Oregon Heath Authority
2021-23 Ways and Means Reference Documents Index

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https://www.oregon.gov/oha/Budget/2021-2023-Governors-Budget.pdf

2021-23 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 eliminate health inequities in Oregon and to provide Oregonians access to affordable health care no matter who they are or where they live. The Governor's budget reduces health inequities while improving health outcomes by:

- Providing significant, targeted investments to address health disparities
- Investing in public health modernization to strengthen our public health systems especially as they respond to a once-in-a-generation pandemic
- Focusing on creating a simple, meaningful, and responsive behavioral health system
- Maintaining coverage for the 1.4 million Oregonians receiving health care coverage through the Oregon Health Plan and Cover All Kids and expanding coverage through a pilot health care coverage program for uninsured, undocumented adults
- Maintaining a sustainable rate of cost growth in Medicaid, PEBB and OEBB
- Continuing funding for the Oregon Reinsurance Program which saves Oregonians an average of 6 percentage points on their health insurance premiums in the individual market[1]

To prioritize funding for needed programs, the budget includes some difficult reductions, including:[2]

- Reduces public health programs including the Oregon Cannabis Commission, communicable disease prevention, and USDA WIC Farmers Market) by $1.3 million
- Eliminates 16 positions from the Oregon State Hospital, $4.1 million
- Eliminates 20 positions agency-wide via administrative reductions, $4.2 million
- Eliminates 8 positions in the Oregon Health Information Technology program after a shortfall in federal funding

OHA also saved taxpayer dollars through reduced agency-wide services and supplies ($30.6 million total funds) and savings from keeping vacant positions open ($15.2 million total funds).

Address Coverage Gaps & Increasing Access to Health Care

- Funds Cover All People, a pilot program to provide state-based coverage to undocumented adults, DACA recipients, legal residents, and young adults who age out of Cover All Kids, $10 million.

[1] The Governor's Budget transfers the Oregon Reinsurance Program and the Compact of Free Association premium assistance program from the Department of Consumer and Business Services to the Oregon Health Authority.
[2] Dollar amounts represent general fund investment unless otherwise noted.

- Funds Compact of Free Association (COFA) premium assistance program and dental coverage for COFA residents, $2.6 million.
- Lays the policy groundwork to further explore an Oregon Public Option aimed at increasing choice while reducing costs for Oregon consumers, $200,000.
- Funds high-quality reproductive health services for the Oregon Health Plan, $2 million.
- Improves access to the Oregon Health Plan by funding the Community Partners & Outreach Program to provide health services navigation, and improve language access and quality, $7.8 million.
- Funding to support traditional health worker licensing program, $600,000.
- Continue to build on Oregon Regional Health Equity Coalitions, $5.8 million.

Strengthen Public Health Systems

- Invests in core public health capacity for community-based organizations, local public health authorities, and tribal governments to help modernize the state's public health system, $30 million.

Improve Native American & Tribal Health

- Establishes an Indian Managed Care Entity to provide critical care and coordination of services to tribal members on OHP, $1.4 million.
- Creates a new Tribal Traditional Health Worker Program category for Indian healthcare providers that supports tribal-based practices, $200,000.
- Increases Medicaid funding to support tribal-based practices and strengthens pathways for further developing a tribal behavioral health workforce, $500,000.

Cost Containment in Health Care

- Value-Based Payments – Promotes the adoption of value-based payments in Oregon. The Governor's Budget includes savings of $12 million General Fund associated with the adoption of value-based payments by hospitals. PEBB and OEBB will also seek to adopt value-based payment methodologies to address cost and quality of health care provided to members, $1.6 million other funds.
- Sustainable Cost Growth – The Governor's Budget maintains benefits and eligibility for the Oregon Health Plan; it includes savings of $21 million from reducing DRG hospital rates from 80% to 76% of Medicare and another $40.7 million by funding Coordinated Care Organizations at 2.9% rather than 3.4% inflation.
- Aligning Purchasing Power – The Governor's Budget invests $1.6 million other funds for staff and contracts needed to increase public sector participation in plans offered by PEBB and OEBB, increasing the plan's bargaining power.
- Pharmacy – Invests in staffing to pursue cost reduction strategies, including coordinated pharmacy purchasing among public sector purchasers in Oregon and in other states, $900,000.

Data Equity

- The Governor's budget funds Sexual Orientation and Gender Identity (SOGI) data collection and a statewide trauma-informed training program that provides technical assistance and support to providers. The budget funds continued implementation of race, ethnicity, language, disability data (REALD) and community-validated and community-driven data collection, $5 million.

Workforce, Behavioral Health & Substance Use Disorder

The Governor's Budget investments in behavioral health including substance use disorder were informed by recommendations from the Alcohol and Drug Policy Commission (ADPC) Strategic Plan, the Tribal Behavioral Health Strategic Plan, and the Governor's Behavioral Health Advisory Council as vetted by the Racial Justice Council Health Equity Committee.

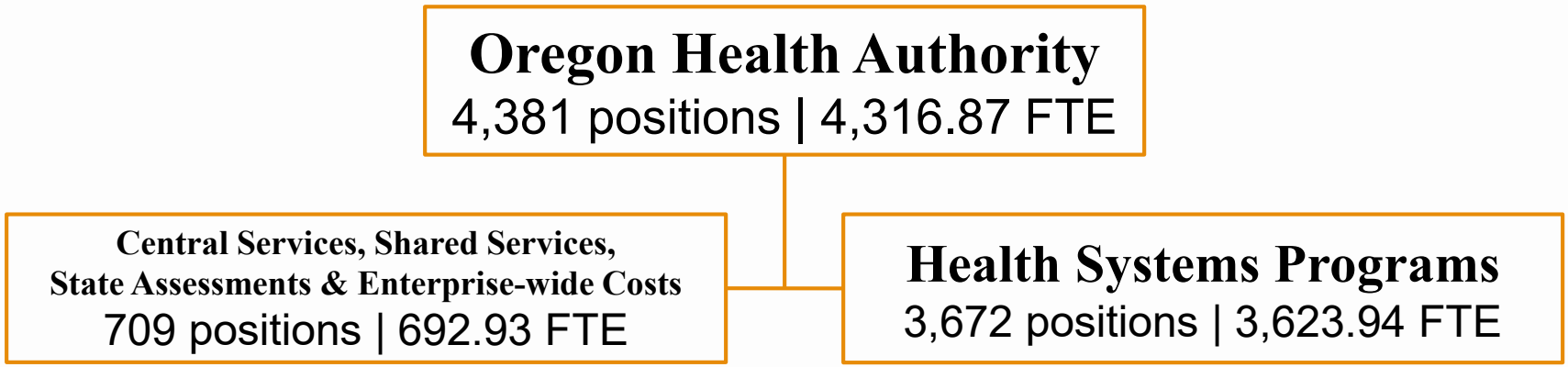
- Workforce Diversification – Creates more and better pathways to diversify Oregon's behavioral health and medical workforces so that they better reflect the communities they are serving; allots seed funding for increased scholarships, tuition reimbursement, enhanced reimbursement rates for culturally-specific services; and establishing culturally-specific internships and clinical placements, $27.5 million.
- Substance Use Disorder 1115 Waiver – Invests in substance use disorder treatment services, crisis intervention services and peer support services to help Oregonians recover from the disease of substance use disorders, $11.5 million.
- Measure 110 – Implement Measure 110, which decriminalizes possession of drugs and uses Marijuana Tax revenues to support drug treatment services. Reduced Marijuana Tax revenues for OHA's current behavioral health services were backfilled with General Fund, $23.8 million.
- Community Behavioral Health Services – Expand residential services for young adults, $5 million; fund peer run respite care centers, $2.4 million; increase fee-for-service rates for behavioral health services including for treatment of co-occurring behavioral health and substance use disorders, $10.1 million; invest in psychiatric residential treatment facilities, $7.5 million; and support the Alcohol and Drug Policy Commission's strategic plan, $200,000; invest in community-based services and care coordination designed to reduce the influx of people from the criminal justice system into the Oregon State Hospital (Aid and Assist), $19.3 million.
- Services Targeted to Child Welfare – Invest in crisis and transition services, $1.3 million; and invest in interdisciplinary assessment teams for children and families involved in the child welfare system, $5.7 million.

I appreciate Governor Brown's focus on health equity, behavioral health, and public 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 health inequities in Oregon, and improve the health and well-being of every Oregonian.

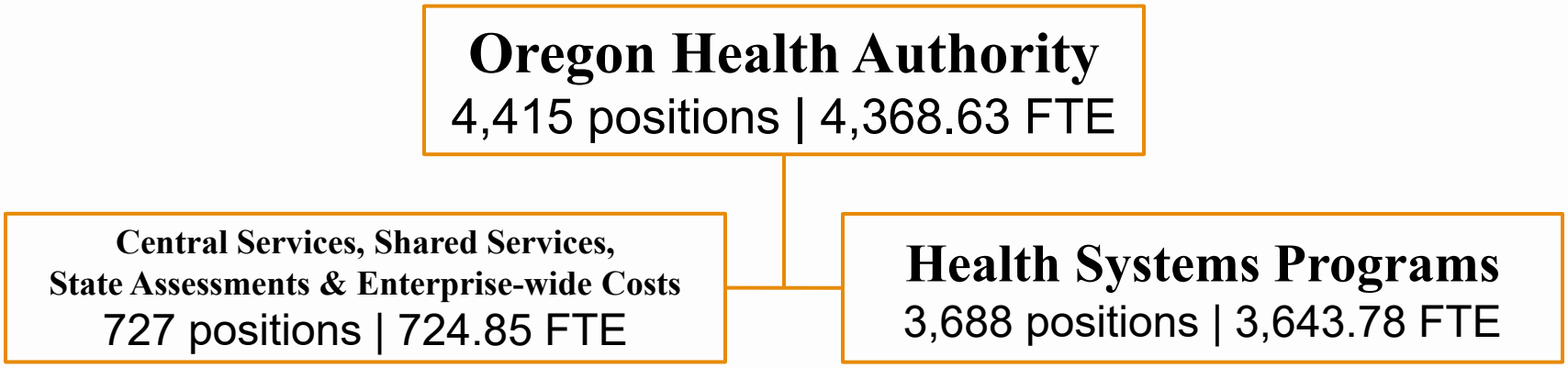
Patrick Allen
Director

2019-21
Legislatively Approved Budget



Oregon Health Authority

2021-23
Governor's Budget



Oregon Health Authority

Oregon Health Authority: Agency Summary Narrative

Mission statement

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

Agency priorities and initiatives

OHA's strategic goal is to eliminate health inequities in Oregon within 10 years. To advance that goal, OHA is focused on accelerating the transformation of Oregon's health care system, expanding health coverage and providing easier access to care, delivering better health outcomes, improving health care quality and containing health costs for Oregon Health Plan members, and improving public health services in all Oregon communities.

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

The Governor's budget reduces health inequities while improving outcomes by:

- Providing significant, targeted investments to address health disparities
- Investing in public health modernization to strengthen our public health systems especially as they respond to a once-in-a-generation pandemic
- Focusing on creating a simple, meaningful, and responsive behavioral health system
- Maintaining coverage for the 1.4 million Oregonians receiving health care coverage through the Oregon Health Plan and Cover All Kids and expanding coverage through a pilot health care coverage program for uninsured, undocumented adults
- Maintaining a sustainable rate of cost growth in Medicaid, PEBB and OEBB
- Continuing funding for the Oregon Reinsurance Program which saves Oregonians an average of 6 percentage points on their health insurance premiums in the individual market[1]

[1] The Oregon Reinsurance Program and the Compact of Free Association (COFA) premium assistance program are transferred from the Department of Consumer and Business Services to the Oregon Health Authority in the Governor's Budget.

Oregon Health Authority: Agency Summary Narrative

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 OHA. This office coordinates with the Governor's Office, the Legislature, other state and federal agencies, tribes, partners and stakeholders, local governments, advocacy and client groups, and the private sector.

The Director's Office provides leadership in achieving the agency's mission. In developing OHA's strategic plan, the agency has adopted a 10-year goal of eliminating health inequities by 2030. In order to achieve that goal, the agency has adopted the following definition of health equity:

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

OHA has a clear direction 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.

Oregon Health Authority: Agency Summary Narrative

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, Tribal Affairs and shared services coordination with the Oregon Department of Human Services (ODHS).
- 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 three functional areas: budget, actuarial services, and program integrity.

- Budget – Developing, coordinating, executing, monitoring and managing OHA budgets within divisions and across the agency. Developing and updating the agency budget as it progresses through the statewide budget process, including Agency Request Budget, Governor's Budget, the Legislatively Adopted Budget, rebalance reports and Emergency Board actions.
- While the Actuarial Services Unit and Office of Program Integrity are functionally within the Fiscal Division of Central Services, they are budgeted in the Health Systems Division Program Support and Administration unit.

The **Equity and Inclusion Division** works on behalf of OHA and the broader health system in Oregon to ensure the elimination of avoidable health 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 contemporary and historical injustices experienced predominantly by racially, ethnically, culturally and linguistically diverse populations, including people with disabilities so that

all people can reach their greatest health potential and well-being, and participate in a more robust and inclusive health delivery system. This division has also led the adoption of an anti-racism framework for the agency including anti-racism training, statewide community engagement with diverse communities for the agency's strategic plan and the development of OHA's 10-year goal to eliminate health inequities in Oregon.

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

- 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.
- Government Relations provides timely health data and analysis to the Legislature, federal partners, and local elected officials to inform evidence-based health policies and legislation. It also develops OHA legislative concepts to eliminate health inequities, ensure access to quality health care, contain costs of health care, and improve overall health for Oregonians.
- The Community Partner Outreach Program has built a one-of-a-kind network of Community Partner Organizations serving all Oregonians in every county in Oregon. The work CPOP and Community Partners do on behalf of OHA is essential to support health system transformation and adequately serve Oregonians to access the health care they need and address equity and health system barriers.
- The Ombuds Program advocates for Oregon Health Plan (OHP) member access to care and quality of care provided through OHP; uses learnings from individual member issues to elevate OHP member voice through the OHA so Medicaid programs, policies, and operations are based on member experience; and elevates identified issues for system improvement. As required by legislation the program reports data and recommendations for improvement to the OHA Director, the Oregon Health Policy Board, and the Governor.
- The Innovator Agents work closely with Oregon's 15 Coordinated Care Organizations (CCOs) as required by legislation and Oregon's Medicaid Waiver to coordinate between OHA, the community, and CCOs to ensure local adaptation and implementation of statewide health priorities. They understand the health needs of the region, the strengths and gaps of the

health resources in the CCO and articulate these needs and gaps to OHA to ensure statewide and local coordination. They prioritize elevating OHP member voice within CCO operations and in CCO 2.0 they elevate local work with CCOs in health equity, Tribe relationships, behavioral health, and emerging statewide priorities such as the COVID-19 response.

Health Systems Division

The Health Systems Division's (HSD) mission is to build and advance a system of care to create a healthy Oregon. The 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.

HSD advances health equity and 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 and non-Medicaid behavioral health services to more than 145,400 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 the Fiscal Division of OHA 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 budget includes state and federal funds used to deliver and pay for health care services to over 1.4 million Oregon Health Plan (OHP) members of which 43 percent are children. The OHP includes Medicaid, the Children's Health Insurance Program (CHIP), Cover All Kids, Reproductive Health Equity Act (RHEA), and other related services. Payments are made to individual health care providers as Fee-for-Service (FFS) and to the coordinated care organizations (CCOs) in the form of a global budget. CCOs serve over 90 percent of all OHP members.

In July 2012, the Centers for Medicaid and Medicare Services (CMS) approved Oregon's 1115 Medicaid Demonstration waiver that was necessary to implement CCOs 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.

In the fall of 2021, HSD and Health Policy and Analytics (HPA) staff will begin work on Oregon's 2022 waiver with the aim of improving upon the existing model and moving the state forward in achieving health equity and transforming the health system. Work will include policy research and analysis and outreach and engagement with diverse communities.

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

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

Statutory Authority

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

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

Health Policy and Analytics

The Health Policy and Analytics division develops and implements innovative approaches to lowering health care costs and achieving better health and better health care, while keeping a focus on health equity. 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, statewide delivery system technology tools to support care coordination, health system transformation support, and health system performance evaluation reports. Together these offices provide services and support focused on achieving health equity through the triple aim of better health, better care, and lower costs.

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

- Supporting and incentivizing payments for value, moving away from paying for service volume and incentivizing investments in better health for all communities.
- Supporting the Oregon Health Policy Board's work including its plans to operationalize OHA's Health Equity Definition and reimagine a health care system capable of achieving health equity.
- Focusing on social determinants of health in addition to medical care.
- Providing the clinical leadership to shape the management of high cost pharmaceuticals.
- Innovating and implementing integration across behavioral health, oral health, physical health and social services using health information technology.
- Implementing legislative directives to align metrics and supporting new and innovative metrics for equity and social determinants of health.
- Facilitating multi-payer alignment to stabilize critical provider services and rebuild a health care system capable of achieving health equity.

