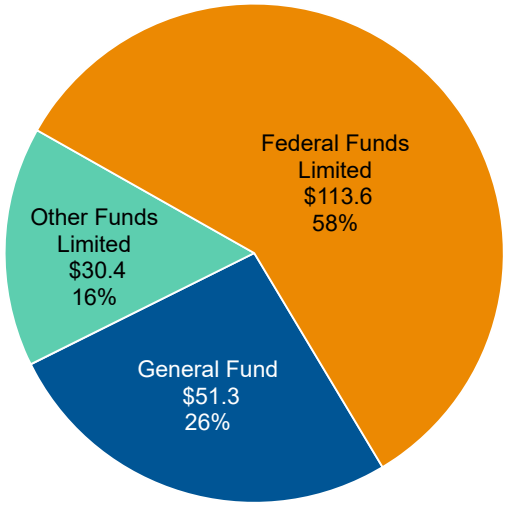
Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2019-21 Current Service Level	**297**	**289.63**	**16,008,591,379**	**2,317,851,205**	**12,762,588**	**2,539,162,810**	11,138,814,776	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	(8,790,947)	-	-	(8,790,947)	-	-	-
Modified 2019-21 Current Service Level	**297**	**289.63**	**15,999,800,432**	**2,317,851,205**	**12,762,588**	**2,530,371,863**	11,138,814,776	**-**	**-**
080 - E-Boards									
080 - May 2018 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2018 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	3	3.00	(28,393,561)	(806,987,778)	(104,307)	810,866,491	(32,167,967)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(130,931)	(39,398)	-	(15,596)	(75,937)	-	-
092 - Statewide AG Adjustment	-	-	(204,516)	(82,608)	(87)	(21,652)	(100,169)	-	-
095 - December 2018 Rebalance	17	17.50	43,993,224	3,393,715	-	7,362,657	33,236,852	-	-
201 - Integratd Eligibility/Medicaid Eligibility	4	4.00	2,309,611	671,490	-	-	1,638,121	-	-
202 - Medicaid Modularity	3	3.00	2,225,378	547,409	-	-	1,677,969	-	-
203 - Overpmt Writing & Recovery Proc Right-Sizing	-	-	-	-	-	-	-	-	-
204 - Interstate Benefit ID (PARIS) Proc Resourcing	-	-	-	-	-	-	-	-	-
205 - Protect, Modernize, Strengthen	-	-	-	-	-	-	-	-	-
206 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
207 - Provider Time Capture	-	-	-	-	-	-	-	-	-
208 - M & O of Centralized Abuse Management	-	-	-	-	-	-	-	-	-
209 - Bldg Cap & Tools for Intagy Data & GIS Dvit	-	-	-	-	-	-	-	-	-
210 - Health, Safety & Wellness	-	-	-	-	-	-	-	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
301 - Oregon Buys	-	-	-	-	-	-	-	-	-
302 - Deferred Maintenance	-	-	-	-	-	-	-	-	-
401 - Universal Family Linkages & Home Visiting Sys	-	-	-	-	-	-	-	-	-
402 - Prev'n, Interv'n & Access thru Lifespan	3	2.64	13,103,059	13,103,059	-	-	-	-	-
403 - Intensive In-Home Behavioral Health Services	-	-	19,639,800	6,575,316	-	-	13,064,484	-	-
404 - Office of Child Health	-	-	-	-	-	-	-	-	-
405 - Public Health Modernization	-	-	-	-	-	-	-	-	-
406 - Increase the Price of Tobacco Products	-	-	-	-	-	-	-	-	-
407 - Increase Taxes for Beer, Wine and Cider	-	-	-	-	-	-	-	-	-
408 - Continuation of Mental Health Funding	-	-	-	-	-	-	-	-	-
409 - Opioid Alt Pain Ed Modules/Addictions	-	-	-	-	-	-	-	-	-
410 - Misdemeanor Defenders	-	-	7,612,914	7,612,914	-	-	-	-	-
411 - Behavioral Health	-	-	-	-	-	-	-	-	-
412 - Safety, Patient Care & Regulatory Compliance	-	-	-	-	-	-	-	-	-
413 - Behavioral Health Funding Shortfall	-	-	9,132,500	9,132,500	-	-	-	-	-
414 - MOTS/COMPASS Modernization & Completion	2	1.76	6,739,793	6,739,793	-	-	-	-	-
415 - Expanding Hepatitis C Coverage	-	-	107,435,900	10,000,000	-	12,307,700	85,128,200	-	-
416 - CCO 2.0	-	-	-	-	-	-	-	-	-
417 - State Support for Local Public Health	-	-	-	-	-	-	-	-	-
418 - Fee Structure Rev for Drinking Water Svcs	-	-	-	-	-	-	-	-	-
419 - Fee Chgs for the Food, Pool and Lodging Pgms	-	-	-	-	-	-	-	-	-
420 - Toxic Free Kids Program	-	-	-	-	-	-	-	-	-
421 - OEBB/PEBB Benefit Management Sys Replacement	-	-	-	-	-	-	-	-	-
422 - Statewide Pharmacy Purchasing Implmtn Group	-	-	-	-	-	-	-	-	-

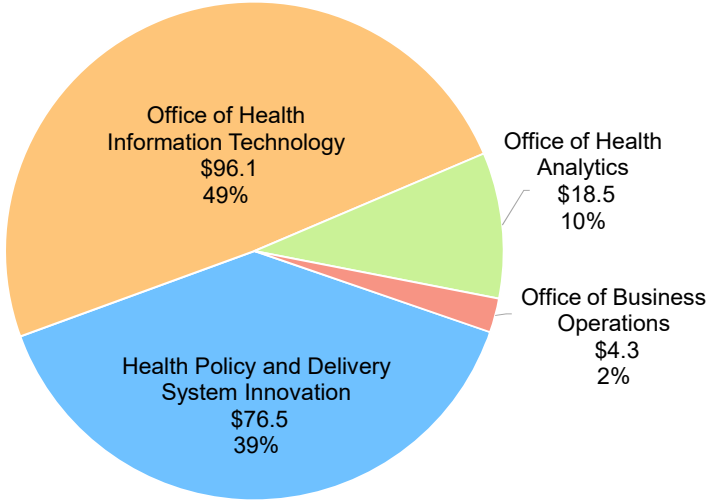
Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal Policy Packages	**32**	**31.90**	**183,463,171**	**(749,333,588)**	**(104,394)**	**830,499,600**	102,401,553	**-**	**-**
Total 2019-21 Governor's Budget	**329**	**321.53**	**16,183,263,603**	**1,568,517,617**	**12,658,194**	**3,360,871,463**	11,241,216,329	**-**	**-**
Percentage Change From 2017-19 Leg Approved Budget	9.30%	-27.53%	9.46%	14.10%	3.39%	25.49%	4.86%	-	-
Percentage Change From 2019-21 Current Service Level	10.77%	11.01%	1.09%	-32.33%	-0.82%	32.36%	0.92%	-	-

Oregon Health Authority
2019-21 Governor's Budget

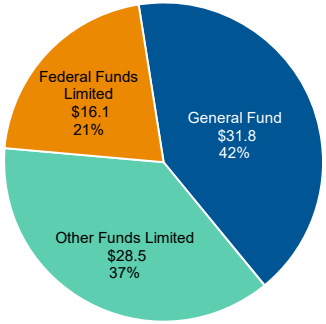
Healthy Policy & Analytics by Fund Type in millions
$195.3 Total Funds



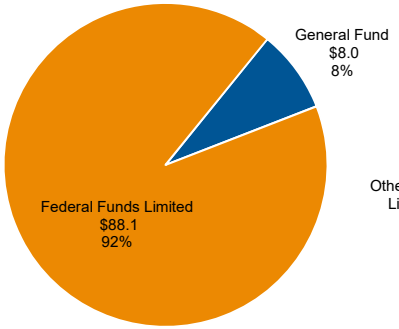
Health Policy & Analytics by Program Area in millions
$195.3 Total Funds



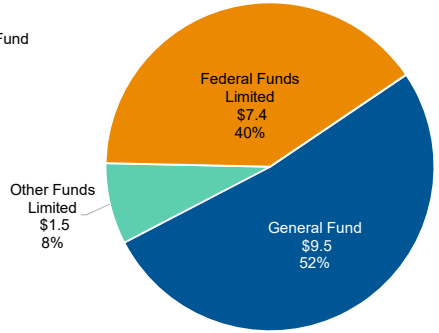
Health Policy & Delivery System Innovation in millions
$76.5 Total Funds



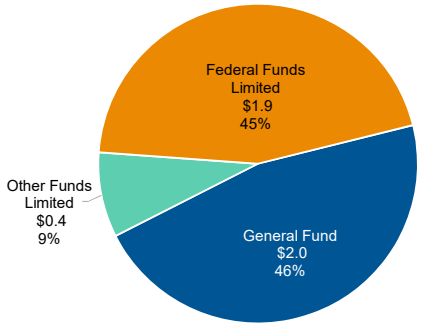
Office of Health Information Technology in millions
$96.1 Total Funds



Office of Health Analytics in millions
$18.4 Total Funds



Office of Business Operations in millions
$4.3 Total Funds



Oregon Health Authority
Health Policy & Analytics
2019-21 Biennium

Governor's Budget
Cross Reference Number: 44300-030-02-00-00000

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
2017-19 Leg Adopted Budget	145	138.90	159,014,757	31,512,233	-	20,061,297	107,441,227	-	-
2017-19 Emergency Boards	5	4.33	23,287,820	11,870,611	24,000	10,452,249	940,960	-	-
2017-19 Leg Approved Budget	**150**	**143.23**	**182,302,577**	**43,382,844**	**24,000**	**30,513,546**	108,382,187	**-**	**-**
2019-21 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(9)	(4.58)	1,424,531	701,587	-	81,044	641,900	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2019-21 Base Budget	**141**	**138.65**	**183,727,108**	**44,084,431**	**24,000**	**30,594,590**	109,024,087	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	936,510	666,919	-	56,336	213,255	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	167,609	66,196	-	19,902	81,511	-	-
Subtotal	**-**	**-**	**1,104,119**	**733,115**	**-**	**76,238**	294,766	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	14	8.65	9,013,602	4,651,432	-	3,367,406	994,764	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(89,292)	(89,292)	-	-	-	-	-
Subtotal	**14**	**8.65**	**8,924,310**	**4,562,140**	**-**	**3,367,406**	994,764	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	5,802,872	1,063,004	912	1,148,621	3,590,335	-	-
Subtotal	**-**	**-**	**5,802,872**	**1,063,004**	**912**	**1,148,621**	3,590,335	**-**	**-**

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	-	-	(2,057,522)	(2,315,455)	-	-	257,933	-	-
Subtotal: 2019-21 Current Service Level	**155**	**147.30**	**197,500,887**	**48,127,235**	**24,912**	**35,186,855**	114,161,885	**-**	**-**

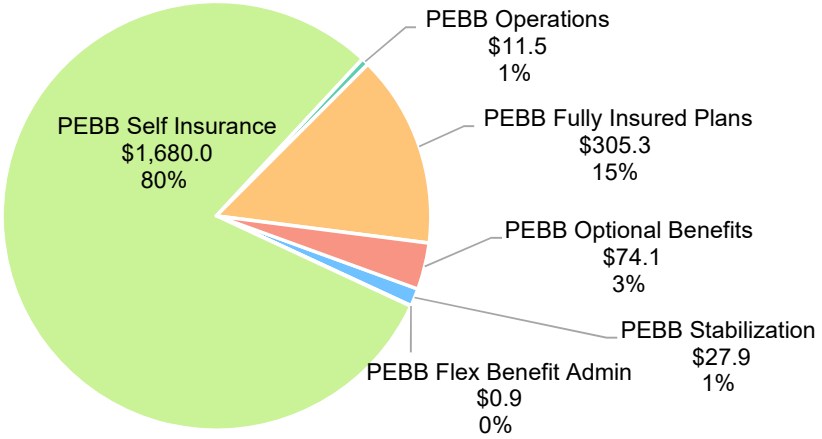
Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2019-21 Current Service Level	**155**	**147.30**	**197,500,887**	**48,127,235**	**24,912**	**35,186,855**	114,161,885	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2019-21 Current Service Level	**155**	**147.30**	**197,500,887**	**48,127,235**	**24,912**	**35,186,855**	114,161,885	**-**	**-**
080 - E-Boards									
080 - May 2018 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2018 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	-	-	(2,871,425)	(1,120,322)	(912)	(652,730)	(1,097,461)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(52,674)	(10,847)	-	(15,423)	(26,404)	-	-
092 - Statewide AG Adjustment	-	-	(4,633)	(256)	-	(4,094)	(283)	-	-
095 - December 2018 Rebalance	(13)	(12.50)	(8,926,947)	(3,472,428)	-	(4,139,393)	(1,315,126)	-	-
201 - Integratd Eligibility/Medicaid Eligibility	-	-	-	-	-	-	-	-	-
202 - Medicaid Modularity	-	-	-	-	-	-	-	-	-
203 - Overpmt Writing & Recovery Proc Right-Sizing	-	-	-	-	-	-	-	-	-
204 - Interstate Benefit ID (PARIS) Proc Resourcing	-	-	-	-	-	-	-	-	-
205 - Protect, Modernize, Strengthen	-	-	-	-	-	-	-	-	-
206 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
207 - Provider Time Capture	-	-	-	-	-	-	-	-	-
208 - M & O of Centralized Abuse Management	-	-	-	-	-	-	-	-	-
209 - Bldg Cap & Tools for Intagy Data & GIS Dvit	-	-	-	-	-	-	-	-	-
210 - Health, Safety & Wellness	-	-	-	-	-	-	-	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
301 - Oregon Buys	-	-	-	-	-	-	-	-	-
302 - Deferred Maintenance	-	-	-	-	-	-	-	-	-
401 - Universal Family Linkages & Home Visiting Sys	-	-	-	-	-	-	-	-	-
402 - Prev'n, Interv'n & Access thru Lifespan	-	-	-	-	-	-	-	-	-
403 - Intensive In-Home Behavioral Health Services	-	-	-	-	-	-	-	-	-
404 - Office of Child Health	4	3.50	921,522	562,875	-	-	358,647	-	-
405 - Public Health Modernization	-	-	-	-	-	-	-	-	-
406 - Increase the Price of Tobacco Products	-	-	-	-	-	-	-	-	-
407 - Increase Taxes for Beer, Wine and Cider	-	-	-	-	-	-	-	-	-
408 - Continuation of Mental Health Funding	-	-	-	-	-	-	-	-	-
409 - Opioid Alt Pain Ed Modules/Addictions	1	0.88	384,534	312,700	-	-	71,834	-	-
410 - Misdemeanor Defenders	-	-	-	-	-	-	-	-	-
411 - Behavioral Health	4	3.50	5,735,196	5,406,573	-	-	328,623	-	-
412 - Safety, Patient Care & Regulatory Compliance	-	-	-	-	-	-	-	-	-
413 - Behavioral Health Funding Shortfall	-	-	-	-	-	-	-	-	-
414 - MOTS/COMPASS Modernization & Completion	-	-	-	-	-	-	-	-	-
415 - Expanding Hepatitis C Coverage	-	-	-	-	-	-	-	-	-
416 - CCO 2.0	7	6.16	1,902,641	1,066,092	-	-	836,549	-	-
417 - State Support for Local Public Health	-	-	-	-	-	-	-	-	-
418 - Fee Structure Rev for Drinking Water Svcs	-	-	-	-	-	-	-	-	-
419 - Fee Chgs for the Food, Pool and Lodging Pgms	-	-	-	-	-	-	-	-	-
420 - Toxic Free Kids Program	-	-	-	-	-	-	-	-	-
421 - OEBB/PEBB Benefit Management Sys Replacement	-	-	-	-	-	-	-	-	-
422 - Statewide Pharmacy Purchasing Implmtn Group	2	1.76	716,130	418,632	-	-	297,498	-	-

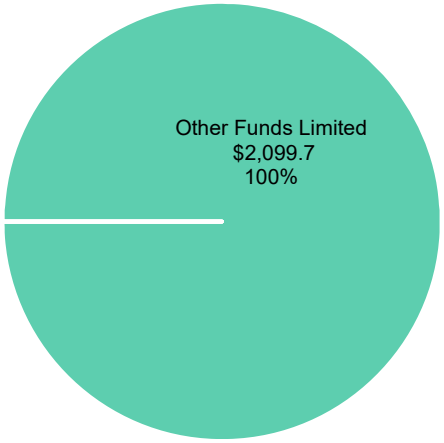
Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal Policy Packages	**5**	**3.30**	**(2,195,656)**	**3,163,019**	**(912)**	**(4,811,640)**	(546,123)	**-**	**-**
Total 2019-21 Governor's Budget	**160**	**150.60**	**195,305,231**	**51,290,254**	**24,000**	**30,375,215**	113,615,762	**-**	**-**
Percentage Change From 2017-19 Leg Approved Budget	6.67%	5.15%	7.13%	18.23%	-	-0.45%	4.83%	-	-
Percentage Change From 2019-21 Current Service Level	3.23%	2.24%	-1.11%	6.57%	-3.66%	-13.67%	-0.48%	-	-

Oregon Health Authority
2019-21 Governor's Budget

Public Employees Benefit Board by Program in millions
$2,099.7 Total Funds



Public Employees Benefit Board by Fund in millions
$2,099.7 Total Funds



Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2017-19 Leg Adopted Budget	19	18.50	1,966,713,889	-	-	1,966,713,889	-	-	-
2017-19 Emergency Boards	-	-	84,520	-	-	84,520	-	-	-
2017-19 Leg Approved Budget	**19**	**18.50**	**1,966,798,409**	**-**	**-**	**1,966,798,409**	-	**-**	**-**
2019-21 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	-	-	209,096	-	-	209,096	-	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2019-21 Base Budget	**19**	**18.50**	**1,967,007,505**	**-**	**-**	**1,967,007,505**	-	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	22,960	-	-	22,960	-	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	14,295	-	-	14,295	-	-	-
Subtotal	**-**	**-**	**37,255**	**-**	**-**	**37,255**	-	**-**	**-**
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)	-	-	131,726,699	-	-	131,726,699	-	-	-
Subtotal	**-**	**-**	**131,726,699**	**-**	**-**	**131,726,699**	-	**-**	**-**

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: 2019-21 Current Service Level	**19**	**18.50**	**2,098,771,459**	**-**	**-**	**2,098,771,459**	-	**-**	**-**

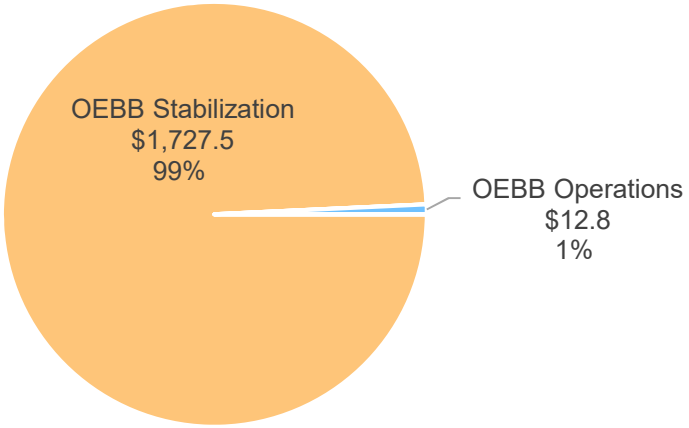
Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2019-21 Current Service Level	**19**	**18.50**	**2,098,771,459**	**-**	**-**	**2,098,771,459**	-	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2019-21 Current Service Level	**19**	**18.50**	**2,098,771,459**	**-**	**-**	**2,098,771,459**	-	**-**	**-**
080 - E-Boards									
080 - May 2018 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2018 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	-	-	-	-	-	-	-	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(5,417)	-	-	(5,417)	-	-	-
092 - Statewide AG Adjustment	-	-	(16,784)	-	-	(16,784)	-	-	-
095 - December 2018 Rebalance	-	-	-	-	-	-	-	-	-
201 - Integratd Eligibility/Medicaid Eligibility	-	-	-	-	-	-	-	-	-
202 - Medicaid Modularity	-	-	-	-	-	-	-	-	-
203 - Overpmt Writing & Recovery Proc Right-Sizing	-	-	-	-	-	-	-	-	-
204 - Interstate Benefit ID (PARIS) Proc Resourcing	-	-	-	-	-	-	-	-	-
205 - Protect, Modernize, Strengthen	-	-	-	-	-	-	-	-	-
206 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
207 - Provider Time Capture	-	-	-	-	-	-	-	-	-
208 - M & O of Centralized Abuse Management	-	-	-	-	-	-	-	-	-
209 - Bldg Cap & Tools for Intagy Data & GIS Dvit	-	-	-	-	-	-	-	-	-
210 - Health, Safety & Wellness	-	-	-	-	-	-	-	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
301 - Oregon Buys	-	-	-	-	-	-	-	-	-
302 - Deferred Maintenance	-	-	-	-	-	-	-	-	-
401 - Universal Family Linkages & Home Visiting Sys	-	-	-	-	-	-	-	-	-
402 - Prev'n, Interv'n & Access thru Lifespan	-	-	-	-	-	-	-	-	-
403 - Intensive In-Home Behavioral Health Services	-	-	-	-	-	-	-	-	-
404 - Office of Child Health	-	-	-	-	-	-	-	-	-
405 - Public Health Modernization	-	-	-	-	-	-	-	-	-
406 - Increase the Price of Tobacco Products	-	-	-	-	-	-	-	-	-
407 - Increase Taxes for Beer, Wine and Cider	-	-	-	-	-	-	-	-	-
408 - Continuation of Mental Health Funding	-	-	-	-	-	-	-	-	-
409 - Opioid Alt Pain Ed Modules/Addictions	-	-	-	-	-	-	-	-	-
410 - Misdemeanor Defenders	-	-	-	-	-	-	-	-	-
411 - Behavioral Health	-	-	-	-	-	-	-	-	-
412 - Safety, Patient Care & Regulatory Compliance	-	-	-	-	-	-	-	-	-
413 - Behavioral Health Funding Shortfall	-	-	-	-	-	-	-	-	-
414 - MOTS/COMPASS Modernization & Completion	-	-	-	-	-	-	-	-	-
415 - Expanding Hepatitis C Coverage	-	-	-	-	-	-	-	-	-
416 - CCO 2.0	-	-	-	-	-	-	-	-	-
417 - State Support for Local Public Health	-	-	-	-	-	-	-	-	-
418 - Fee Structure Rev for Drinking Water Svcs	-	-	-	-	-	-	-	-	-
419 - Fee Chgs for the Food, Pool and Lodging Pgms	-	-	-	-	-	-	-	-	-
420 - Toxic Free Kids Program	-	-	-	-	-	-	-	-	-
421 - OEBB/PEBB Benefit Management Sys Replacement	2	2.00	908,395	-	-	908,395	-	-	-
422 - Statewide Pharmacy Purchasing Implmtn Group	-	-	-	-	-	-	-	-	-

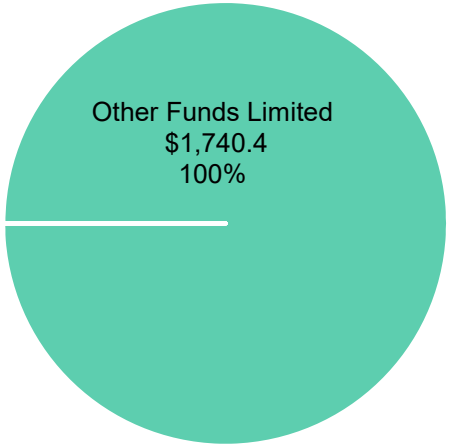
Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal Policy Packages	**2**	**2.00**	**886,194**	**-**	**-**	**886,194**	-	**-**	**-**
Total 2019-21 Governor's Budget	**21**	**20.50**	**2,099,657,653**	**-**	**-**	**2,099,657,653**	-	**-**	**-**
Percentage Change From 2017-19 Leg Approved Budget	10.53%	10.81%	6.76%	-	-	6.76%	-	-	-
Percentage Change From 2019-21 Current Service Level	10.53%	10.81%	0.04%	-	-	0.04%	-	-	-

Oregon Health Authority
2019-21 Governor's Budget

Oregon Educators Benefit Board by Program in millions
$1,740.4 Total Funds



Oregon Educators Benefit Board by Fund in millions
$1,740.4 Total Funds



Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2017-19 Leg Adopted Budget	19	19.00	1,628,844,689	-	-	1,628,844,689	-	-	-
2017-19 Emergency Boards	-	-	37,416	-	-	37,416	-	-	-
2017-19 Leg Approved Budget	**19**	**19.00**	**1,628,882,105**	**-**	**-**	**1,628,882,105**	-	**-**	**-**
2019-21 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	-	-	137,156	-	-	137,156	-	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2019-21 Base Budget	**19**	**19.00**	**1,629,019,261**	**-**	**-**	**1,629,019,261**	-	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	81,752	-	-	81,752	-	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	15,335	-	-	15,335	-	-	-
Subtotal	**-**	**-**	**97,087**	**-**	**-**	**97,087**	-	**-**	**-**
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)	-	-	110,410,522	-	-	110,410,522	-	-	-
Subtotal	**-**	**-**	**110,410,522**	**-**	**-**	**110,410,522**	-	**-**	**-**

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: 2019-21 Current Service Level	**19**	**19.00**	**1,739,526,870**	**-**	**-**	**1,739,526,870**	-	**-**	**-**

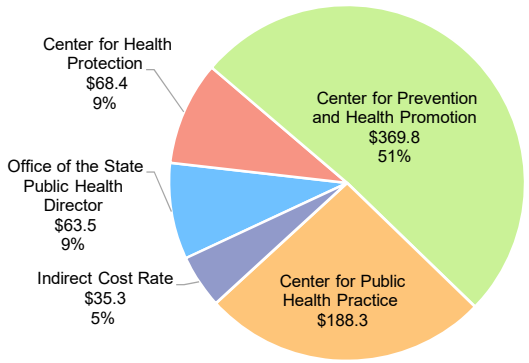
Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2019-21 Current Service Level	**19**	**19.00**	**1,739,526,870**	**-**	**-**	**1,739,526,870**	-	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2019-21 Current Service Level	**19**	**19.00**	**1,739,526,870**	**-**	**-**	**1,739,526,870**	-	**-**	**-**
080 - E-Boards									
080 - May 2018 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2018 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	-	-	-	-	-	-	-	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(6,326)	-	-	(6,326)	-	-	-
092 - Statewide AG Adjustment	-	-	(57,034)	-	-	(57,034)	-	-	-
095 - December 2018 Rebalance	-	-	-	-	-	-	-	-	-
201 - Integratd Eligibility/Medicaid Eligibility	-	-	-	-	-	-	-	-	-
202 - Medicaid Modularity	-	-	-	-	-	-	-	-	-
203 - Overpmt Writing & Recovery Proc Right-Sizing	-	-	-	-	-	-	-	-	-
204 - Interstate Benefit ID (PARIS) Proc Resourcing	-	-	-	-	-	-	-	-	-
205 - Protect, Modernize, Strengthen	-	-	-	-	-	-	-	-	-
206 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
207 - Provider Time Capture	-	-	-	-	-	-	-	-	-
208 - M & O of Centralized Abuse Management	-	-	-	-	-	-	-	-	-
209 - Bldg Cap & Tools for Intagy Data & GIS Dvit	-	-	-	-	-	-	-	-	-
210 - Health, Safety & Wellness	-	-	-	-	-	-	-	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
301 - Oregon Buys	-	-	-	-	-	-	-	-	-
302 - Deferred Maintenance	-	-	-	-	-	-	-	-	-
401 - Universal Family Linkages & Home Visiting Sys	-	-	-	-	-	-	-	-	-
402 - Prev'n, Interv'n & Access thru Lifespan	-	-	-	-	-	-	-	-	-
403 - Intensive In-Home Behavioral Health Services	-	-	-	-	-	-	-	-	-
404 - Office of Child Health	-	-	-	-	-	-	-	-	-
405 - Public Health Modernization	-	-	-	-	-	-	-	-	-
406 - Increase the Price of Tobacco Products	-	-	-	-	-	-	-	-	-
407 - Increase Taxes for Beer, Wine and Cider	-	-	-	-	-	-	-	-	-
408 - Continuation of Mental Health Funding	-	-	-	-	-	-	-	-	-
409 - Opioid Alt Pain Ed Modules/Addictions	-	-	-	-	-	-	-	-	-
410 - Misdemeanor Defenders	-	-	-	-	-	-	-	-	-
411 - Behavioral Health	-	-	-	-	-	-	-	-	-
412 - Safety, Patient Care & Regulatory Compliance	-	-	-	-	-	-	-	-	-
413 - Behavioral Health Funding Shortfall	-	-	-	-	-	-	-	-	-
414 - MOTS/COMPASS Modernization & Completion	-	-	-	-	-	-	-	-	-
415 - Expanding Hepatitis C Coverage	-	-	-	-	-	-	-	-	-
416 - CCO 2.0	-	-	-	-	-	-	-	-	-
417 - State Support for Local Public Health	-	-	-	-	-	-	-	-	-
418 - Fee Structure Rev for Drinking Water Svcs	-	-	-	-	-	-	-	-	-
419 - Fee Chgs for the Food, Pool and Lodging Pgms	-	-	-	-	-	-	-	-	-
420 - Toxic Free Kids Program	-	-	-	-	-	-	-	-	-
421 - OEBB/PEBB Benefit Management Sys Replacement	2	2.00	897,707	-	-	897,707	-	-	-
422 - Statewide Pharmacy Purchasing Implmtn Group	-	-	-	-	-	-	-	-	-