Public Employees' Benefit Board

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

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 some counties and special districts. OEBB serves more than 155,000 members (employees, early retirees and their family members) in more than 251 publicly-funded entities throughout Oregon.

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

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

Public Health

The Public Health Division (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. OHA-PHD is central to achieving OHA's

10-year goal to end health inequities. OHA-PHD provides leadership for the 2020-24 State Health Improvement Plan (SHIP), Healthier Together Oregon. The plan development included state, local, Tribes, and community-based organizations (CBO) working together on the root causes of poor health outcomes, including systemic racism and oppression. Healthier Together Oregon's 62 strategies are encompassed in five priority areas: Institutional bias; Adversity, trauma and toxic stress; Economic drivers of health (including issues related to housing, living wage, food security and transportation); Access to equitable preventive health care; Behavioral health (including mental health and substance use).

The equity-centered, cross-sector strategies included in Healthier Together Oregon are a result of the work the public health system has done to modernize its practice. Oregon's public health system includes tribal and local public health authorities (LPHA), CBO's and OHA-PHD. The public health infrastructure developed as a result of public health modernization has been essential to Oregon's response to COVID-19. Specifically, Oregon has benefited from additional highly qualified state and local epidemiologists to track data, and quickly manage and respond to outbreaks in high risk settings like long-term care facilities, worksites and correctional institutions. The ongoing focus on health equity and cultural responsiveness by the public health system has allowed engagement with community members and CBO's to provide testing, culturally and linguistically responsive communications, and delivery of wraparound services to allow people to safely isolate or quarantine.

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

Oregon State Hospital

Oregon State Hospital (OSH) is an essential part of the statewide behavioral health system, providing the highest level of psychiatric care for adults from all 36 counties. The hospital's primary goal is to help people recover from their mental illness and return to life in the community, contributing to healthy and safe communities for all people in Oregon. Oregon State Hospital promotes public safety by treating people who are dangerous to themselves or others in a secure, therapeutic setting. The hospital works in partnership with the other divisions of 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 utilizing 650 beds across two levels of care (Hospital Level of Care and Secured Residential Treatment Facility level of care), with 592 beds in Salem and 100 beds in Junction City. Services are provided 24 hours per day, seven days a week. Commitment types include:

- **Civil** – People who come to Oregon State Hospital through a civil commitment require 24-hour care that is not available through community programs. These patients have been found by the court to be a danger to themselves or others, or unable to provide for their own basic needs – such as health and safety – because of a mental disorder.
- **Guilty Except for Insanity** – People who come to Oregon State Hospital who have successfully pleaded Guilty Except for Insanity (GEI) for crimes related to their mental illness. These patients are under the jurisdiction of the Psychiatric Security Review Board.
- **Aid and Assist** – People who come to Oregon State Hospital through a court order under Oregon law (ORS 161.370) for treatment that will help them understand the criminal charges against them and to assist in their own defense.

Oregon State Hospital's role is to provide services and treatment to individuals that will prepare them for discharge when they no longer require hospital level of care. Services include 24-hour on-site nursing, psychiatric and other credentialed professional services, treatment planning, pharmacy, laboratory, food and nutritional services, and vocational and educational services. The hospital is accredited by the Joint Commission on the Accreditation of Health Organizations and all 24 hospital-licensed units (21 on the Salem Campus and 3 in Junction City) are certified by the Centers for Medicare & Medicaid Services (CMS). Services are provided by psychiatrists, nurses, and mental health professionals. Upon discharge, people transition to the community with improved skills to better 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. Pendleton Cottage, a 16-bed facility, is located on the grounds of the former Eastern Oregon Training Center in Pendleton. The secure mental health treatment program provides a community treatment setting for people who need a secure level of care as their first step out of the state hospital.

Statutory Authority

The following ORS references provide OSH its authority:

- ORS 161.295-400 – Determination of fitness to proceed/commitment

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

OHA Shared Services

Office of Information Services (OIS) is a shared service provider for ODHS and OHA. It provides information technology (IT) systems and services for nearly 16,000 agency and partner staff at 162 local offices, Oregon State Hospital locations, and the public health laboratory. 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 ODHS and OHA staff and partners statewide in support of programs that:

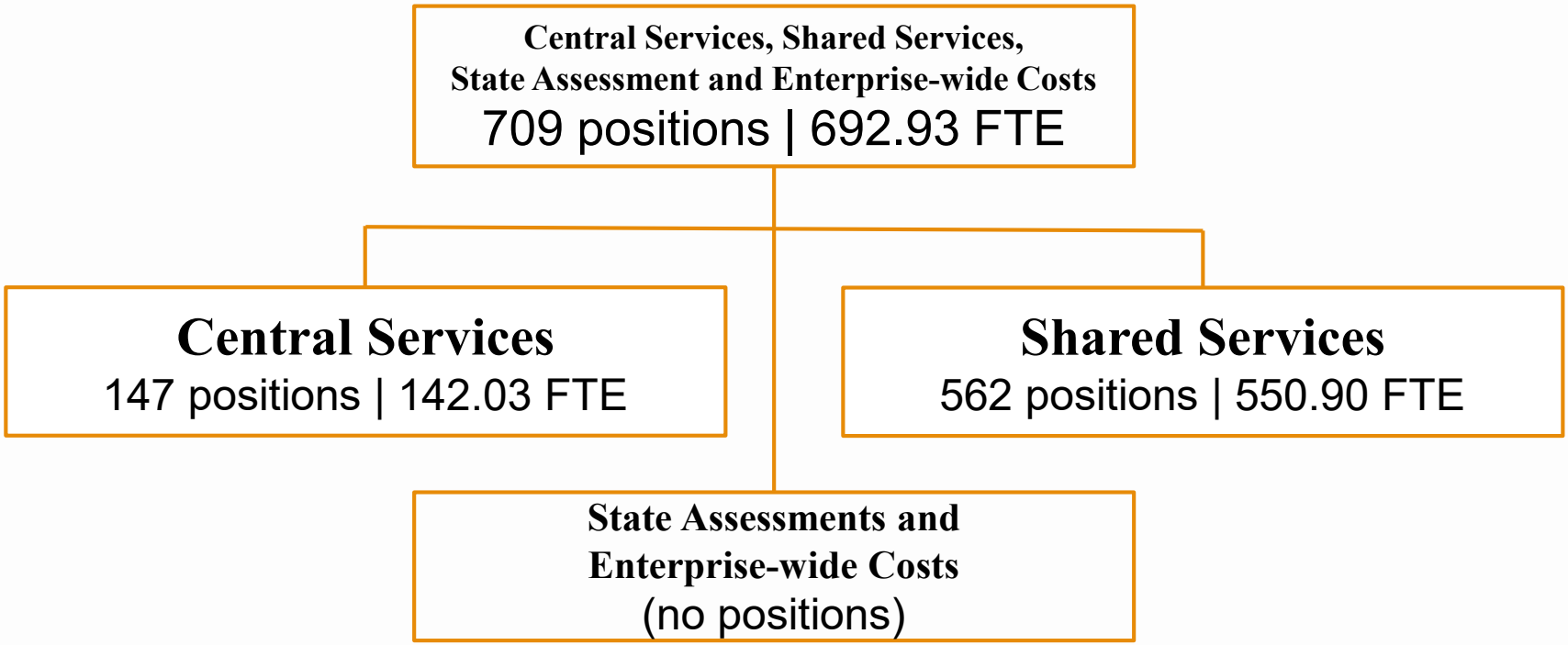
- Determine client eligibility.
- Provide medical, housing, food and job assistance.
- Provide addiction, mental health, and vocational and rehabilitative services.
- Protect children, seniors and people with physical and developmental disabilities.
- Process claims and benefits.
- Manage provider licensing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

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

OIS now also provides a sub-section of services which were formerly provided by the Information Security and Privacy Office (ISPO), primarily the IT security functions, as the over-arching Security & Privacy functions moved to the Department of Administrative Services (DAS) in the 2017-19 biennium.

2019-21

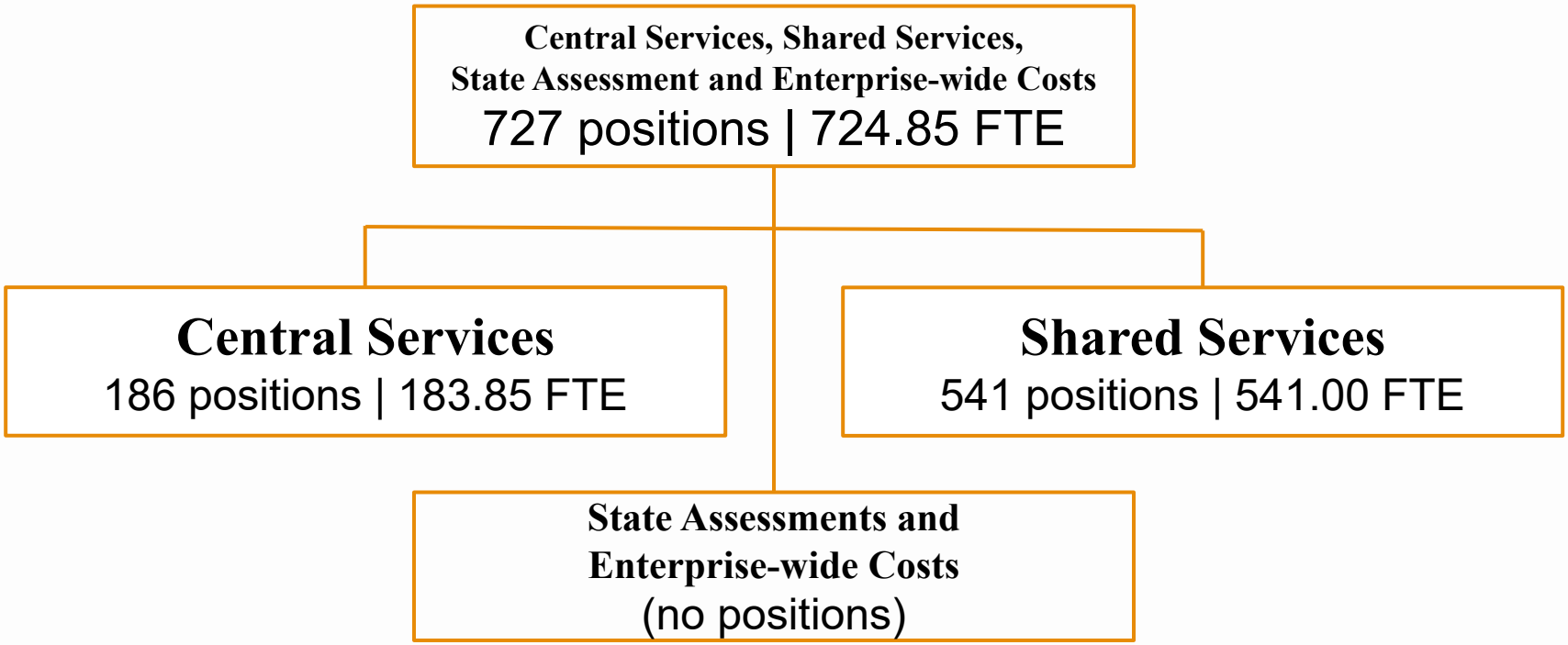
Legislatively Approved Budget



Oregon Health Authority

2021-23

Governor's Budget

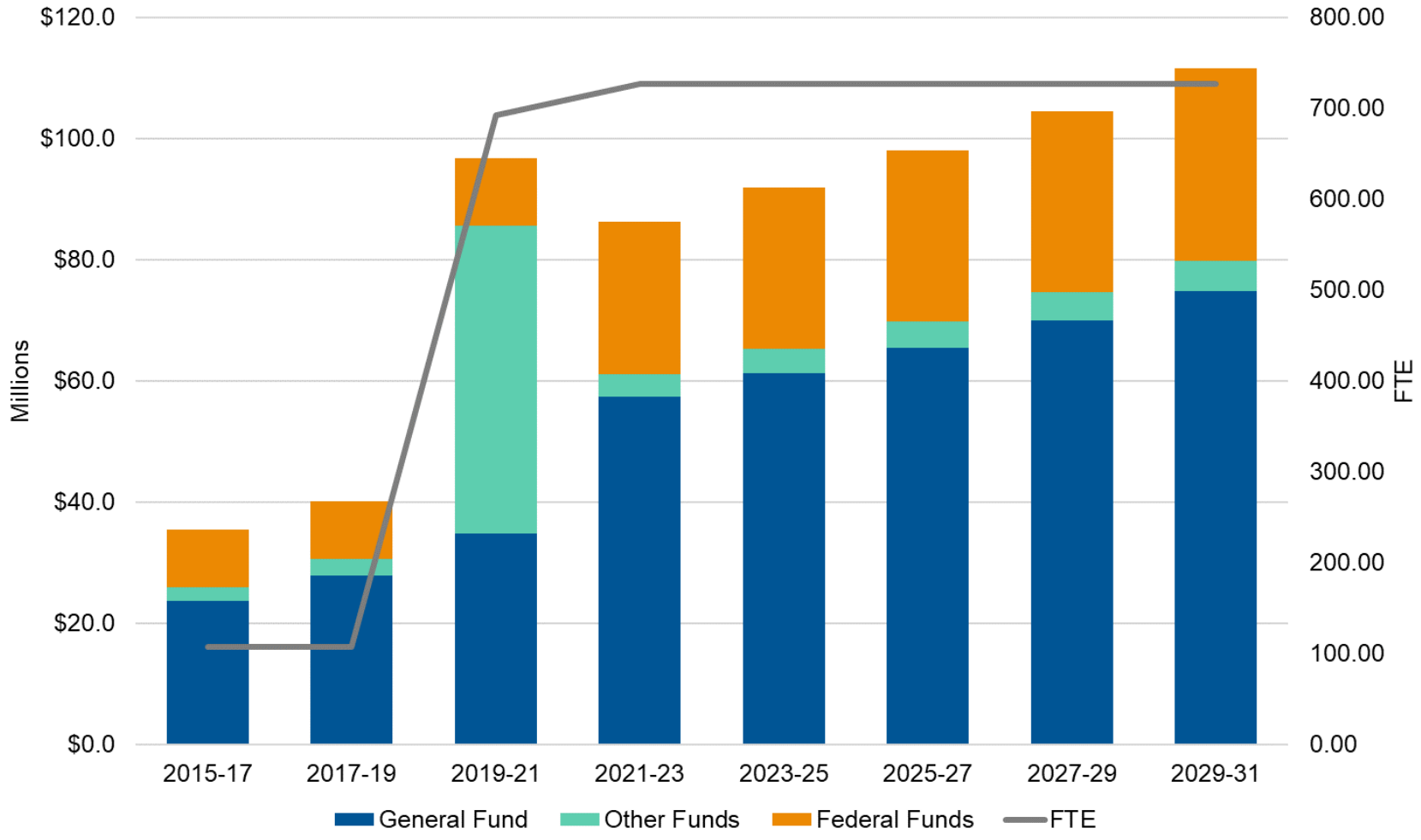


Oregon Health Authority

Oregon Health Authority: Central Services

Executive Summary

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



Executive Summary

Expenditures by fund type (in millions), positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$34.91	$50.66	$11.18	$96.76	147	142.03
Gov. Budget 2021-23	$57.43	$3.71	$25.16	$86.30	186	183.85
Difference	$22.52	-$46.95	$13.97	-$10.46	39	41.82
Percent Change	64%	-93%	125%	-11%	27%	29%

Division overview

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

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

Funding request

The Governor's Budget of $86.3 million Total Funds for Central Services continues funding at the current service level for the 2021-23 biennium. The budget includes policy packages to invest in the Equity and Inclusion Division and support OHA's 10-year goal of eliminating health inequities in Oregon; create a Tribal Traditional Health Worker program; and create an Enterprise Risk Management unit.

Executive Summary

Program descriptions

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

The Director's Office provides leadership in achieving the agency's mission. In developing OHA's strategic plan, the agency has adopted a 10-year goal of eliminating health inequities by 2030. And, in order to achieve that goal, the agency has adopted the following definition of health equity:

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

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

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

Executive Summary

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

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

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

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

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

The **Equity and Inclusion Division** works on behalf of the Oregon Health Authority and the broader health system in Oregon to ensure the elimination of avoidable health gaps 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 work and initiatives. The division engages community partners and stakeholders, and uses data, best practice research and practice-based evidence to carry out its work. The division's policy and program initiatives address contemporary and historical injustices experienced predominantly by racially, ethnically, culturally and linguistically diverse populations, including people with disabilities so that all people can reach their greatest health potential and well-being, and participate in a more robust and inclusive health delivery system. This division has also led the adoption of an anti-racism framework for the agency including anti-racism training, statewide community engagement with diverse communities for the agency's strategic plan and the development of OHA's 10-year goal to eliminate health inequities in Oregon.

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

- 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.
- Government Relations provides timely health data and analysis to the Legislature, federal partners, and local elected officials to inform evidence-based health policies and legislation. It also develops OHA legislative concepts to ensure access to quality health care, contain costs of health care, and improve overall health for Oregonians.
- The Community Partner Outreach Program has built a one-of-a-kind network of Community Partner Organizations serving all Oregonians in every county in Oregon. The work CPOP and Community Partners do on behalf of OHA is essential to support health system transformation and adequately serve Oregonians to eliminate health inequities, ensure access to quality health care, contain costs of health care, and improve overall health for Oregonians.
- The Ombuds Program advocates for Oregon Health Plan (OHP) member access to care and quality of care provided through OHP; uses learnings from individual member issues to elevate OHP member voice through the OHA so Medicaid programs, policies, and operations are based on member experience; and elevates identified issues for system improvement. As required

by legislation the program reports data and recommendations for improvement to the OHA Director, the Oregon Health Policy Board, and the Governor.

- The Innovator Agents work closely with Oregon's 15 Coordinated Care Organizations (CCOs) as required by legislation and Oregon's Medicaid Waiver to coordinate between OHA, the community, and CCOs to ensure local adaptation and implementation of statewide health priorities. They understand the health needs of the region, the strengths and gaps of the health resources in the CCO and articulate these needs and gaps to OHA to ensure statewide and local coordination. They prioritize elevating OHP member voice within CCO operations and in CCO 2.0 they elevate local work with CCOs in health equity, Tribe relationships, behavioral health, and emerging statewide priorities such as the COVID-19 response.

Program justification and link to long-term outcomes

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

Program performance

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

- **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

Executive Summary

The Office of Human Resources serves as a business partner to its customers. Through this partnership HR provides proactive, comprehensive human resource services that support the agency in achieving its mission and goals. HR works closely with internal customers on workforce initiatives and strategies at the program and agency level. It promotes a healthy workplace culture of ongoing development and feedback to ensure the workforce has the needed 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 $3 billion in General Fund dollars. The Health Care Finance staff provided financial oversight of coordinated care organizations, which receive over $5 billion dollars annually in gross premiums.

In 2019, the **Equity and Inclusion Division**:

- Fully embedded health equity requirements into coordinated care organization (CCO) contracts with accountability measures, including all policy recommendations from the Traditional Health Worker (THW) Commission.
- Partnered with Health Policy and Analytics to develop an incentivized health equity metric for CCOs to develop language access plans and collect and report language interpreter data.
- Designed with OIS a public facing registry for 715 Health Care Interpreters (HCI) who provide interpretation in over 40 languages throughout the state.
- Delivered HCI training in the Linn Benton area and in underserved rural regions.
- Approved 25 Cultural Competency Continuing Education trainings to serve 23 health care professional boards.
- Analyzed 120 Legislative bills with an equity, diversity and inclusion framework.
- Led the development of a new health equity definition with the Health Equity Committee which was adopted by the Oregon Health Policy Board (OHPB) for OHA and all OHPB committees.
- Led the development of a REAL D measure in the OHA Performance System and OHA Quarterly Performance Review.
- Convened and manage the REAL D Governance Committee to review REAL D workplans and compliance.
- Managed the registry for 3,533 certified Traditional Health Workers.
- Developed an Affirmative Action reporting dashboard in Tableau.

Executive Summary

- Commissioned research by Coalition of Communities of Color on Behavioral Health in communities of color.
- Commissioned research on health inequities including a participatory process with Chuukese and African American/Black communities.
- Co-led the Institutional Bias Subcommittee as one of five priorities for the State Health Improvement Plan.
- Led and conducted with the Community Partner Outreach Program, 24+ community engagement events for input into the OHA strategic plan.
- Presented at national conferences including the THW Conference (Sacramento) and for Princeton/Robert Wood Johnson (webinar), National Academy for State Health Policy (Chicago) and the National Governor's Association (Nashville).
- Evaluated Community Health Improvement Plans for all 16 CCOs.
- Led development, recruitment and finalization of members for the Director's agency-wide Diversity Leadership Team.

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.

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.

Executive Summary

Significant proposed program changes from 2019-21

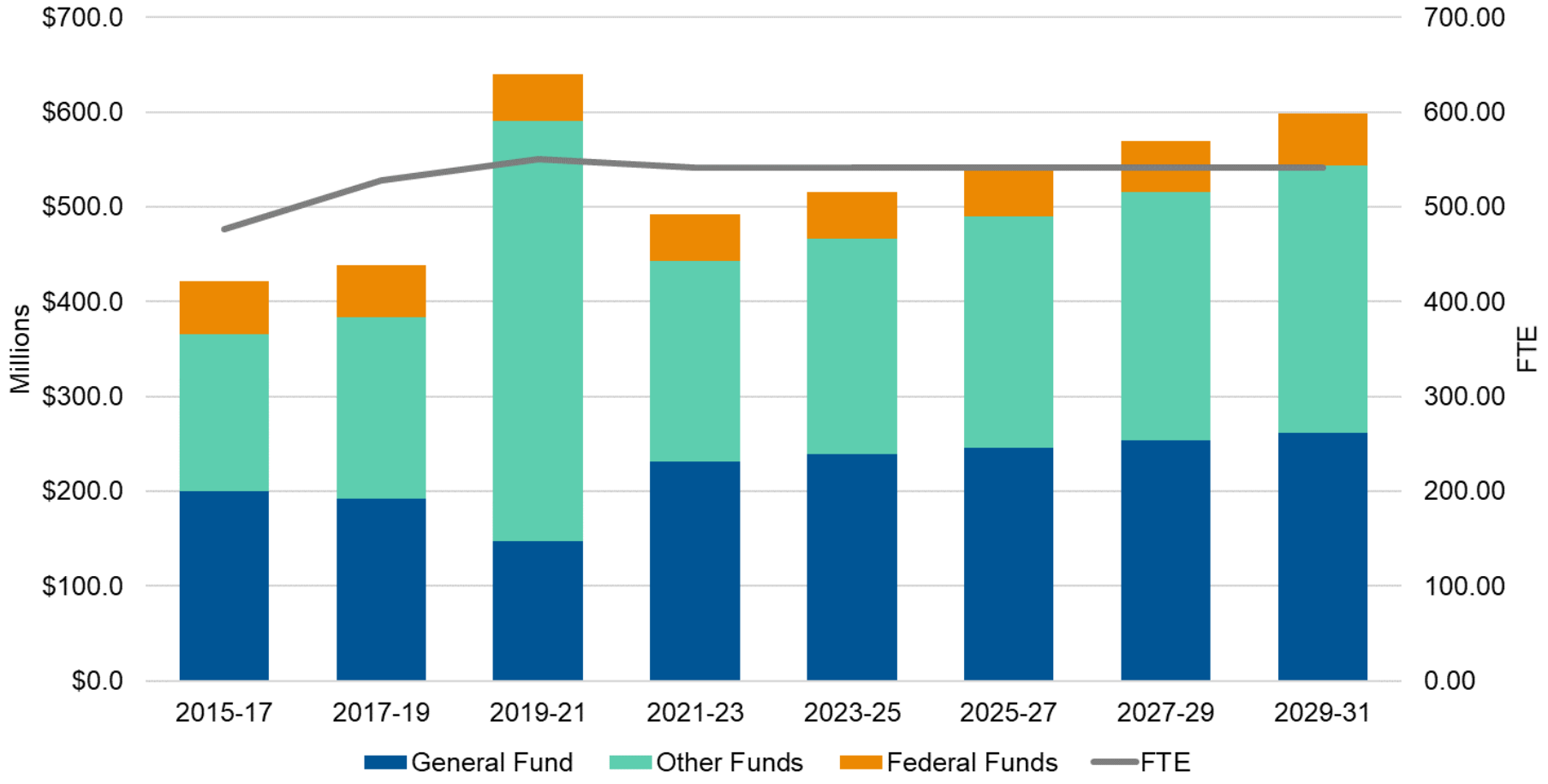
OHA proposes in policy package #402 that the Equity and Inclusion Division, in addition to rightsizing existing staff, grow its expertise in community engagement and outreach capacity. OHA has a unique opportunity and responsibility to engage and form more effective partnerships with communities to identify, analyze, research and address policy and systemic barriers to guide effective implementation of strategic priorities. Investing in continuous and meaningful community engagement is essential to build trust and relationships with communities that experience the greatest health inequities due to structural and institutionalized oppression and racism.

OHA also proposes creating and administering a Tribal Traditional Health Worker program in legislative concept #46 and its corresponding policy package #404. Situated in the Equity and Inclusion Division, the program would include partnering closely with Tribal Affairs, Health Systems Division Tribal Liaisons and the Tribal Health Programs and support the process to develop a curriculum, organize trainings, update the THW registry, assist in the application process and provide technical assistance for certification.

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

Executive Summary

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



Executive Summary

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$207.45	$443.58	$48.61	$699.65	562	550.9
Governor's Budget 2021-23	$231.70	$211.80	$48.52	$492.02	541	541.00
Difference	$24.25	-$231.78	-$0.10	-$207.62	-21	-9.9
Percent Change	12%	-52%	0%	-30%	-4%	-2%

Division overview

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

OHA Shared Services contains the Office of Information Services.

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

Executive Summary

- All others

Risk Management Program, price list
Under ORS 278.405, DAS manages state government risk management and insurance programs. It has responsibility to:

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

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

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

- Rent or lease workspace for staff (includes escalations and reconciliation costs).
- Lease building maintenance management (janitorial, repair and maintenance).

Executive Summary

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

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

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

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

Executive Summary

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

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

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

Funding request

The Governor's Budget of $184.4 million Total Funds continues funding for the Office of Information Services for 2021-23 at current service level, less statewide reductions and an administrative reduction. The policy package for Provider Time Capture M&O was funded in the Governor's Budget, as was a small investment to accommodate Ballot Measure 109 – Psilocybin treatment. The Governor's Budget of $307.6 million Total Funds continues the State Assessment and Enterprise-wide Cost budget for 2021-23 at current service level, plus impacts of the 2019-21 August 2020 Special Session and December rebalance rollup impacts, less statewide reductions. SAEC also received an investment for Ballot Measure 109, and the following Policy Packages: Provider Time Capture, Health Equity Innovation & Implementation, Tribal Traditional Health Worker, and several Capital Finance projects at the Oregon State Hospital (related Cost of Issuance and Debt Service costs).

Executive Summary

Program descriptions

Office of Information Services (OIS) is a shared service provider for ODHS and OHA. It provides information technology (IT) systems and services for nearly 16,000 agency and partner staff at 162 local offices, Oregon State Hospital locations, and the public health laboratory.

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 ODHS and OHA staff and partners statewide in support of programs that:

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

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

OIS now also provides a sub-section of services which were formerly provided by the Information Security and Privacy Office (ISPO), primarily the IT security functions, as the over-arching Security & Privacy functions moved to DAS in the 2017-19 biennium.

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

Customer-driven shared services. With the creation of separate agencies, ODHS and OHA agreed to maintain many 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.
ODHS and OHA govern their shared services through a board of the two agencies' operational leaders. This approach ensures that shared services are prioritized and managed to support program needs. The board and its chartered subgroups have:

- Established service-level agreements and performance measures for each service.
- Selectively implemented mandated budget cuts.
- 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.

Program performance

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

Enabling legislation/program authorization

House Bill 2009 created the Oregon Health Authority in 2009.

Executive Summary

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.

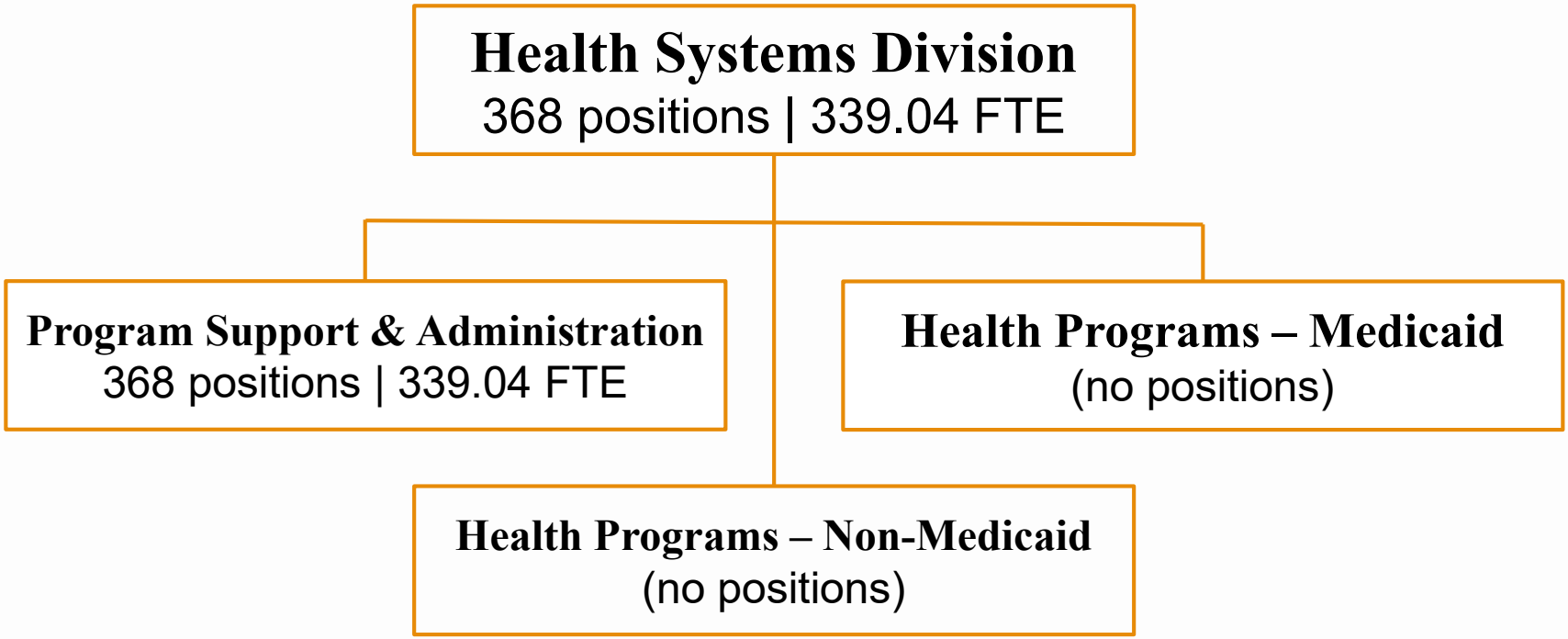
Both modules allocate aggregated costs monthly as outlined in the federally approved plan.

Significant proposed program changes from 2019-21

Only the investment into the above-mentioned Policy Packages and Ballot Measure as investments to the infrastructure.