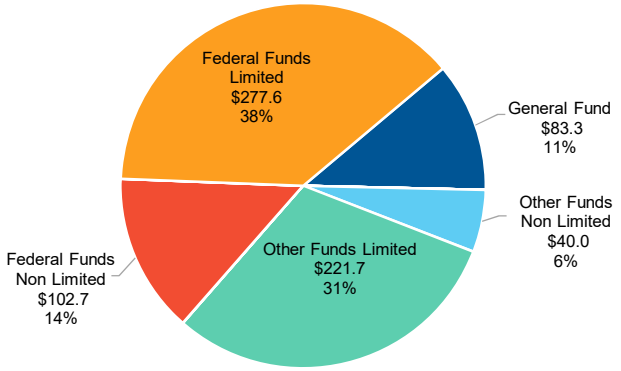
Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal Policy Packages	**2**	**2.00**	**834,347**	**-**	**-**	**834,347**	-	**-**	**-**
Total 2019-21 Governor's Budget	**21**	**21.00**	**1,740,361,217**	**-**	**-**	**1,740,361,217**	-	**-**	**-**
Percentage Change From 2017-19 Leg Approved Budget	10.53%	10.53%	6.84%	-	-	6.84%	-	-	-
Percentage Change From 2019-21 Current Service Level	10.53%	10.53%	0.05%	-	-	0.05%	-	-	-

Oregon Health Authority
2019-21 Governor's Budget

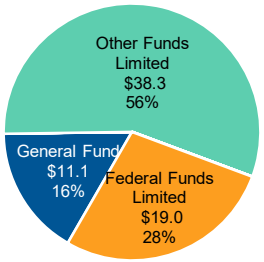
Public Health by Program in millions
$725.4 Total Funds



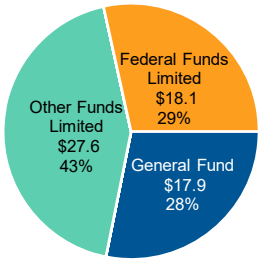
Public Health by Fund in millions
$725.4 Total Funds



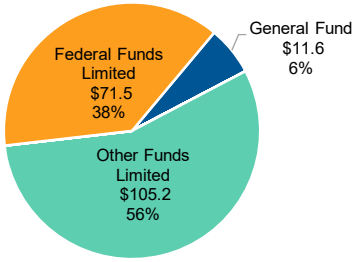
Center for Health Protection in millions
$68.4 Total Funds



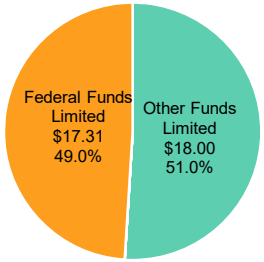
Office of the State Public Health Director in millions
$63.6 Total Funds



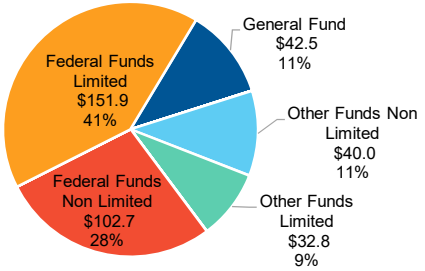
Center for Public Health Practice in millions
$175.6 Total Funds



Indirect Costs by Fund in millions
$35.3 Total Funds



Center for Prevention & Health Promotion in millions
$443.4 Total Funds



Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2017-19 Leg Adopted Budget	754	735.67	594,649,343	65,196,109	-	150,073,638	236,650,545	40,000,000	102,729,051
2017-19 Emergency Boards	6	2.54	16,780,667	(283,466)	-	17,568,599	(504,466)	-	-
2017-19 Leg Approved Budget	**760**	**738.21**	**611,430,010**	**64,912,643**	**-**	**167,642,237**	236,146,079	**40,000,000**	**102,729,051**
2019-21 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(28)	(9.75)	5,546,962	1,449,393	-	1,200,203	2,897,366	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2019-21 Base Budget	**732**	**728.46**	**616,976,972**	**66,362,036**	**-**	**168,842,440**	239,043,445	**40,000,000**	**102,729,051**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	1,337,833	1,007,659	-	155,601	174,573	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	386,201	77,357	-	264,615	44,229	-	-
Subtotal	**-**	**-**	**1,724,034**	**1,085,016**	**-**	**420,216**	218,802	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	7	2.65	41,359,078	5,321,144	-	18,491,181	17,546,753	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(1,200,000)	(1,200,000)	-	-	-	-	-
Subtotal	**7**	**2.65**	**40,159,078**	**4,121,144**	**-**	**18,491,181**	17,546,753	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	12,363,163	1,748,451	-	4,613,888	6,000,824	-	-
Subtotal	**-**	**-**	**12,363,163**	**1,748,451**	**-**	**4,613,888**	6,000,824	**-**	**-**

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	-	-	(199,592)	(23,883)	-	(149,512)	(26,197)	-	-
Subtotal: 2019-21 Current Service Level	**739**	**731.11**	**671,023,655**	**73,292,764**	**-**	**192,218,213**	262,783,627	**40,000,000**	**102,729,051**

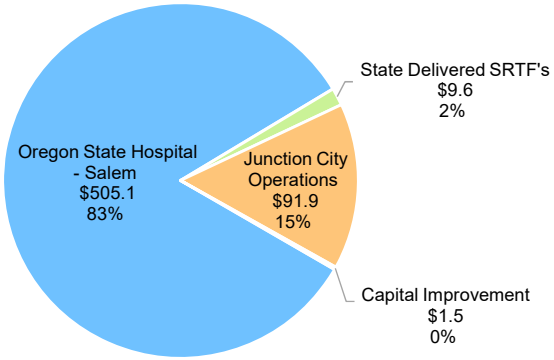
Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2019-21 Current Service Level	**739**	**731.11**	**671,023,655**	**73,292,764**	**-**	**192,218,213**	262,783,627	**40,000,000**	**102,729,051**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2019-21 Current Service Level	**739**	**731.11**	**671,023,655**	**73,292,764**	**-**	**192,218,213**	262,783,627	**40,000,000**	**102,729,051**
080 - E-Boards									
080 - May 2018 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2018 Emergency Board	1	1.00	245,621	245,621	-	-	-	-	-
090 - Analyst Adjustments	-	-	(5,796,874)	(444,546)	-	(3,513,831)	(1,838,497)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(201,312)	(11,983)	-	(113,011)	(76,318)	-	-
092 - Statewide AG Adjustment	-	-	(114,510)	(11,114)	-	(90,591)	(12,805)	-	-
095 - December 2018 Rebalance	9	9.50	30,065,973	656,012	-	17,637,822	11,772,139	-	-
201 - Integratd Eligibility/Medicaid Eligibility	-	-	-	-	-	-	-	-	-
202 - Medicaid Modularity	-	-	-	-	-	-	-	-	-
203 - Overpmt Writing & Recovery Proc Right-Sizing	-	-	-	-	-	-	-	-	-
204 - Interstate Benefit ID (PARIS) Proc Resourcing	-	-	-	-	-	-	-	-	-
205 - Protect, Modernize, Strengthen	-	-	-	-	-	-	-	-	-
206 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
207 - Provider Time Capture	-	-	-	-	-	-	-	-	-
208 - M & O of Centralized Abuse Management	-	-	-	-	-	-	-	-	-
209 - Bldg Cap & Tools for Intagy Data & GIS Dvit	-	-	-	-	-	-	-	-	-
210 - Health, Safety & Wellness	-	-	-	-	-	-	-	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
301 - Oregon Buys	-	-	-	-	-	-	-	-	-
302 - Deferred Maintenance	-	-	-	-	-	-	-	-	-
401 - Universal Family Linkages & Home Visiting Sys	4	3.00	8,732,515	4,056,925	-	-	4,675,590	-	-
402 - Prev'n, Interv'n & Access thru Lifespan	-	-	-	-	-	-	-	-	-
403 - Intensive In-Home Behavioral Health Services	-	-	-	-	-	-	-	-	-
404 - Office of Child Health	-	-	-	-	-	-	-	-	-
405 - Public Health Modernization	6	1.50	13,943,287	-	-	13,600,000	343,287	-	-
406 - Increase the Price of Tobacco Products	-	-	-	-	-	-	-	-	-
407 - Increase Taxes for Beer, Wine and Cider	-	-	-	-	-	-	-	-	-
408 - Continuation of Mental Health Funding	-	-	-	-	-	-	-	-	-
409 - Opioid Alt Pain Ed Modules/Addictions	-	-	-	-	-	-	-	-	-
410 - Misdemeanor Defenders	-	-	-	-	-	-	-	-	-
411 - Behavioral Health	-	-	-	-	-	-	-	-	-
412 - Safety, Patient Care & Regulatory Compliance	-	-	-	-	-	-	-	-	-
413 - Behavioral Health Funding Shortfall	-	-	-	-	-	-	-	-	-
414 - MOTS/COMPASS Modernization & Completion	-	-	-	-	-	-	-	-	-
415 - Expanding Hepatitis C Coverage	-	-	-	-	-	-	-	-	-
416 - CCO 2.0	-	-	-	-	-	-	-	-	-
417 - State Support for Local Public Health	-	-	5,480,601	5,480,601	-	-	-	-	-
418 - Fee Structure Rev for Drinking Water Svcs	5	5.00	1,853,297	-	-	1,853,297	-	-	-
419 - Fee Chgs for the Food, Pool and Lodging Pgms	-	-	64,450	-	-	64,450	-	-	-
420 - Toxic Free Kids Program	-	-	111,511	-	-	111,511	-	-	-
421 - OEBB/PEBB Benefit Management Sys Replacement	-	-	-	-	-	-	-	-	-
422 - Statewide Pharmacy Purchasing Implmtn Group	-	-	-	-	-	-	-	-	-

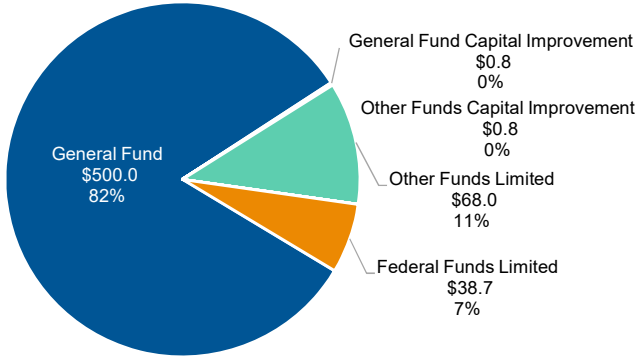
Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal Policy Packages	**25**	**20.00**	**54,384,559**	**9,971,516**	**-**	**29,549,647**	14,863,396	**-**	**-**
Total 2019-21 Governor's Budget	**764**	**751.11**	**725,408,214**	**83,264,280**	**-**	**221,767,860**	277,647,023	**40,000,000**	**102,729,051**
Percentage Change From 2017-19 Leg Approved Budget	0.53%	1.75%	18.64%	28.27%	-	32.29%	17.57%	-	-
Percentage Change From 2019-21 Current Service Level	3.38%	2.74%	8.10%	13.61%	-	15.37%	5.66%	-	-

Oregon Health Authority
2019-21 Governor's Budget

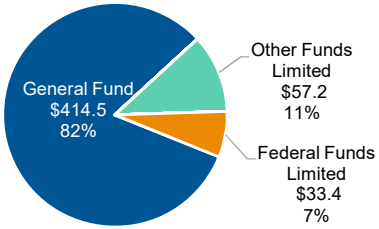
Oregon State Hospital by Program in millions
$608.1 Total Funds



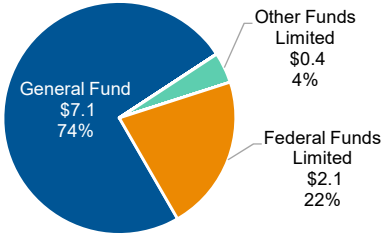
Oregon State Hospital by Fund in millions
$608.1 Total Funds



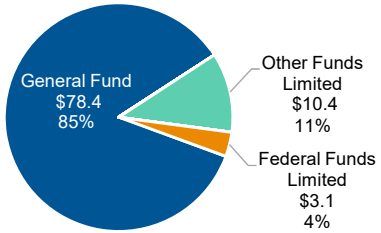
Oregon State Hospital - Salem in millions
$505.1 Total Funds



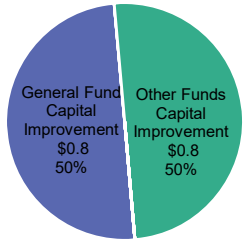
State Delivered SRTF's in millions
$9.6 Total Funds



Junction City Operations in millions
$91.9 Total Funds



Capital Improvements in millions
$1.5 Total Funds



Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2017-19 Leg Adopted Budget	2,289	2,281.95	546,817,029	451,041,430	-	64,382,972	31,392,627	-	-
2017-19 Emergency Boards	(3)	(2.50)	14,762,185	13,173,159	-	679,626	909,400	-	-
2017-19 Leg Approved Budget	**2,286**	**2,279.45**	**561,579,214**	**464,214,589**	**-**	**65,062,598**	32,302,027	**-**	**-**
2019-21 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(3)	3.37	28,415,847	24,426,505	-	2,076,975	1,912,367	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2019-21 Base Budget	**2,283**	**2,282.82**	**589,995,061**	**488,641,094**	**-**	**67,139,573**	34,214,394	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	6,674,264	803,446	-	1,798,722	4,072,096	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	4,146,313	3,718,294	-	207,697	220,322	-	-
Subtotal	**-**	**-**	**10,820,577**	**4,521,740**	**-**	**2,006,419**	4,292,418	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	-	-	180,604	31,858	-	148,746	-	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(990,708)	(261,589)	-	(729,119)	-	-	-
Subtotal	**-**	**-**	**(810,104)**	**(229,731)**	**-**	**(580,373)**	-	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	3,440,797	1,380,251	-	1,775,044	285,502	-	-
Subtotal	**-**	**-**	**3,440,797**	**1,380,251**	**-**	**1,775,044**	285,502	**-**	**-**

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: 2019-21 Current Service Level	**2,283**	**2,282.82**	**603,446,331**	**494,313,354**	**-**	**70,340,663**	38,792,314	**-**	**-**

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2019-21 Current Service Level	**2,283**	**2,282.82**	**603,446,331**	**494,313,354**	**-**	**70,340,663**	38,792,314	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2019-21 Current Service Level	**2,283**	**2,282.82**	**603,446,331**	**494,313,354**	**-**	**70,340,663**	38,792,314	**-**	**-**
080 - E-Boards									
080 - May 2018 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2018 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	61	30.50	4,280,311	6,062,289	-	(1,512,835)	(269,143)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(101,074)	(35,280)	-	(58,876)	(6,918)	-	-
092 - Statewide AG Adjustment	-	-	(62,155)	(45,387)	-	(16,593)	(175)	-	-
095 - December 2018 Rebalance	1	1.00	585,003	459,634	-	(11,871)	137,240	-	-
201 - Integratd Eligibility/Medicaid Eligibility	-	-	-	-	-	-	-	-	-
202 - Medicaid Modularity	-	-	-	-	-	-	-	-	-
203 - Overpmt Writing & Recovery Proc Right-Sizing	-	-	-	-	-	-	-	-	-
204 - Interstate Benefit ID (PARIS) Proc Resourcing	-	-	-	-	-	-	-	-	-
205 - Protect, Modernize, Strengthen	-	-	-	-	-	-	-	-	-
206 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
207 - Provider Time Capture	-	-	-	-	-	-	-	-	-
208 - M & O of Centralized Abuse Management	-	-	-	-	-	-	-	-	-
209 - Bldg Cap & Tools for Intagy Data & GIS Dvit	-	-	-	-	-	-	-	-	-
210 - Health, Safety & Wellness	-	-	-	-	-	-	-	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
301 - Oregon Buys	-	-	-	-	-	-	-	-	-
302 - Deferred Maintenance	-	-	-	-	-	-	-	-	-
401 - Universal Family Linkages & Home Visiting Sys	-	-	-	-	-	-	-	-	-
402 - Prev'n, Interv'n & Access thru Lifespan	-	-	-	-	-	-	-	-	-
403 - Intensive In-Home Behavioral Health Services	-	-	-	-	-	-	-	-	-
404 - Office of Child Health	-	-	-	-	-	-	-	-	-
405 - Public Health Modernization	-	-	-	-	-	-	-	-	-
406 - Increase the Price of Tobacco Products	-	-	-	-	-	-	-	-	-
407 - Increase Taxes for Beer, Wine and Cider	-	-	-	-	-	-	-	-	-
408 - Continuation of Mental Health Funding	-	-	-	-	-	-	-	-	-
409 - Opioid Alt Pain Ed Modules/Addictions	-	-	-	-	-	-	-	-	-
410 - Misdemeanor Defenders	-	-	-	-	-	-	-	-	-
411 - Behavioral Health	-	-	-	-	-	-	-	-	-
412 - Safety, Patient Care & Regulatory Compliance	-	-	-	-	-	-	-	-	-
413 - Behavioral Health Funding Shortfall	-	-	-	-	-	-	-	-	-
414 - MOTS/COMPASS Modernization & Completion	-	-	-	-	-	-	-	-	-
415 - Expanding Hepatitis C Coverage	-	-	-	-	-	-	-	-	-
416 - CCO 2.0	-	-	-	-	-	-	-	-	-
417 - State Support for Local Public Health	-	-	-	-	-	-	-	-	-
418 - Fee Structure Rev for Drinking Water Svcs	-	-	-	-	-	-	-	-	-
419 - Fee Chgs for the Food, Pool and Lodging Pgms	-	-	-	-	-	-	-	-	-
420 - Toxic Free Kids Program	-	-	-	-	-	-	-	-	-
421 - OEBB/PEBB Benefit Management Sys Replacement	-	-	-	-	-	-	-	-	-
422 - Statewide Pharmacy Purchasing Implmtn Group	-	-	-	-	-	-	-	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal Policy Packages	**62**	**31.50**	**4,702,085**	**6,441,256**	**-**	**(1,600,175)**	(138,996)	**-**	**-**
Total 2019-21 Governor's Budget	**2,345**	**2,314.32**	**608,148,416**	**500,754,610**	**-**	**68,740,488**	38,653,318	**-**	**-**
Percentage Change From 2017-19 Leg Approved Budget	2.58%	1.53%	8.29%	7.87%	-	5.65%	19.66%	-	-
Percentage Change From 2019-21 Current Service Level	2.72%	1.38%	0.78%	1.30%	-	-2.27%	-0.36%	-	-

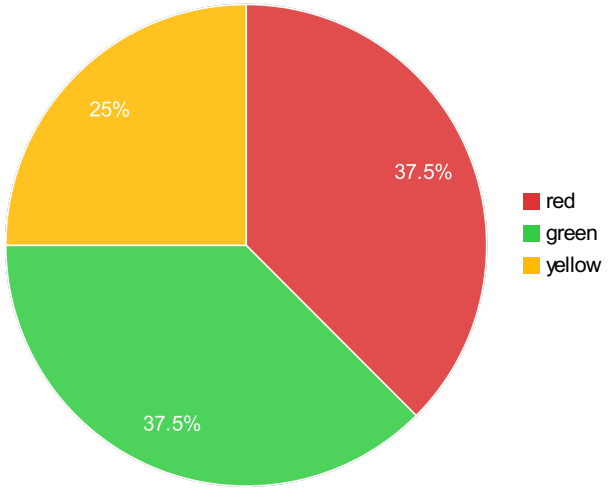
Oregon Health Authority

Annual Performance Progress Report

Reporting Year 2018

Published: 12/20/2018 5:51:48 PM

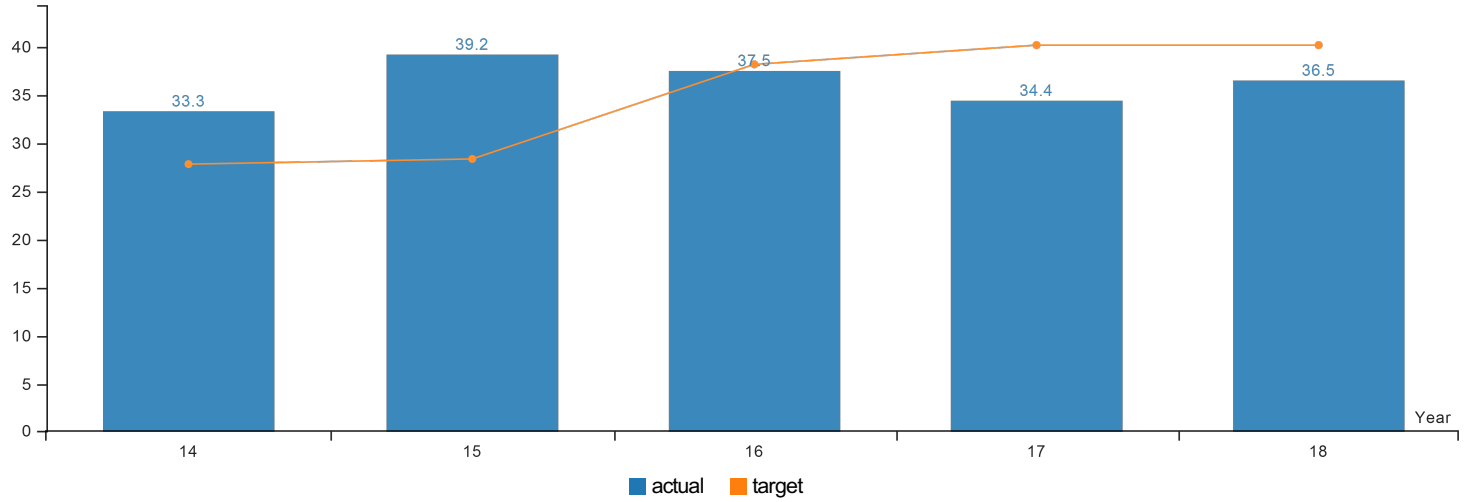
KPM #	Approved Key Performance Measures (KPMs)
1	INITIATION OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received initiation of AOD treatment within 14 days of diagnosis.
2	ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received two or more services within 30 days of initiation visit.
3	FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS - Percentage of enrollees 6 years of age and older who were hospitalized for treatment of mental health disorders and who were seen on an outpatient basis or were in intermediate treatment within seven days of discharge.
4	MENTAL, PHYSICAL, AND DENTAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY - Percentage of children in DHS custody who receive a mental, physical, and dental health assessment within 60 days of the state notifying CCOs that the children were placed into custody with DHS (foster care).
5	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (INITIATION) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
6	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (CONTINUATION AND MAINTENANCE) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
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	PATIENT CENTERED PRIMARY CARE HOME (PCPCH) ENROLLMENT - Number of members enrolled in patient-centered primary care homes by tier.
16	PQI 01: Diabetes Short-Term Complication Admission Rate -
17	PQI 05: COPD or Asthma in Older Adults Admission Rate -
18	PQI 08: Congestive Heart Failure Admission Rate -
19	ACCESS TO CARE - Percentage of members who responded "always" or "usually" too getting care quickly (composite for adult and child).
19	PQI 15: Asthma in Younger Adults Admission Rate -
20	MEMBER EXPERIENCE OF CARE - Composite measurement: how well doctors communicate; health plan information and customer service (Medicaid population).
21	MEMBER HEALTH STATUS - Percentage of CAHPS survey respondents with a positive self-reported rating of overall health (excellent, very good, or good).
22	RATE OF TOBACCO USE (POPULATION) - Rate of tobacco use among adults.
23	RATE OF TOBACCO USE (MEDICAID) - Percentage of CCO enrollees who currently smoke cigarettes or use tobacco every day or some days.
24	RATE OF OBESITY (POPULATION) - Percentage of adults who are obese among Oregonians.
25	EFFECTIVE CONTRACEPTIVE USE (POPULATION) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
26	EFFECTIVE CONTRACEPTIVE USE (MEDICAID) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
27	FLU SHOTS (POPULATION) - Percentage of adults ages 50-64 who receive a flu vaccine.
28	CHILD IMMUNIZATION RATES (POPULATION) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
29	CHILD IMMUNIZATION RATES (MEDICAID) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
30	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.
31	ELIGIBILITY PROCESSING TIME - Median number of days processing time from date of request to eligibility determination.
32	OHP MEMBERS IN CCOs - Percent of Oregon Health Plan members enrolled in Coordinated Care Organizations.
33	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.



Performance Summary	Green	Yellow	Red
	= Target to -5%	= Target -5% to -15%	= Target > -15%
Summary Stats:	37.50%	25%	37.50%

KPM #1	INITIATION OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received initiation of AOD treatment within 14 days of diagnosis.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
Initiation of alcohol and other drug dependence treatment					
Actual	33.30%	39.20%	37.50%	34.40%	36.50%
Target	27.81%	28.35%	38.20%	40.20%	40.20%

How Are We Doing

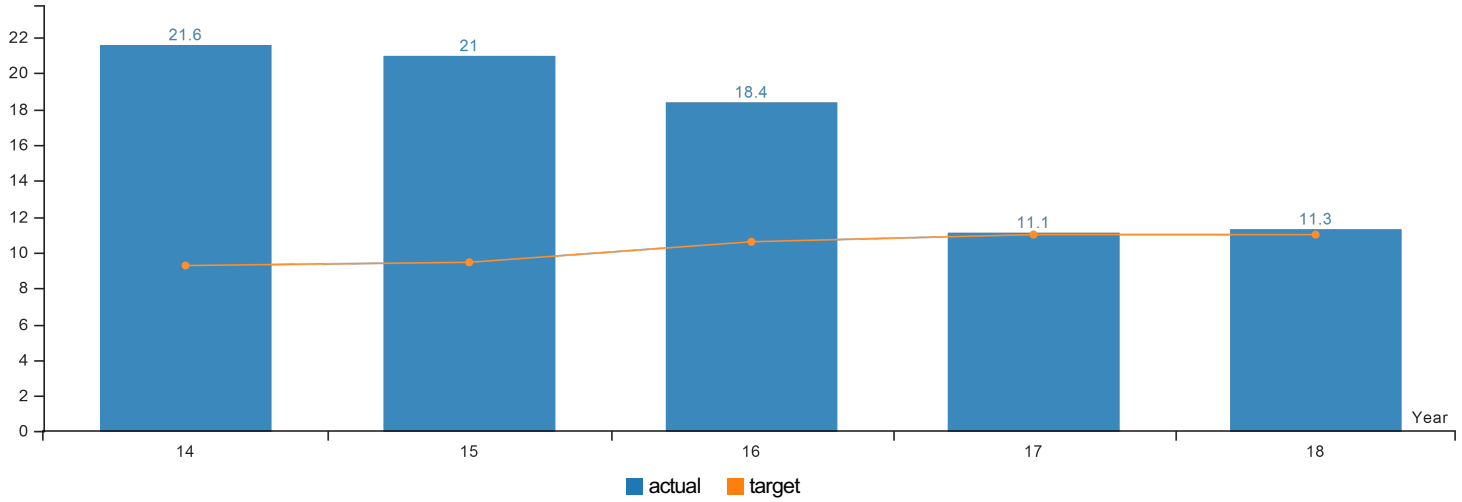
After an 18 percent increase between 2013-2014, the percentage of Medicaid members age 13+ who were newly diagnosed with alcohol or other drug dependence and who began treatment within 14 days of initial diagnosis has been slowly decreasing back to 2013 levels. However, there was an uptick from 2016 to 2017 (from 34.4% to 36.5%).

Factors Affecting Results

It is possible that the increased statewide emphasis on alcohol and drug use screening (SBIRT) due to the CCO incentive measure resulted in an increase in initiation of alcohol and drug treatment, as more individuals with risky or problematic substance use are identified and referred to treatment services.

KPM #2	ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received two or more services within 30 days of initiation visit.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
Engagement of alcohol and other drug dependence treatment					
Actual	21.60%	21%	18.40%	11.10%	11.30%
Target	9.27%	9.45%	10.60%	11%	11%

How Are We Doing

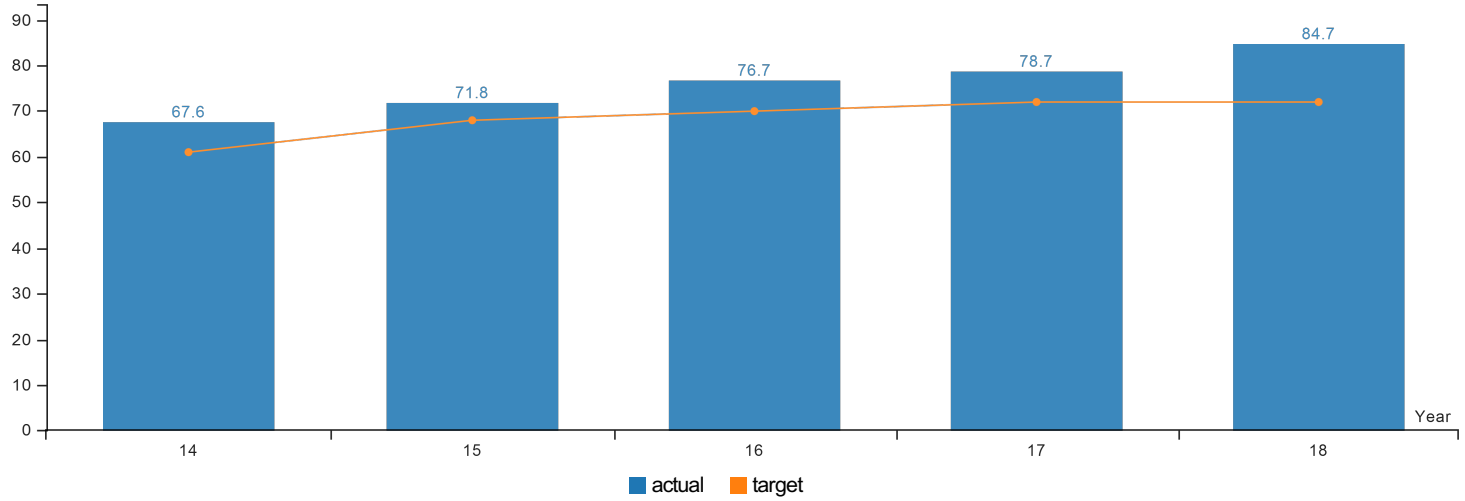
The percentage of CCO members who continued their treatment (had two or more visit within 30 days of their initial treatment) was nearly twice the national average in 2013 (21.6%). Since 2013, this percentage has been steadily declining, and in 2017 only 11.3% of CCO members continued their treatment. While this is a considerable decline since 2013, performance remains slightly above the KPM target.