2019-21

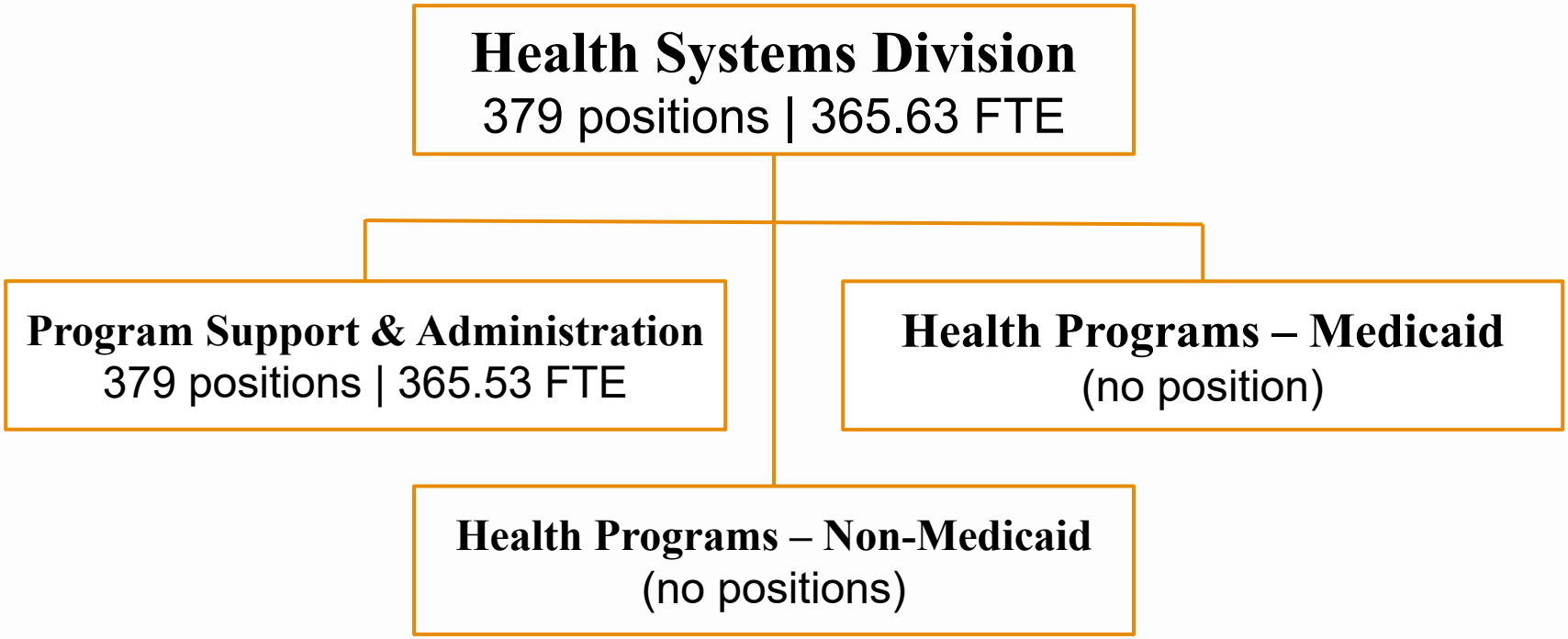
Legislatively Approved Budget



Oregon Health Authority

2021-23

Governor's Budget

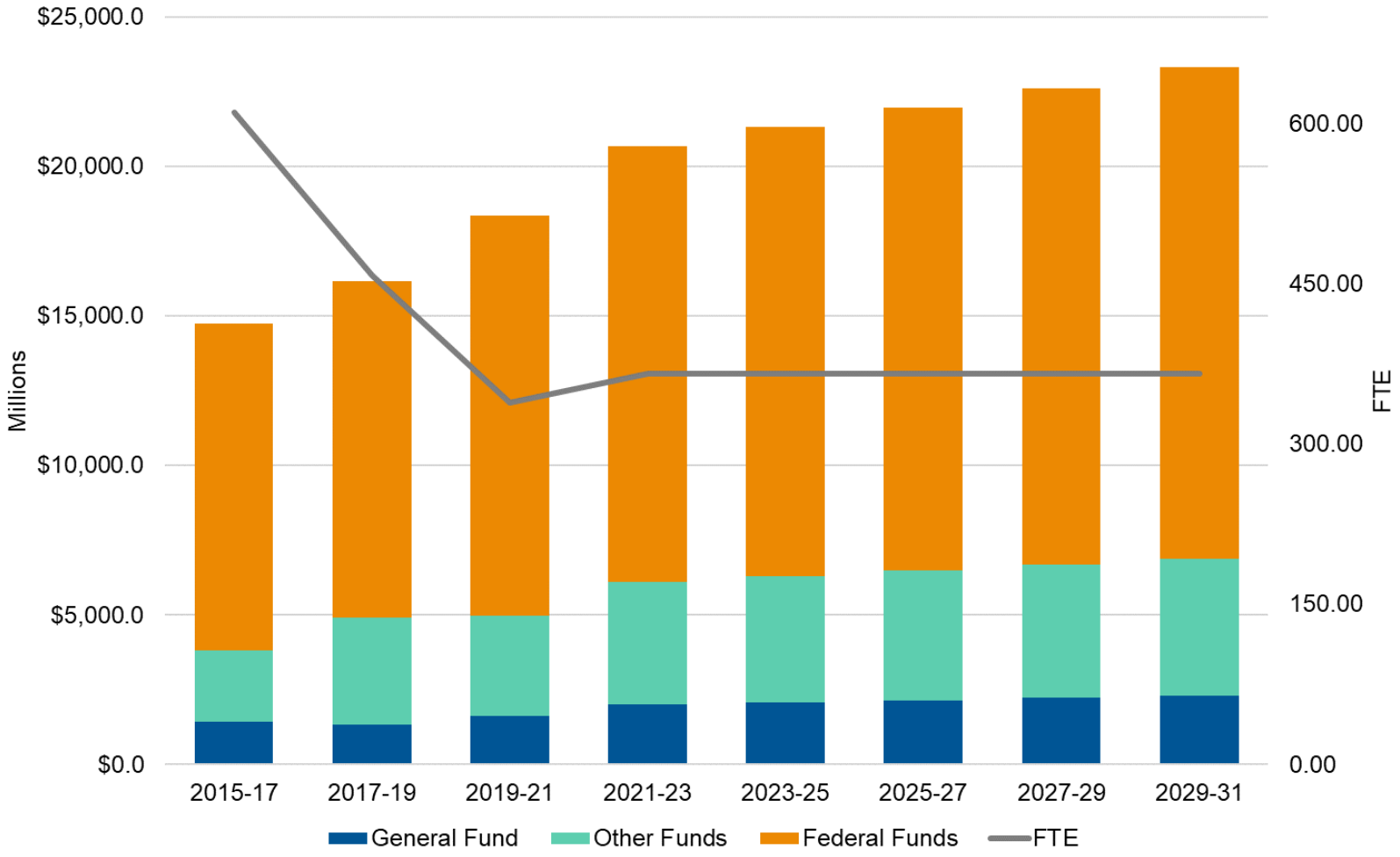


Oregon Health Authority

Oregon Health Authority: Health Systems Division

Executive Summary

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



Executive Summary

Division 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 $18,340.7 million Total Funds continues funding for the Health Systems Division's (HSD) Medicaid and Non-Medicaid programs at the current service level for the 2021-23 biennium and includes policy packages, which would:

- Establish Indian Managed Care Entities.
- Address gaps in the behavioral health continuum of care for children, youth, and adults.
- Improve the health care delivery system for Oregon Health Plan (OHP) fee-for-service (FFS) members.

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. HSD administers state and federal funds to deliver and pay for health care services to over 1 million people in Oregon, primarily through the OHP. Enrollment in OHP contributes to Oregon achieving one of the lowest uninsured rates in the nation.

HSD also administers community mental health and addiction programs statewide.

Executive Summary

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

HSD's major cost drivers are:

- Increased demand for community-based behavioral health services and affordable housing, in tandem with shortages in those resources.
- Rising health care costs, including the continued increase in prescription drug costs.
- 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 (behavioral and physical) health care costs and improve outcomes through increasing access to quality physical and behavioral health care. HSD incentivizes evidence-based, preventive practices through quality payments to CCOs and hospitals.

HSD works with partners to develop and strengthen culturally and linguistically responsive services aligned with social determinants. 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

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.

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 2021-23 biennium, HSD's budget comprises 52 percent Federal Funds, 36 percent General Fund, 11 percent Other Funds, and 1 percent Lottery Funds. Federal revenue sources include Medicaid and the Children's Health Insurance Program for approximately 1,100,000 OHP members, as well as various federal mental health and substance use disorder grants.

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

In the 2021-23 biennium, the division anticipates decreases in many of its funding streams due to the economic downturn associated with COVID-19. In particular, impacted funding streams will likely be those associated with individuals' ability to spend on taxable products and with health care provider net patient revenue and insurer premiums revenue. This will be accompanied by an increased demand on services through the Oregon Health Plan, as enrollment increases due to economic hardships.

Significant proposed program changes from 2019-21

In the 2021-23 biennium, HSD will further integrate health care delivery systems and increase access to physical, behavioral and oral health care by advancing in the following areas:

Executive Summary

- **Medicaid Programs:** Compared with 2019-21, HSD's goals will remain the same but have even greater significance. HSD will continue progress on 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, which are imperative with the expected budget shortfalls. This includes expanding CCO responsibilities to further integrate behavioral health care; pursuing alternate payment methodologies; addressing 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:** Integration expected within the Medicaid system is also expected between Medicaid and Non-Medicaid funded behavioral health system. OHA expects to continue updating and evolving the behavioral health system to fit within today's health care system and better integrate with Medicaid funding. This is expected to result in changes in how Non-Medicaid services are funded and accounted for through increased monitoring of outcomes.

Program Support and Administration

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$79.81	$26.07	$121.89	$227.77	368	339.04
Governor's Budget 2021-23	$89.77	$30.59	$130.62	$250.97	379	365.63
Difference	$9.96	$4.52	$8.72	$23.20	11	26.59
Percent Change	12%	17%	7%	10%	3%	8%

The Governor's Budget of $251 million Total Funds continues funding for Program Support and Administration at the current level for the 2021-23 biennium and includes funding and staff to support several policy packages in both the Medicaid and Non-Medicaid Behavioral Health programs.

Activities, programs and issues in the program unit base budget

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

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

Program Support and Administration

Division administration and support

Business Operations

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

The Contracts Unit oversees county contracts and grants that fund mental health and substance use disorder programs. These include intergovernmental agreements with local mental health authorities (LMHA) and community mental health programs (CMHP), direct contracts with tribes and tribal organizations, and contracts administered by the Oregon Health Authority (OHA). Program Support and Administration works directly with staff, program, leadership, community mental health programs and other agency partners to support effective programs and successful agency outcomes.

Governance and Process Improvement

The Governance & Performance Improvement unit has several areas of work: Quality management in the form of audits, issues resolution, and complaints; Performance System; Governance & Compliance; Business Implementation and Project Management.

The Quality portion of this unit works to ensure audit findings are resolved, complaints are handled appropriately and timely, and issues on the Issues Resolution list are completed thoroughly. This team also tracks internal issues to elevate to leadership. Process documentation is integral to the scope of this work.

The Performance System is a methodology adopted by OHA to ensure coordination of work priorities with the agency's vision. This methodology includes metrics development and coordination across the agency horizontally and vertically. This unit supports the Performance System actions for HSD, working closely with the Tier 1 team and consultants from Mass Ingenuity.

HSD's Governance & Compliance program focuses on Medicaid and Behavioral Health oversight with the intent of ensuring all state and federal regulations are met. This includes process overview, ensuring the adoption of new rules, and evaluating

deliverables. The unit works closely with the Medicaid and Behavioral Health teams to ensure they complete requirements as efficiently as possible. It also supports the development of compliance programs within the different areas and will facilitate process development and brainstorming as needed.

The Project Management team focuses on the highest priority and most complex HSD projects. They utilize project management tools to facilitate operationalizing projects within HSD. The Mental Health Residential Rate Standardization project was a high-profile project that went live July 2019. In addition, this team trains and consults with HSD staff on implementing their own business initiatives. Not every project requires full project management structure so ensuring HSD staff are trained on the proper process results in the standardization and streamlining of new initiatives and changes to current initiatives. This team regularly consults with HSD staff and ensures metrics are developed to track progress.

Business Information Systems

The Business Information Systems (BIS) team includes business-related functions and expenditures for information technology to support the Health Systems Division. The team provides overall coordination, monitoring and evaluation of technology initiatives and cross-system IT activities. BIS is responsible for helping guide Enterprise-wide modernization efforts related to the Medicaid Enterprise System in a manner that strategically leverage existing systems and available funding sources. As a significant source and customer of enterprise data, BIS is also working on OHA and enterprise-wide data quality and integrity projects with ODHS and OIS including coordination of efforts with the Oregon State Data Officer to support efforts to eliminate health inequities and provide a 360 degree view of Oregonians receiving services.

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

The MMIS team manages benefits, drug and pharmacy programs, enrollment, claim processing, provider portal, prior authorizations and plans of care issues, user training, MMIS security protocols, including system access agreements, third party

liability functions, and payments for services delivered through the Oregon Health Plan. The MMIS also issues payments to coordinated care organizations (CCO) and individual providers.

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

For MMIS, the major cost drivers are the number of and rising cost for required MMIS system changes, and the increased number and scale of changes that have been mandated over the past 3 years. The existing system requires a variety of changes to implement any single policy or benefit change, as well as intensive work by MMIS staff and DXC. Some examples include:

- Changes to the MMIS are driven in a descending order of priority, by federal requirements, followed by state rules and legislatively mandated changes, and finally by business need. Examples include the legislatively mandated REAL D changes and conforming to federal Transformed Medicaid Statistical Information System (TMSIS) reporting guidelines.
- Transition of Care
- Drug Rebate changes mandated by the Centers for Medicare and Medicaid Services (CMS)
- COVID-19 changes in claims coding and rules, and financial configurations in MMIS

The Compass Team collects and reports data on behavioral health, substance use disorder, and problem gambling services provided to people in Oregon through approximately 400 behavioral health agencies and providers. COMPASS staff collaborate with the Office of Information Services, HSD Behavioral Health program staff, MMIS team members, and behavioral health providers to maintain the systems and improve data submission quality. The COMPASS team supports eight data systems that include:

- 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 over 132,000 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 data. The providers using OWITS contract directly with FEI for EBHR maintenance and updates. OHA supports OWITS by answering provider questions about OWITS, resetting passwords, and paying FEI to host the EBHR data.
- *Acute Care Reporting System (ACS)* is the system used by acute care hospitals to submit client information for civil commitment admissions and discharges to HSD.

The Compass team functions also include the ongoing portfolio of work to modernize the behavioral health data systems. This work includes leading projects, gathering and prioritizing IT system requirements that align with federal and state policies and determining short and long-term technology strategies that support OHA's goals.

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

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

ASU supports OHA and CCOs through data analysis and collaboration; communication of rates-related and financial information; budgetary impact analyses for legislative and program change proposals; support for grant applications; calculating and publishing qualified directed payments to hospitals; development and implementation of cost-containment strategies; review and analysis of fee-for-service reimbursement rates; evaluation of alternative payment methodologies; and policy development in support of Oregon's health system transformation. ASU also collects, reviews, consolidates, and publishes

CCOs' financial reports. Under CCO 2.0, ASU is scheduled to regulate CCOs' financial solvency under NAIC standards, design and potentially establish a reinsurance program for CCOs, and implement a performance-based reward system as a component of CCO capitation rates.

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

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

Non-Medicaid (behavioral health)

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 SUD treatment results in decreased criminal activity and recidivism rates for individuals who complete treatment. This work includes:

- Oversight of intoxicated driver services.
- Oversight of problem gambling treatment and prevention programs in all 36 counties in Oregon through community mental health programs and by for-profit and non-profit providers. The state also has one residential treatment program for people with gambling disorders.

- Funding, development and oversight of several initiatives to address opioid use and misuse issues, in partnership with the Public Health Division and community partners throughout the state. This includes increasing patient access to Naloxone and office-based opioid treatment options, especially in underserved, rural and frontier areas.
- Oversight of peer-delivered addiction treatment and recovery services. This is an evidence-based practice that uses trained and certified recovery mentors as part of a comprehensive recovery support team. This budget also includes sobering centers, a vital component of the safety net system for people struggling with substance use disorders.
- Oversight of outpatient, crisis, and residential treatment programs for people with substance use disorders. The goal of SUD treatment is to help individuals stop substance use and allow them to lead active lives in their family, workplace, and community. The current system of care in Oregon includes outpatient, intensive outpatient, and residential treatment services throughout the state. Counselors provide individualized treatment at many different program sites, including health clinics, community mental health clinics, counselors' offices, hospital clinics, and local health department offices. Many meet in the evenings and on weekends so participants can go to school or work.

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

- Supports community-based crisis intervention services such as transportation, assessment, de-escalation and referral to treatment. This helps people experiencing a mental health crisis avoid needing a higher level of care their community may not offer.
- Monitors, funds and develops strategies to expedite discharge of Oregon State Hospital (OSH) residents and prevent re-hospitalization. This includes ensuring safety and stability in housing, employment and community integration. This unit works with the Psychiatric Security Review Board, OSH treatment teams and community mental health programs to ensure individuals are placed in the appropriate level of care and receive the treatments and services needed to live as independently as possible. Supports the provision of evidence-based practices including Assertive Community Treatment, Supported Employment, Suicide Prevention, and Peer Delivered Services.

Program Support and Administration

- 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.

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

- Plans and administers federal behavioral health block grants for non-Medicaid services.
- Ensures consumers provide input into the planning and delivery of services and supports at state and local levels through the Office of Consumer Activities.
- 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.
- Advances policies and supports implementation of behavioral health integration through CCOs to improve the behavioral health system.
- Assesses the needs of the behavioral health workforce and develops policies and a strategic plan to improve the quality and availability of the behavioral health workforce to ensure all Oregonians have access to behavioral health care.
- Plans, administers, develops and directs lottery dollars associated with veteran behavioral health programming.
- Provides coordination between systems serving veterans and military service members.
- Manages administrative rulemaking for Behavioral Health programs.

Program Support and Administration

This unit includes the State Opioid Authority (SOTA). The SOTA is responsible for:

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

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

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

Program Support and Administration

Serving children, youth and their families in their local communities through robust community-based interventions that can safely support youth, including assessing them for suicide risk, in their homes; and that can reinforce out of home care, including foster homes and residential-based interventions, serving those who need specialized or substitute care.

The unit does this through:

- Support for the Governor's System of Care Advisory Council created by Senate Bill 1 (2019) and tasked with forming policy for improving Oregon's System of Care.
- Funding and oversight of technical support in coordinating care for children, youth and young adults with emotional and behavioral disorders served across multiple systems such as the juvenile justice, education, child welfare, and mental health.
- Promoting peer-delivered services, where a person with lived experience provides supports and services to parents, caregivers and youth experiencing behavioral health challenges.
- Funds a statewide Parent/Caregiver/family audio and virtual help line to support positive solutions to parenting issues and connection with formal and informal resources to reduce the use of crisis services by de-escalation of tension and stress.
- 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 contract management and coordination of the Big Six[2] suicide prevention programs, suicide prevention work with school districts, and evaluation efforts. The 2021-2025 Youth Suicide Intervention and Prevention Plan is scheduled to be released July 1, 2021.
- Funding, promotion and oversight of effective interventions that improve outcomes for children and their families experiencing parent-child relationship problems, behavioral problems, or Mental Health/addiction disorders to include addiction and problem gambling.
    - Parent-Child Interaction Therapy (PCIT) is a preferred treatment for families with young children.
    - Collaborative Problem Solving reduces the use of seclusion and restraint in child programs and improves parent-child communication.

[2] Mental Health First Aid, Sources of Strength, Question, Persuade, Refer, safeTALK, Applied Suicide Intervention Skills Training (ASIST), Connect: Postvention

  - "Triple P" is an evidence-based positive parenting program utilized to prevent behavioral and emotional problems for children and youth at home, in school and in the community, creating family environments that encourage children to realize their potential.
  - Parent Management Training of Oregon (PMTO)
  - Trauma Focused Cognitive Behavioral Treatment (TFCBT)
  - Wraparound
- 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 disrupt exploitation and provide survivors with skills and opportunities which hopefully prevent further victimization upon return to the community.
- 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), a community- based alternative to psychiatric hospitalization for children and their families presenting with a mental health crisis to the emergency room. CATS providers respond to the emergency room within 3 hours of referral and work directly with the child and family to assess the clinical and safety needs of the family. The CATS team develop a safety plan in collaboration with the child and family to enable the child to remain in their community, and provides interim mental health therapy, family support services and 24/7 crisis response to the family

while connecting the child and family to community resources and supports. CATS providers provide services for up to 45 days from referral.

- Provision of Intensive In-Home Behavioral Health Treatment (IIBHT) – which is a new level of care serving children and youth up to age 17. IIBHT offers intensive mental health treatment for children and their families to children with complex mental health needs who are at risk of being placed out of their home or who are stepping down from facility-based care. IIBHT services may include individual and family therapy, family support services, skills training, psychiatric services and 24/7 crisis response.
- 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.
- Provide funding and technical assistance to local communities for mental wellness, mental health promotion and prevention, and reduction of stigma for utilizing behavioral health and peer-delivered services when needed. This includes but is not limited to suicide prevention, addiction prevention, and community connections which enhance social and emotional determinants of health, provide support and prevent isolation and other types of marginalization.

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

- Adult Foster Homes
- 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

Medical Assistance Programs

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

Staff work with provider associations, community partners, the federal Centers for Medicare and Medicaid Services, ODHS, other state agencies, and other OHA divisions to implement and promote changes to benefits or programs. Recent efforts include establishing policy and issuing guidance for COVID-19 response. This response included adding OHP coverage for COVID testing and treatment, expanding access to telehealth services, and working with providers and partners to address financial challenges. COVID response has been an all-hands-on-deck effort that came on top of the tremendous work involved with implementing new CCO 2.0 contracts and several other major initiatives. Other notable efforts include working with Oregon's tribes to develop first in the nation Indian Managed Care Entities, working with ODHS and OYA to update rates and improve operations for the Behavioral Rehabilitation Services program serving vulnerable youth, and launching the ONE eligibility system.

The Medicaid program oversees the following elements of Oregon's medical assistance program administration:

- Implementation and monitoring of the CCO contracts including the new CCO 2.0 contracts that began January 1, 2020.
- The policies, rules and processes that govern Oregon Health Plan eligibility, covered health care services, eligible health care providers and participating managed care health plans, including CCOs.
- Contracts and agreements with CCOs, health care providers, and other vendors that approve, coordinate and/or deliver care to members.

Program Support and Administration

- Changes to Oregon's Medicaid and CHIP State Plans and the Medicaid 1115 Demonstration Waiver. Combined, these documents explain how Oregon administers its federally funded medical assistance programs and the requirements for members and providers to participate in these programs.
- The state's Medicaid Management Information System (MMIS), which manages benefits, enrollment, claim processing and payments for services delivered through the Oregon Health Plan. The MMIS also issues payments to managed care entities (coordinated care organizations, dental care organizations and mental health organization), individual providers and organizational providers.
- Customer service for participating health care providers and plans to ensure they meet state and federal requirements. This includes provider enrollment, a provider services call center, clinical review staff, claim processing and reporting.
- Customer service for members.
- Contested case hearings for OHP members who disagree with a state or CCO decision to deny, reduce or end coverage of a specific health care service.
- Administrative reviews for OHP providers who disagree with a state or CCO decision to deny, reduce or end coverage of a specific health care service.

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

Additionally, Medicaid staff work with CCOs, community partners, OHA's Tribal Director and the OHA Equity and Inclusion Division 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.

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

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

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.

Provider Services staff provide customer service for over 99,000 health care providers. Services include but are not limited to clinical and technical review of health care claims and requests to approve payment of health care services; enrollment of participating providers; and the Provider Services customer service line for help with billing, provider enrollment, prior authorization requests and MMIS access. Provider Services staff also work with Oregon's contracted managed care entities to ensure they submit data about the health care encounters they coordinate for OHP members, and review provider appeals of OHA and CCO coverage decisions through claim redeterminations and administrative reviews.

Program Support and Administration

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

Eligibility Policy staff work with Medicaid Programs and Department of Human Services staff to coordinate updates in state policies, programs and information systems when federal Medicaid and CHIP eligibility rules change. Staff inform system enhancements, such as "automated renewal" functionality in November 2017, Hospital Presumptive Eligibility in April 2018, and an upgrade to an integrated eligibility system in 2020. These enhancements have not only improved accuracy but have also allowed for faster, more automated, and more consistent determinations.

Hearings staff work with members, health care providers, CCOs and Oregon's Office of Administrative Hearings to coordinate the contested case hearing process for Oregon Health Plan members. From July 2018 through June 2019, staff processed over 1,800 hearing requests.

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

Claims and Encounter Data Services staff work with CCOs on submitting encounter data. This includes enrolling CCO providers, identifying and correcting errors and submitting necessary backup documentation. The unit also includes staff who work on fee-for-service claims and appeals that need to be handled manually. Electronic Data Interchange is also housed within CEDSU. Those staff work with providers and clearinghouses on being set up, testing and production issues around the submission and retrieval of electronic claims, enrollment and eligibility data. Other functions in this unit are enrollment and capitation reconciliation with the CCOs, Administrative Reviews requested by providers who disagree with claims determinations made by CCOs and running queries of DSSURS data utilized internally by other teams within HSD.

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 270 non-Medicaid contracts and grants.
- Managing and monitoring the implementation of legislative initiatives.
- Monitoring and improving division compliance and performance.
  Development and management of capitation rates.
- Ensures Oregon's Medicaid program and its providers, either through contract or by fee-for-service, follow federal and state Medicaid service and billing regulations
- Development and maintenance of behavioral health and Medicaid data and reporting systems.

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

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

For COMPASS, the outdated computer systems require time-consuming and costly manual work-arounds to meet the data and reporting needs of OHA-HSD Behavioral Health Programs. Existing information systems do not easily integrate with providers' external systems (including electronic health records systems) or with OHA internal systems, which affects reporting frequency and accuracy. Upgrading these systems would decrease system and administrative costs for Behavioral Health Programs and their

partners. COMPASS will also be migrating the CANS assessment (Child and Adolescent Needs and Strengths) from a paper-based system to an electronic system to facilitate data collection and reporting.

Revenue sources and changes

The 2021-23 budget for Program Support and Administration comprises 52 Federal Funds, 36 percent General Fund, 11 percent Other Funds, and 1 percent Lottery Funds.

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

Program Support and Administration receives Federal Funds through Medicaid administrative match, small amounts of federal block grants to meet administrative requirements, and other federal grants to fulfill the grant obligations. Medicaid provides a 50:50 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.

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
- 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.

Medicaid

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$1,292.24	$3,133.86	$13,142.21	$17,568.31	0	0
Gov. Budget 2021-23	$1,604.66	$3,799.25	$14,357.26	$19,761.17	0	0.00
Difference	$312.42	$665.38	$1,215.05	$2,192.85	0	0
Percent Change	24%	21%	9%	12%	N/A	N/A

The Governor's Budget of $19,761 million Total Funds continues funding for Oregon's medical assistance programs at the current service level for the 2021-23 biennium and includes funding for:

- Policy package #403 to establish and support Indian Managed Care Entities.
- Policy package #407 to operate the Medicaid Fee-for- Service (FFS) delivery system like a coordinated care organization (CCO). Includes funding for FFS Interpreter Services, transition services, Behavior Rehabilitation Services home rates, Enteral/Parenteral -Intravenous rates, and Applied Behavior Analysis rates.

Activities, programs and issues in the program unit base budget

The Medicaid budget includes state and federal funds used to deliver and pay for health care services to over 1 million Oregon Health Plan (OHP) members of which 43 percent are children. The OHP includes Medicaid, the Children's Health Insurance Program (CHIP), Cover All Kids, Reproductive Health Equity Act (RHEA), and other related services. Payments are made to individual health care providers as Fee-for-Service (FFS) and to the coordinated care organizations (CCOs) in the form of a global budget. CCOs serve over 90 percent of all OHP members.

The Medicaid budget is based on caseload forecasts and cost estimates projected for the coming two years. Because of the budget's size, even minor changes from forecasted caseload numbers to actual caseload numbers can result significant changes from the projected budget—either shortfalls or savings. For all medical assistance program recipients, as of Fall 2020, OHA projects the 2021-23 biennial average caseload to be 1,174,702 individuals. However, that projections was made prior to the

extension of the allowances we currently have associated with the pandemic. Current caseload numbers have exceeded 1,200,000 and are expected to stay at this level throughout next biennium.

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

Background information

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 Oregon's 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 the bill led to the transition of some CAWEM members into the Cover All Kids program, which is funded by General Fund, while the remaining CAWEM members maintained Medicaid funding.

Revenue sources and changes

The 2021-23 Medicaid budget comprises 73 percent Federal Funds, 8 percent General Fund, and 19 percent Other Funds.

General Fund revenue supports Oregon's medical assistance programs. The Medicaid program (OHP) receives Federal Funds for services provided to Medicaid-eligible individuals through the following sources:

- The Medicaid Title XIX entitlement provides a 61:39 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 61 cents and OHA funds the rest.

- The Children's Health Insurance Program (CHIP) Title XXI entitlement provides a 72:18 match on health care services to CHIP members.
- Medicaid Title XIX provides a 90:10 match for health services for low-income adults (expansion population).

Other Funds revenues include tobacco tax revenues, hospital assessments, an intergovernmental transfer agreement with the Oregon Health & Science University (OHSU), insurers assessments, grants, third party recoveries, pharmaceutical rebates, and the Tobacco Master Settlement Agreement (TMSA). For the 2021-23 biennium, tobacco tax revenues will increase since Oregon's voters approved legislation referred by the Legislature to the November 2020 ballot that will increase Oregon's cigarette tax by $2.00 per pack, extend the existing wholesale tax on other tobacco products to vaping products and increase other non-cigarette tobacco taxes.

Proposed new laws that apply to the program unit

None.

Oregon Health Authority: Health Systems Division

Non-Medicaid

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$248.12	$182.82	$113.73	$544.66	0	0.00
Governor's Budget 2021-23	$328.09	$248.80	$98.90	$675.79	0	0.00
Difference	$79.97	$65.98	-$14.82	$131.13	0	0.00
Percent Change	32%	36%	-13%	24%	N/A	N/A

The Governor's Budget of $675.8 million Total Funds continues funding for Non-Medicaid Behavioral Health programs at the current service level for the 2021-23 as well as additional funding and position authority for three policy packages. The programs and services in the base budget and policy packages will advance the OHA 10-year goal to eliminate inequities in health outcomes, particularly for people who need behavioral health services. Further, OHA seeks to ensure behavioral health services are simple to access, responsive to people's needs, and result in meaningful outcomes for people. COVID-19 has had a profound impact on people who receive behavioral health services and how services are provided. As the pandemic continues, the need for enhanced and expanded behavioral health services and supports will likely continue into 2021 and beyond.

In 2019, the Governor's Behavioral Health Advisory Council (GBHAC) was established. The 47-member council established by Executive Order 19-06 represented a broad range of perspectives and experiences relating to Oregon's behavioral health system. The GBHAC developed actions, and proposed policies and investments to preserve and improve services and supports for youth and adults with serious mental illness, including those with co-occurring substance use disorders.

Policy package #409 includes recommendations from the GBHAC:

- Expand the young adult in transition residential system.
- Develop psychiatric residential treatment capacity.
- Develop peer-run respite pilot to provide culturally informed, voluntary, short-term residential support in a home like setting to adults who are experiencing acute mental health or emotional distress.

- Fund tribal-based practice component of the Tribal Behavioral Health Strategic Plan.
- Implement the Alcohol and Drug Policy Commission Strategic Plan.
- Develop a payment methodology to fund integrated co-occurring disorder treatment.
- Fund incentives for the behavioral health workforce to increase the workforce and improve recruitment and retention.

Policy package #411 increases local capacity to serve the "Aid and Assist" population to reduce long-term costs and address capacity challenges at the Oregon State Hospital.

Policy package #416 expands mobile crisis response for children, young adults, and their parents and caregivers.

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 for adults and children including:

- A safety net of behavioral health crisis services
- Supports and services for uninsured or underinsured individuals to improve a person's ability to be successful with their family, education, employment, and in their community
- Timely access to behavioral health care that is a critical aspect for increasing protective factors and reducing risk factors that lead to suicide
- Assistance with housing and other social determinants of health

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

Non-Medicaid

Cost drivers

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

- Increased need for behavioral health services in response to COVID-19.
- A youth suicide rate that has been increasing since 2011.
- Stigma and bias present barriers to tribal communities and communities of color seeking or receiving behavioral health care.
- Need for more services options in people's home communities.
- The number of individuals entering mental health treatment through crisis services, including emergency departments and arrest.
- The number of individuals entering treatment who have multiple and complex physical and mental health needs.
- Behavioral health workforce shortage across all provider types.
- Access to methamphetamines and opioids, which drives social problems including overdose, death and the demand for treatment.
- Lack of safe, affordable and drug-free housing.
- Ease of access to highly addictive gambling games.

The 2021-23 continuing caseload is forecast for a biennial average of 55,752 clients, which is 11.1 percent higher than the 2019-21 biennium. The caseload includes clients in forensic, aid and assist, guilty except for insanity (GEI), civil commitments, previously committed, never committed populations.

Opportunities for improvement

- Expanding access to a range of mental health 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.
- Increasing members of tribal communities and communities of color in our stakeholder and advisory groups to create an equitable behavioral health system.

- Since 2016, Oregon has experienced a shortage of beds for youth under age 18 at the intensive psychiatric residential level of care. OHA is actively working with the Oregon Department of Human Services (ODHS) on capacity, developing a short-term strategy to address needs. Additionally, OHA and ODHS are engaging CCOs, counties, stakeholders and partners in investigating mid- to long-term solutions for meeting the intensive service needs of our youth and families in the state while conceptualizing alternatives to the current model.

Background information

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

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

- Mobile Crisis and Jail Diversion services in every county to assist individuals in getting services prior to encounters with law enforcement and to encourage treatment options instead of jail.
- Assertive Community Treatment (ACT) services for 1,200 individuals in their homes and communities.
- Supported Employment (SE) for 730 people.
- Older Adult Programs.
- Community services for people under the jurisdiction of the Psychiatric Security Review Board
- Care coordination.
- 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.

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

- Early and young childhood training and interventions with parents

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

Addiction Treatment and Substance Use Disorder services and supports
Opioid Response: The SAMHSA State Opioid Response Grant provides Oregon with targeted funds to address the opioid epidemic.

Housing Services: OHA and Oregon Housing and Community Services (OHCS) are engaged in an ongoing collaborative effort to expand Permanent Supportive Housing. Rental assistance is available statewide for up to 1,254 people.

Problem Gambling Services: Lottery revenues fund problem gambling treatment and prevention services. Fifty treatment programs ensure problem gambling treatment services are offered in every county. These programs include traditional outpatient, residential, respite, home-based, and prison-based programs as well as a full-service help line. In state fiscal year 2019, 1,026 Oregonians received problem gambling treatment services, including individuals with gambling disorders and their family members at a cost of $1,743 per case. Of the individuals in outpatient services, 28 percent successfully completed treatment. Of those who completed treatment, 33 percent reported they were still abstaining from gambling six months later and 45 percent reported gambling much less.

Revenue sources and changes

The 2021-23 Non-Medicaid Behavioral Health revenues include 48 percent General Fund, 35 percent Other Funds, 15 percent Federal Funds, and 2 percent Lottery Funds.

Non-Medicaid

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

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.
- 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

Governor's Behavioral Health Advisory Council (House Bill 2086) Governor Brown issued an Executive Order to convene the Behavioral Health Advisory Council. The council is tasked with developing recommendations aimed at improving access to effective behavioral health services and supports for all adults and transitional-aged youth with serious mental illness or co-occurring mental illness and substance use disorders.