Factors Affecting Results

Nationally, performance on this measure 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

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
Follow-up after hospitalization for mental illness					
Actual	67.60%	71.80%	76.70%	78.70%	84.70%
Target	61%	68%	70%	72%	72%

How Are We Doing

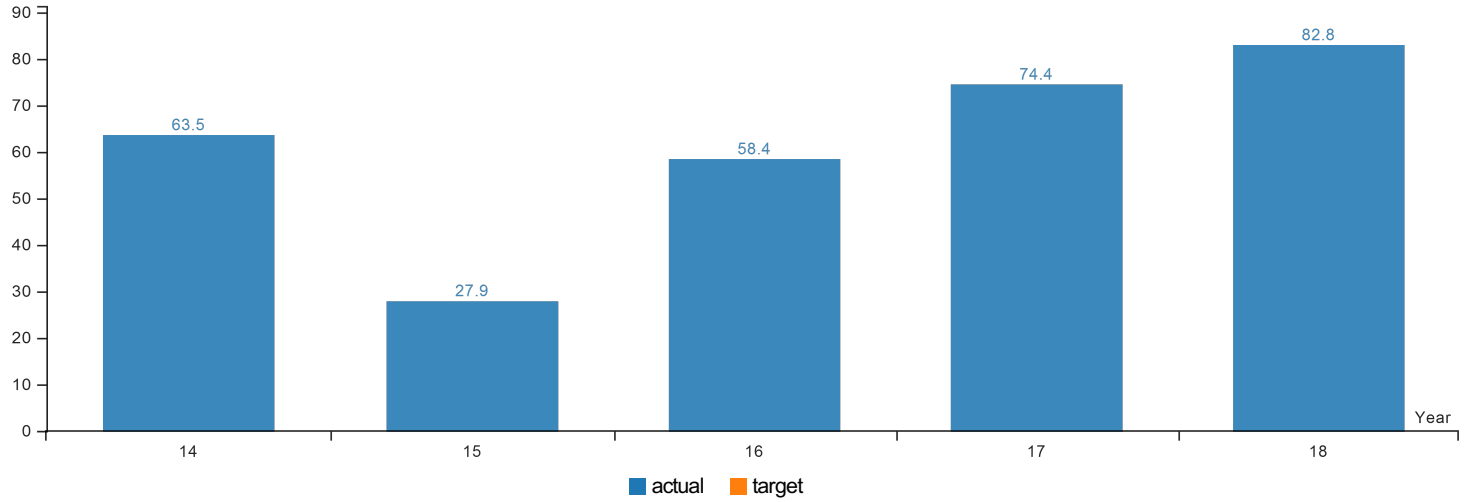
In 2017, 84.7% of CCO members (ages 6 and older) who were admitted to the hospital for mental illness received follow-up with a health care provider within seven days of discharge. Oregon is consistently surpassing the KPM target and in 2015 surpassed the 2014 national Medicaid 90th percentile. Beginning in 2015, follow-up visits on the same day of discharge were included in the measure. Given our high performance in this area, this measure is no longer included in the incentive measure program, though OHA continues to track and monitor performance.

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.

KPM #4	MENTAL, PHYSICAL, AND DENTAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY - Percentage of children in DHS custody who receive a mental, physical, and dental health assessment within 60 days of the state notifying CCOs that the children were placed into custody with DHS (foster care).
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
MENTAL, PHYSICAL, AND DENTAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY					
Actual	63.50%	27.90%	58.40%	74.40%	82.80%
Target	TBD	TBD	TBD	TBD	TBD

How Are We Doing

While there is still continued room for improvement, CCOs improved tremendously in 2015 (58.4%), 2016 (74.4%), and 2017 (82.8%).

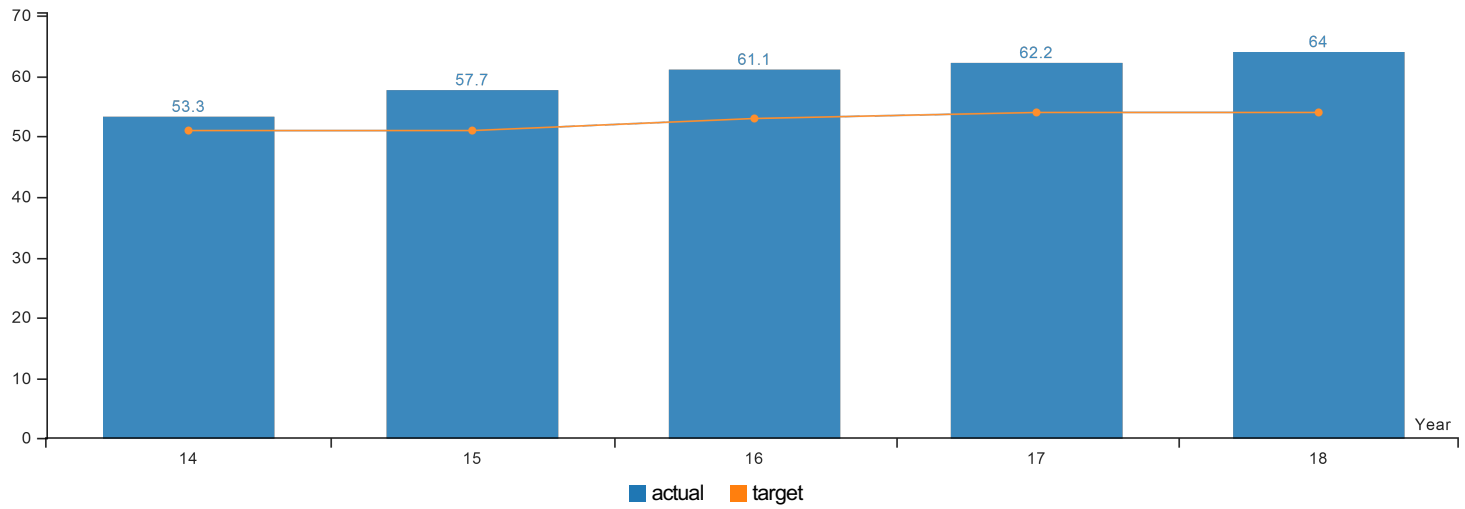
Factors Affecting Results

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.

NOTE: 2013 not comparable to later years due to methodology change. In addition, dental assessments added in 2014.

KPM #5	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (INITIATION) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
Follow-up care for children prescribed with ADHD medication (initiation)					
Actual	53.30%	57.70%	61.10%	62.20%	64%
Target	51%	51%	53%	54%	54%

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 64.0% of patients newly prescribed ADHD medication receiving follow up in 2017. Oregon is above the national 90th percentile for both Medicaid and Commercial.

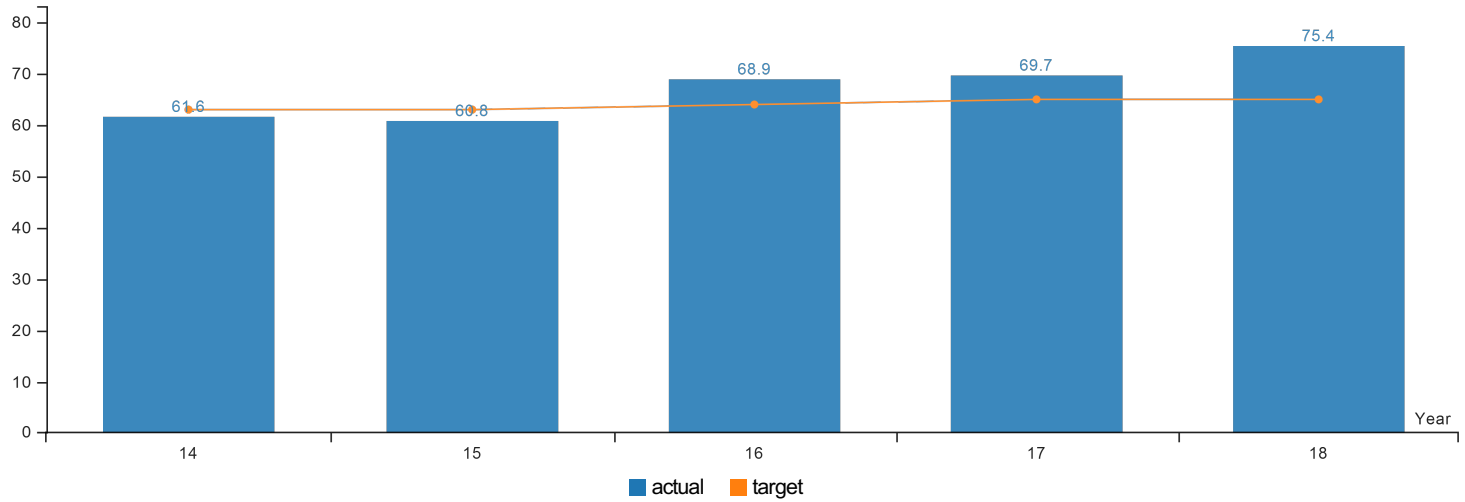
NOTE: This measure was incentivized in 2013 and 2014.

Factors Affecting Results

We have heard from providers that limiting the follow up visit to within the first 30 days is not well aligned with some of the current ADHD medications, which may require a 45 day initial prescription. Children with these longer initial prescriptions would fall outside of the 30 day window for this measure.

KPM #6	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (CONTINUATION AND MAINTENANCE) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
Follow-up care for children prescribed with ADHD medication (continuation and maintenance)					
Actual	61.60%	60.80%	68.90%	69.70%	75.40%
Target	63%	63%	64%	65%	65%

How Are We Doing

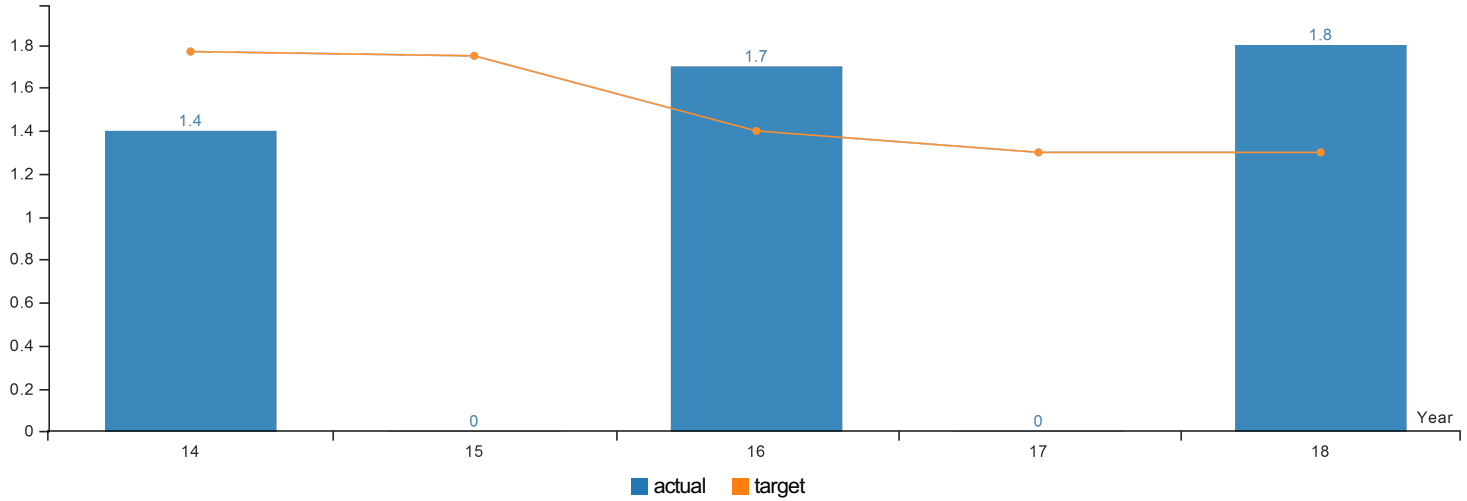
Calendar year 2011 is the baseline for this measure. In 2011, 61.0% of children who remained on ADHD medication for 210 days after receiving a new prescription also had at least two follow up visits with a provider. This rate remained fairly steady in CY's 2013 and 2014, and increased notably in CY2015, with 68.9% of children receiving continued follow-up with a provider. In CY2017, the rate was 75.4%, above the KPM target of 65%.

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

** Upward Trend = negative result*



Report Year	2014	2015	2016	2017	2018
30 day illicit drug use among 6th graders					
Actual	1.40%	No Data	1.70%	No Data	1.80%
Target	1.77%	1.75%	1.40%	1.30%	1.30%

How Are We Doing

The rates reported in the key performance metrics were previously collected by the AMH division of the Oregon Health Authority. In 2015, ownership of the measure was transferred to the Public Health Division. Student Wellness Survey data is only collected in the even numbered years. Past figures included marijuana use. Beginning in 2020, the Oregon Healthy Teens survey and the Student Wellness survey will be merged to the Student Health Survey which PHD will issue every other year in even numbered years. The Student health survey will include 6th, 8th and 11th grade statistics.

These data can be found published here: https://oregon.pridesurveys.com/dl.php?pdf=Oregon_SWS_Statewide_Report_2018.pdf&type=region

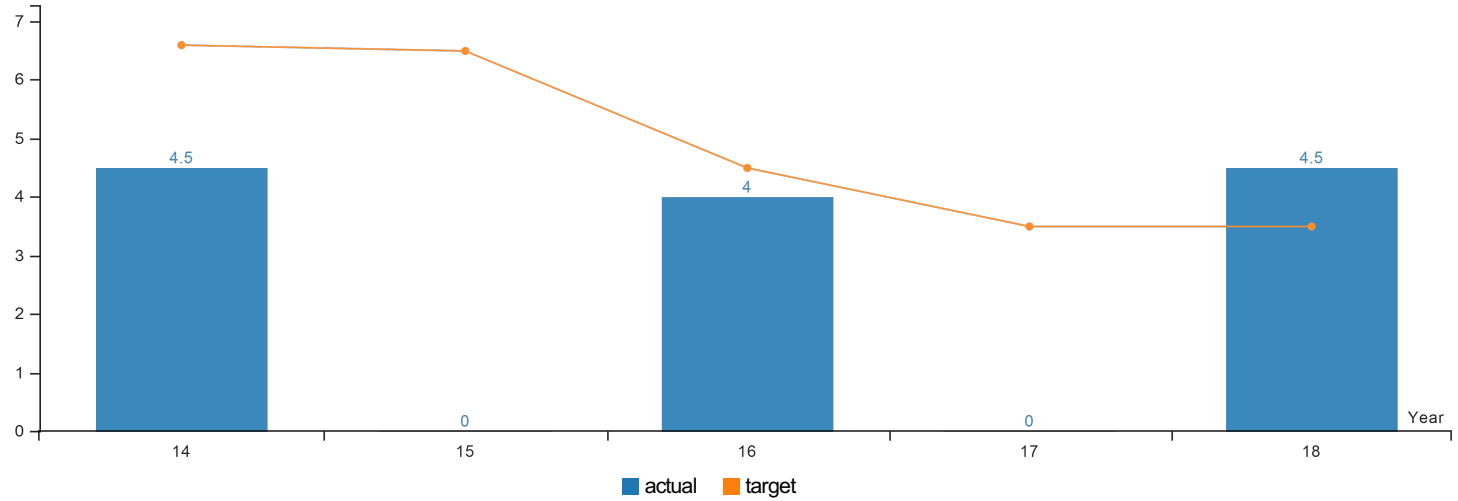
In 2012, the percentage of 6th graders who used any illicit drug in the past 30 days was 1.8%; in 2014 this decreased slightly to 1.4%; and in 2016 this increased again to 1.7%.

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 drug 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

** Upward Trend = negative result*



Report Year	2014	2015	2016	2017	2018
30 day alcohol use among 6th graders					
Actual	4.50%	No Data	4%	No Data	4.50%
Target	6.60%	6.50%	4.50%	3.50%	3.50%

How Are We Doing

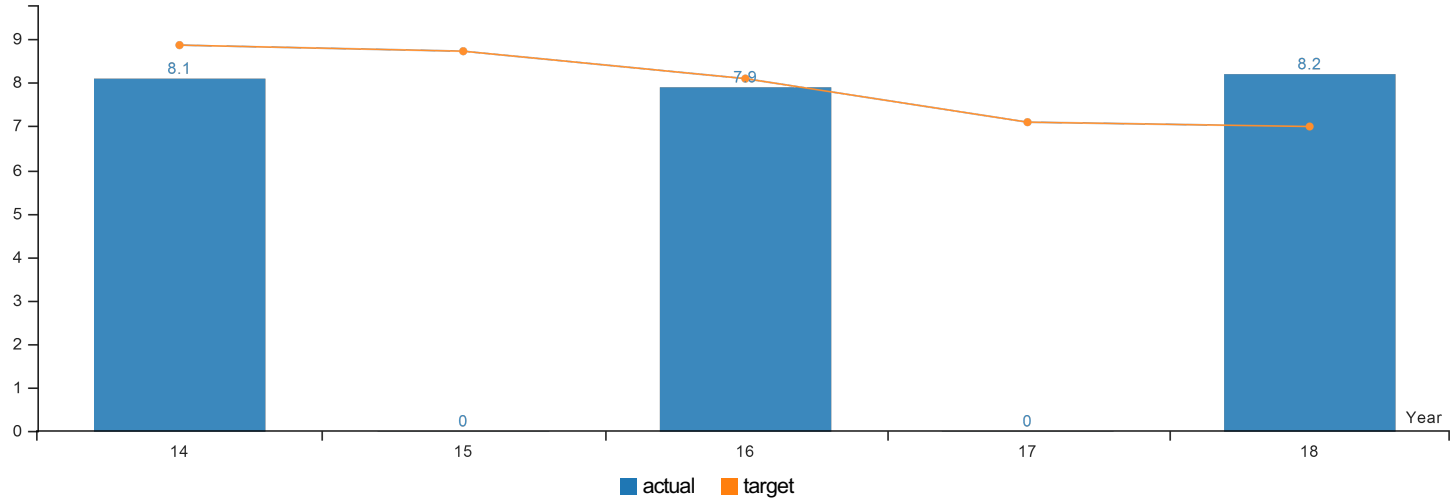
The rates reported in the key performance metrics were previously collected by the AMH division of the Oregon Health Authority. In 2015, ownership of the measure was transferred to the Public Health Division. Student Wellness Survey data is only collected in the even numbered years. Beginning in 2020, the Oregon Healthy Teens survey and the Student Wellness survey will be merged to the Student Health Survey which PHD will issue every other year in even numbered years. The Student health survey will include 6th, 8th and 11th grade statistics.

These data can be found published here:
https://oregon.pridesurveys.com/dl.php?pdf=Oregon_SWS_Statewide_Report_2018.pdf&type=region

Factors Affecting Results

KPM #9	30 DAY ILLICIT DRUG USE AMONG 8TH GRADERS - Percentage of 8th graders who have used illicit drugs in the past 30 days.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2014	2015	2016	2017	2018
30 day illicit drug use among 8th graders					
Actual	8.10%	No Data	7.90%	No Data	8.20%
Target	8.87%	8.73%	8.10%	7.10%	7%

How Are We Doing

The rates reported in the key performance metrics were previously collected by the AMH division of the Oregon Health Authority. In 2015, ownership of the measure was transferred to the Public Health Division. Student Wellness Survey data is only collected in the even numbered years. Past figures included marijuana use. Beginning in 2020, the Oregon Healthy Teens survey and the Student Wellness survey will be merged to the Student Health Survey which PHD will issue every other year in even numbered years. The Student health survey will include 6th, 8th and 11th grade statistics.

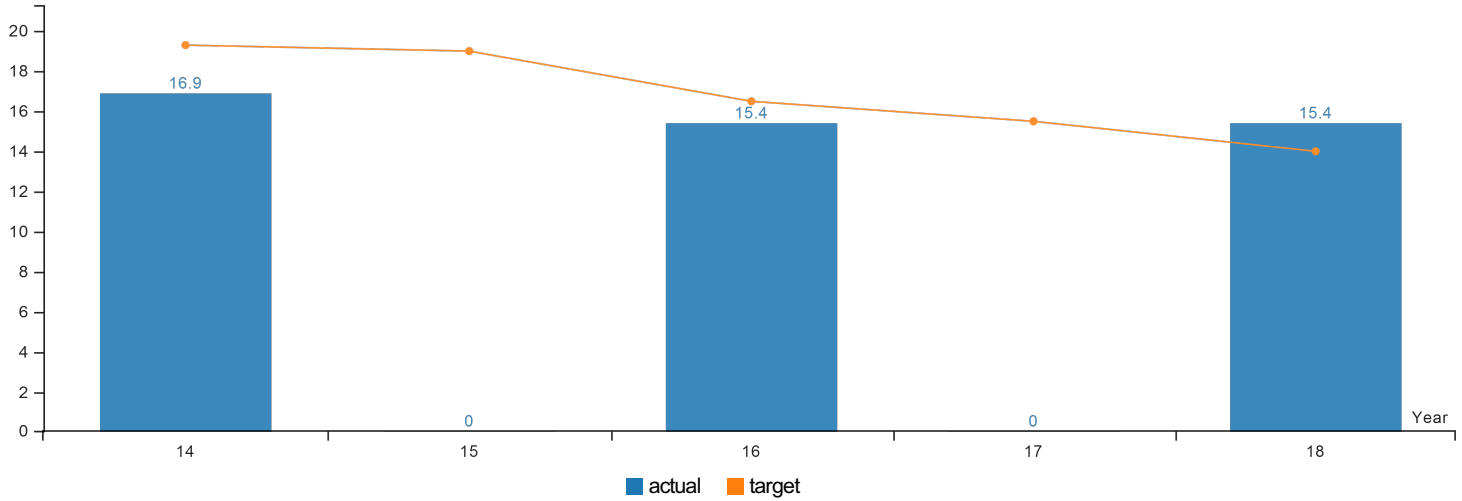
These data can be found published here:
https://oregon.pridesurveys.com/dl.php?pdf=Oregon_SWS_Statewide_Report_2018.pdf&type=region

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

** Upward Trend = negative result*



Report Year	2014	2015	2016	2017	2018
30 day alcohol use among 8th graders					
Actual	16.90%	No Data	15.40%	No Data	15.40%
Target	19.31%	19.01%	16.50%	15.50%	14%

How Are We Doing

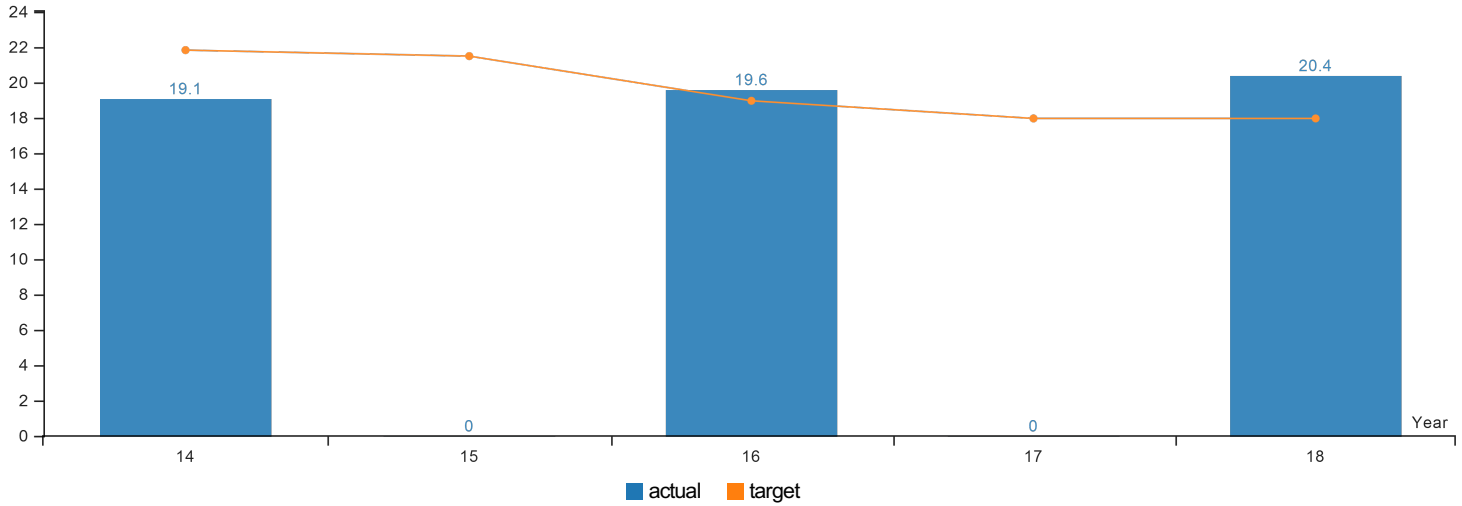
The rates reported in the key performance metrics were previously collected by the AMH division of the Oregon Health Authority. In 2015, ownership of the measure was transferred to the Public Health Division. Student Wellness Survey data is only collected in the even numbered years. Beginning in 2020, the Oregon Healthy Teens survey and the Student Wellness survey will be merged to the Student Health Survey which PHD will issue every other year in even numbered years. The Student health survey will include 6th, 8th and 11th grade statistics.

These data can be found published here:
https://oregon.pridesurveys.com/dl.php?pdf=Oregon_SWS_Statewide_Report_2018.pdf&type=region

Factors Affecting Results

KPM #11	30 DAY ILLICIT DRUG USE AMONG 11TH GRADERS - Percentage of 11th graders who have used illicit drugs in the past 30 days.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2014	2015	2016	2017	2018
30 day illicit drug use among 11th graders					
Actual	19.10%	No Data	19.60%	No Data	20.40%
Target	21.87%	21.53%	19%	18%	18%

How Are We Doing

The rates reported in the key performance metrics were previously collected by the AMH division of the Oregon Health Authority. In 2015, ownership of the measure was transferred to the Public Health Division. Student Wellness Survey data is only collected in the even numbered years. Past figures included marijuana use. Beginning in 2020, the Oregon Healthy Teens survey and the Student Wellness survey will be merged to the Student Health Survey which PHD will issue every other year in even numbered years. The Student health survey will include 6th, 8th and 11th grade statistics.

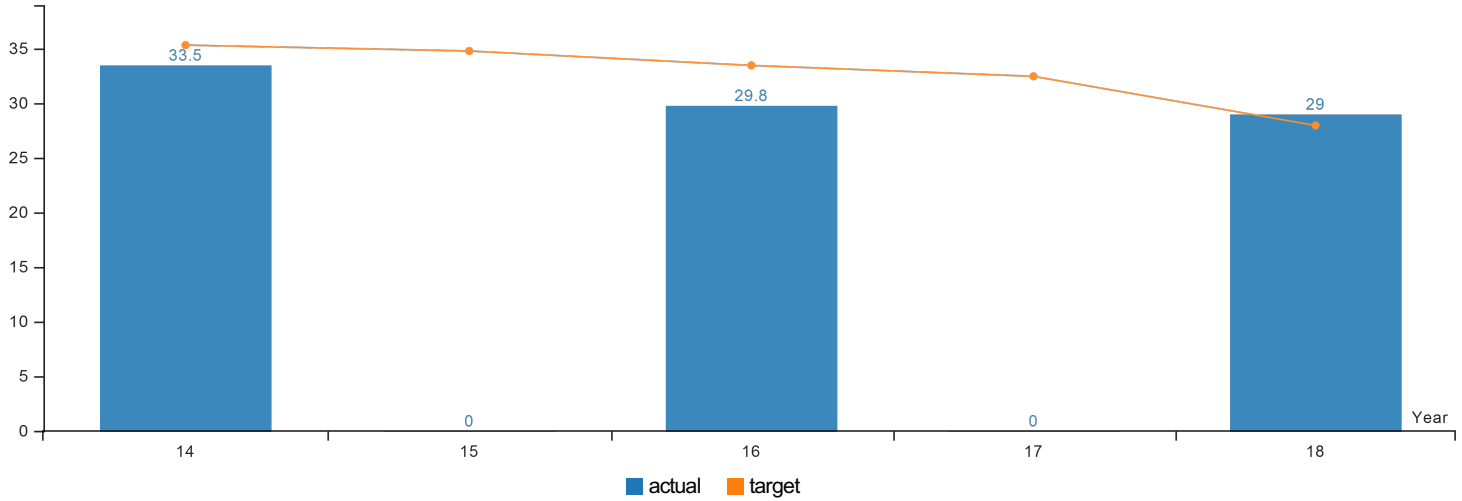
These data can be found published here:
https://oregon.pridesurveys.com/dl.php?pdf=Oregon_SWS_Statewide_Report_2018.pdf&type=region

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

** Upward Trend = negative result*



Report Year	2014	2015	2016	2017	2018
30 day alcohol use among 11th graders					
Actual	33.50%	No Data	29.80%	No Data	29%
Target	35.36%	34.82%	33.50%	32.50%	28%

How Are We Doing

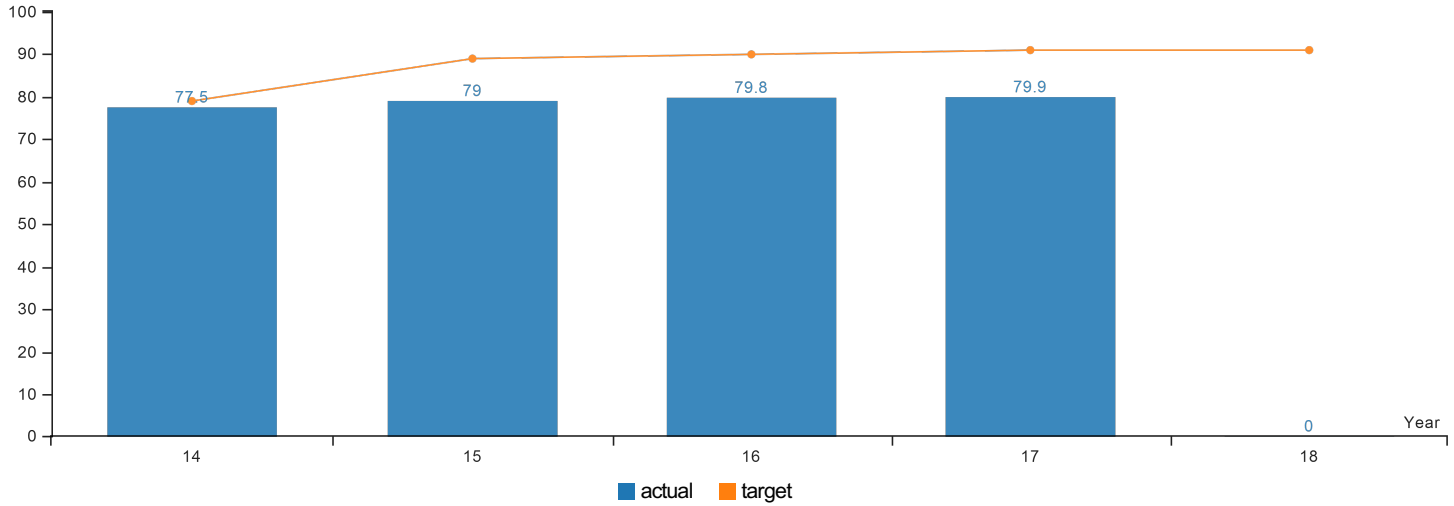
The rates reported in the key performance metrics were previously collected by the AMH division of the Oregon Health Authority. In 2015, ownership of the measure was transferred to the Public Health Division. Student Wellness Survey data is only collected in the even numbered years. Beginning in 2020, the Oregon Healthy Teens survey and the Student Wellness survey will be merged to the Student Health Survey which PHD will issue every other year in even numbered years. The Student health survey will include 6th, 8th and 11th grade statistics.