System of Care Advisory Council (Senate Bill 68) The System of Care (SOC) Advisory Council is directed under Senate Bill 1 (2019) to improve the effectiveness and efficacy of child serving state agencies and the continuum of care that provides services to

youth ages 0 to 25 by providing centralized and impartial forum for statewide policy development, funding strategy recommendations and planning. The recommendations to the legislature and agency directors are highly likely to include the need for new legislation and changes or updates to existing statutes in order to address continuum of care gaps and needs and develop and more functional SOC for Oregon.

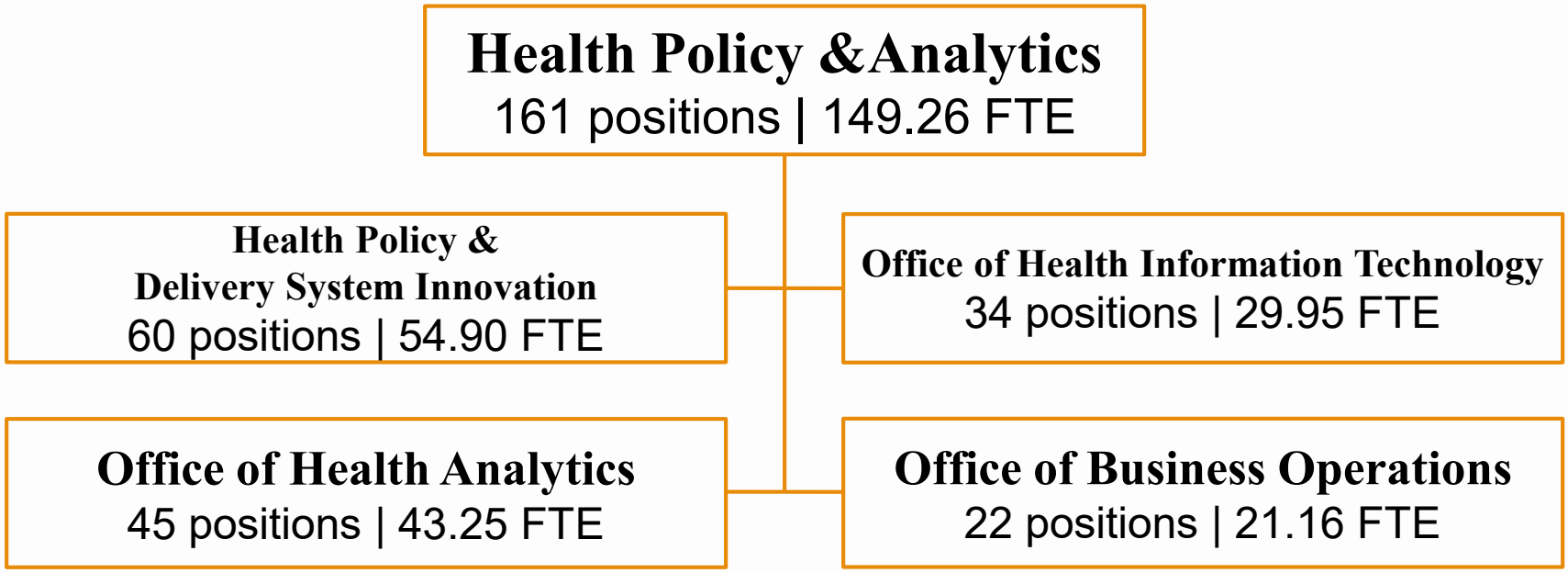
Medical examiner and law enforcement reporting of deaths suspected to be suicide and uniform postvention response (Senate Bill 66) ORS 418.735 does not require medical examiners or law enforcement to report a suspected suicide death to the local mental health authorities (LMHAs), which creates inconsistent and unreliable suicide postvention responses. Currently, postvention response varies widely across the state – and in some counties there is no postvention response from the local mental health authority. This bill proposes changing the ORS 418.735 to address these concerns.

Recovery Housing (Senate Bill 69) Current statute only allows for funding of recovery housing that is Alcohol and Drug Free, whereas a full range of options are necessary to ensure a continuum of care that embraces harm reduction as well as abstinence-based recovery. The proposed solution changes statutory language to allow for multiples treatment models in housing.

Improve Treatment of Co-occurring Disorders (Senate Bill 67) The behavioral health workforce is not consistently trained to screen, assess, or treat co-occurring disorders (such as mental health and substance use, or problem gambling or intellectual and a developmental disability (I/DD) diagnosis). Additionally, Oregon facilities are credentialed or licensed as either substance use or mental health facilities, creating barriers to care for individuals seeking treatment. There is not a billing code for co-occurring disorders and there are separate funding sources for substance use and mental health. This results in lack of data for co-occurring disorders. Lastly, providers are required to complete separate assessment screenings and tools for mental health and substance use disorder (the American Society of Addiction Medicine (ASAM)). This will be used to address barriers to having a comprehensive system that treats the behavioral health needs of the individual holistically.

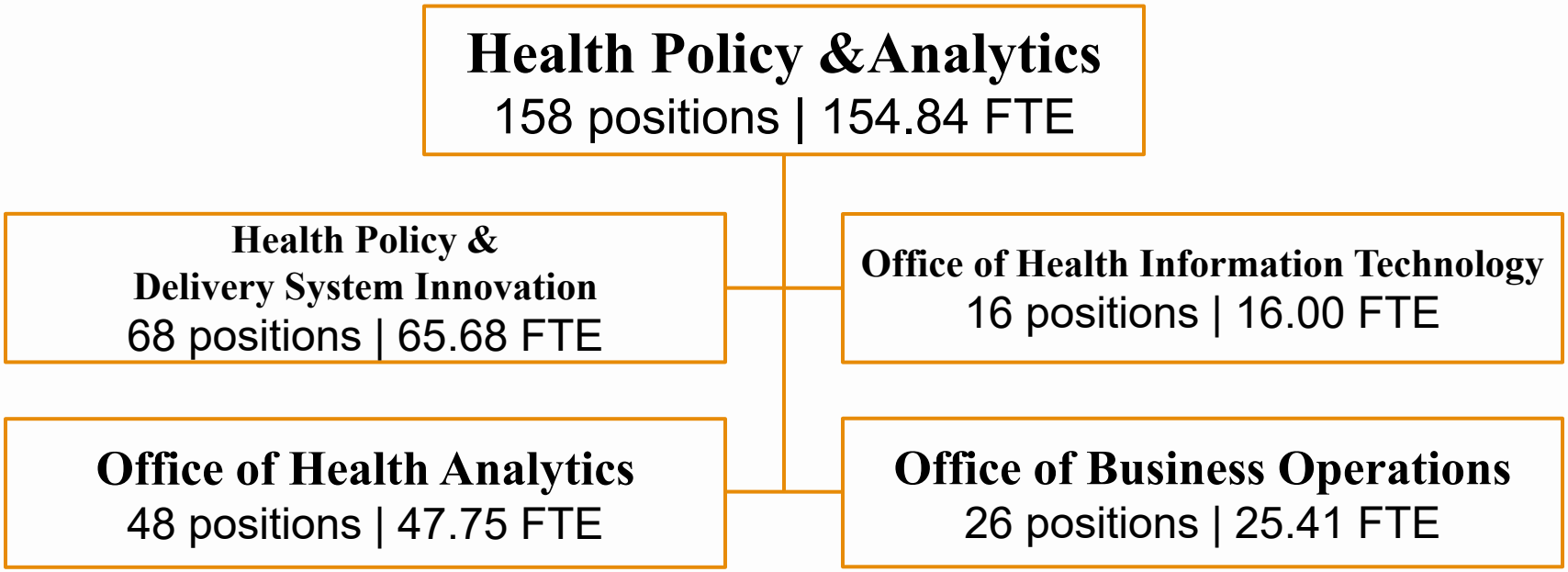
2019-21

Legislatively Approved Budget



Oregon Health Authority

2021-23
Governor's Budget



Oregon Health Authority

Oregon Health Authority: Health Policy & Analytics

Executive Summary

Program Contact: Jeremy Vandehey, Director of Health Policy & Analytics
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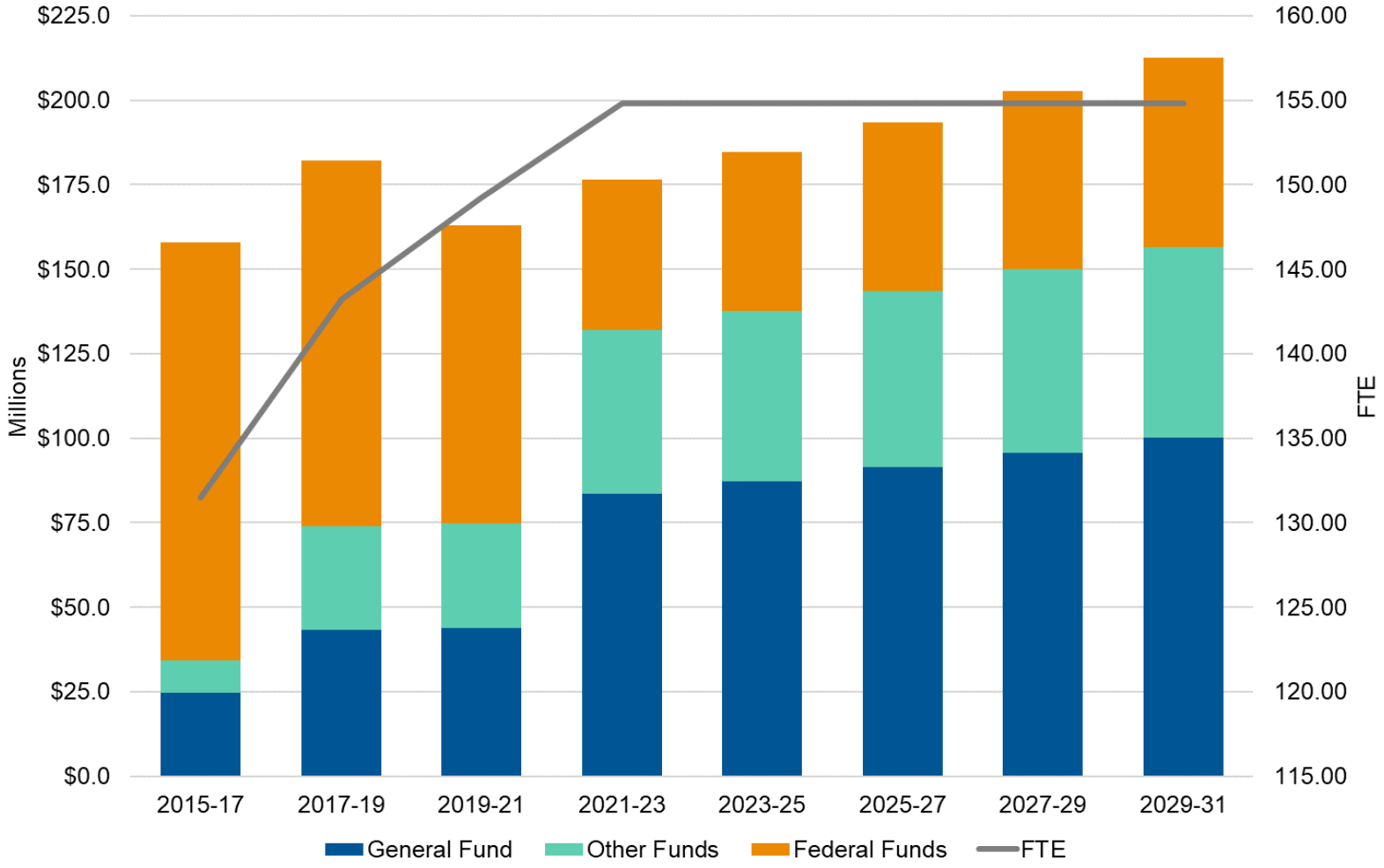


Executive Summary

Division overview

The Health Policy and Analytics division develops and implements innovative approaches to lowering health care costs and achieving better health and better health care, while keeping a central focus on health equity. 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, statewide delivery system technology tools to support care coordination, health system transformation support, and health system performance evaluation reports. Together these offices provide services and support focused on achieving health equity through the triple aim of better health, better care, and lower costs.

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

- Supporting and incentivizing payments for value, moving away from paying for service volume and incentivizing investments in better health for all communities.
- Supporting the Oregon Health Policy Board's work including its plans to operationalize OHA's Health Equity Definition and reimagine a health care system capable of achieving health equity.
- Focusing on social determinants of health in addition to medical care.
- Providing the clinical leadership to shape the management of high cost pharmaceuticals.
- Innovating and implementing integration across behavioral health, oral health, physical health and social services using health information technology.

Executive Summary

- Implementing legislative directives to align metrics and supporting new and innovative metrics for equity and social determinants of health.
- Facilitating multi-payer alignment to stabilize critical provider services and rebuild a health care system capable of achieving health equity.

Funding request

The Governor's Budget of $162.9 million Total Funds continues funding for the Health Policy and Analytics Divisions at the current service level for 2021-23, with the exception of the Office of Health Information Technology (OHIT) which is reduced due to a reduction Federal Funds match rates. The Governor's Budget includes a $27.5 million General Fund investment in workforce development and retention in underserved communities as well as policy packages to invest in policy development to achieve the triple aim of better health, better care, and lower costs.

Program descriptions

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

The **Office of Delivery Systems Innovation** (DSI) is designed to align and integrate clinical resources and policies to support implementation of the coordinated care model throughout 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** 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,

Executive Summary

the Oregon Health Policy Board (OHPB), OHA, and other participants in Oregon's health system transformation. These services help Oregon Health Authority identify opportunities, articulate program options, implement policy, and assess its progress toward achieving the triple aim. The Office of Health Policy serves three key functions:

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

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

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

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

- Accelerate state and federal health reform goals through organized support for adoption, implementation and integration of health information technologies.
- Leverage health IT funding opportunities from federal agencies, 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 annual per-member-per-month cost increases at 3.4 percent.

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

Executive Summary

These offices recommend the policy direction, measure the results, and suggest strategies for improving all health-related outcomes. Recently, HPA has focused on monitoring and developing strategies around:

- Reducing per capita costs.
- Leveraging public purchasing power to drive value-based payments and coordinated care models
- Reducing the number of uninsured Oregonians.
- Improving specific health measures tracked by the CCOs.

Program performance

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

Enabling legislation/program authorization

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

Funding streams

Health Policy and Analytics is supported primarily by General Funds matched with Medicaid Administrative and Medicaid Health Information Technology 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 Office grant, HRSA Oral Health Workforce grant, the Integrated Care for Kids (InCK) grant, and Center for Medicare & Medicaid Services (CMS) Health Information Technology Electronic Health Record funds (phases out during the 2021-23 biennium). It receives Other Funds from fees (workforce, inpatient data, ambulatory surgical data, All Payer All Claim, J1 Visa, Oregon Prescription Drug Program) and the Health Care Incentive Fund.

Significant proposed program changes for 2021-23

House Bill 2081, Policy Package #409 – Community Behavioral Health Services: Strategies and recommendations from the Governor's Behavioral Health Advisory Council to improve the behavioral health system for adults and transitioned-aged youth who

experience serious mental illness and co-occurring substance use disorders. Health Policy and Analytics element includes a $22M investment in workforce diversification for Oregon's behavioral health and medical workforces in underserved communities.

House Bill 2083, Policy Package #425 – Aligning Purchasing Power Across PEBB/OEBB: Allows for additional special procurement authority for joint purchasing initiatives and adds resources to continue to transform the delivery systems in alignment with coordinated care organizations (CCO) and the coordinated care model.

Policy Package #427 – Public Option/Medicaid Buy-in: Enables OHA to further research and report on the details of health insurance reforms that could increase access to health insurance while reducing premiums paid by consumers – potentially through a public option or a "Medicaid buy-in" plan as envisioned by Senate Bill 770 (2019).

House Bill 2082, Policy Package #429 – Statewide VBP Infrastructure and Alignment: To leverage OHA's leadership role in establishing a statewide value-based payment roadmap and requisite technical assistance infrastructure to support increased adoption and alignment of VBP across Oregon.

House Bill 2080, Policy Package #436 – Pharmacy Omnibus: Equips OHA with staffing and clarified statutory authority to support and manage pharmacy purchasing in a collaborative and innovative manner. Without this legislation and funding, OHA will be limited in its ability to effectively innovate and keep pace with the dynamic and quickly evolving pharmacy marketplace/supply chain.

Senate Bill 65, Policy Package #437 – Strengthen Purchasing Power of the Marketplace: Moves the Marketplace from DCBS to OHA, creating greater opportunities for aligned policy, which would utilize all state levers to maximize opportunities for greater alignment in pursuit of the triple-aim.

Policy Package #411 – Community Mental Health Aid and Assist: Will be used to increase community services to meet the immediate needs of people who have been arrested and court-ordered for services under Oregon's "Aid and Assist" laws (ORS 161.365 & 161.370). Additional OHA staff will ensure better coordination between courts, the Oregon State Hospital (OSH) and

Executive Summary

Community Mental Health (CMH) and Substance Use Disorder (SUD) service providers for people who have intensive behavioral health service needs.

Policy Package #426 – PEBB/OEBB Benefits Management System Replacement Project: Integrates the administration and support of the two systems, with improved user experience and customer care, into a single platform to meet the legislative direction provided under SB 1067 (2017).

Office of Business Operations

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$1.93	$0.32	$1.70	$3.96	22	21.16
Governor's Budget 2021-23	$2.96	$0.40	$2.56	$5.92	26	25.41
Difference	$1.02	$0.08	$0.86	$1.97	4	4.25
Percent Change	53%	24%	51%	50%	18%	20%

Activities, programs and issues in the program unit base budget

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

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

Contracts and Project Management:

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

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.

Background information

The Office of Business Operations has focused on consolidating, identifying, documenting and maintaining the division's operational processes. The office is identifying meaningful metrics for each process, benchmarking the current state of the

measures for those processes and setting goals for improvement. The focus will be incremental improvements using a maturity model and pinpointing the processes deemed to be of most importance by the collective input of the division.

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

Revenue sources and changes

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

Proposed new laws that apply to the program unit

None.

Health Policy and Delivery Systems Innovation

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$29.62	$29.02	$14.66	$73.29	60	54.9
Governor's Budget 2021-23	$65.44	$46.66	$22.32	$134.42	68	65.68
Difference	$35.82	$17.64	$7.66	$61.12	8	10.78
Percent Change	121%	61%	52%	83%	13%	20%

Activities, programs and issues in the program unit base budget

Health Policy Office

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

1. Research, Analysis, and Policy Development

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

2. Coordination & Tracking

- Track and coordinate, when needed, policy development and implementation across HPA and OHA to ensure alignment with strategic direction.

- Coordinate and synthesize responses to proposed federal regulations and legislation, incorporating feedback from across HPA (and OHA when needed).
- Coordinate development of legislative concepts; coordinate analysis on priority legislation; and track and support implementation of legislation.
- Staff OHPB, coordinate committees of OHPB, and provide staff and policy leadership to OHPB committees to ensure committee work is connected to OHPB vision and direction.
- Help maintain consistent strategic direction and vision between OHPB, HPA, and OHA.

3. Partnerships

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

Additionally, the Health Policy Office houses the Oregon Integrated Care for Kids (InCK) model team, funded by the Centers for Medicare and Medicaid Innovation (CMMI). The InCK team supports activities of the demonstration model in a five county service area that aims to improve health outcomes, reduce out-of-home placements, and reduce costs associated with unnecessary ER visits and inpatient stays for children/youth age 0-21 who are eligible for Medicaid.

Office of Delivery Systems 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 the Office of Delivery Systems Innovation was to better align medical management practices and coordinate delivery system policies across coordinated care organizations (CCOs), the fee-for-service population, other

plans and payers, and all OHA departments. The goals of the CMO and the Office of Delivery System Innovation (formerly known as the Office of Clinical Services Improvement) are to:

- Integrate clinical policies and resources to support the coordinated care model.
- Align and coordinate strategies to improve health care delivery 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 and transformation efforts across OHA, PEBB- and OEBB-contracted plans, CCOs, and other entities involved in quality improvement.

One goal of the CMO and the Office of Delivery Systems Innovation is to focus the agency's clinical and delivery system knowledge and expertise on achieving transformation, quality, and cost containment goals. The CMO 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.
- Oregon Prescription Drug Program and pharmacy purchasing director.

The Transformation Center director also serves as the deputy director of the Office of Delivery Systems Innovation, and in this capacity directly supervises the following two positions:

- Quality Improvement director.
- Clinical Supports, Integration and Workforce Unit director.

Health Policy and Delivery Systems Innovation

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

Background information

The CMO oversees the HERC within the Office of Delivery System Innovation. Among other responsibilities, the HERC:

- Conducts research into comparative effectiveness and benefit design to inform public and private sector transformation efforts.
- Performs medical technology reviews.
- Develops clinical and coverage guidelines based on clinical evidence.
- Maintains the Oregon Health Plan's Prioritized List of Health Services.
- Disseminates information on the clinical- and cost-effectiveness of medical treatments and technologies.

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

The Office of Delivery System Innovation also sponsors performance improvement projects overseen by the Quality Improvement Director and oversees the Transformation Center to coordinate and support health system transformation and quality improvement across Oregon's health system. The Transformation Center is a key lever in OHA's efforts to support and spread Oregon's health reform progress by sharing innovation at the system, community and practice levels. Since its inception in 2013, the Transformation Center has provided capacity-building support to over 13,000 representatives of CCOs and other payers, providers, and community partners through more than 550 individual technical assistance sessions and large convenings across the entire range of OHA key health priorities, from behavioral health to health equity. Evaluation data from the Transformation Center's capacity-building sessions and convenings since May 2017 indicate that almost 97 percent of

participants planned to take action as a result of what they learned. Further, the Transformation Center shares key health care trends with our partner agencies, the Department of Human Services, the Department of Consumer and Business Services Insurance Division, the Governor's Office, and the Legislature.

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

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

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)

Revenue sources and changes

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

Proposed new laws that apply to the program unit

All new law proposals are captured in the division executive summary. The proposed new laws that affect DSI are House Bill 2082 and House Bill 2080. The proposed new laws that affect this program unit are House Bill 2081 and House Bill 2084.

Office of Health Information Technology

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$2.55	$0.00	$64.55	$67.10	34	29.95
Agency Request 2021-23	$2.85	$0.00	$11.78	$14.63	16	16.00
Difference	$0.31	$0.00	-$52.77	-$52.46	-18	-13.95
Percent Change	12%	-100%	-82%	-78%	-53%	-47%

The Governor's Budget for the 2021-23 for the Office of Health Information Technology includes policy package 070, which removes federal funding allocation and 8 FTE associated with reductions in federal funding match that begin in October 2021. This reduction will reduce or eliminate the Oregon Provider Directory program, Clinical Quality Metrics Registry, and Medicaid Pre-Manage subscription.

Activities, programs and issues in the program unit base budget

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

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

- Health IT is computerized storage, retrieval and sharing of clinical health information and data. A good example is electronic health records (EHRs) 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 health IT systems. This can include finding (query); sharing (send) and exchanging (receive) patient information. Health information exchange may also sometimes refer to an organization that provides HIE technology services.

OHIT is working with Oregon's health care community to improve health and support health system transformation efforts by supporting policies, programs, and public/private partnerships that bring tools for securely sharing patient information across providers, health plans and individuals. These tools and programs provide critical infrastructure to make care more efficient and effective and are even more critical as Oregon faces the COVID-19 pandemic as well as focuses sharp attention on health equity.

- In particular, health IT infrastructure is needed to connect systems, increase efficiencies, fill gaps in the data and infrastructure needed to support coordination in real time across hospitals, providers, coordinated care organizations (CCOs), and health plans.
- Health IT can also connect health care stakeholders to social service providers that can help vulnerable Oregonians when they need safety net programs and other supports, such as, to manage quarantine or self-isolation safely.
- Health IT is a critical component of OHA's efforts to end health inequities across the state.

OHA is statutorily required to staff the Health IT Oversight Council (HITOC) and operate the Oregon Health IT Program, which includes health IT services and other supports needed to ensure our health system transformation efforts are successful. OHA's programs are rooted in stakeholder support and partnership, including with the Oregon Health Leadership Council (OHLC), Oregon Association of Hospitals and Health Systems (OAHHS), Oregon Medical Association (OMA), Oregon Primary Care Association (OPCA), Office of Rural Health, Association of Community Mental Health Programs (AOCMHP), and many others.

HITOC and OHA's health IT activities include:

- **Creation of a statewide health IT vision and goals, health IT strategic and operational plans, environmental scans, and policy recommendations,** under HITOC and its workgroups and committees. HITOC reports regularly to the Oregon Health Policy Board and oversees the Oregon Health IT Program. A 2019 HITOC Data Report[1] provided comprehensive information on EHR and HIE adoption and use in Oregon and support for HITOC's upcoming work to update the 5-year Oregon Health IT Strategic Plan. HITOC charters a Behavioral Health HIT Workgroup and a Health IT/HIE Panel. HITOC's 2021 work includes updating the Strategic Plan for HIT, including identifying strategies to support social determinants of health and using health IT to support OHA's goal of eliminating health inequities by 2030.
- **Support for strong adoption of high functioning electronic health record systems since 2011**, bringing more than $209 million in federal incentives to 60 Oregon hospitals and more than 3,800 Oregon providers. In the 2019-21 biennium, more than half of OHIT's budget was Federal Funds for incentive payments under 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. The program sunsets at the end of 2021.
- **A successful public/private partnership to accelerate health IT use** – through Oregon's Health IT (HIT) Commons, jointly funded by OHA, all Oregon hospitals, major health plans and CCOs, and co-sponsored by OHA and the Oregon Health Leadership Council. HIT Commons supports critical health IT initiatives and has the ability to target efforts on shared goals and bring key stakeholders to the table, including recent work mobilizing support for COVID-19 response efforts. Current efforts HIT projects have successfully:
    - **Connected real-time hospital data across hundreds of organizations** – Oregon's Emergency Department Information Exchange (EDie)/PreManage (aka Collective Platform) is now used by all hospitals, CCOs, major health plans, a majority of Oregon's Patient-Centered Primary Care Home clinics, over one-third of licensed behavioral health agencies, over half of Oregon's Skilled Nursing Facilities, and many others, including OHA and

[1] HITOC 2019 Data Report: https://www.oregon.gov/oha/HPA/OHIT-HITOC/Documents/2019HITReport_HIEOverview_TwoWorlds_Combined.pdf

DHS programs. This program provides real-time alerts about hospitalizations and emergency department use so that care can be coordinated and individuals receive appropriate care and follow up.

- **Reduced emergency department visits for high utilizers -** Broad use of EDie/PreManage across Oregon has led to some astounding results. Emergency Department visits by high utilizers decreased by 25 percent in the 90 days following the initial creation of a care guideline in EDie/PreManage. This program allows everyone working with a patient to know when they have been in the ED or hospital, and coordinate their care across their primary care, CCO, behavioral health team, and hospital.
- **Helped reduce risky prescribing of opiates** – by connecting Oregon prescribers to data on controlled substance prescriptions, through their EHR. The Prescription Drug Monitoring Program (PDMP) Integration initiative has been an important factor in sustained reduction of risky opioid prescribing patterns, including prescribing of high quantities or multiple types of controlled substances.[2] Integration of PDMP access into the prescriber's EHR removes the need to remember passwords and log into the PDMP portal. More than 20,000 prescribers at more than 150 organizations (health systems, clinics) and more than 650 pharmacies in Oregon now benefit from "one-click" access to controlled substance prescription data in Oregon's PDMP.
- **Connected health care and social services to address social determinants of health** – by working with a broad group of stakeholders to conduct an assessment of the Oregon landscape and launch planning for a statewide Oregon Community Information Exchange (CIE). CIE is a network of healthcare and human/social service partners using a technology platform with functions such as a shared resource directory, "closed loop" referrals, reporting, social needs screening, and other features to electronically connect people to social services and supports that address the social determinants of health needs. Organizations such as CCOs and health plans have extended their CIEs at no cost to interested community-based organizations, local public health authorities, and Tribes to coordinate wraparound and social services support for COVID-19 isolation and quarantine.

[2] HITOC 2019 Data Report, page 27
https://www.oregon.gov/oha/HPA/OHIT-HITOC/Documents/2019HITReport_HIEOverview_TwoWorlds_Combined.pdf

- **Tackled administrative burden and supported Oregonians' need for accurate provider data** - Oregonians are often frustrated when they learn that the provider they want to see is no longer on their health plan, or find that important information about that provider (including cultural competency, languages spoken) is missing. The Provider Directory provides one central place for reporting and identifying erroneous or missing data, and supports CCOs, health plans, providers, state programs, and others. Oregon's Provider Directory includes more than 10,000 organization records and 130,000 provider records and includes more than 18,400 HIE addresses from across more than 880 unique health care organizations (primary care, hospital, behavioral health, dentistry, FQHC, etc.). Health plans and clinics struggle to share and update provider information, causing significant burden related to managing provider data. *The Governor's Budget includes policy package 070, which reduces federal funding and removes 8 FTE due to reductions in federal match rates that begin in October 2021. This reduction will eliminate the Oregon Provider Directory program.*
- **Supported the quality and accountability for Oregon's Medicaid program** - by providing a tool, the Clinical Quality Metrics Registry, to collect quality metrics from primary care providers that cover roughly 744,000 Oregon's Medicaid members (about 75 percent). As of the end of 2020, the CQMR service has been suspended,[3] because national standards for reporting patient-level clinical quality data from electronic health records (EHRs) are in transition. During this transitional period, the CQMR cannot effectively meet its intended purpose of supporting value-based payment and reducing provider administrative burdens. Because EHR data can provide more robust insights into clinical outcomes for Medicaid members, such as metrics showing whether diabetic members are keeping their blood sugar under control, OHA remains committed to the goal of collecting robust clinical data. *The Governor's Budget includes policy package 070, which reduces federal funding and removes 8 FTE due to reductions in federal match rates that begin in October 2021. This reduction will eliminate the budget that preserves the CQMR program in suspension, effectively eliminating the CQMR program.*
- **Connected Medicaid providers to their local community-based health information exchange**. OHA's HIE Onboarding Program leverages 90 percent federal matching funds to support the one-time costs of connecting to Reliance

[3] For more information on the suspension of CQMR: https://www.oregon.gov/oha/HPA/OHIT/Documents/CQMR_Suspension_FAQs.pdf

eHealth Collaborative's community based HIE. About half of Oregon's CCOs participate in Reliance. Federal and state funds for the program are available through June 2021.

- **Clarified complex requirements related to behavioral health information sharing** with the OHA Confidentiality Tool Kit[4] in response to a recognized need for more information around when and with whom providers can share information about their patients to facilitate care. The toolkit has sample consent form templates, FAQs, links to further information, and some examples of use cases for information sharing.

Background information

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

- 2009: Federal HITECH Act passes, creating several programs including: federal EHR incentive programs, state HIE cooperative agreements (ended in 2014), and 90/10 match for state health IT efforts to support HITECH incentive program objectives.
- 2010: **HITOC** establishes the State Health IT Strategic and Operational plans as required for federal HITECH funding.
- 2011: Launch of federal EHR incentive programs (both Medicare and Medicaid programs). More than $536 million in federal Medicare and Medicaid incentive payments have been disbursed to all Oregon hospitals and nearly 8,500 Oregon providers. Included in that total, **Oregon's Medicaid EHR Incentive Program** has disbursed more than $209 million to eligible hospitals and health care providers.
- 2013: All CCOs agreed that OHA should leverage $3 million Transformation Fund (General Fund) investment to draw down 90/10 federal match and implement several statewide health IT programs/services, including: Oregon Provider Directory, Clinical Quality Metrics Registry, health information exchange including EDie/PreManage, and EHR/HIE

[4] OHA Confidentiality Tool Kit: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le8271.pdf; Cover Letter: https://www.oregon.gov/oha/HSD/AMH/docs/Tool-Kit-091820.pdf

technical assistance for Medicaid providers (through the **Oregon Medicaid Meaningful Use Technical Assistance Program (OMMUTAP)** that concluded in May 2019).

- 2014: OHA partners with the Oregon Health Leadership Council to establish the **Emergency Department Information Exchange (EDie) Utility**, a public/private partnership. The EDie Utility officially launches in 2015, with financial support by OHA, all Oregon hospitals, and all major health plans.
- 2015: OHA establishes the **Oregon Health IT Program** mandated by House Bill 2294 (2015) to connect and support community and organizational health IT efforts where they exist, fill gaps where these efforts do not exist, and ensure all providers on a care team have the means to participate in basic sharing of information needed to coordinate care.
    - Currently, the Oregon Health IT Program includes the programs described in this narrative – the Medicaid EHR Incentive Program, HIT Commons, EDie/PreManage, PDMP Integration initiative, Oregon Provider Directory, Clinical Quality Metrics Registry, HIE Onboarding Program. Past programs include OMMUTAP and CareAccord, a HIPAA-compliant Direct secure messaging service.
- 2017: HITOC updates its Strategic Plan for Health IT/HIE[5], with approval from the Oregon Health Policy Board. The updated plan includes strategies to achieve statewide health information sharing, leveraging existing regional, statewide and national HIE networks. HITOC is scheduled to update the Strategic Plan again in 2021/2022.
- 2018: OHA and the Oregon Health Leadership Council transition the EDie Utility to a broader public/private partnership, the **HIT Commons**, to provide long-term sustainability for statewide health IT efforts. The HIT Commons governs two initiatives:
    - **EDie/PreManage (aka Collective Platform):** EDie connects all Oregon hospitals and provides emergency rooms with critical, concise information about patients who are high utilizers of emergency department (ED) services and patients with complex care needs. PreManage, a companion service to EDie, brings real-time hospital event notifications from EDie to participating CCOs, health plans, providers, and OHA/DHS programs who subscribe to receive real-time information when their patient, member, or client has a hospital event in any hospital in Oregon or Washington.