These data can be found published here:
https://oregon.pridesurveys.com/dl.php?pdf=Oregon_SWS_Statewide_Report_2018.pdf&type=region

Factors Affecting Results

KPM #13	PRENATAL CARE (POPULATION) - Percentage of women who initiated prenatal care in the first 3 months of pregnancy.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
Prenatal care - population					
Actual	77.50%	79%	79.80%	79.90%	No Data
Target	79%	89%	90%	91%	91%

How Are We Doing

The percentage of women accessing prenatal care during the first trimester of pregnancy remained stable from 2016. Early prenatal care is important to identify and treat babies or mothers at risk for health conditions that can affect the pregnancy. It is also important because health care providers can educate and assist mothers with health issues related to pregnancy including nutrition, alcohol use, smoking, exercise, and preparing for childbirth and infant care. Babies born to women who receive prenatal care early and often throughout the pregnancy are less likely to have low birth weight or to be born prematurely.

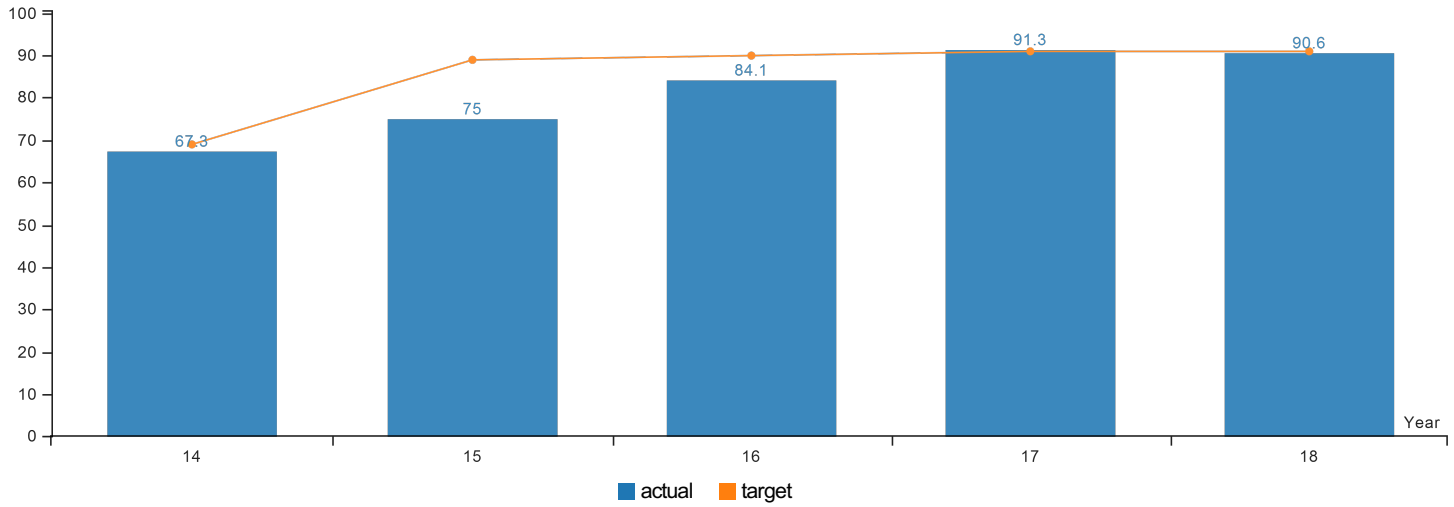
Factors Affecting Results

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.

2018 data is not available yet.

KPM #14	PRENATAL CARE (MEDICAID) - Percentage of women who initiated prenatal care within 42 days of enrollment.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
Prenatal care - Medicaid					
Actual	67.30%	75%	84.10%	91.30%	90.60%
Target	69%	89%	90%	91%	91%

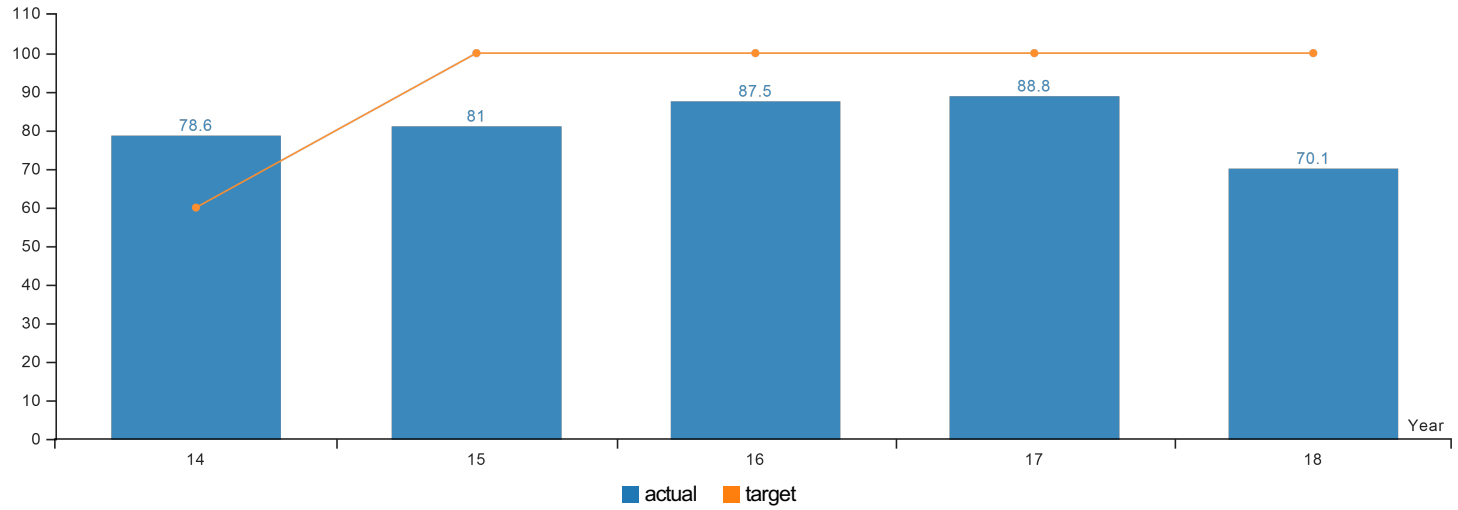
How Are We Doing

Factors Affecting Results

NOTE: Results prior to 2014 are not directly comparable to later years due to change in methodology.

KPM #15	PATIENT CENTERED PRIMARY CARE HOME (PCPCH) ENROLLMENT - Number of members enrolled in patient-centered primary care homes by tier.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
Patient centered primary care home (PCPCH) enrollment					
Actual	78.60%	81%	87.50%	88.80%	70.10%
Target	60%	100%	100%	100%	100%

How Are We Doing

This measure uses a weighted methodology to ensure members are not just enrolled in a PCPCH, but are enrolled in the higher PCPCH tiers.

92 percent of CCO members are enrolled in a PCPCH, resulting in a weighted score of 70.1 percent.

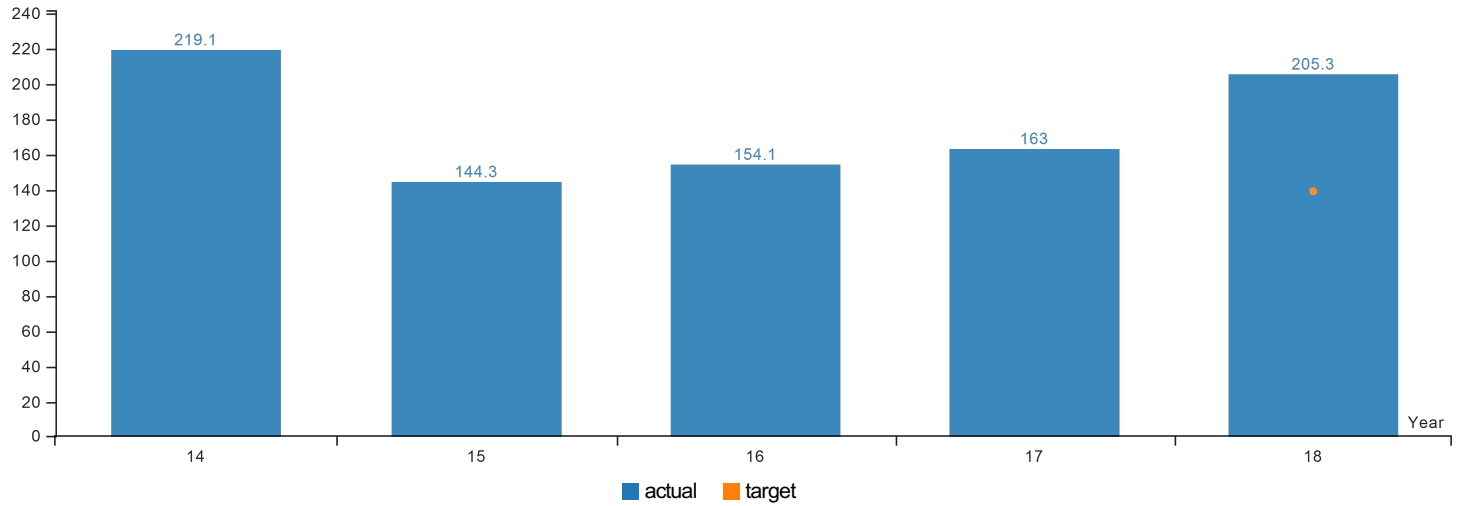
Beginning in 2017, the PCPCH program launched 5 STAR recognition. This new level of recognition was incorporated into the weighting formula for PCPCH score. Thus, scores are not comparable to previous years.

Factors Affecting Results

Coordinated care organizations are driving improvement on this measure through two main efforts: (1) working with contracted providers to go through the PCPCH recognition process, and (2) preferentially assigning members to certified PCPCHs. PCPCH enrollment is also a CCO incentive measure.

KPM #16	PQI 01: Diabetes Short-Term Complication Admission Rate -
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
PQI 01: Diabetes Short-Term Complication Admission Rate					
Actual	219.10	144.30	154.10	163	205.30
Target	TBD	TBD	TBD	TBD	139

How Are We Doing

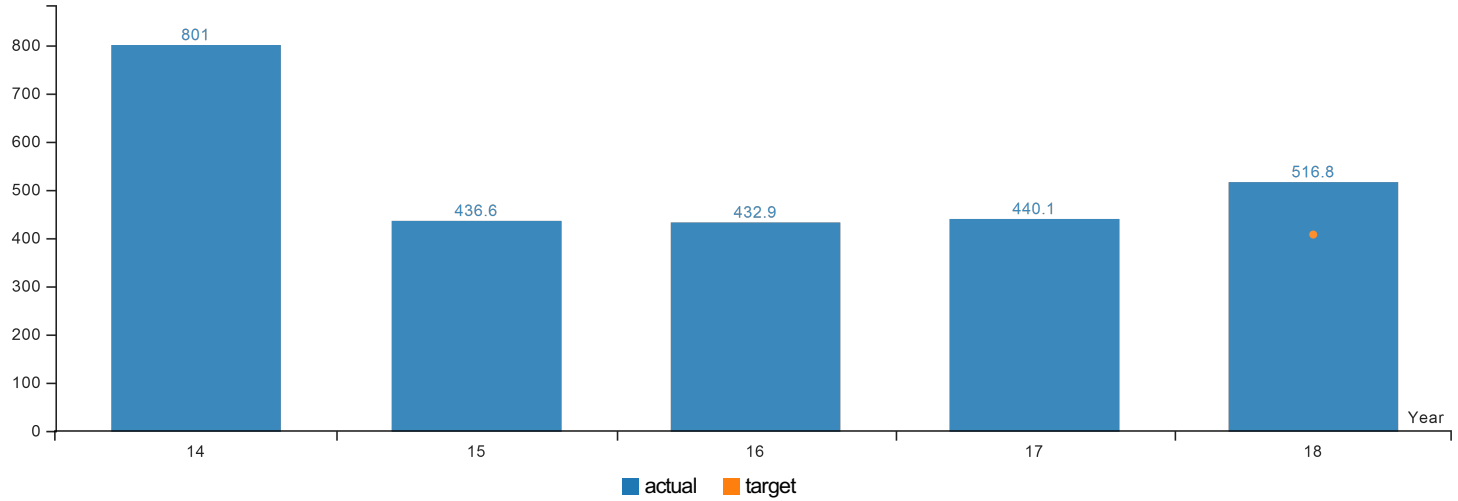
In 2011, there were 198 admissions per 100,000 member years for diabetes short-term complications. This rate increased slightly in 2014 (219 per 100,000 MY) before declining more than 50 percent in 2014, with only 144 admissions per 100,000 member years. In 2015 and 2016, the rate increased slightly with 163/100,000 MY in 2016; this increase continued in 2017 (205.3/100,000 MY when lower is better.)

Factors Affecting Results

Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. As the coordinated care model helps ensure that members receive the appropriate care at the appropriate time in the appropriate place, chronic and acute conditions are more likely to be addressed outside of hospital settings, resulting in improvements in this metric. Moreover, as enrollment in patient-centered primary care homes continues to increase (see KPM #15), CCOs and providers continue to emphasize the importance of preventive care.

KPM #17	PQI 05: COPD or Asthma in Older Adults Admission Rate -
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
PQI 05: COPD or Asthma in Older Adults Admission Rate					
Actual	801	436.60	432.90	440.10	516.80
Target	TBD	TBD	TBD	TBD	408

How Are We Doing

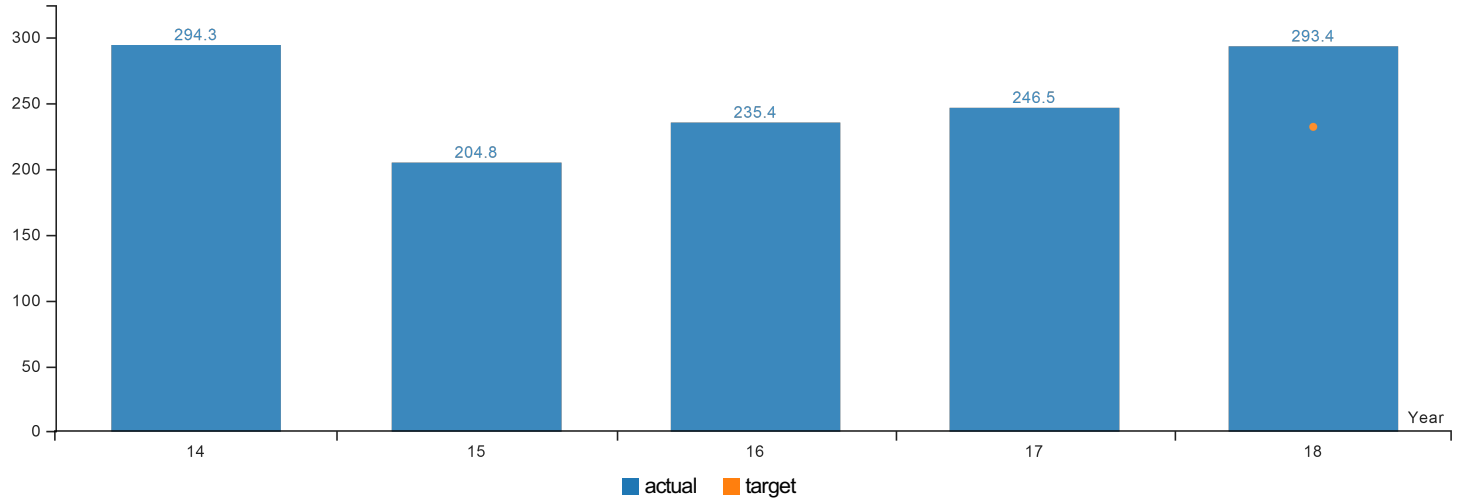
In 2011, there were 1,102 hospital admissions for COPD or asthma in older adults. This rate declined in 2013 to 801/100,000 Member Years (MY); and since 2014 the rate has remained steady around 440 /100,000 MY. In 2016, performance on this metric was below the KPM benchmark (lower is better). However, in 2017 performance was above the KPM benchmark (when lower is better).

Factors Affecting Results

Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. As the coordinated care model helps ensure that members receive the appropriate care at the appropriate time in the appropriate place, chronic and acute conditions are more likely to be addressed outside of hospital settings, resulting in improvements in this metric. Moreover, as enrollment in patient-centered primary care homes continues to increase (see KPM #15), CCOs and providers continue to emphasize the importance of preventive care.

KPM #18	PQI 08: Congestive Heart Failure Admission Rate -
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
PQI 08: Congestive Heart Failure Admission Rate					
Actual	294.30	204.80	235.40	246.50	293.40
Target	TBD	TBD	TBD	TBD	232

How Are We Doing

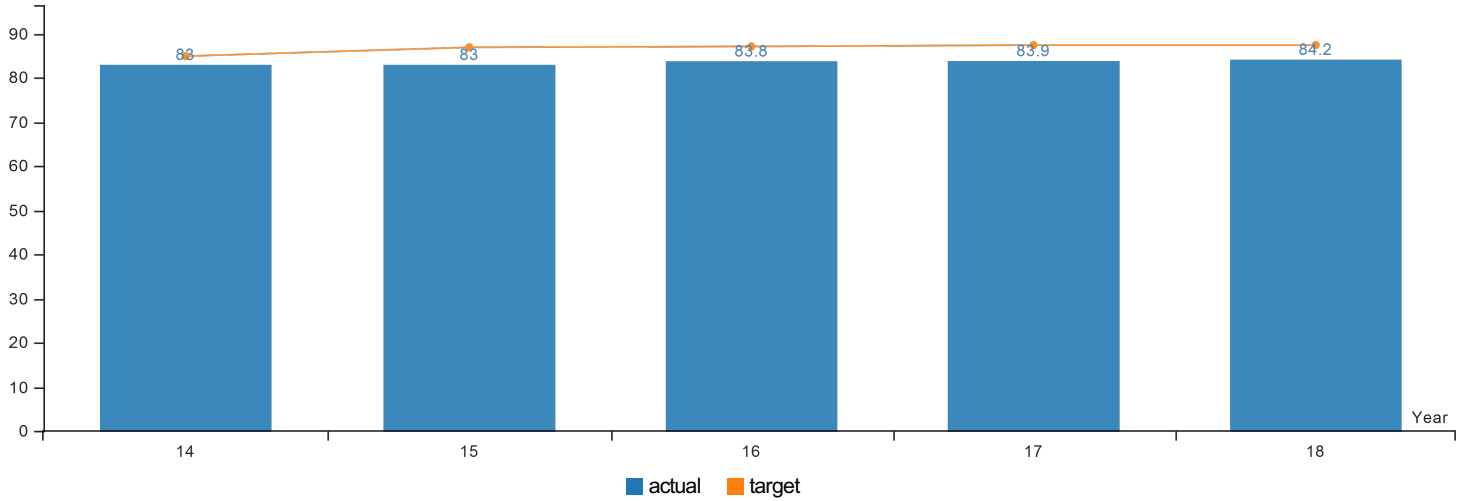
In 2011, there were 345 hospital admissions for congestive heart failure per 100,000 member years (MY). This rate declined in 2013 and 2014, with just 205/100,000 MY in 2014. In 2016, the rate of hospital admissions for congestive heart failure was above the KPM target (246.5 vs 232), and this continued in 2017. Lower is better on this metric.

Factors Affecting Results

Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. As the coordinated care model helps ensure that members receive the appropriate care at the appropriate time in the appropriate place, chronic and acute conditions are more likely to be addressed outside of hospital settings, resulting in improvements in this metric. Moreover, as enrollment in patient-centered primary care homes continues to increase (see KPM #15), CCOs and providers continue to emphasize the importance of preventive care.

KPM #19	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

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
Access to care					
Actual	83%	83%	83.80%	83.90%	84.20%
Target	85%	87%	87.20%	87.50%	87.50%

How Are We Doing

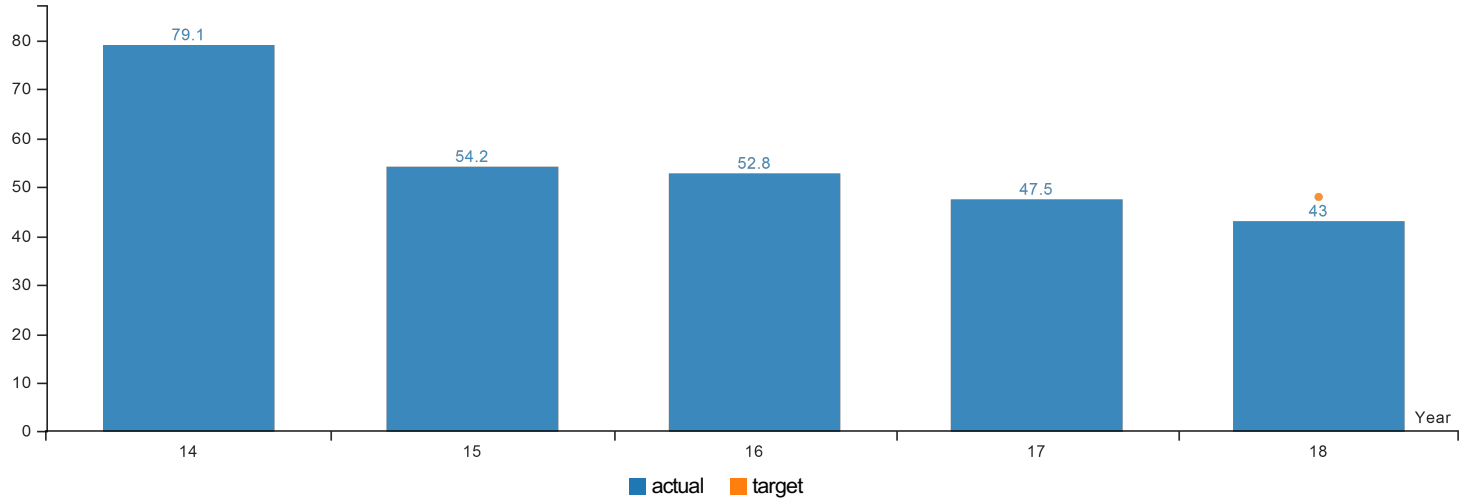
The percent of Medicaid members reporting they were able to receive appointments and care when they needed them has remained steady since 2011, with the percentage of members reporting that they "always or usually" received appointments and care when they needed them hovering near 83-84%.

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 75-percentile declined from 88.0% in 2013 to 87.2%). Inclusion in the CCO incentive program helps ensure that CCOs focus on improving member satisfaction and experiences with their health plan.

KPM #19	PQI 15: Asthma in Younger Adults Admission Rate -
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
PQI 15: Asthma in Younger Adults Admission Rate					
Actual	79.10	54.20	52.80	47.50	43
Target	TBD	TBD	TBD	TBD	48

How Are We Doing

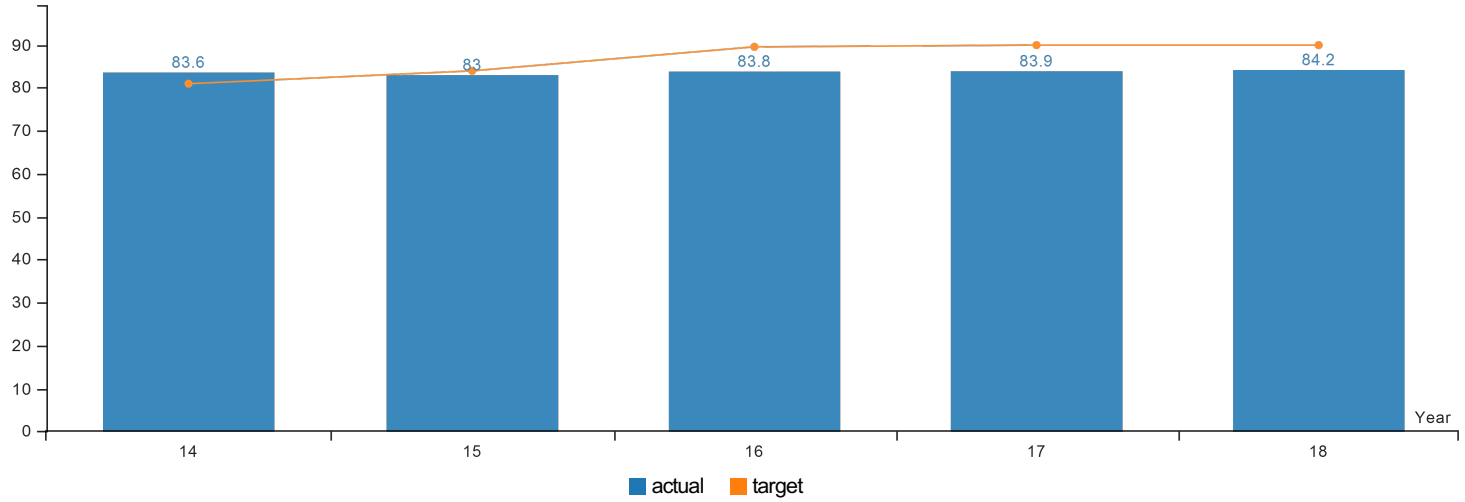
In 2011, there were 96 hospital admissions for asthma in younger adults. This rate declined in 2013 to 79/100,000 member years (MY); and since 2014 the rate has remained steady at around 50 /100,000 MY. In 2016, performance on this metric was below the KPM benchmark (lower is better), and this positive trend continued in 2017.

Factors Affecting Results

Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. As the coordinated care model helps ensure that members receive the appropriate care at the appropriate time in the appropriate place, chronic and acute conditions are more likely to be addressed outside of hospital settings, resulting in improvements in this metric. Moreover, as enrollment in patient-centered primary care homes continues to increase (see KPM #15), CCOs and providers continue to emphasize the importance of preventive care.

KPM #20	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

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
Member experience of care					
Actual	83.60%	83%	83.80%	83.90%	84.20%
Target	81%	84%	89.60%	90%	90%

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. Since 2014, the rate has remained steady at around 85%.

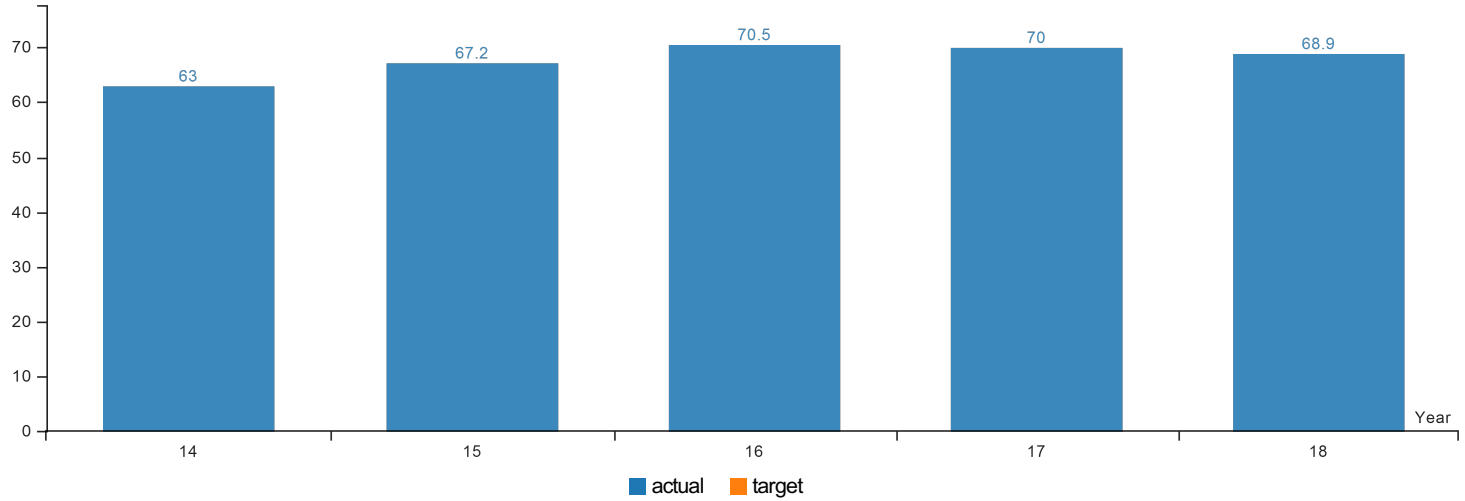
The description of this measure is incorrect (communication with doctors is not included in the composite).

Factors Affecting Results

This was the last year in which this measure is included in the incentive measure set.

KPM #21	MEMBER HEALTH STATUS - Percentage of CAHPS survey respondents with a positive self-reported rating of overall health (excellent, very good, or good).
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
MEMBER HEALTH STATUS					
Actual	63%	67.20%	70.50%	70%	68.90%
Target	TBD	TBD	TBD	TBD	TBD

How Are We Doing

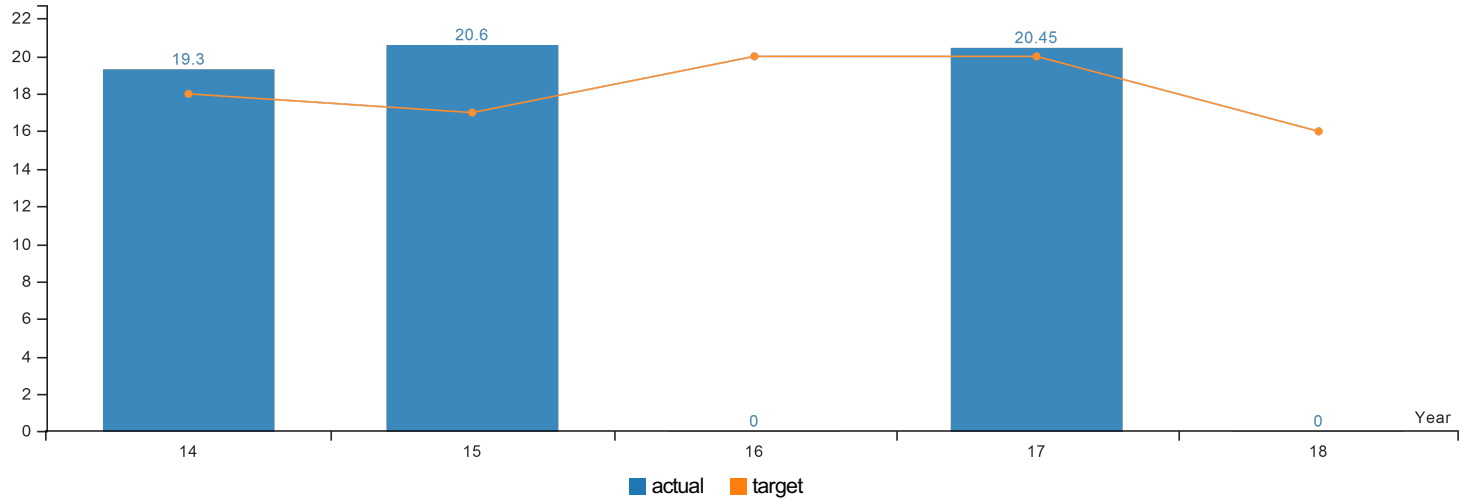
This has increased steadily each year since 2011, when 56% of members reported their health status as excellent, very good, or good (to 68.9% in 2017); however, this was a decrease from 2016, when performance was at 70%.

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 #22	RATE OF TOBACCO USE (POPULATION) - Rate of tobacco use among adults.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2014	2015	2016	2017	2018
Rate of tobacco use - adult population					
Actual	19.30%	20.60%	No Data	20.45%	No Data
Target	18%	17%	20%	20%	16%

How Are We Doing

Tobacco use (smoking cigarette or chewing tobacco) among adults has slowly declined from 2012 to 2017. This can be a bit misleading, however, due to the introduction of alternative tobacco products such as e-cigs, hookah, juul and other tobacco products. Beginning in 2015 the Public Health Division started reporting both unadjusted and age-adjusted rates which reflect population tobacco use and includes cigarettes, little cigars, large cigars, hookah, e-cigs and smokeless tobacco use.

This data is collected yearly and can be found published here:
https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/CHRONICDISEASE/DATAREPORTS/Documents/datatables/ORAnnualBRFSS_tobacco.pdf

For e-cigs, hookahs and smokeless tobacco use data, those can be found publshed here:
https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/CHRONICDISEASE/DATAREPORTS/Documents/datatables/ORTrendBRFSS_tobacco.pdf

Note 20% goal all smoking/16% cigarettes only

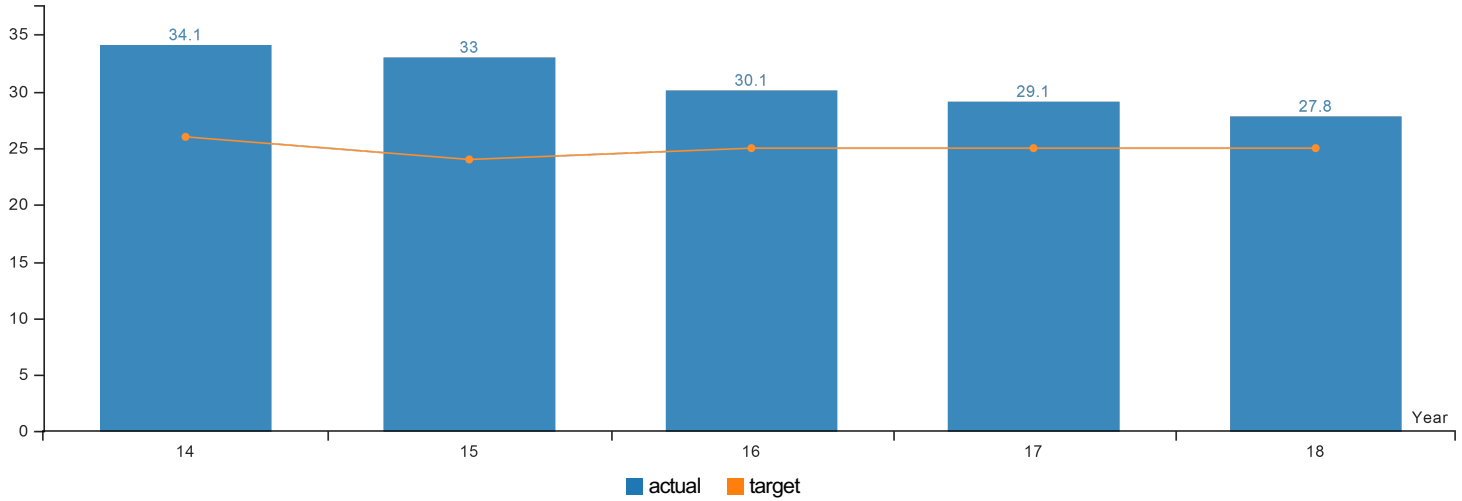
Factors Affecting Results

Includes only cigarettes and tobacco chew/not e-cigs.

2018 data is not available yet.

KPM #23	RATE OF TOBACCO USE (MEDICAID) - Percentage of CCO enrollees who currently smoke cigarettes or use tobacco every day or some days.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2014	2015	2016	2017	2018
Rate of tobacco use - Medicaid population					
Actual	34.10%	33%	30.10%	29.10%	27.80%
Target	26%	24%	25%	25%	25%

How Are We Doing

The percent of Medicaid members who use tobacco has decreased each year since 2013, the baseline for this measure. Compared to the non-Medicaid adult population (see KPM #19), adults on Medicaid are fifty percent more likely than the general population to use tobacco. The rate has decreased from 2016 to 2017 (which is positive).

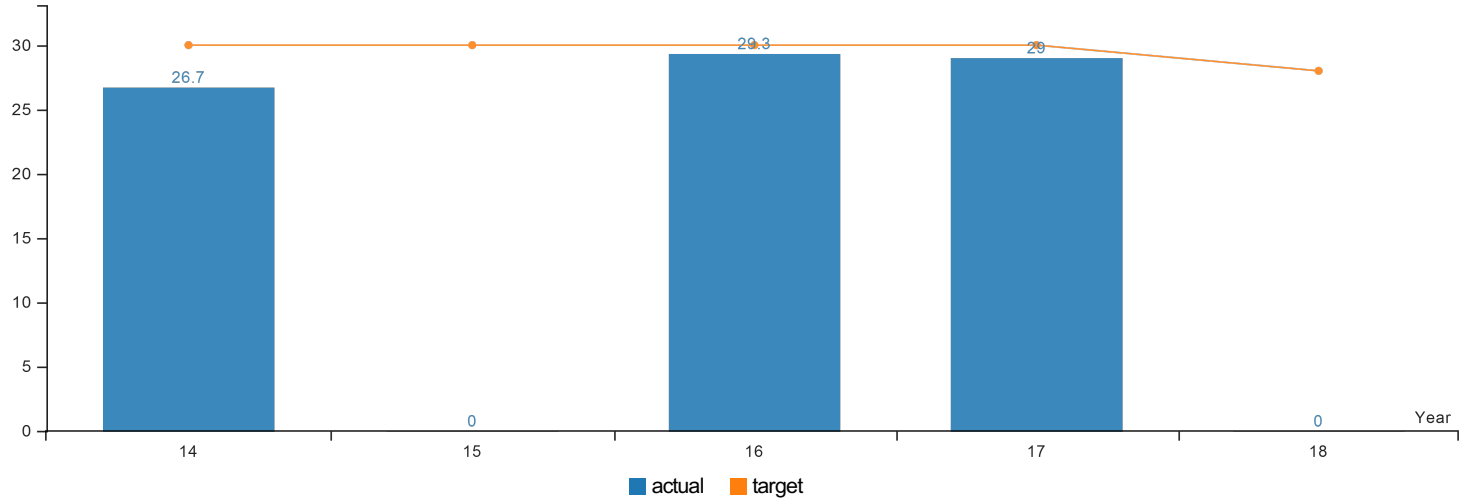
Factors Affecting Results

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.

Beginning in 2016, cigarette smoking prevalence is a CCO incentive measure. 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 #24	RATE OF OBESITY (POPULATION) - Percentage of adults who are obese among Oregonians.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2014	2015	2016	2017	2018
Rate of obesity - adult population					
Actual	26.70%	No Data	29.30%	29%	No Data
Target	30%	30%	30%	30%	28%

How Are We Doing

This data is collected every year.

The Public Health Division does not have a funded program which specifically addresses the issue of obesity (including morbid obesity) among the population in Oregon. CDC funding has not been extended to the Public Health Division since 2005. As a proxy, the Health Prevention & Chronic Disease Prevention program has been focusing on active transportation methods to increase activity.

The survey data can be found here:https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/CHRONICDISEASE/DATAREPORTS/Documents/datatables/ORTrendBRFSS_riskfactors.pdf

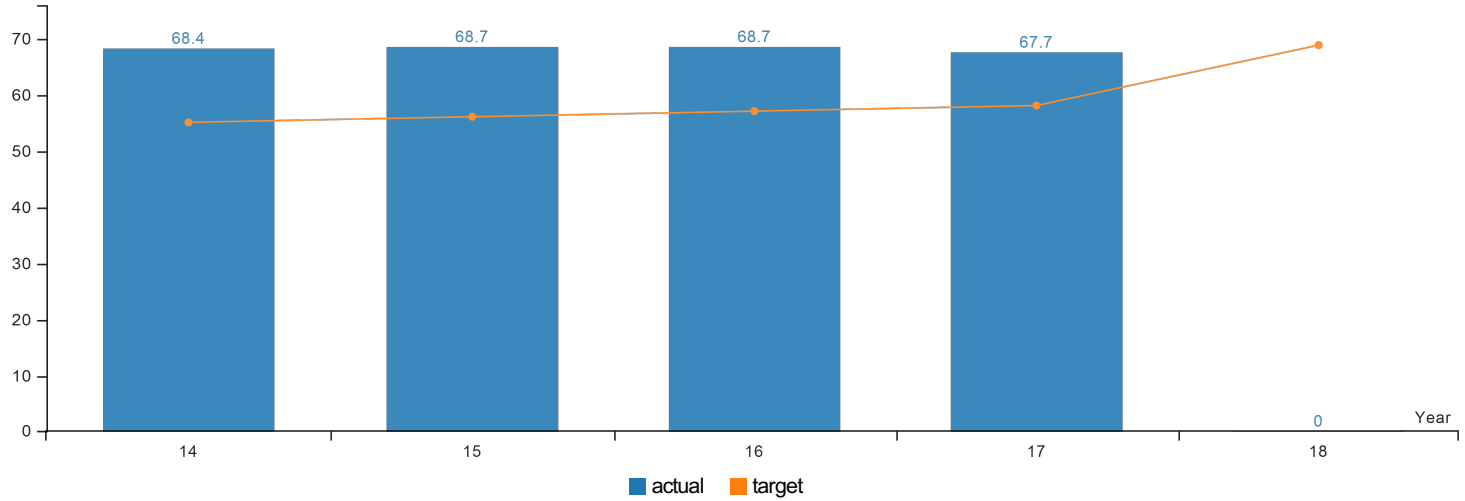
Factors Affecting Results

It should be noted that this measure is based on survey data.

2018 data is not available yet.

KPM #25	EFFECTIVE CONTRACEPTIVE USE (POPULATION) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
Effective contraceptive use - population					
Actual	68.40%	68.70%	68.70%	67.70%	No Data
Target	55.20%	56.20%	57.20%	58.20%	69%

How Are We Doing

Beginning in calendar year 2015, effective contraceptive use among women at risk of unintended pregnancy is a CCO incentive metric. The incentive measure is calculated using administrative claims data and cannot be compared directly to this KPM, which come from survey data. For example, BRFSS survey data include a substantial number of women who are using sterilization methods and long-acting reversible methods, which may not be apparent from administrative claims data.

Incentive measure results can be found online at: http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx

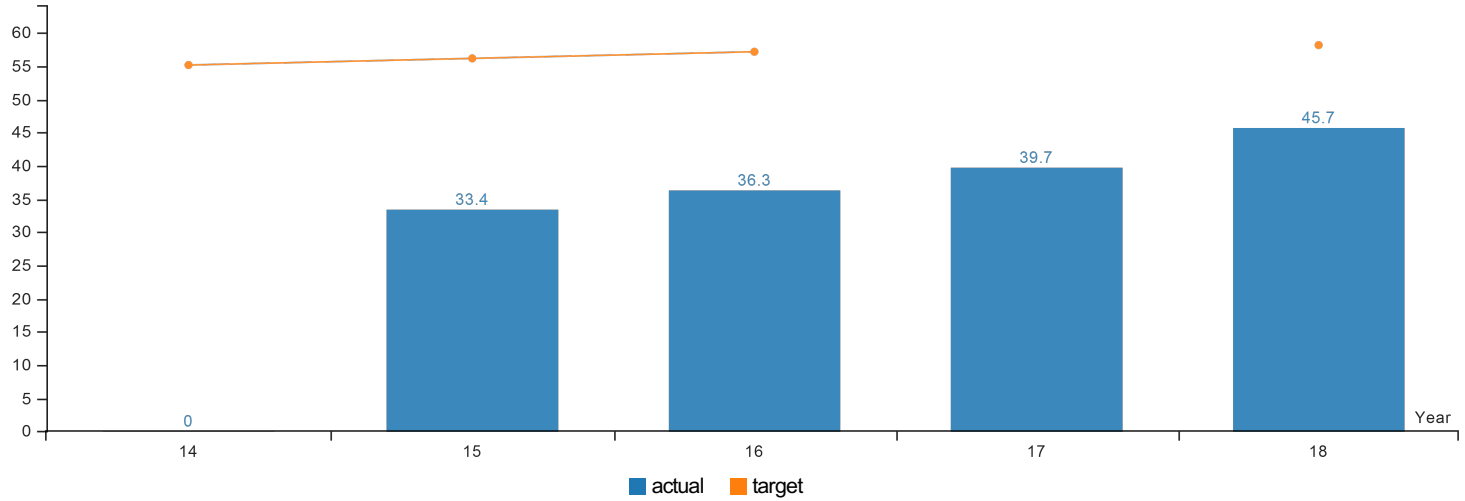
Factors Affecting Results

It should be noted that this measure is based on survey data whereas KPM #26 uses administrative claims data. Thus, KPM #25 is more likely to accurately capture individuals who are using permanent and long-acting contraceptive methods, resulting in higher overall rates of effective contraceptive use compared to KPM #26. In recent years the Oregon legislature has passed several bills intended to increase access to contraception, including enhanced confidentiality provisions and insurance coverage for a full year's worth of contraceptive methods. In addition, the passage of the Reproductive Health Equity Act in the Oregon legislature in 2017 will both ensure that private insurance plans continue to cover preventive services, including contraception, without cost sharing, and also will help to support funding for Oregon's family planning clinics starting in 2018, which may impact results in future years.

2018 data is not available yet.

KPM #26	EFFECTIVE CONTRACEPTIVE USE (MEDICAID) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
Effective contraceptive use - Medicaid population					
Actual	0%	33.40%	36.30%	39.70%	45.70%
Target	55.20%	56.20%	57.20%	TBD	58.20%

How Are We Doing

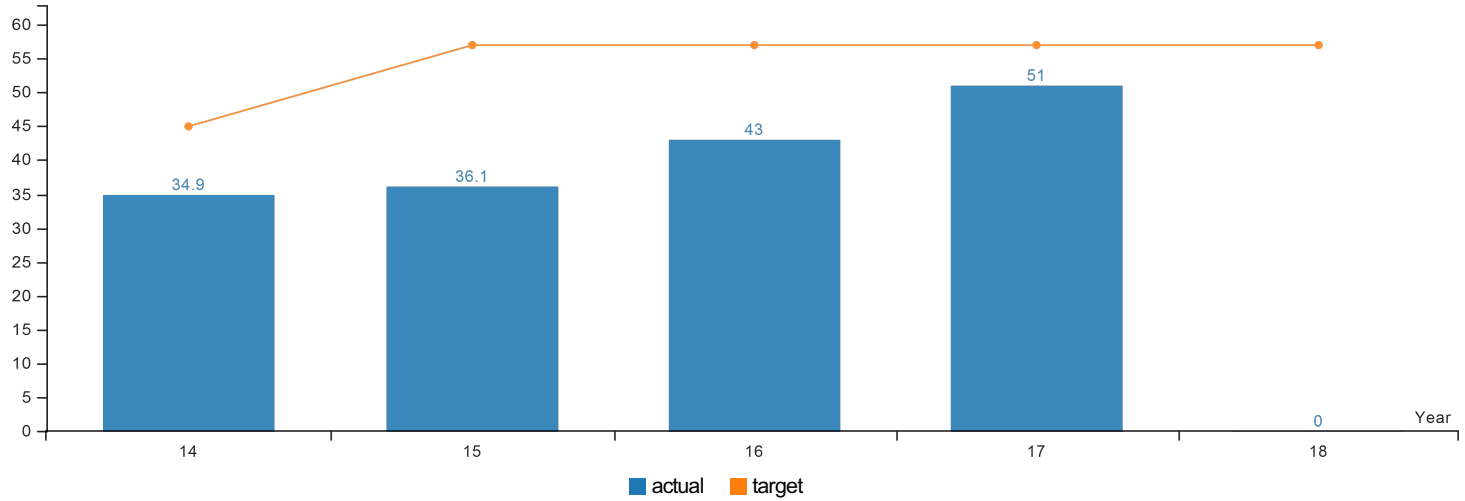
NOTE: data represents women ages 18-50

Factors Affecting Results

CCOs have a target of 50% per the 2017 benchmark source from the Metrics and Scoring Committee

KPM #27	FLU SHOTS (POPULATION) - Percentage of adults ages 50-64 who receive a flu vaccine.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
Flu shots - population					
Actual	34.90%	36.10%	43%	51%	No Data
Target	45%	57%	57%	57%	57%

How Are We Doing

According to the CDC, over 48 million Americans were sick with influenza in the 2017-18 season, with almost a million of these having to be admitted to a hospital. (1) Immunizations for influenza provide both direct protection, so that you are less likely to catch flu when exposed, and a community protection, so that you are less likely to pass flu on to others. Senior adults are at the greatest risk of hospitalization from influenza disease. However the majority of influenza disease cases, (61%), are actually among working age adults. Older working age adults, from age 50 to 64, are at a greater risk of serious influenza consequences than younger adults, and typically have substantially lower influenza immunization rates than seniors age 65+. While seniors age 65+ under Medicare have wide access to influenza immunization, working age adults may still have barriers to accessing influenza immunizations. Improving immunization rates for adults age 50 to 64 would close a gap in needed protection against influenza.

While each influenza season is different, immunization rates for adults age 50 to 64 in Oregon have been increasing across most seasons. One item that needs to be addressed to further increase rates is that non-senior adult men tend to have lower immunization rates than women. Another factor is that different parts of Oregon have higher or lower influenza immunization rates; adults in many rural or southern regions of Oregon typically have lower influenza immunization rates.

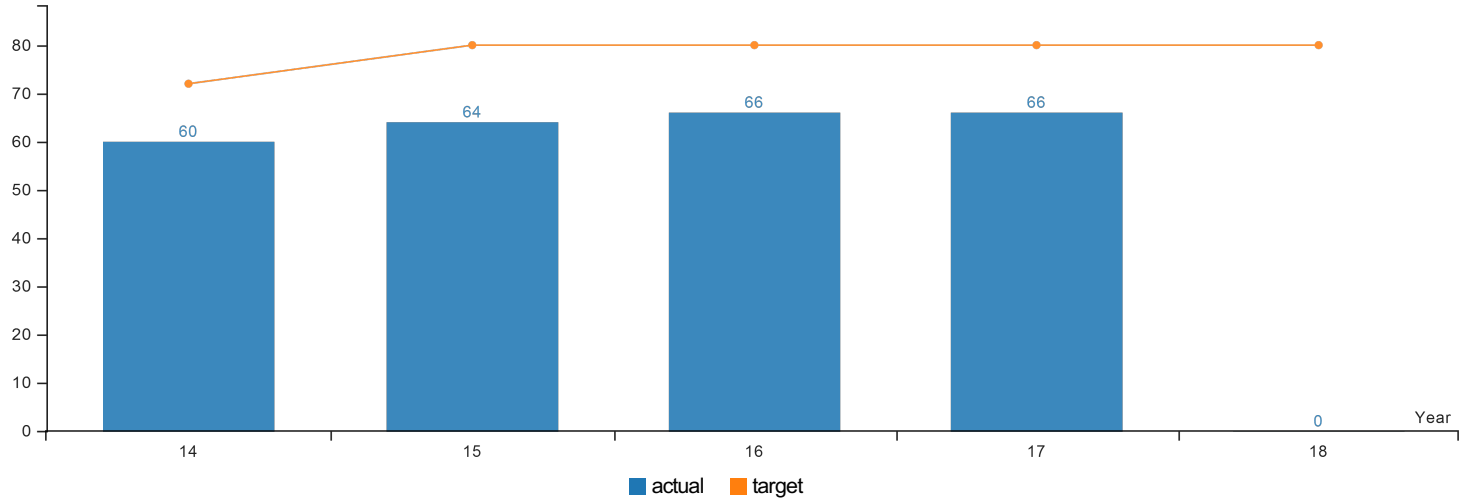
These data are collected annually and can be found published here: http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx

Factors Affecting Results

2018 data is not available yet.

KPM #28	CHILD IMMUNIZATION RATES (POPULATION) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
Child immunization rates - population					
Actual	60%	64%	66%	66%	No Data
Target	72%	80%	80%	80%	80%

How Are We Doing

Nationally, the most common measures of immunizations are related to whether two-year olds have received the recommended early childhood vaccines. Infants are vulnerable to vaccine-preventable diseases (VPDs). The reduction in infant hospitalizations and deaths from VPDs because of immunization is one of the greatest successes in public health. According to the American Academy of Pediatrics, between birth and age two 11 well-baby or preventative health care visits are recommended, with immunizations due at up to eight of these visits.(1) Receiving recommended immunizations and immunization visits is often considered as a proxy for whether infants are receiving adequate preventive care visits.

By age two, infants should receive vaccinations protecting against 14 separate diseases. A widely used measure of adequate early immunizations is the 4:3:1:3:3:1:4 series, which is based on infants receiving 4 diphtheria/tetanus/pertussis (combined) immunizations, 3 polio immunizations, 1 measles/mumps/rubella (combined) immunization, 3 hepatitis B immunizations, 3 Hib (Haemophilus influenza type b) immunizations, 1 varicella immunization, and 4 pneumoccoal immunizations.

In Oregon, the percentage of two-year old children having complete 4:3:1:3:3:1:4 series immunizations has been slowly increasing over the last five years. Incentives provided to CCOs to increase immunization rates are one type of factor behind this increase. Importantly, most Oregon two year olds who are not complete for this series only need one more immunization visit to catch up.

For more information, check out the Oregon Immunization Program's website, at https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/VACCINESIMMUNIZATION/Pages/researchchild.aspx

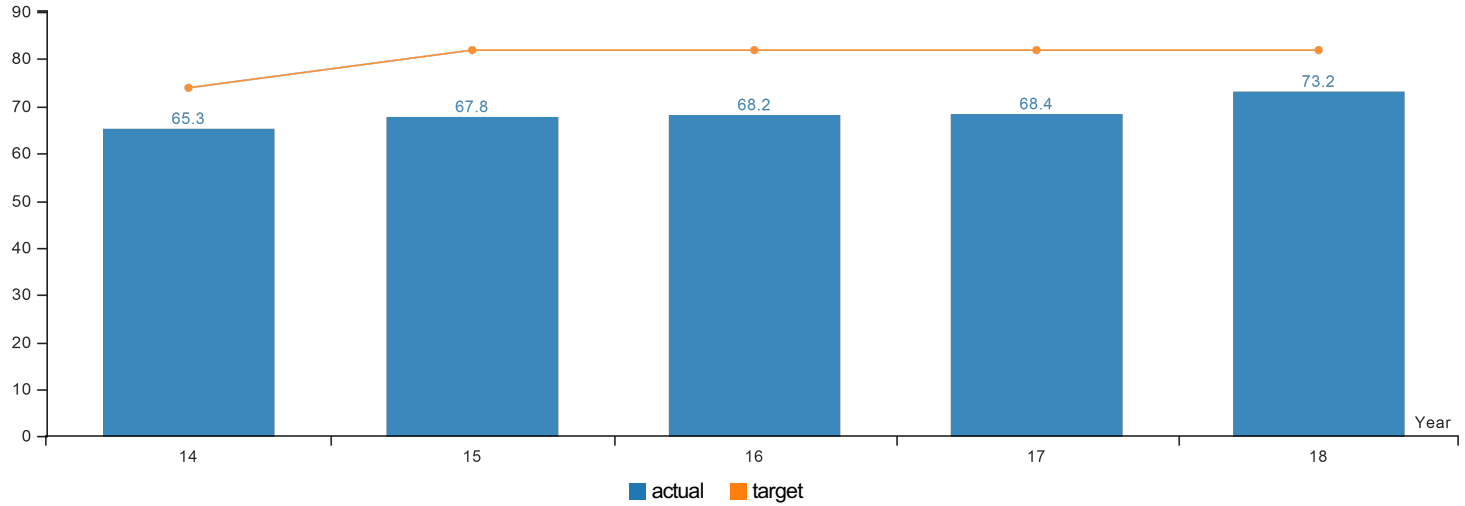
Factors Affecting Results

CCO incentive measures have impacted raise in rates.

2018 data is not available yet.

KPM #29	CHILD IMMUNIZATION RATES (MEDICAID) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
Child immunization rates - Medicaid population					
Actual	65.30%	67.80%	68.20%	68.40%	73.20%
Target	74%	82%	82%	82%	82%

How Are We Doing

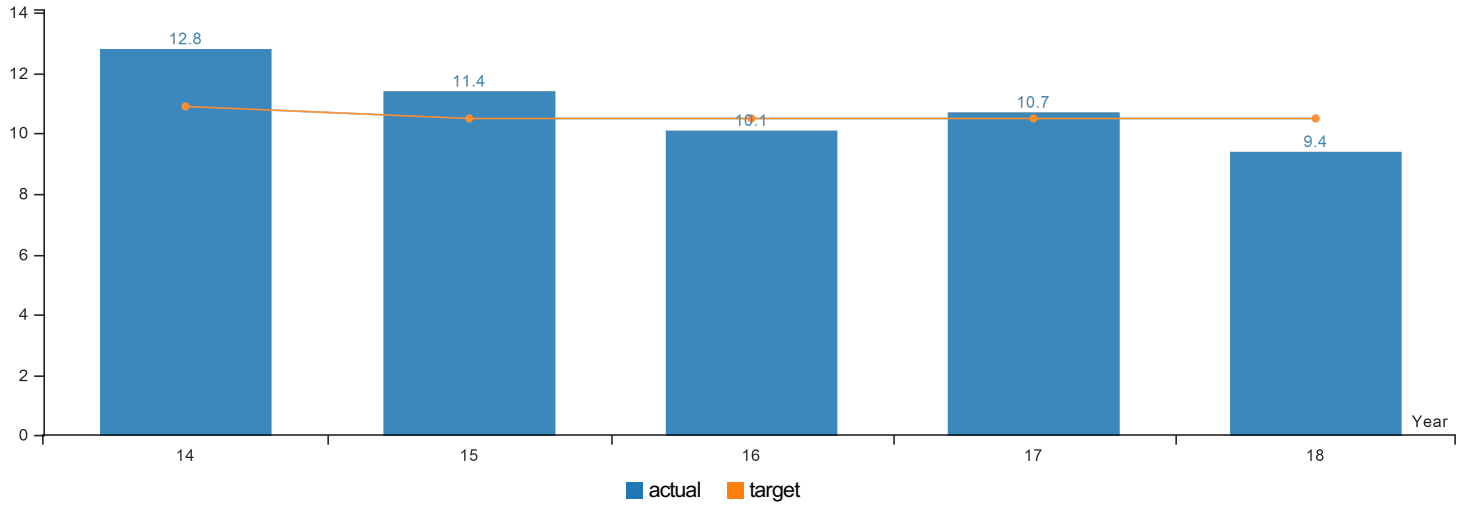
In CY2015, 68.2% of CCO members received recommended vaccines before their second birthday. Positively, this increased to 73.2% in CY2017.

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 #30	PLAN ALL CAUSE READMISSIONS - Percentage of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for members 18 years and older.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2014	2015	2016	2017	2018
Plan all cause readmissions					
Actual	12.80%	11.40%	10.10%	10.70%	9.40%
Target	10.90%	10.50%	10.50%	10.50%	10.50%

How Are We Doing

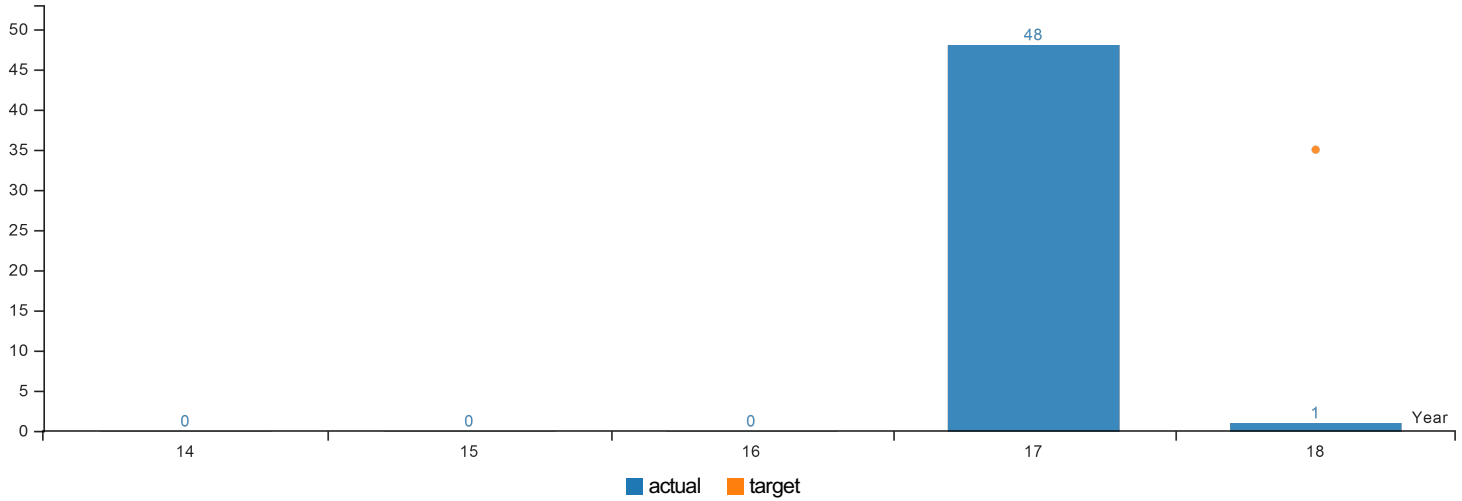
Hospital readmissions continue to decline in Oregon (lower is better) and in CY2016 achieved the KPM target; this trend continued in CY2017.

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 continue 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 addressed, resulting in a reduction in this readmission rate.

KPM #31	ELIGIBILITY PROCESSING TIME - Median number of days processing time from date of request to eligibility determination.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
ELIGIBILITY PROCESSING TIME					
Actual	No Data	No Data	No Data	48	1
Target	TBD	TBD	TBD	TBD	35

How Are We Doing

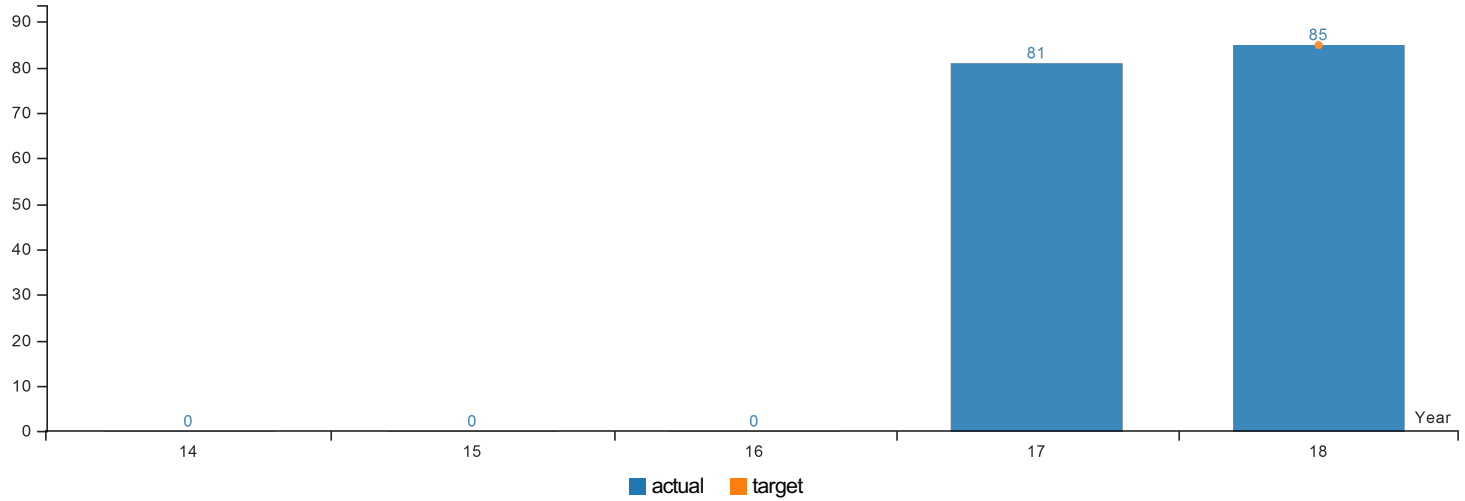
Previous years counted all applications in the processing time indicator. CMS asked that we only report processing times for new applications according to their metric definitions. This change in our reporting methods became effective in February 2018. This means that the CMS processing time indicator does NOT include renewal applications for 2018. This is the median processing time, which is only one type of measure of central tendency. The processing time is fast for new applications because the vast majority are online applications through the ONE Applicant Portal. We confirmed with our system admins that the report reflects the difference in days between the application submission and determination dates.

Factors Affecting Results

Oregon uses data from the ONE system to report on median processing time for new Medicaid/CHIP applications. The data for CY 2018 showed an unusually fast time from application to determination, so we took the extra step of validating this data before we finalized the report.

KPM #32	OHP MEMBERS IN CCOs - Percent of Oregon Health Plan members enrolled in Coordinated Care Organizations.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2014	2015	2016	2017	2018
OHP MEMBERS IN CCOs					
Actual	No Data	No Data	No Data	81%	85%
Target	TBD	TBD	TBD	TBD	85%

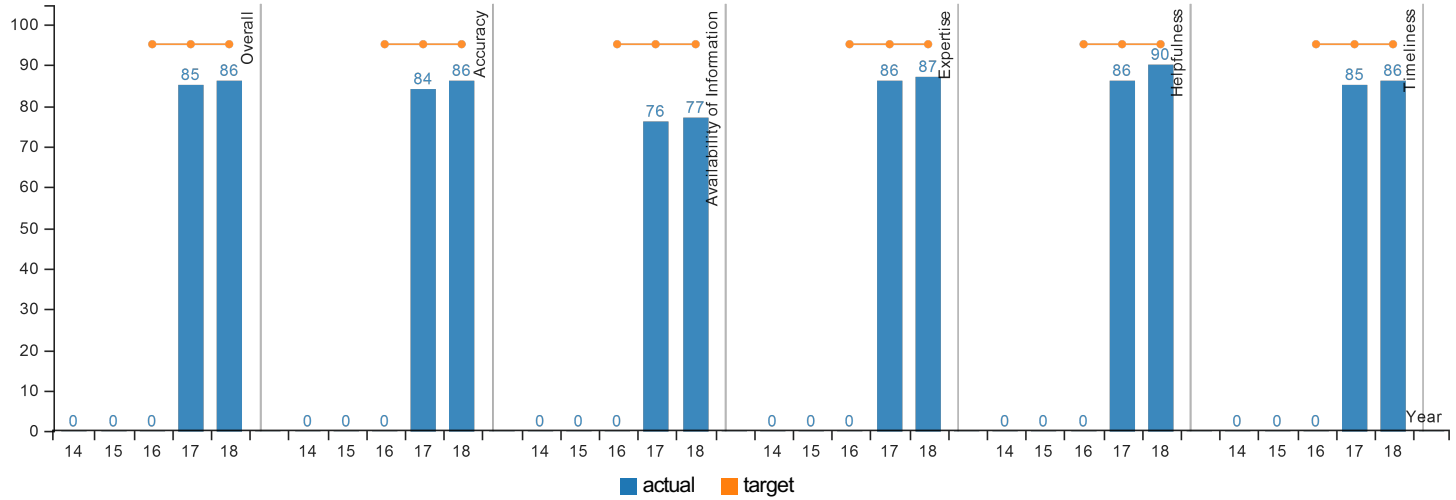
How Are We Doing

OHA met the target of 85% in September 2018 and we are on track to meet the target of 88% for 2019.

Factors Affecting Results

The Oregon Health Authority (OHA) is implementing program changes that will increase the number of Medicaid eligibles enrolled in CCOs. For example, starting in 2019, OHA will automatically enroll duals into CCOs for their physical health care. This process will happen as a regional roll-out, including two pilot regions in January and April of 2019. Duals will have the option, at any time, to opt-out of the CCO for physical health care. In addition, Oregon Health Authority has updated the eligibility renewal process for Oregon Health Plan (OHP) members to begin federally-mandated automated eligibility verification, in appropriate cases. This streamlined and accurate verification method will 1) improve the renewal process for OHP members, 2) reduce the risk members will experience unwarranted disruptions in coverage, care or CCO enrollment.

KPM #33	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	2014	2015	2016	2017	2018
Overall					
Actual	No Data	No Data	No Data	85%	86%
Target	TBD	TBD	95%	95%	95%
Accuracy					
Actual	No Data	No Data	No Data	84%	86%
Target	TBD	TBD	95%	95%	95%
Availability of Information					
Actual	No Data	No Data	No Data	76%	77%
Target	TBD	TBD	95%	95%	95%
Expertise					
Actual	No Data	No Data	No Data	86%	87%
Target	TBD	TBD	95%	95%	95%
Helpfulness					
Actual	No Data	No Data	No Data	86%	90%
Target	TBD	TBD	95%	95%	95%
Timeliness					
Actual	No Data	No Data	No Data	85%	86%
Target	TBD	TBD	95%	95%	95%

PEBB surveys members each year following open enrollment for the new plan year. This year's results show continued improvement of at least 1-2% in all customer service categories over 2017. Employee helpfulness showed a 4% improvement over last year. We expect these results to show continued improvement.

Factors Affecting Results

PEBB continues to refine business processes, train staff, and focus on information sharing. We have further refined web content and communication materials focusing on ADA standards and plain language to improve accessibility and readability. We continue to update systems and processes. Benefits have remained fairly stable and the Health Engagement Model (HEM) has been in place for several years.

Oregon Health Authority IT Related Projects/Initiatives

Program Area	Agency	Project Name	Project Description	Estimated Start Date	Estimated End Date	Project cost to date	Estimated 19-21 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
Public Health	OHA	HIVE (HIV-Electronic)	This project is to replace the existing CAREAssist and HIVCAT applications with application(s) that address current system reliability system issues, missing critical functionalities, replaces antiquated technology, poor usability, and inadequate system audit functions. The current HIV Electronics (HIV-E), a.k.a. HIVCaT Program, uses case management and tracking applications known as the CAREAssist and HIVCaT. The systems are used by program staff to administer, track and monitor the eligibility of clients and their use of program benefits.	4-Feb-15	30-Dec-22	$ 368,554	$ 3,969,232	$ 4,417,000	Base	P	Y,2	L	PHD - HIV	
Public Health	OHA	TWIST to Web	Replace the existing, outdated Women, Infants, and Children (WIC) Management Information System (MIS) called TWIST. The new MIS system will utilize advanced web-based technology and comply with the United States Department of Agriculture, Food and Nutrition Service (USDA-FNS) standards and guidelines.	3-Jan-17	31-Dec-20	$ 680,000	$ 8,849,144	$ 9,529,144	Base	P	N	L	Woman, Infants and Children (WIC)	
Public Health	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.	TBD	1-Jun-20	$ -	$ 950,000	$ 950,000	Base	I	N	N	Immunization	Project queued to begin in late 2019
Public Health	OHA	Tracking Home visiting Effectiveness in Oregon (THEO) Phase I	Deliver a maternal and child health home visiting data collection, case management and reporting system.	8-Jan-16	31-Jul-19	$ 1,976,997	$ 76,738	$ 2,563,000	Base	E	Y, 5	U	Maternal and Child Health	Project schedule extended into 19-21 biennium.
Public Health	OHA	Tracking Home visiting Effectiveness in Oregon (THEO) Phase II	Provide enhancements to the maternal and child health home visiting data collection, case management and reporting system. Enhancements to THEO (Phase II) will complete the development and implementation work focusing on Health Information Exchange (HIE), referral integration planning and development, mobile interface development for home visiting staff referrals, Medicaid claim submission to Health Services Division (HSD), and reporting of Meaningful Use utilization.	TBD	TBD	TBD	TBD	TBD	Base	I	N	U	Maternal and Child Health	Project queued to begin in late 2019
OEBB/PEBB	OHA	OEBB/PEBB - Benefit Management System (BMS) Replacement Planning	OEBB and PEBB share the goal of implementing a centralized, standardized, supportable, and scalable solution to replace both MyOEBB and pebb.benefits, which will provide easier enrollment, better coordination of benefits management, improved access to plan information, and enhanced integration with other tools that improve the overall experience for all customers and users.	TBD	30-Jun-21	$ -	$ 1,806,102	$ 1,806,102	POP	I	N	N	OEBB/PEBB	Project queued to begin in late 2019
Health Policy and Analytics	OHA	APAC Data Vendor Transition	Replace current All Payers All Claims (APAC) solution with one that provides the agency with better value. The Oregon State Legislature established APAC in 2009 and authorized the formation of a health care data reporting program to measure the quality, quantity, and value of health care in Oregon. To support the APAC's ability to evolve alongside Oregon's Health system and expand its data collection capabilities, Health Analytics intends to evaluate the current pool of qualified APCD data vendors and execute a new contract that ensures the best overall return on investment.	1-Sep-17	31-Dec-20	$ 8,024	$ 829,418	$ 928,400	Base	P	N	N	Health Policy and Analytics	
Health Systems Division	OHA	COMPASS Modernization	OHA envisions a data management and processing system for behavioral health service outcomes that can hold millions of individual records, directly interface with a variety of internal and external data systems, and electronic health records systems, and provide multi-functional reporting to support state and federal requirements. Additionally, the work is expected to support improved treatment outcomes for Oregonians through the exchange, analysis and reporting of data; support improved business practices and reduced administrative burden for OHA through the ability to better analyze and forecast outcomes and need; and support improved customer service and reduced administrative burden to providers.	27-Nov-18	30-Jun-21	$ -	$ 6,739,793	$ 6,739,793	POP	I	N	L/N	Behavioral Health	
Health Systems Division	OHA	Capacity Management System	HB 3440 and the Federal Substance Use Block Grant requires the Health Policy and Analytics (HPA) division and the Health Systems Division (HSD) to establish and maintain a capacity management and referral tracking system for Oregon opioids and substance use disorder treatment providers. OHA will leverage a statement of work process with Lines for Life, software already used for capacity management, to streamline the implementation. This will provide the needed referral method for adults who need residential services, improving geographic access and tracking treatment options, referrals, and provider types to treat individuals suffering from opioids or opiate abuse or dependency.	TBD	TBD	$ -	TBD	TBD	TBD	I	N	U	HSD	HSD has determined that this project can be accomplished without going out for an RFP bid, and will now be moving forward with adding a SOW as an amendment to an existing contract that they have with the vendor Lines for Life.

Oregon Health Authority IT Related Projects/Initiatives

Program Area	Agency	Project Name	Project Description	Estimated Start Date	Estimated End Date	Project cost to date	Estimated 19-21 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
Oregon State Hospital	OHA	HASP 2.0	The purpose of the existing HASP system is to provide a highly-available Health Information System (HIS) environment based on the Avatar Application from Netsmart, to ensure that OSH is able to continue operating in a secure and safe manner in the event of a significant systems or other failure that renders the primary data systems at the SDC inoperative or unavailable. As OSH has gained more experience the Avatar systems in production, and with use of the HASP 1.0 capabilities, we have a clearer understanding of the areas that need to be expanded, many of which were identified in the original HASP Gap Analysis.	TBD	18 months - 36 months	$ -	TBD	TBD	Base	I	N	U	OSH	Project queued to begin in mid 2019
Health Systems Division	OHA	Electronic Child and Adolescent Needs and Strengths (eCANS)	Health Systems Division (HSD) Child and Family Behavioral Health Unit (CFBH) is implementing an e-CANS system for collecting, managing, and reporting data from the Child and Adolescent Needs and Strengths (CANS) assessment tool utilized by Behavioral Health Providers for children/youth in Wraparound services.	18-Sep-17	27-Aug-19	$ -	$ -	$ 350,000	Base	I	N	N	HSD	Project on pause until funding and resources become available to move project forward. The anticipated timeline for moving project forward is expected in 2019-2021 biennium.
Fiscal	OHA	MMIS Program Integrity	Implement updated Program Integrity functionality to recoup fraud and abuse charges incorrectly paid for Medicaid claims. • Implement a more thorough and enterprise-wide fraud, waste and abuse (FWA) detection, prevention and investigation program in the Medicaid and the OHA non-Medicaid investment • Initiate FWA audits and investigations of CCO's and their network provider environment • Comply with new and enhanced CMS-driven program integrity requirements for MCO's • Increase FWA oversight of vulnerable provider types and practices, e.g. 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 • Work with FWA contractor(s) to investigate and audit data analytic-based leads and discoveries • Augment Medicaid beneficiary fraud investigations • Strengthen program integrity principles throughout Medicaid rules	26-Nov-18	15-Aug-20	$ -	$ 2,009,679	$ 7,859,046	Base	I	N	N	Fiscal, Office of Program Integrity	
Health Systems Division	OHA	1095B Solution	TBD	TBD	TBD	$ -	TBD	TBD	TBD	I	N	TBD	HSD, MMIS	Project queued to begin in mid 2019
Office of Information Services	Enterprise	Host Explorer	Current enterprise PC desktop emulation software enabling connection to the mainframe is Open Text's Host Explorer 6.0 software. This software allows access to the mainframe and supports Transport Layer Security (TLS) 1.0 level encryption. Before the close of 2017, ETS will be upgrading the mainframe to TLS 1.2 level encryption. OHA/DHS need emulation software that can support this upgrade.	TBD	TBD	$ -	TBD	TBD	TBD	I	N	L	TBD	
Health Systems Division	Enterprise	MMIS Medicaid Modularity Planning	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.	1-Jan-17	TBD	$ 128,529	$ 415,802	$ 3,468,003	POP	P	N	L	HSD	
Shared Background Check Unit	Enterprise	CRIMS	Replace the existing background check software with one approved by CMS and CJIS compliant. BCU is seeking approval and support to implement the NBCP BCS system. Implementation is inclusive of: an interface to LEDS and data migration from CRIMS.	10-Aug-18	31-Dec-19	$ 200,704	$ 676,449	$ 912,203	Base	I	N	N	BCU	Being prioritized through DHS Governance Counsel - in process
Shared	Enterprise	Integrated Eligibility (IE)	Quick, correct and efficient eligibility determinations for Medicaid (MAGI and Non-MAGI), SNAP, TANF, and Child Care. Extend the OregoNEligibility (ONE) to include eligibility determination for the Non-Modified Adjusted Gross Income (Non-MAGI) Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Employment Related Day Care (ERDC) programs. The system will include an on-line portal for applicants, better support for eligibility workers, and it will integrate with other Department of Human Services (DHS), Oregon Health Authority (OHA), and external systems.	1-Jul-15	30-Nov-20	$ 108,605,026	$ 177,512,265	$ 385,840,367	POP	E	Y,3	U/N	SS/HSD	Project formerly known as "ONE Integrated Eligibility & Medicaid Eligibility"
Shared	Enterprise	Office 365 Implementation	Implement Office 365 (Phase 1 Functionality) throughout OHA and DHS.	24-Apr-17	30-Aug-19	$ 187,648	TBD	$ 450,356	Base	I	Y	U	Shared	Project scheduled completion in 19-21 biennium.

Oregon Health Authority IT Related Projects/Initiatives														
Program Area	**Agency**	**Project Name**	**Project Description**	**Estimated Start Date**	**Estimated End Date**	**Project cost to date**	**Estimated 19-21 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**
Aging and People with Disabilities	Enterprise	Centralized Abuse Management (CAM)	Implementation of a Centralized Abuse Management System to allow OAAPI and its program partners to monitor abuse screenings and investigations occurring around the state in real time, provide critical and accurate abuse data and performance metrics to internal and external partners, connect the dots' statewide to protect vulnerable Oregonians and prevent abusers from moving from one system or region to another undetected, and protect DHS and OHA programs from the risk of abuse referrals or investigations 'falling through the cracks' or going unaddressed without detection.	1-Jul-15	31-Mar-20	$ 6,289,970	$ 2,574,007	$ 13,530,447	POP	E	Y, 8	U	OTIS, APD, DD, HSD	Project schedule extended into 19-21 biennium

Federal Audits
Current Status of OHA Audits
12/15/18

Ongoing Audits	Scope
PERM FFY 2017	Cycle activities began in August 2016. The Data Processing Reviewers are reviewing the entire sample of 1700 claims for both FFS and MC. Receiving possible expectations for review and possible appeal. Anticipate report to be received by December 2018.
OIG Oregon's Section 1115(a) Medicaid Demonstration - OHP	This engagement was previously a survey to better understand the Oregon Health Plan waiver and now has become an audit, focused on CCO client access and quality of services. The entrance conference was held April 20, 2018. Visiting CCOs in May - July 2018. Plan to meet with OHA in early August for a wrap up of this audit.
GAO Study of Medicaid HCBS 2018	Five state GAO study regarding access to Medicaid Home and Community Based Care (HCBC). Will focus on how states design their Medicaid HCBS benefits. Will involve both DHS-APD and DD, and OHA. Initial interview held January 31 2018. Additional information provided in February of 2018.
CMS Oregon Asset Verification Program (AVP) State Plan Amendment	CMS is requesting information to ensure Oregon is in compliance with requirements of Section 1940 for the Social Security Act, related to implementation of an Asset Verification Program (AVP). DHS and OHA provided initial response in November 2017 and submitted an updated plan to CMS by February 9, 2018. Oregon has committed to implementing an asset verification system by December 31, 2018.
CMS Medicaid Program Integrity 2018	This is a review of OHA and DHS Medicaid Program Integrity efforts, focusing on Managed Care. CMS conducted its on-site review from May 22-24, 2018 and OHA and the CMS review team are ensuring all documents requested during the on-site are submitted. The exit conference is currently being scheduled. A draft report is expected in late September or early October 2018. Once the draft report is issued, OHA will have 30 days to respond to the report. Final report is expected by February 2019.

Ongoing Audits	Scope
CMS School Based Services Financial Management Review	Site visit held 9/18/2017. Exit conference held March 5, 2018. Working out final repayment details with CMS.
CMS HCBS ICF/IDD Support Services Waiver Review (375.R03)	Determine that Oregon meets the assurances for the Home and Community-Based ICF/IDD Support Services Waiver. The Waiver is effective from July 1, 2014 through June 30, 2019 and serves over 7,000 beneficiaries. Evidence regarding the assurances provided to CMS on 9/29/2017. Received response back from CMS mid January 2018. Provided responses to CMS' draft report April 11, 2018. No final report has been issued.
GAO Interview on CMS Fraud Management	GAO conducted interviews on March 7, 2017 with OHA management and are also talking to three other states. OHA validated information on September 27, 2017. We are currently awaiting a final report.
FNS-Oregon WIC Management Evaluation 2018	FNS conducted a Management Evaluation (ME) for Fiscal Year 2018 that covers the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). The purpose of the review is to assess the State agency's compliance with Federal Regulations, Instructions, and policies pertaining to WIC; provide technical assistance; and promote a collaborative partnership with the State agency WIC Program. Review was conducted the week of August 6, 2018.
CMS Medical Loss Ratio Review (OHA)	CMS conducted a review from August 13-through August 16, 2018 to determine how MLR is calculated on the CMS 64 report.
OIG Survey for Specialty Drugs	Survey sent to all states to examine the State Medicaid program's coverage and reimbursement for specialty drugs. Request for information is due January 4, 2019.

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, 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.

  Aging and People with Disabilities (APD) has obtained missing applications from all clients except those that were determined to be deceased. For those individuals, APD followed up with the Estate Recovery Unit to ensure that they were aware of the clients' passing and were filing an estate claim if appropriate. APD has continued to remind managers and staff of the importance of maintaining complete files through meetings and "In the Loop"

newsletter articles. For the clients who experienced eligibility-coding errors, the state has returned the federal funds. All corrective actions are complete.

- 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.

  The Information Security & Privacy Office (ISPO) has embarked on a multi-tiered process that will result in an information security plan for the Department of Human Services (DHS) and the Oregon Health Authority (OHA). In alignment with the state's Enterprise Security Office, ISPO is using the Center for Internet Security's (CIS) Top 20 Critical Security Controls as our roadmap to identify and mitigate risks and compliance findings.

  We are using Tenable Nessus to perform vulnerability assessments of our enterprise to identify vulnerabilities and develop an asset inventory. The vulnerability management process, including regularly scheduled scanning and patching, has been implemented. The asset inventory will inform the information security plan.

  We have developed our information security risk assessment policy and process and have initiated an aggressive risk assessment schedule. Seven risk assessments have been accomplished in 2017 and more are scheduled. Like the vulnerability assessments, the risks (vulnerabilities and threats) and gaps identified from these assessments will inform the information security plan.

  The aforementioned are the CIS Critical Security Controls prerequisites for accomplishing an information security plan. ISPO recruited a Senior Information Security Advisor in May 2017 and have assigned the information security plan to him to complete no later than December 2017.

  The Information Security and Privacy Office (ISPO) is continuing to develop a plan to implement a framework for conducting the required security assessments on the Automatic Data Processing (ADP) systems which support the Medicaid program in Oregon. Vulnerability assessment scans of the MMIS system software are now performed monthly or whenever major changes are made to the system.
  A Vulnerability Management policy has been developed, approved and was published in September 2017. In support of this policy, ISPO already began scanning in excess of 15,000 devices utilizing the states vulnerability

assessment solution, Tenable Security Center (TSC). ISPO is concurrently working with OSCIO to determine how TSC will access and scans the remaining Medicaid systems residing on the mainframe.

The Information Security & Privacy Office (ISPO) is in the process of developing a risk analysis process that will establish the roles and responsibilities of the different parties for contracting all required types of independent assessments, as required by Federal Regulations.

Revisions to parent policy DHS|OHA 090-006 Risk Assessment to be submitted for review to Office of Information Services (OIS) Policy, Standards and Processes (PSP) Committee by September 1, 2017. Revisions to widen the scope to encompass all security assessments required by 45 CFR 95.621 (iii) Periodic risk analyses and (3) ADP System Security Reviews. Policy revisions and process will be based on CMS Risk Management Handbook (RMH) Chapter 12: Security and Privacy Planning, Version 1.0, January 31, 2017; Appendix E. ARS Standards – Planning (PL); Control PL-01.

The ISPO Risk Assessment Analyst is a member of a chartered advisory group within the Enterprise Security Office which acts in an advisory capacity to the ESO Risk Program Committee. In the course of that work, tools are under development to ensure that risk mitigation plans are established with state agencies. These tools will be leveraged to develop the "Risk Triage" process, to establish and implement a plan of action "Develop a Plan of Action (POA)"; see Attachment A. The Risk Triage process will be a sub-process of the DRAFT ISPO Independent Security Risk Assessment (ISRA) Process and will be submitted to the PSP Committee by September 1, 2017 with the policy revisions and parent process. The ISPO Risk Assessment Analyst meets on a monthly basis with OIS ISPO Audit Coordinator to coordinate risk mitigation efforts throughout DHS|OHA.

The OR-Kids system underwent an independent security risk assessment from March 2017 to May 2017. Tests included:

- *Information Security Web Application Penetration Test*
- *Application and Server Infrastructure Penetration Test*
- *Internal Technical Test (workstations)*
- *NIST Cybersecurity Framework Assessment*
- *OWASP Secure Coding Practices Assessment*

The final report was received at the end of June. Agreement was reached between ISPO and the Director of Development Disability Services to commence with an independent security risk assessment of the eXPRS system in third quarter of 2017.

- 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 also has a process in place to automate this transfer within the MMIS system.

  A coding matrix was 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 has been negotiated. Adjustments were made to ensure correct federal funding.

- Recommend management ensure staff are documenting that all databases were verified for new and revalidated providers.

  The authority implemented Change Request #20606 to create additional labels for the Provider Verification panel. This update will enable enrollment staff to properly label the reason for the database checks. In addition, the authority conducted specific database check training for enrollment staff between December 2017 and February 2018. The state provided additional database check training in July 2018 as part of a new enrollment quality improvement plan.

- 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, has 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, complete the bulk of our required site visits, and 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 planned 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. All federal and state targets were met in 2016.

- 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 worked 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 as of August 2016.

- 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 has continued 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 (DCA) 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.

Currently, the agency submits the cost allocation plan on an annual basis to the federal DHHS Cost Allocation Services (CAS), formerly DCA. A formal change log was created in March of 2017 to ensure all updates are included in each subsequent submission.

2. OHA: Safe Drinking Water Revolving Loan Fund –Applying Agreed-Upon Procedures for Fiscal Year Ended June 30, 2015, audit #2016-13 (dated June 2016)

- 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.

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.

State Financial Reporting (SFR) has also made several changes to our review process that should further reduce errors in the report. In 2016, 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, who conducted a formal, detailed review of this year's 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, the grant accountants more closely review 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 concludes with a final review by the unit manager.

3. DHS and OHA: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2016, audit #2017-08 (dated March 2017)

- Recommend management review the coding that points transactions to rebates and recoveries and other revenues to ensure proper classification of these transactions.

  The agency has updated its year-end close procedure to ensure the Rebate & Recovery revenue is appropriately coded for proper classification. The close procedure now includes a review of Other Revenue account transactions.

- Recommend authority management strengthen its methodology to ensure a more accurate estimate of the collectability of drug rebates for the current period.

  The Office of Financial Services is using a new set of reports that we believe will provide more accurate information than the ones used in prior years. Our procedures have been updated for these new reports.

- Recommend department management ensure the proper application of established accrual methodologies and that accrual efforts are not resulting in duplicate expenditures or revenues.

  The agency updated its close procedures to include additional reviews in an effort to avoid duplication of estimated accrual amounts.

- Recommend management strengthen controls to verify applications exist upon client eligibility redeterminations, perform eligibility redeterminations timely, identify any other clients that may have been impacted due to the override of system controls, and reimburse the program for unallowable costs.

  On March 21, 2017, federal funds in the amount of $1,329 that the department was unable to locate to support the costs charged to Medicaid, was returned. The department's Aging and People with Disabilities Office discussed with managers and staff the policies, appropriate documentation, and retention of applications needed to determine eligibility for our program. These reminders were included in the March 2017 "In the Loop" newsletter article and will be included as agenda items in future quarterly meetings. The department has returned the federal funds for the client whose determination was not completed timely. In addition, beginning in January 2016 and concluding August 31, 2017, OHA has worked to process redeterminations for the entire MAGI population and for those individuals who were part of an ACA–related deferred renewal population.

- Recommend management strengthen controls to ensure database searches are documented and enrollment agreements are maintained. For the specific items noted above, we recommend the authority obtain updated provider agreement forms and document that database checks were completed.

  The state obtained current provider enrollment agreements from the providers noted in the findings. The state conducted specific database check training for enrollment staff between December 2017 and February 2018. The state provided additional database check training in July 2018 as part of a new enrollment quality improvement plan. Additionally, the state will be requiring new provider enrollment agreements during our annual revalidation efforts for payable providers. This will begin in Spring 2019.

- Recommend management finalize its plan for other Medicaid systems and then perform risk analyses and security reviews of those system in accordance with the plan.

  The Information Security & Privacy Office (ISPO) has embarked on a multi-tiered process that will result in an information security plan for the Department of Human Services (DHS) and the Oregon Health Authority (OHA). In alignment with the state's Enterprise Security Office, ISPO is using the Center for Internet Security's (CIS) Top 20 Critical Security Controls as our roadmap to identify and mitigate risks and compliance findings.

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The Information Security and Privacy Office (ISPO) is continuing to develop a plan to implement a framework for conducting the required security assessments on the Automatic Data Processing (ADP) systems which support the Medicaid program in Oregon. Vulnerability assessment scans of the MMIS system software are now performed monthly or whenever major changes are made to the system.

A Vulnerability Management policy has been developed, approved and was published in September 2017. In support of this policy, ISPO already began scanning in excess of 15,000 devices utilizing the state's vulnerability assessment solution, Tenable Security Center (TSC). ISPO is concurrently working with OSCIO to determine how TSC will access and scans the remaining Medicaid systems residing on the mainframe.
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The OR-Kids system underwent an independent security risk assessment from March 2017 to May 2017. Tests included:

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- *Application and Server Infrastructure Penetration Test*
- *Internal Technical Test (workstations)*
- *NIST Cybersecurity Framework Assessment*
- *OWASP Secure Coding Practices Assessment*

The final report was received at the end of June 2017. Agreement has been reached between ISPO and the Director of Development Disability Services to commence with an independent security risk assessment of the eXPRS system in the third quarter of 2017.

- Recommend department management strengthen its controls over the reviews of monthly employee cell phone invoices.

  In March of 2017, The Office of Information Services (OIS) Collaborative Communications generated a communication to all coordinators to remind them of their responsibility to review/acknowledge the monthly billing data and that their acknowledgement is recorded and audited.

  Further, OIS Collaborative Communications has developed a process and automated email notification system to alert the coordinator(s) and the manager if the monthly review is not completed timely. The first distribution of this message was sent out automatically beginning on June 28, 2017 to all MCD Coordinators that have un-acknowledged billing records. This notice will continue monthly.

- Recommend department management strengthen its controls over the reviews of monthly employee timesheets and cell phone invoices.

  Corrective action for the above findings has been broken down into four steps:
  - *Ensuring proper training of current staff members in the use of work charge codes.*

- *Ensuring the work charge code training is a part of our onboarding process to ensure that all new employees are trained going forward.*
- *Establish a process for signing and archiving timesheets that were not approved in the ePayroll system.*
- *Return of unallowable funds to federal partners related to misuse of work charge codes.*

Training for the use of work charge codes was provided on two separate occasions to staff members in the Health Policy and Analytics division. Those trainings occurred in January of 2017. The participants included all staff members and managers whose positions and workload require the use of work charge codes. Training for the use of work charge codes by future employees and managers will be ensured by the onboarding process. This is now a documented step in the permanent process used for all employees.

The Payroll department now sends an automated reminder to all managers who have not approved timesheets for their employees. In addition, it has now been written into the duties of the staffing manager in HPA to review monthly the timesheets for approval. Any that have not been approved will be delivered to the owning manager for physical written signature. These signed timesheets will be archived on site in a locked filing cabinet.

Adjustments to federal expenditures of $12,530 were made to address the questioned costs.

- Recommend management review expenditures to ensure sub-awards were used for authorized purposes.

In April 2018, the division initiated desk reviews of ACA expenditures within the three counties that received these funds. These reviews aimed to achieve the following objectives:

- *Ensure the subrecipient obligated, expended, and used grant funds in accordance with the rules and terms of the agreement.*
- *Verify that grant expenditures were properly authorized and supported by the subrecipient's source documentation and that costs were allowable and allocable to the grant program.*
- *Validate the subrecipient's reporting of periodic income and expenses matched with their general ledger.*

These desk reviews were conducted by the Office of Financial Services between May and June. Two of the reports were finalized in July 2018, the third was finalized August 2018.

- Recommend department management strengthen controls to ensure verification of suspension and debarment is performed for all contracts, evidence is retained, and contracts are complete.

  The Office of Contracts & Procurement has implemented internal contract processing standards beginning November 1, 2016. These new standards require a two-pronged approach to verify whether or not vendors are able to receive federal funding. Beginning with support staff searching the System for Award Management (SAM) for each vendor to verify that the vendor is neither suspended nor debarred from receiving funds and then saving the findings in the central electronic contract folder. Further, contract staff, once they have taken assignment of the contract action, are required to verify that the reports are correct and proper and if not, run a new report and address concerns if evident.

- Recommend management develop a formal tracking mechanism to ensure all changes to the plans are tracked for the inclusion in future updates communicated to the federal oversight agency. We also recommend management strengthen controls to ensure the cost allocation process follows the plans submitted for approval and interim changes, and all costs entering the cost pools are reviewed for allowability.

  The agency currently submits the cost allocation plans on an annual basis to the federal DHHS Cost Allocation Services (CAS), formerly DCA. A formal change log was created in March of 2017 to ensure all updates are included in each subsequent submission. The most recent cost allocation plan was submitted on June 30, 2017.

4. OHA: Medicaid Management Information System (MMIS) /Oregon Eligibility System (ONE) Information Technology (IT) Review, audit #2017-09 (dated May 2017)

- Recommend management continue to develop strategies to evaluate and improve caseworker input accuracy. In particular, we recommend management consider implementing a review process for portions of input identified as having higher error rates and that negatively affect eligibility determination.

  In early 2016, OHA took initial steps to develop a quality control (QC) process for data entry, which included a statistical sampling plan, data entry standards, auditing methods, quality metrics and data reporting. In mid-2017, DHS assumed the operational responsibility for the Oregon Health Plan eligibility processing and for the continuing development and deployment of the QC process.

DHS will expand this process beyond the main processing center and include SSP field offices. Because of this change of the scope, DHS/OHA will need to reassess the implementation progress in December 2018.

To address other factors that negatively affect eligibility determination, OHA generates a monthly MMIS validation report for all individuals who have crossed an age threshold without redetermination of eligibility in a defined period. DHS Operations meet on a bi-monthly basis with DHS and OHA subject matter experts to review accuracy and decide what corrective actions will be necessary.

- Recommend management develop procedures to monitor overrides to ensure they are performed only for approved reasons and that needed subsequent actions on these cases are timely.

  DHS Operations recognizes the risk of error when using overrides in the system. To mitigate this risk, DHS Operations has:

  - *Assigned key managers to monitor the override tasks to ensure appropriate use of the override and timely correction when appropriate.*
  - *Documented override procedures and trained staff on appropriate use of the override feature.*

  DHS is also in the process of developing and implementing data collection and reporting for the override process.

- Recommend management ensure system documentation is available to facilitate a granular review of permissions granted for each role.

  In July 2017, OHA began review of all current MMIS roles and successfully completed an assessment of OHP eligibility processing staff. OHA will continue a broad assessment throughout OHA and DHS in 2018 and 2019. OHA will also coordinate with DHS to update the names of current MMIS roles to better reflect their represented programs. This change will help managers better determine appropriate roles for the programs they administer and is expected to be completed April 2019.

In addition, OHA is developing a process for the annual review of MMIS roles, and a web-based directory tool that contains the definitions of current roles and access levels. The current access request forms will contain a link to this tool.

- Recommend management perform effective periodic reviews of access granted to their personnel.

  In 2017, OHA worked with the DHS|OHA Information Security and Privacy Office (ISPO) to change the MMIS security access process ensuring logical access is reviewed and can be audited. OHA is coordinating with its partners on a new tool that will allow OHA to make on-demand, real-time queries about changes to MMIS access (created, modified, expired, or removed access). OHA expects this reporting tool to be available by July 2018.

5. OHA: Improve Efforts to Detect and Prevent Improper Medicaid Payments, audit #2017-25 (dated November 2017)

- Develop a comprehensive inventory of MMIS system controls and proactively test the effectiveness and completeness of those controls.

  A team of OHA staff from the Office of Payment Accuracy and Recovery (OPAR), the Office of Program Integrity (OPI), the Provider Services Unit, and the MMIS BSU will be formed to review processes, identify opportunities for improvement, and propose prioritization of resources to address identified areas for improvement. These may include recommendations for process changes or enhancements or documentation of existing procedures.

  We acknowledge that the documentation for existing procedures should be improved, but it is important to note existing, effective procedures. Many FFS claims are auto-adjudicated through the MMIS system, with some claims requiring manual intervention to finalize payment. The PAU within OPI monitors for spikes in the usage of certain edits and requests validation of the edit from the Claims Unit, when appropriate. The Claims Unit coordinates with the MMIS BSU to review the correctness of the edit.

  The audit team identified a specific gap in our procedures to review and verify that system edits are working as intended. As a result, OHA has identified a small percentage of questionable payments that will

require adjustments. OHA's Health Systems Division (HSD) has developed a preliminary approach to address this noted deficiency. This approach will include:

- *Development of testing processes for the top 20% of MMIS edits with the most significant financial impact.*
- *Monitoring of remaining edits to confirm accurate functionality, using daily MMIS reports that detail denied or partially-denied claims and the edit that stopped payment. A monthly report will be created to flag edits not shown on the daily reports for testing.*

It is estimated that one full-time staff could effectively test and validate 10 edits per week, or approximately 500 edits per year, and monitor all remaining edits. We will need to evaluate existing resources and constraints related to ongoing technology projects, but we expect to implement these activities by January 2019.

- Adopt leading practices highlighted in the report, such as setting clear standards for acceptable program integrity efforts and including clear expectations in CCO contracts about when a sanction will occur and the automatic penalty that will be imposed for non-compliance.

  OPI has hired an Operations and Policy Analyst 4 (OPA4) to work with HSD and with CCOs to strengthen the program integrity and accountability constructs over the next two contract cycles. As the 2018 CCO contract is in the final stages of review, we expect to complete implementation with the 2019 CCO contract.

- Increase oversight of CCO program integrity efforts, such as approving CCO's fraud, waste, and abuse policies and reviewing how CCO's prevent, detect, and recover improper payments.

  OPI has hired an OPA4 to work with HSD and with CCOs to strengthen the program integrity and accountability constructs over the next two contract cycles. OPI is also in the process of hiring seven Government Auditor 2 (GA2) positions to audit the medical claims of network providers. In addition, OPI supports systematic training of CCO Compliance Officers, as coordinated by the External Quality Review Organization (EQRO), Health Insights. OHA has contracted with new EQRO and will be coordinating the program integrity aspects with the new contractor. As the 2018 CCO contract is in the final stages of review, we expect to complete implementation with the 2019 CCO contract.

- Develop robust efforts to validate the accuracy and completeness of encounter data, which may include hiring an External Quality Reviewer or developing internal monitoring efforts by the Office of Program Integrity.

  While several teams throughout OHA validate encounter data on a regular basis to ensure accurate metrics reporting, rate development, and contract compliance, encounter data is not currently audited against medical chart notes. OPI is in the process of hiring seven GA2 positions to audit medical claims of network providers. The target date to complete implementation activities also aligns with the implementation of the 2019 CCO contract.

- Review and clarify Oregon Administrative Rules so Medicaid providers can be held accountable for improper payments.

  We agree with this recommendation and had begun taking steps to address it prior to this audit. The Office of Program Integrity has hired an OPA4 to work with HSD and with CCOs to strengthen the program integrity and accountability constructs over the next two contract cycles. This position will also review Medicaid administrative rules and work with stakeholders to update them for clarity and to enhance program integrity.

- Work with U.S. Treasury Do Not Pay center on utilizing free, sophisticated data mining techniques and explore other internal opportunities for data matching.

  The Office of Program Integrity and the Office of Payment Accuracy and Recovery have completed the review of the "Do Not Pay" center information. The Office of Program Integrity has engaged in additional discussions with the U.S. Treasury, and are considering the opportunities to utilize the program. In January 2018, the U.S. Treasury received permission to work with Washington, Oregon and Tennessee.

- Work with CMS to explore pilot incentive programs to increase efforts to prevent, detect, and recover improper payments.

  The Office of Program Integrity (OPI) will engage with CMS and other state program integrity offices, through the Medicaid Integrity Institute and the National Association for Medicaid Program Integrity (NAMPI), to explore potential pilot incentive programs. The target date to complete implementation is aligned with the scheduled date for the next NAMPI national conference.

- Ensure there is an annual reconciliation process for all individuals in the agency's various computer systems to verify their eligibility is appropriately re-determined.

  Annual redeterminations are being performed through the transfer of the Member Services Center operations to DHS. Initial monitoring reports have been developed and are reviewed monthly. Ongoing collaboration between OHA and DHS to establish regular process for reviewing reports and resolving issues is being developed.

6. DHS and OHA: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2017, audit #2018-11 (dated April 2018)

- Recommend management ensure the transaction review process includes examination of proper coding and accounting periods.

  The agency updated their transaction review procedures with additional process steps to ensure that coding is correct and that transactions are posted to the correct fiscal year. These additional processes include reviewing the account balances after entries are posted to ensure the transaction had the correct effect, ensuring pass-through accounts are zero at the object level and not just at the fund level, and specifically noting when payroll transactions occur in two different fiscal years.

  The agency will continue to refine year-end procedures to ensure they are complete, reducing coding issues and errors. The procedures that affected the findings in FY18 have been updated to ensure these errors do not occur in future years.

- Recommend department management review OR-Kids transaction processing and make system modifications as appropriate to ensure proper financial reporting of program expenditures. We also recommend department management review prior year and current year transactions and reimburse the federal agency for grant expenditures claimed inappropriately.

  A report has been developed to identify adjustments that impact a state grant rather than the federal grant, and is in the final validation stage. Once the report is validated, the report will be used going forward to accurately report federal expenditures. The report will first be used for the reporting period ending September 30, 2018.

Adjustments for previous quarters reported incorrectly will be reported on the federal report for the period ending December 31, 2018. Disallowance of $103,130 was repaid to the federal agency, reported on 6/30/18 CB-496 report.

A change request for a system fix has been written. However, the date for the system fix is not yet determined.

- Recommend management strengthen controls to verify applications exist during client eligibility redeterminations, perform timely eligibility redeterminations and verification of client resources, close benefits for clients no longer eligible, and ensure eligible clients are enrolled in both Medicare and Medicaid. We also recommend management correct all identified issues and reimburse the federal agency for unallowable costs.

  In response to the individual who was enrolled in a correctional facility, the agency has reviewed the identified issue and has taken partial action. Eligibility and related payments have been reversed from the MMIS system. Procedures and system updates are still being reviewed and implemented and the return of unallowable costs is being confirmed. The anticipated completion date is December 31, 2019.

- Recommend management strengthen controls to ensure documentation supporting a provider's eligibility determination is retained. For current providers with missing documentation, we recommend the department verify they are eligible to provide services and obtain the necessary documentation.

  The Office of Developmental Disability Services (ODDS) has begun the process of amending the contract with PPL, the Fiscal Intermediary, to validate the I9's prior to paying providers. We anticipate the completion of this amendment by December 31, 2018. In addition, questioned cost of $5,573 has been reimbursed as of September 30, 2018.

  The management of the Oregon Health Authority (OHA) Provider Support Services conducted specific database check training for enrollment staff between December 2017 and February 2018. The state will provide additional database check training beginning July 2018 as part of a second enrollment quality improvement plan and continues to pull quarterly, a missing database check report, to ensure all missing database checks are completed.

For the one provider that was the responsibility of the Aging and People with Disabilities program (APD), the Department obtained a current completed I-9 form and confirmed the provider's eligibility; therefore, there are no questionable costs remaining for the APD program.

- Recommend management resolve the inconsistencies between the planned funding sources communicated to the Contracts and Procurement Unit and the actual funding sources used to make contract payments.

  The Department contract had the correct funding source when it was submitted to the Office of Contracts and Procurement (OC&P) on the original request form. Subsequently, there was an invoice miscoded by Adult and People with Disabilities (APD) program staff. APD will emphasize to their staff the need to verify that coding matches the correct funding stream prior to submitting an invoice for payment.

  The Authority contract was originally requested utilizing General Funds. Six months after the request, OHA Public Health Division (PHD) found a federal funding source to apply toward the contract. Upon changing funding sources, PHD should have submitted a request to OC&P to amend the contract to include the new funding source. In the future when programs need to change funding sources, a contract amendment request to identify the new funding source is required, to allow OC&P to add pertinent information such as CFDA numbers and appropriate terms and conditions to the contract. OC&P has contacted the PHD Contract Administrator to alert them to this requirement for future requests. In addition, OC&P included language in the June contract administration update under the "Did You Know" section to remind all contract administrators if the funding changes, an amendment will need to be requested.

7. OHA: Constraints on Oregon's Prescription Drug Monitoring Program Limit the State's Ability to Help Address Opioid Misuse and Abuse, audit #2018-40 (dated December 2018)

- Maintain an ongoing partnership with health licensing boards to target outreach efforts to get all required prescribers registered with the PDMP.

  Partnerships between the PDMP, prescribers, and licensing boards regarding opioid prescribing are a key means of ensuring patient safety. OHA has partnered with health licensing boards and medical associations to promote use of the PDMP for several years. In response to HB 4143's requirement for all prescribers to register as PDMP

users, OHA supported licensing boards in conducting provider outreach. With the help of medical licensing board promotion of PDMP registration and utilization, as of early November 2018, 92.7% of the 4,000 highest-volume prescribers of Schedule II-IV medications (which includes opioids) had registered for the PDMP. This is a substantial increase from March 2018 when only 55.4% of this group had registered. PDMP provider queries have increased more than fourfold since 2012. This effective work will continue.

- Provide guidance, including examples, to prescribers on ways to integrate accessing the PDMP database into their daily workflow.

  OHA provides guidance and assistance to providers to integrate PDMP use into their work flows in several ways.

  - *Tools for clinicians: In collaboration with the PDMP, in 2017 Oregon Opioid Prescribing Guidelines Taskforce members developed opioid prescribing guideline implementation tools. These materials are available on the Oregon Pain Guidance website at https://www.oregonpainguidance.org, which currently receives more than 30,000 unique visitors per month. These clinical tools include work flows, a PDMP electronic health record integration guide, a quality improvement reporting guide, a PDMP training video, and guidance on medical director access to the PDMP. The website also provides an opioid patient registry template that enables providers to use the PDMP to identify and track their patients with opioid and benzodiazepine prescriptions, as this functionality is limited within most electronic health records. In response to this recommendation, OHA will review and update the PDMP website to ensure the broadest possible reach of these resources.*
  - *Training and technical assistance on PDMP use in clinical workflows: OHA also provides training and in-person support for PDMP use in clinical workflows place under the auspices of the Public Health Division's Prescription Drug Overdose prevention project, a sister program to the PDMP that is coordinated through the Injury and Violence Prevention Program. This work takes place via OHA contracts with members of the Pain Management Improvement Team, an expert interdisciplinary group of Oregon clinicians that assists health systems and clinics to improve opioid prescribing and treatment of pain and substance use disorder. One of the contractors is a health informaticist who specializes in assisting clinics in maximizing their use of the PDMP within clinical workflows. Clinics in need of assistance are identified in collaboration with the Oregon Medical Board. This work has been nationally recognized as a model for a team-based primary care approach to address the opioid epidemic. In response to this recommendation, OHA will continue its collaboration with the Oregon Medical Board*

and the Pain Management Improvement Team to identify and support clinics in need of assistance with PDMP/electronic health record integration.

- *Electronic medical record/PDMP integration: The statewide Prescription Drug Monitoring Program Integration initiative was launched in August 2018 by the Oregon Health Leadership Council, OHA, and other stakeholders under a public/private partnership called the HIT Commons. For the first time, authorized Oregon prescribers and pharmacists can have one-click access to PDMP data within their own electronic workflow. This initiative aligns with broader state and federal efforts to increase the use of PDMPs to reduce inappropriate prescriptions, improve patient outcomes, and promote more informed prescribing practices. Oregon emergency departments have already seen the benefits of PDMP Integration. Earlier this year, the PDMP Integration initiative targeted the Emergency Department Information Exchange (EDIE)/PDMP integration as its highest priority. As of September 2018, 25 Oregon hospital emergency departments (more than 600 prescribing clinicians) across Oregon are receiving PDMP data via EDIE. In response to this recommendation, this work will continue.*

- Verify practitioner specialty information with the respective health licensing board and update the PDMP database with this information.

  Medical specialty information is an important element within the PDMP dataset and can help identify appropriateness of opioid prescribing. However, many prescriber types (e.g., naturopathic physician, dentist, nurse practitioner) do not have designated specialties, so it is not possible to identify specialty information for all PDMP users. Since October 2018, PDMP staff have been collecting available specialty information from licensing boards for upload into PDMP user profiles. This is a planned activity that is in process, one of the program's final steps in migration to the new PDMP platform. In response to this recommendation, this work will continue.

- Develop a process for, and facilitate the sharing of, data between PDMP and Medicaid to help ensure completeness of PDMP prescription history and to allow Medicaid to better monitor the prescription behavior of its clients.

  Completeness of prescription history is an important component of high-quality PDMP data. In response to this recommendation, OHA will confer with the Oregon Department of Justice to clarify the scope of the program's authority for data sharing with the Medicaid program. Based upon that advice, OHA will continue to provide data and best practices to legislators to inform statutory change to enable implementation of this recommendation.

- Identify and propose drugs of concern, such as gabapentin, to the Board of Pharmacy and Legislature that should be added to the state's-controlled substance schedule and collected by the PDMP.

  In response to this recommendation, OHA will continue to track emerging best practices regarding addition of drugs of potential abuse or misuse to Oregon's PDMP. This ongoing work is informed by emerging medical and public health literature and program evaluations conducted within the community of agencies implementing PDMPs across the country. OHA will also continue its partnership with the Oregon High Intensity Drug Trafficking Area (HIDTA) program to stay current on trends in the local illicit drug market.

  OHA will also continue to partner with the Board of Pharmacy as new drugs of concern emerge. Examples of previous partnership include OHA's collaboration with the Board of Pharmacy on naloxone distribution and naloxone training, and the State Health Officer's provision of data to inform discussions about the potential establishment of kratom as a scheduled medication (the Board of Pharmacy voted against this).

  As new drugs emerge as potential additions to the PDMP, OHA will provide data and information to legislators.

- Work with the PDMP vendor and the Board of Pharmacy to make sure prescriptions made by X-waivered prescribers are included in the PDMP database.

  Complete prescription data within the PDMP is crucial for ensuring that the system enables clinicians to make safe and accurate prescribing decisions. OHA, like many other agencies that operate PDMPs across the country, recognizes the current gaps in X-waivered prescribing records as an area of focus for ongoing data quality improvement. Because identification of an up-to-date list of X-waivered providers has proved challenging, OHA is utilizing data from multiple sources, including the U.S. Drug Enforcement Agency and SAMHSA, to ensure that prescriptions filled under X-designated DEA numbers can be seen within the PDMP system. OHA is in the process of obtaining complete, current lists of X-waivered prescribers and as a response to this recommendation will continue to update PDMP records with this information as part of its ongoing data quality assurance activities.

- Expand statutes to allow the PDMP to conduct and share analyses on prescription data, including:
  - analyzing prescriber, pharmacy, and patient prescription practices;
  - making prescriber report cards available; and

- preparing and issuing unsolicited reports to licensing boards and law enforcement

Under PDMP's current statutory authority, the legislatively mandated PDMP Clinical Review Subcommittee confidentially reviews prescriber, pharmacy, and patient prescription practices. Practice in other states has shown that peer comparison is an effective means of changing opioid prescribing practice. As guided by the Governor's Office, OHA would support expansion of legislative authority to enable the full implementation of this recommendation. In response to this recommendation, OHA will provide data and best practices to legislators on evidence-based recommendations to improve the PDMP and health outcomes.

- Seek legislative action to address the issue of prescribers not registering with the PDMP as required and pharmacies not submitting corrected data within statutory requirements.

  OHA agrees that complete, accurate PDMP data are important, and that routine use of the PDMP helps to reduce risky opioid prescribing and ensure patient safety. OHA awaits direction from the Oregon legislature regarding implementation of this recommendation and will support decision making with data and evidence-based practice.

- Provide further authority to the Clinical Review Subcommittee to require the justification of practices deemed concerning, and allow the collaboration with licensing boards and law enforcement for concerning practices.

  The PDMP Clinical Review Subcommittee has reviewed data, created risky opioid prescribing criteria, identified risky prescribers, and sent letters to these providers informing them of resources for improving their prescribing practices. OHA agrees that the ability to share more information about prescribing practices—especially among those providers prescribing the highest numbers of opioids—will enhance patient safety. OHA awaits direction from the Oregon legislature regarding implementation of this recommendation and will support decision making with data and evidence-based practice.

- Expand authority for other professional and state entities authorized access to PDMP information.

  OHA agrees that expanding authorized access to specific groups—including dental directors and Coordinated Care medical and pharmacy directors—would enhance oversight of prescribing practices and improve patient safety. OHA awaits direction from the Oregon legislature regarding implementation of this recommendation and will support decision making with data and evidence-based practice.

- Require and set parameters for when prescribers must query the PDMP database to review a patient's prescription history. This should include, at a minimum, requiring the querying of the PDMP database prior to prescribing controlled substances and substances of concern, and for dispensers to query the database prior to issuing a medication and periodically while the patient is taking those medications.

  OHA agrees that routine use of the PDMP by providers and pharmacists is important for reducing opioid prescribing. The agency will await direction from the Oregon legislature regarding this recommendation and support decision making with data and evidence-based practice.

- Allow for additional information to be collected by the PDMP. This should include:

  - prescriptions for Schedule V controlled substances and other drugs of concern;
  - applicable prescriptions from other types of pharmacies, not solely retail pharmacies;
  - applicable prescriptions prescribed by veterinarians;
  - method of payment used to pay for the prescription;
  - patients who are restricted or have a "lock-in" to a single prescriber and a single pharmacy for obtaining controlled substances; and diagnosis code related to the prescription

  OHA agrees that complete, accurate PDMP data are important, and that routine use of the PDMP by providers and pharmacists is important for reducing opioid prescribing. The agency will await direction from the Oregon legislature regarding this recommendation and support decision making with data and evidence-based practice.

PROGRAM PRIORITIZATION FOR 2019-21

Agency Name: Oregon Health Authority

2019-21 Biennium

Agency-Wide Priorities for 2019 -2021 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	1,947,471,262	-	2,432,696,150	-	11,531,669,633	-	15,911,837,045
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	333,479,636	9,443,888	122,727,423	-	64,036,012	-	529,686,959
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	24,785,323		34,870,691	40,000,000	97,211,117	102,729,051	299,596,182
4	Public Health Programs	State Public Health Director	No	Responsible for state emergency preparedness, planning, and response.		8, 10	49,862,632	-	7,537,063	-	256,725	-	57,656,420
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	3,511,892		5,837,248		15,779,506	-	25,128,646
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	3,027,078		1,226,402		2,709,404	-	6,962,884

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	487,849,183		69,170,986		36,719,113	-	593,739,282
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	7,103,554	-	416,607	-	2,073,201	-	9,593,362
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			2,088,188,484				2,088,188,484
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	-	-	1,727,512,598	-	-	-	1,727,512,598
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.			-	-	-	-	66,317,546	-	66,317,546
							2,857,090,560	9,443,888	6,490,183,652	40,000,000	11,816,772,257	102,729,051	$ 21,316,219,408

OREGON HEALTH AUTHORITY: 10 PERCENT REDUCTION OPTIONS

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

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.
- Avoiding reductions that have a negative impact on populations already disproportionately impacted by health inequities and health disparities.
- Minimizing impact on prenatal and early childhood health initiatives.
- Applying the OHA goals of containing costs, improving quality and increasing access to health care.
- Avoiding reductions that shift people to more costly service models within OHA or DHS.
- Minimizing effect on OHA Health Systems Transformation efforts and the obligation to maintain the growth of health care costs to 3.4% per year or below.

In recent years, OHA streamlined the agency by completing an organizational restructure to further integrate programs and services to better deliver services to Oregonians. Divisions are now structured based on function and ongoing work is prioritized within existing resources. Since its restructure, OHA continues to diligently manage to its position authority and effectively control 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 ongoing 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 two percent of this budget. Administrative cuts through staff reductions or vacancies, or cuts to professional service contracts have been implemented in previous biennia. As OHA continues with its health system transformation efforts, any further reductions in these areas would have a direct impact on the Director's Office, as well as many of the OHA dedicated service offices (e.g., Human Resources, External Relations, and Equity and Inclusion).

The 2019-21 Governor's Budget includes removing inflation for select Services and Supplies accounts and a reduction of over 5 percent in Personal Services from vacancy savings.

Health Systems Division

Inflation increases for coordinated care organization (CCO) capitation rates and Oregon Health Plan fee-for-service provider rates would be less than 3.4 percent annual inflation. ***The 2019-21 Governor's Budget includes a 0.75 percent reduction in the 2019 CCO Quality Incentive Pool.***

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. ***The 2019-21 Governor's Budget includes this reduction.***

Non-Medicaid budget for cost of living increases for alcohol and drug treatment and community mental health programs would be eliminated.

Elimination of the 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.

Rental assistance funding would be reduced. This would have a direct impact on individuals and their stability in maintaining housing.

Funding 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 would be reduced 50 percent.

Oregon Health Plan coverage would be reduced by limiting or eliminating specific services or reducing line items covered on the Prioritized List of Health Services. Specific options reduce dental services, eliminate non-emergent dental coverage for nonpregnant clients, and eliminate treatment of substance abuse disorders for non-pregnant adults. Obviously, some individuals could experience immediate adverse impacts to their health without these services; others could see their health deteriorate.

All reductions to the Oregon Health Plan would require approval by the Centers for Medicare & Medicaid Services (CMS) and most would be prohibited under the special terms and conditions previously agreed upon by OHA and CMS.

Public Health

Funding for Oregon Contraceptive Care program payments would be reduced by 42 percent. The program would not be able to serve approximately 24,000 Oregonians during the 2019-21 biennium.

Pass-through funding to the Patient Safety Commission would be reduced 50 percent.

Farmers Market Food Voucher program for both WIC families and low-income seniors would be eliminated.

Oregon State Hospital

The hospital would reduce capacity and staffing by closing units, requiring some patients to be discharged earlier back to community settings and placing additional burden on community resources to find appropriate placement settings. To accommodate patients discharged from the hospital, investments would be needed to build additional capacity for community-based services.

Health Policy & Analytics

Funding for the Health Care Incentive Fund would be reduced by over 35 percent. This funding supports underserved communities in their recruitment and retention of high quality providers by repaying student loan debt.

Oregon Health Authority

2019 - 2021 Biennium

Detail of Reductions to 2019-21 Current Service Level Budget

1	2	3	4	5	6	7	8	10	12	13	14	15	16
Reduction of CSL GF	**Priority** (ranked most to least preferred)	**Agency**	**SCR or Activity Initials**	**Program Unit/Activity Description**	**GF**	**LF**	**OF**	**FF**	**TOTAL FUNDS**	**Pos.**	**FTE**	**Used in Gov. Budget Yes / No**	**Impact of Reduction on Services and Outcomes**
$3,113,039,502	**Dept / Prgm/ Div**												
-0.12%	OHA	44300		**Governor's Budget Reduction:** Remove inflation for Services and Supplies.	(3,750,986)	(81,485)	(6,332,952)	(6,361,132)	$ (16,526,555)			Yes	OHA would need to manage costs for services and supplies.
-0.18%	OHA	44300		**Governor's Budget Reduction:** Personal Services savings up to 5%.	(1,920,992)				$ (1,920,992)			Yes	OHA would need to implement a hiring process that ensures these savings are achieved.
-0.21%	OHA	44300		**Governor's Budget Reduction:** Additional Personal Services savings.	(1,000,000)				$ (1,000,000)			Yes	OHA would need to implement a hiring process that ensures these savings are achieved.
-0.43%	HSD Medicaid	44300	030-01	**Governor's Budget Reduction:** 2019 CCO Quality Incentive Pool reduction of 0.75%.	(6,700,000)			(25,000,000)	$ (31,700,000)			Yes	Reduction for 2019 CCO Quality Incentive Pool has been communicated to CCOs.
-0.61%	HSD Medicaid	44300	030-01	**Governor's Budget Reduction:** Remove 2019-21 phase-in budget adjustment for Hepatitis C treatment expansion.	(5,480,388)			(9,468,099)	$ (14,948,487)			Yes	
-0.82%	HSD Medicaid	44300	030-01	**Included in Governor's Budget:** 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.	(6,661,462)			(10,809,000)	$ (17,470,462)			Yes	Oregon's teaching hospitals depend on these payments to supplement their teaching programs. Discontinuing payments would be a hardship on these 11 teaching facilities and would de-incentivize hospitals from training new physicians. Discontinuing GME payments would also impact the physician workforce as there is already a shortage in the primary care specialty, which is one of the largest specialties in a teaching program. A reduction of trained providers may limit access to quality health care.
-1.37%	HSD Medicaid	44300	030-01	**Included in Governor's Budget:** 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	(17,130,000)			(27,794,000)	$ (44,924,000)			Yes	Oregon's teaching hospitals depend on these payments to supplement their teaching programs. Discontinuing payments would be a hardship on these 11 teaching facilities and would de-incentivize hospitals from training new physicians. Discontinuing GME payments would also impact the physician workforce as there is already a shortage in the primary care specialty, which is one of the largest specialties in a teaching program. A reduction of trained providers may limit access to quality health care.
-2.26%	HSD Medicaid	44300	030-01	Reduce Oregon Health Plan inflation for managed care and fee-for-service from 3.4% to 3.0% per year.	(27,800,000)			(75,460,057)	$ (103,260,057)			No	Coordinated care organization capitation rates would still require federal approval as meeting requirements for actuarial soundness. Coordinated care organizations would be even more challenged to reduce the growth in cost for providing services to their Oregon Health Plan members. There would also be less money available to increase Oregon Health Plan rates for providers that are paid by OHA on a fee-for-service basis.
-2.58%	HSD Medicaid	44300	030-01	Remove inflation for Community Mental Health Programs.	(9,800,000)			(600,000)	$ (10,400,000)			No	Since actual costs do increase, removing inflation for Non-Medicaid CMH would hinder the program's ability to provide the same level of service to clients in community programs. Eliminating inflation could lead to reductions in workforce within community providers and the loss of smaller providers due to the inability to secure funding through other sources.
-3.24%	HSD Medicaid	44300	030-01	Further reduce Medicaid inflation for managed care and fee-for-service from 3.0% to 2.7% per year.	(20,700,000)			(56,100,000)	$ (76,800,000)			No	Coordinated care organization capitation rates would still require federal approval as meeting requirements for actuarial soundness. Coordinated care organizations would be even more challenged to reduce the growth in cost for providing services to their Oregon Health Plan members. There would also be less money available to increase Oregon Health Plan rates for providers that are paid by OHA on a fee-for-service basis.
-3.27%	HSD	44300	030-01	Eliminate Mental Health Services Fund (MHSF) Residential Development.	(1,000,000)				$ (1,000,000)			No	The MHSF is used to update and remodel existing residential programs to maintain safe and healthy environments for residents. Its elimination 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.
-3.31%	PHD	44300	030-05	Reduction of Oregon Contraceptive Care Program funding.	(1,000,000)			(9,000,000)	$ (10,000,000)			No	The Oregon Contraceptive Care (CCARE) Program provides contraceptive and counseling services to eligible clients. CCare state funds match 9:1 with federal Medicaid funds for clinical services payments. CCare enrollment has been very steady in the 2017-19 biennium following a drop after the implementation of the Affordable Care Act and Medicaid Expansion in 2014. Without a change in budget CCare is projected to serve 57,500 clients in the 2019-21 biennium. A $1 million reduction in GF represents a 42% reduction in special payments, which would result in 24,000 fewer clients served by CCARE during the 2019-21 biennium. Fourteen percent of CCare clients have an unintended pregnancy averted through the provision of effective contraceptive methods and counseling services. With the proposed budget reduction, an additional 3,360 unintended pregnancies would occur among clients unable to receive services. Based on national estimates, approximately 1,546 of these unintended pregnancies would end in abortion and 1,814 would end 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 million in Medicaid expenditures (state and federal) would be expected as a result of these additional unintended pregnancies.
-3.39%	HSD Non-Medicaid	44300	030-01	Reduce Rental Assistance by 25%	(2,650,000)		(2,000,000)		$ (4,650,000)			No	These funds would continue rental assistance for individuals that receive rental assistance and support services this biennium. This reduction would result in clients losing 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 become homeless, move in with friends or relatives or end up in higher levels of care. Any reduction in new mental health investments may result in USDOJ issuing findings and proceeding with an Olmstead lawsuit against the state. USDOJ has been pleased with the steps 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.
-3.42%	PHD	44300	030-05	Reduce pass through to Patient Safety Commission by 50%.	(975,000)				$ (975,000)			No	This reduction would reduce funding for the Oregon Patient Safety Commission, which allows for health care facilities and professionals to report on adverse medical instances.

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1	2	3	4	5	6	7	8	10	12	13	14	15	16
Reduction of CSL GF	**Priority** (ranked most to least preferred)	**Agency**	**SCR or Activity Initials**	**Program Unit/Activity Description**	**GF**	**LF**	**OF**	**FF**	**TOTAL FUNDS**	**Pos.**	**FTE**	**Used in Gov. Budget Yes / No**	**Impact of Reduction on Services and Outcomes**
$3,113,039,502	**Dept** **Prgm/ Div**												
-3.43%	PHD	44300	030-05	Elimination of the USDA/WIC Farmers Market Food Voucher Program.	(232,598)			(1,496,000)	$ (1,728,598)			No	Vouchers would no longer be provided to 25,300 low income WIC participants each summer to purchase locally grown fresh fruits and vegetables. This vulnerable population would have reduced access to healthy food choices. Local farmers would see reduced incomes as over 90 percent of the dollars go directly to over 500 local Oregon farmers. This program supports the State Health Improvement Plan (SHIP) priority: Slow the increase of obesity, Strategy 4--Improve availability of affordable, healthy food and beverage choices for two identified target groups, 2 to 5 year-olds and adults.
-3.43%	PHD	44300	050-05	Elimination of the USDA/Senior Farmers Market Program.	(37,000)			(1,718,000)	$ (1,755,000)			No	Vouchers would no longer be provided to 43,000 low income seniors each summer to purchase fresh locally grown fruits and vegetables. This would lead to reduced access to healthy choices for this population, which is at risk for inadequate intake of fruits and vegetables and food insecurity. Local farmers would see reduced incomes as over 90 percent of the dollars go directly to over 500 local Oregon farmers. This program supports the State Health Improvement Plan (SHIP) priority: Slow the increase of obesity, Strategy 4--Improve availability of affordable, healthy food and beverage choices for adults, a primary target group.
-4.10%	HSD Medicaid	44300	030-01	Further reduce Medicaid inflation for managed care and fee-for-service from 2.7% to 2.4% per year.	(20,700,000)			(56,100,000)	$ (76,800,000)			No	Coordinated care organization capitation rates would still require federal approval as meeting requirements for actuarial soundness. Coordinated care organizations would be even more challenged to reduce the growth in cost for providing services to their Oregon Health Plan members. There would also be less money available to increase Oregon Health Plan rates for providers that are paid by OHA on a fee-for-service basis.
-4.29%	HSD Medicaid	44300	030-01	Eliminate coverage for specific dental services for adult Oregon Health Plan (OHP) clients. The agency would no longer cover the following dental services for adults (including pregnant adults) on OHP: Crowns, full and partial dentures; scaling & root planning. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions prohibit the state from reducing eligibility or benefits.	(5,973,817)			(45,713,075)	$ (51,686,892)			No	Adverse impact on clients' overall health including worsening of chronic diseases and poor pregnancy outcomes. Shifts costs to other areas due to unmet dental treatment needs including increased emergency department utilization. Exacerbation of opioid crisis due to untreated dental pain. Increased unnecessary tooth loss. Difficulty finding jobs. Missed days from work and school. Providers decreased willingness to reconstitute the delivery system in the future due to repeated system degradations.
-5.28%	HSD Medicaid	44300	030-01	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, 2019, OHP would cover lines 1 through 444. The agency would seek federal approval to no longer cover lines 444 through 469 for the OHP benefit packages. LEGISLATIVE ACTION REQUIRED. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions prohibit the state from reducing eligibility or benefits.	(31,000,000)			(94,900,000)	$ (125,900,000)			No	This reduction would eliminate coverage of 25 lines on the Prioritized List representing important medical, dental and vision services for conditions on the Oregon Health Plan, including children and pregnant women. The reduction includes services for children's vision services, certain mental health conditions, services that can prevent blindness and prevent fatal aneurisms. Failure to cover these services could result in other conditions that are more expensive to treat and lead to more emergency department visits. This reduction could cause disability, tooth loss, more serious mental health conditions, and death. Eliminating coverage for these services would result in sicker Oregonians that are unable to work or may experience more missed work days due to untreated conditions. Oregon Health Plan members may find it more difficult to maintain or obtain employment due to tooth extractions and other untreated conditions. Children with vision problems would experience barriers to quality education. These changes would require federal approval, including renegotiating the Oregon Health Plan Section 1115 Medicaid demonstration. They would also result in a loss of revenue to hospitals, physicians, and dental and mental health providers.
-5.54%	OSH	44300	030-06	Close 25 bed unit.	(7,910,519)				$ (7,910,519)	(36)	(36.00)	No	Closure may result in requiring some patients to discharge back to community settings earlier than they currently do with fewer available SRTF-licensed beds at OSH. It may also result in some patients remaining on hospital-licensed units beyond medical necessity if a suitable placement is not available in the community, and SRTF-licensed beds are no longer available at OSH. This reduction would put pressure on the Psychiatric Security Review Board's (PSRB) caseload and increase the need for SRTF or other appropriate settings within communities to accommodate patients discharged from OSH, shifting part of the financial burden to community mental health providers. (Note: Patients served in community-based, 16-bed SRTFs are Medicaid eligible, while SRTFs within OSH are not eligible due to the Institution for Mental Disease exclusion. A portion of this reduction could provide the State match needed draw federal funding for community SRTFs.) This action includes reducing OSH position authority which would likely require initiation of the state lay-off protocol related interaction with SEIU &/or ASFME.

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Detail of Reductions to 2019-21 Current Service Level Budget

1	2	3	4	5	6	7	8	10	12	13	14	15	16
Reduction of CSL GF	**Priority** (ranked most to least preferred)	**Agency**	**SCR or Activity Initials**	**Program Unit/Activity Description**	**GF**	**LF**	**OF**	**FF**	**TOTAL FUNDS**	**Pos.**	**FTE**	**Used in Gov. Budget Yes / No**	**Impact of Reduction on Services and Outcomes**
$3,113,039,502	**Dept** **Prgm/ Div**												
-5.81%	OSH	44300	030-06	Close 30 bed unit.	(8,447,669)				$ (8,447,669)	(35)	(35.00)	No	Closure may result in requiring some patients to discharge back to community settings earlier than they currently do with fewer available SRTF-licensed beds at OSH. It may also result in some patients remaining on hospital-licensed units beyond medical necessity if a suitable placement is not available in the community, and SRTF-licensed beds are no longer available at OSH. This reduction would put pressure on the Psychiatric Security Review Board's (PSRB) caseload and increase the need for SRTF or other appropriate settings within communities to accommodate patients discharged from OSH, shifting part of the financial burden to community mental health providers. (Note: Patients served in community-based, 16-bed SRTFs are Medicaid eligible, while SRTFs within OSH are not eligible due to the Institution for Mental Disease exclusion. A portion of this reduction could provide the State match needed draw federal funding for community SRTFs.) This action includes reducing OSH position authority which would likely require initiation of the state lay-off protocol related interaction with SEIU &/or ASFME.
-6.15%	HSD Non-Medicaid	44300	030-01	Reduce Community Mental Health (CMH) Choice Funding by 50%.	(10,600,000)				$ (10,600,000)			No	These funds are used to facilitate the transition of civilly committed adults from the state hospital to the community when they no longer need hospital level of care. These funds have reduced the length of time adults wait for discharge by 50%. Reduction of these funds would increase the length of stay in the hospital and increase the number of people waiting in acute care for state hospitalization, which results in reduced access to acute care services. This jeopardizes Oregon's compliance with the Olmstead court decision.
-6.24%	HSD Non-Medicaid	44300	030-01	Reduce Rental Assistance by an additional 25% for a total of 50%.	(2,650,000)		(2,000,000)		$ (4,650,000)			No	These funds would continue rental assistance for individuals that receive rental assistance and support services this biennium. This reduction would result in clients losing 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 become homeless, move in with friends or relatives or end up in higher levels of care. Any reduction in new mental health investments may result in USDOJ issuing findings and proceeding with an Olmstead lawsuit against the state. USDOJ has been pleased with the steps 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.
-6.39%	HPA	44300	030-02	Reduce funding for the Health Care Incentive Fund.	(4,896,057)		(5,162,515)		$ (10,058,572)			No	This reduction option would decrease funding for the Health Care Incentive Fund by over 35%. This would significantly impact multiple contracts currently in place with providers in rural areas. The funding supports underserved communities in their recruitment and retention of high quality providers. This reduction would greatly reduce the program's ability to achieve its intended outcomes.
-7.83%	HSD Medicaid	44300	030-01	Reduce the covered lines on the Prioritized List of Health Services by an additional 25 lines. 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, 2019, OHP would cover lines 1 through 419. The agency would seek federal approval to no longer cover lines 420 through 444 for the OHP benefit packages. LEGISLATIVE ACTION REQUIRED. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions prohibit the state from reducing eligibility or benefits.	(44,841,853)			(131,454,209)	$ (176,296,062)			No	This reduction would eliminate coverage of 25 lines on the Prioritized List (for a total of 50 when including 25 lines in a separate reduction package) representing important medical, dental and mental health services for conditions on the Oregon Health Plan, including children and pregnant women. The reduction includes services for hearing loss, severe skin conditions, common painful women's health conditions, certain mental health conditions, and cancer of the gallbladder. Failure to cover these services could result in other conditions which are more expensive to treat and cause more emergency department visits. This reduction could cause disability, tooth loss, more serious mental health conditions, and death. Eliminating coverage for these services will result in sicker Oregonians that are unable to work or may experience more missed work days due to untreated conditions. Oregon Health Plan members may find it more difficult to maintain or obtain employment due to tooth extractions and other untreated conditions. Children with hearing problems will experience barriers to quality education. These changes would require federal approval, including renegotiating the Oregon Health Plan 1115 Medicaid demonstration, and result in a loss of revenue to hospitals, physicians, dental and mental health providers.
-9.88%	HSD Medicaid	44300	030-01	Eliminate dental coverage for Oregon Health Plan (OHP) non-pregnant adults. The agency would eliminate the remaining non-pregnant adult dental coverage for the OHP benefit package. LEGISLATIVE ACTION REQUIRED. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions prohibit the state from reducing eligibility or benefits.	(63,618,156)			(282,630,676)	$ (346,248,832)			No	Reduction to clients' over-all health including worsening of chronic diseases and poor pregnancy outcomes. Shifts costs to other areas due to unmet dental treatment needs including increased emergency department utilization. Exacerbation of opioid crisis due to untreated dental pain. Increased unnecessary tooth loss. Difficulty finding jobs. Missed days from work/school. Providers decreased willingness to reconstitute the delivery system in the future due to repeated system degradations.

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Detail of Reductions to 2019-21 Current Service Level Budget

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Reduction of CSL GF	**Priority** (ranked most to least preferred)	**Agency**	**SCR or Activity Initials**	**Program Unit/Activity Description**	**GF**	**LF**	**OF**	**FF**	**TOTAL FUNDS**	**Pos.**	**FTE**	**Used in Gov. Budget Yes / No**	**Impact of Reduction on Services and Outcomes**
$3,113,039,502	**Dept** / **Prgm/ Div**												
-10.00%	HSD / Medicaid	44300	030-01	Reduce Addiction Services for non-pregnant adults on Oregon Health Plan.	(3,827,453)				$ (3,827,453)			No	This reduction would reduce substance use disorder (SUD) benefits for non-pregnant Oregon Health Plan (OHP) members. While these services are optional, inpatient mental health services are not optional and are not being eliminated. Mental health drugs would remain part of the benefit package. This reduction would negatively impact the physical and mental health of many current OHP clients, the community mental health delivery system, and system transformation efforts. It eliminates critical services just as we are battling the increase in opioid addiction and continue to see rates of methamphetamine, alcohol, and marijuana addiction increase. Lack of substance use resources will increase higher cost services from emergency rooms driving up health care costs. SUD care for this population would have ripple effects on providers of substance use disorder services. Small programs that are heavily reliant on OHP reimbursement for treating their clients may go out of business, and larger programs would likely have layoffs or staffing reductions. This would result in a need for increased GF in community mental health budgets, as indigent services will still be needed and at higher rates than before.
					(311,303,950)	(81,485)	(15,495,467)	(834,604,248)	$ (1,161,485,150)	(71)	(71.00)		

Governor's Budget Current Service Level **$3,113,039,502**
10% General Fund Target **-$311,303,950**

UPDATED **OTHER FUNDS ENDING BALANCES FOR THE 2017-19 & 2019-21 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	2017-19 Ending Balance In LAB	2017-19 Ending Balance Revised	2019-21 Ending Balance In CSL	2019-21 Ending Balance Revised	Comments
Limited	44300-030-03	0433 Operations	PEBB Operating	ORS 243.165	5,322,182		5,322,182		
Limited	44300-030-03	1381 Flex Benefits	PEBB Flexable Spending Admin	ORS 243.165	305,000		305,000		
Limited	44300-030-03	1384 Stabilization	PEBB Self-Insured, Stabilization	ORS 243.165	266,800,000	243,326,290	243,326,290	193,326,290	Includeds GB $50mil sweep
Limited	44300-030-04	1387 Operations	Operating	Senate Bill 426; Section 12	550,000		550,000		
Limited	44300-030-04	1388 Revolving	Revolving fund (Stabilization)	Senate Bill 426; Section 12	9,700,000	9,150,000	9,700,000	9,150,000	
Capital Improvement	44300-030-06-00 Oregon State Hospital	Fund 3421 - Treasury Account 0401. Grant #400089 OSH Capital Improvement OF	Operations	Section 2, Chapter 838, Oregon Laws 2015.	100,000	400,000	0	0	Capital Improvement - Based on current plans, some of the current funding will be rolled forward and used with 2019-21 funding to complete a larger project.
Limited	44300-030-06-00 Oregon State Hospital	0401	Operations		0	600,000	0	0	Safety Grant - Revenues received from SAIF for the Preferred Worker Program (PWP) & the Employer-at-Injury Program (EAIP). The revenues are used to fund safety enhancements at OSH. Based on current expenditure trends we will not expend the amount of revenue in this grant and are working with our Safety Committee to outline a plan for projects going forward.
Limited	44300-030-06-00 Oregon State Hospital	0401	Operations		0	0	0	0	Forensic Certification Program - Revenues received from the certification program for Forensic Evaluators. Anticipate no revenues to be carried forward at this time.
Limited	44300-030-06-00 Oregon State Hospital	0401	Operations		0	0	0	0	Research Literacy Grant - Revenue received from Transforming Chaplaincy for development and implementation of a research literacy curriculum into our CPE program.
Limited	44300-030-05-00-00000	0401	Operations		0	1,727,320	2,294,000	2,294,000	HRCQI
Limited	44300-030-05-00-00000	0401	Operations		6,750,000	3,600,000	4,549,237	3,600,000	OMMP
Limited	44300-030-05-00-00000	0401	Operations		0	615,000	357,000	357,000	DWS
Limited	44300-030-05-00-00000	0401	Operations		0	405,000	740,000	740,000	RPS
Limited	44300-030-05-00-00000	0401	Operations		0	375,000	819,152	819,152	EPH

Other Fund Type	Program Area (SCR)	Treasury Fund #/Name	Category/Description	Constitutional and/or Statutory reference	2017-19 Ending Balance		2019-21 Ending Balance		Comments
					In LAB	Revised	In CSL	Revised	
Limited	44300-030-05-00-00000	0401	Operations		1,895,000	3,800,000	2,915,000	2,915,000	HLO
Limited	44300-030-05-00-00000	0401	Operations		0	0	146,528	146,528	Prevention
Limited	44300-030-05-00-00000	0401	Other		0	4,310,000	2,100,000	2,100,000	JP Morgan settlement account decicated to TWIST to Web Implementation.
Limited	44300-030-05-00-00000	0401	Operations		650,000	650,000	650,000	650,000	PDMP
Limited	44300-030-05-00-00000	0401	Grant	Federal	45,000,000	69,471,806	43,975,727	50,000,000	Care Assist; restricted fund
Limited	44300-030-05-00-00000	0401	Other		1,849,843	1,849,843	700,000	700,000	Contributions dedicated to ALERT IIS
Limited	44300-030-02 Health Policy & Analytics	1389 Prescription Drug Purchasing Fund	Other	ORS 414.312	0	0	0	0	Oregon Prescription Drug Program is currently spending all of their funds.
Limited	44300-030-02 Health Policy & Analytics	1793 Healthcare Provider Incentive Fund	Other	ORS 676.450	0	1,880,504	0	0	Health Care Provider Incentive Fund established by HB 3261 consists of multiple programs. While there is currently a small ending balance showing in 2017-19, those funds have been obligated via loan repayment and other incentive agreements with providers and is fully obligated.
Limited	44300-030-02 Health Policy & Analytics	0401 General	Other	ORS 442.466	0	188,661	0	92,661	All Payers All Claims (APAC)
Limited	44300-030-02 Health Policy & Analytics	0401 General	Other	ORS 409.745	0	0	0	0	J-1 Conrad Physician Visa Waiver Program is funded by small application fees. These fees are spent in full for program operations costs.
Limited	44300-030-02 Health Policy & Analytics	0401 General	Other	ORS 413.570	0	0	0	0	Pain Management Commission
Limited	44300-030-02 Health Policy & Analytics	0401 General	Other	ORS 442.468	0	365,688	0	290,688	Oregon Healthcare Workforce Database
Limited	44300-030-02 Health Policy & Analytics	0401 General	Other	ORS 413.310	0	0	0	0	Common Credentialing program suspended in July 2018
Limited	44300-030-02 Health Policy & Analytics	0401 General	Other	ORS 442.468	0	31,987	0	0	Ambulatory Surgery Data fees collected when the program was active resulted in a small amount of remaining revenue. HB 4020 (2018) re-establishes the need for a data contract and fees to be collected to cover those costs.
Limited	010-40-06	0401 General	Grant Funds		0	21,904	0	0	Continued Use for the OHA Office of Equity and Inclusion - DELTA Statewide Leadership Training program

Other Fund Type	Program Area (SCR)	Treasury Fund #/Name	Category/Description	Constitutional and/or Statutory reference	2017-19 Ending Balance		2019-21 Ending Balance		Comments
					In LAB	Revised	In CSL	Revised	
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,	17,200,000		0		
Limited	44300-030-01-00 Health Systems Division	Fund 3449 - Treasury Fund Acct 1390, Grant 426000 Tobacco Tax	Grant Fund: Medicaid	Chapter 595 Oregon Laws 2009 section SECTION 18	17,717,956		0		
Limited	44300-030-01-00 Health Systems Division	Fund 3402 - Treasury Fund Acct, Grant 424000 Law Enforcement Medical	Grant Fund: Non Mediciad	414.815 Law Enforcement Medical Liability Account; The	0	1,043,000	0		
Limited	44300-030-01-00 Health Systems Division	Fund 3400 - Treasury Fund Acct, Grant 421200HSD- Marijuana	Grant Fund: Non Mediciad	ORS 475B.759 Established the Oregon Marijuana	0	1,700,000	0		

Objective: Provide updated Other Funds ending balance information for potential use in the development of the 2019-21 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 2017-19 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 2017-19 Legislatively Approved Budget and the 2019-21 Current Service Level at the Agency Request Budget level.

Columns (g) and (i): Provide updated ending balances based on revised expenditure patterns or revenue trends. Do not include adjustments for reduction options that have been submitted unless the options have already been implemented as part of the 2017-19 General Fund approved budget or otherwise incorporated in the 2017-19 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 2017 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.