[5] https://www.oregon.gov/oha/HPA/OHIT-HITOC/Documents/OHA%209920%20Health%20IT%20Final.pdf

- All of Oregon's eligible hospitals have made their ED and inpatient data available in EDie, adding Oregon's data to the data from Washington and other states. In 2019, Oregon's Skilled Nursing Facilities (SNFs) were able to join EDie, and today over half of SNFs in Oregon participate.
- Today, all CCOs and major health plans are subscribed to PreManage, most of whom extend this service to their key contracted physical, behavioral and oral health clinics. Today, a majority of Oregon's Patient-Centered Primary Care Home clinics, over one-third of licensed behavioral health agencies, and four of nine Tribes' tribal clinics participate, as well as all of Oregon's Dental Care Organizations.
- OHA supports the **Medicaid PreManage program**, which supports CCOs, Tribal clinics, OHA/DHS programs and others. OHA/DHS programs also use PreManage – including Medicaid and behavioral health staff coordinating care, Oregon State Hospital teams, DHS long-term services and supports program staff including all Type B Area Agency on Aging and Aging & People with Disability District offices, and DHS Intellectual & Developmental Disability program staff and contractors. *The Governor's Budget includes policy package 070, which would significantly reduce OHA's Medicaid PreManage subscription.*

  - **The Oregon PDMP Integration Initiative,** launched in 2018, 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.

- 2019-2020: **Statewide CIE**: Oregon communities are leading the way to addressing social determinants of health through CIEs, which connect CCOs, health plans, hospitals and health care providers to social services. These efforts utilize technology platforms that provide social service resource directories, closed loop referrals to social services, and data and analytics capabilities that have unprecedented ability to support vulnerable populations and help target local and statewide investments.
  - HIT Commons assessed the Oregon landscape and convened a statewide advisory group focusing on common functions and the future of CIE, in partnership with OHA and other stakeholders
  - OHA and HIT Commons continue to monitor the environment and communicate about opportunities of CIE to connect health care and culturally and linguistically specific social service agencies across Oregon's communities.

  - Organizations such as CCOs and health plans have extended their CIEs for free to interested community-based organizations, local public health authorities, and Tribes to coordinate wraparound and social services support for COVID-19 isolation and quarantine.
- 2019: CCO 2.0 Contracts include more specific health IT requirements to ensure CCO support of physical, behavioral, and oral health providers' health IT needs in four areas: EHR adoption, HIE for care coordination, hospital event notifications (e.g., through EDie/PreManage), and health IT to support value-based payments. All CCOs have OHA-approved Health IT Roadmaps and will report annually on progress metrics and Roadmap updates.
- 2019: OHA launched the **HIE Onboarding Program,** which aims to increase Medicaid providers' capability to exchange health information. This program supports the costs to onboard high-priority physical, behavioral, and oral health Medicaid providers, and their major trading partners, to Reliance eHealth Collaborative, a community-based HIE. Seven CCOs are participating in bringing this program to their clinics. Federal funding for this program ends in 2021.
- 2019: OHA launched the **Oregon Provider Directory (OPD)** to centralize the collection and improve the overall quality of provider data (e.g., race and ethnicity, provider specialties, practice location, contact information, affiliations, etc.). Healthcare organizations, including OHA/DHS stakeholders and providers, face significant challenges and costs in managing provider directories and having a single source of truth for provider data. They can use the OPD to advance operational efficiencies, care coordination and health information exchange, and analytics, network management, and accountability efforts. As a statewide directory, the OPD includes more than 10,000 organization records and 130,000 provider records and is in process of rolling out its initial use cases. The OPD provides an interoperable, statewide infrastructure needed for unifying the collection of provider data from multiple sources, providing one place to access high quality provider data. *The Governor's Budget includes policy package 070, which would eliminate the Oregon Provider Directory program due to reductions in federal match rates.*
- 2019: OHA launched the **Clinical Quality Metrics Registry (CQMR)**, which collected electronic clinical quality metrics data for Oregon's Medicaid program and also supported reporting for two federal health IT and quality programs, the Merit-based Incentive Payment System (MIPS) and the Comprehensive Primary Care Plus (CPC+) program. The vision for the CQMR was to provide the statewide infrastructure needed to ensure quality in the Medicaid program and to

support aligned reporting, administrative efficiencies, and reduced reporting burdens for providers. Because of changing federal regulations related to electronic health records, the CQMR's planned glide path to patient-level quality data is no longer viable. During this transitional period for national standards, the CQMR service has been suspended as of the end of 2020. *The Governor's Budget includes policy package 070, which would eliminate the CQMR program due to reductions in federal match rates.*

Revenue sources and changes

Since 2009, OHA's health IT efforts have been almost exclusively funded by federal 90/10 Medicaid match, under the HITECH Act,[6] as well as some funding from Medicaid Enterprise Systems (MES) federal (formerly MMIS) matching dollars, and state General Fund. More than half of OHIT's 2019-21 budget is federal funding through the HITECH Act to provide incentive payments to Oregon hospitals and providers under Oregon's Medicaid EHR Incentive Program. Incentive payments are 100 percent federally funded. In 2021-23, the Medicaid EHR Incentive Program will end, with all federal incentive payments disbursed by the end of 2021.

Unfortunately, federal 90/10 health IT funding is sunsetting for all states in 2021, as HITECH state funding is attached to the Medicaid EHR Incentive Program. OHA's work is poised to transition to ongoing 75/25 MES federal match (with some staff transitioning to 50/50 or 39/61 match). Federal match rates depend on several factors, including whether the money is spent on planning, implementation or operations.

The 2021-23 Governor's Budget includes policy package 070, which captures the impact of the October 2021 sunset of the 90/10 health IT match rate by reducing federal funding and removing 8 FTE. Though OHIT would be able to buffer some of the impact of lower federal match rates by reducing scope and focusing on only the most essential work, the policy package would eliminate the Oregon Provider Directory program, Clinical Quality Metrics Registry, and Medicaid PreManage subscription.

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

Enabling legislation

In the 2009 regular session, House Bill 2009 established the HITOC, which coordinates Oregon's public and private statewide efforts in EHR adoption, health IT and HIE. Since its creation, HITOC has created strategic and operational plans for achieving statewide electronic HIE and other health IT needed to support Oregon's health system transformation objectives. In the same session, House Bill 3650, defined health care transformation in Oregon. It included significant health IT requirements, including that CCOs use health IT for care coordination. It also requires OHA 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 establish a common credentialing database and program as well as establish fees for the sustainability of the program. The program is intended to provide a common credentialing solution to 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 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 2021, OHA anticipates housekeeping legislation (House Bill 2078) will remove the remaining statutory language related to this program.

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

- Established the Oregon Health IT 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.

- Provided 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 health IT infrastructure tools.
- Moved HITOC under the Oregon Health Policy Board to ensure statewide health IT efforts align with and support health system transformation.

Proposed new laws that apply to the program unit

HPA housekeeping legislation (House Bill 2078), if passed by the 2021 Legislature, would remove remaining statutory language related to the Oregon Common Credentialing Program, which ended in 2018.

Office of Health Analytics

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$9.77	$1.67	$7.12	$18.55	45	43.25
Governor's Budget 2021-23	$12.33	$1.35	$8.00	$21.69	48	47.75
Difference	$2.56	-$0.31	$0.89	$3.14	3	4.5
Percent Change	26%	-19%	12%	17%	7%	10%

Activities, programs and issues in the program unit base budget

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

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

Office of Health Analytics

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

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

- Analysis and reporting for the Metrics Unit.
- Analysis, reporting, interpretation and development of dashboards for the Director's Office, Tribal Affairs, the Health Services Division's Behavioral Health Office and Medicaid Assistance Programs, and the Alcohol and Drug Policy Commission.
- Cross agency data integration, analysis, interpretation and reporting for Health Services Division's Behavioral Health Office and Medicaid Assistance Programs.
- Extraction and submission of client-level treatment episode data (TEDS) for the Substance Abuse and Mental Health Services Administrations' Behavioral Health Services Information System (BHSIS).
- Data extraction and summarized analyses for external research and evaluations.

The Medicaid Analytics and Data Integration Unit collects, analyzes and reports Medicaid operations data to other OHA programs, and provides technology, system and infrastructure support for the Office of Health Analytics through:

- Analysis and reporting for the Metrics Program.
- Analysis, reporting, interpretation and development of dashboards for Health Services Division's Medicaid Assistance Programs.
- 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.

Office of Health Analytics

The Quality Metrics Surveys & Evaluation Unit facilitates implementation and evaluation of the quality metrics program through:

- Evaluation of Coordinated Care Organizations' performance using the CCO incentive metrics, state quality metrics and CMS Core metrics.
- Program evaluations, including the 1115 Oregon Health Plan Medicaid demonstration waiver.
- Consumer surveys, including the Consumer Assessment of Health Providers and Systems Survey (CAHPS) of Medicaid members, the Mental Health Services Improvement Program (MHSIP) surveys for adults and children receiving mental health services, and the Oregon Health Insurance Survey (OHIS) conducted among all people living in Oregon.
- Metrics development to track the most innovative aspects of the health care transformation, including social determinants of health and health equity.

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

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

Background information

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

Health Analytics' primary roles are:

- To develop analyses, data strategies, and monitoring tools to assess the performance Oregon's health care systems.

Office of Health Analytics

- To support OHA policy development, implementation, and evaluation.

During the 2019-21 biennium, Health Analytics supported numerous high-priority policy initiatives, including:

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

InCK Grant. Oregon's Integrated Care for Kids (InCK) Model is a new, seven-year effort that was funded by the Center for Medicare and Medicaid Services (CMS) and the Center for Medicare and Medicaid Innovation (CMMI) in January 2020. The Oregon Health Authority is the Awardee for this funding and will lead the oversight and implementation of the Model in partnership with the Oregon Pediatric Improvement Partnership and local partners. The target population for Oregon's InCK Model includes all children and youth ages 0 to 21 enrolled in Medicaid/CHIP in the following five counties: Deschutes, Jefferson, Crook, Polk and Marion. Oregon's InCK Model builds on Coordinated Care Organization 2.0 key goals, regional partnerships and existing infrastructure with the following goals:

1. Improve health outcomes of children and youth ages 0 to 21.
2. Reduce out of home placements (e.g., foster care, juvenile justice, residential behavior health).
3. Reduce costs associated with unnecessary emergency department visits and inpatient stays.

Health Analytics helps support the InCK Model implementation by providing population-level data and analytic support for the InCK target regions; informing data sharing arrangements and infrastructure; as well as collaborating to align the Model with

state child health policy priorities, ensure engagement with child-focused state agencies, and develop a pediatric APM with CCO partners and consultants.

Sustainable Health Care Cost Growth Target. Senate Bill 889 (2019) established the Sustainable Health Care Cost Growth Target Program within the Oregon Health Authority (OHA). The cost of health care in Oregon has grown and is projected to grow faster than both the state economy and Oregonians' wages. A health care cost growth target will serve as a target for the annual per capita rate of growth of total health care spending in the state. Cost increases of health insurance companies and health care providers will be compared to the growth target each year. The program will also evaluate and annually report on cost increases and drivers of health care costs. The Office of Health Analytics is supporting this program by developing data reporting templates, analyzing existing data sets to establish a common understanding of historical health care cost trends, and supporting the program's Implementation Committee tasked with making key programmatic decisions.

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

APAC Data Vendor Transition. In January 2021, Health Analytics will transition the state's legislatively-mandated All Payer All Claims database to a new vendor, the Human Services Research Institute (HSRI). HSRI's more robust technical infrastructure will allow for greater processing speeds for OHA's data analysts, and its transparent and user-friendly submission portal will improve the experience of APAC's mandatory data submitters. The transition to HSRI will also increase transparency by allowing data users to see how most data enhancements are done, whereas the previous vendor's proprietary model did not allow such transparency. This transition will allow APAC to provide timely and reliable data essential to assessing and controlling the cost of health care, improving quality, and promoting transparency.

Office of Health Analytics

Examples of Health Analytics' reports:

Medicaid Enrollment Reports

- October 2020 Physical health plan by age groups and CCOs[1]
- October 2020 Physical health plan by county and CCOs[2]
- October 2020 Physical health plan by eligibility groups and CCOs[3]
- October 2020 Physical health plan by gender, race/ethnicity and CCOs[4]
- October 2020 CCO, managed care and open card by county (includes non-CCO managed care)[5]
- More Medicaid Enrollment reports can be found here[6]

CCO Metrics Reports

- Medicaid Quality Performance – Current[7] and Historical[8]
- Consumer Assessment of Health Plan Survey (Medicaid Experience)[9]
- Mental Health Statistical Improvement Program Survey (MHSIP-Consumer) - Overall and by CCO[10] and Historical[11]

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

- Tableau: Insurance Coverage[12]

[1] https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/October%202020%20Physical%20Health%20Service%20Delivery%20by%20Age%20Group.pdf
[2] https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/October%202020%20Physical%20Health%20Service%20Delivery%20by%20County.pdf
[3] https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/October%202020%20Physical%20Health%20Service%20Delivery%20by%20Eligibility%20Group.pdf
[4] https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/October%202020%20Physical%20Health%20Service%20Delivery%20by%20Gender%20and%20Race-Ethnicity.pdf
[5] https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/October%202020%20Total%20CCO-Managed%20Care%20and%20FFS%20Enrollment.pdf
[6] https://www.oregon.gov/oha/hsd/ohp/pages/reports.aspx
[7] https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-CCO-Performance-Report.pdf
[8] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx
[9] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CAHPS.aspx
[10] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Mental-Health-Statistics-Improvement-Program-Survey.aspx
[11] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/MHSIP-Survey-Archives.aspx
[12] https://visual-data.dhsoha.state.or.us/t/OHA/views/OregonHealthInsuranceCoverageRates/Overview?:iid=1&:isGuestRedirectFromVizportal=y&:embed=y

- Tableau: The Uninsured[13]
- Webpage with historical static reports[14]

Children's health complexity data
- State, County and CCO medical and social complexity scores[15]

Hospital financials (quarterly hospital financial and utilization data)
- Tableau dashboard[16] (updated quarterly)
- Tableau dashboard appendix with individual hospital data[17] (updated quarterly):
- Static report summaries of current trends and historical reports[18]

Hospital payment reports (annual report of median amounts paid by insurers for common hospital procedures)
- Tableau dashboard[19] (updated annually)
- Website with data files and historical reports[20]

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

[13] https://visual-data.dhsoha.state.or.us/t/OHA/views/OregonUninsuranceRates/Overview?:iid=2&:isGuestRedirectFromVizportal=y&:embed=y
[14] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/OHIS-Past-Reports.aspx
[15] https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Child-Health-Complexity-Data.aspx
[16] https://visual-data.dhsoha.state.or.us/t/OHA/views/Databankdashboard/Mainpage?iframeSizedToWindow=true&:embed=y&:showAppBanner=false&:display_count=no&:showVizHome=no&:origin=viz_share_link
[17] https://visual-data.dhsoha.state.or.us/t/OHA/views/DatabankAppendix/Welcome?:isGuestRedirectFromVizportal=y&:embed=y%20%E2%80%A2Static%20report%20summaries%20of%20current%20trends%20and%20historical%20reports
[18] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Reporting.aspx
[19] https://visual-data.dhsoha.state.or.us/t/OHA/views/OregonHospitalPaymentReport2018/Welcome?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no&%3Aorigin=viz_share_link
[20] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Reporting.aspx

- Tableau dashboard: [Coming soon - not yet published]
- Website with historical reports[21]

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

- Tableau dashboard[22] (updated annually)
- Website with historical reports[23]

Health care workforce diversity reports

- 2020 report - coming soon
- Tableau dashboard report appendix: [Coming soon - not yet published]
- Website with historical reports[24]

Health care workforce supply reports

- 2020 report - coming soon
- Tableau dashboard report appendix: [Coming soon - not yet published]
- Website with historical reports[25]

Other reports

- Low Value Care Report[26]

[21] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Reporting.aspx
[22] https://visual-data.dhsoha.state.or.us/t/OHA/views/Oregonslicensedhealthcareworkforce/Overview?%3Aorigin=card_share_link&%3Aembed=y&%3AisGuestRedirectFromVizportal=y#1
[23] https://www.oregon.gov/oha/hpa/analytics/Pages/Health-Care-Workforce-Reporting.aspx
[24] https://www.oregon.gov/oha/hpa/analytics/Pages/Health-Care-Workforce-Reporting.aspx
[25] https://www.oregon.gov/oha/hpa/analytics/Pages/Health-Care-Workforce-Reporting.aspx
[26] https://www.oregon.gov/oha/ERD/Pages/ReportIdentifiesLowValueCareInOregonHealthSystem.aspx#:~:text=There%20were%20772%2C094%20services%20found,in%202016%2C%202017%20and%202018

Office of Health Analytics

- Primary Care Spending Reports - 2020 report[27] and Historical[28] reports

Revenue sources and changes

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

Several programs within Health Analytics, including the health care workforce reporting program, hospital reporting program, APAC and TEDS BHSIS data submissions receive some other funds.

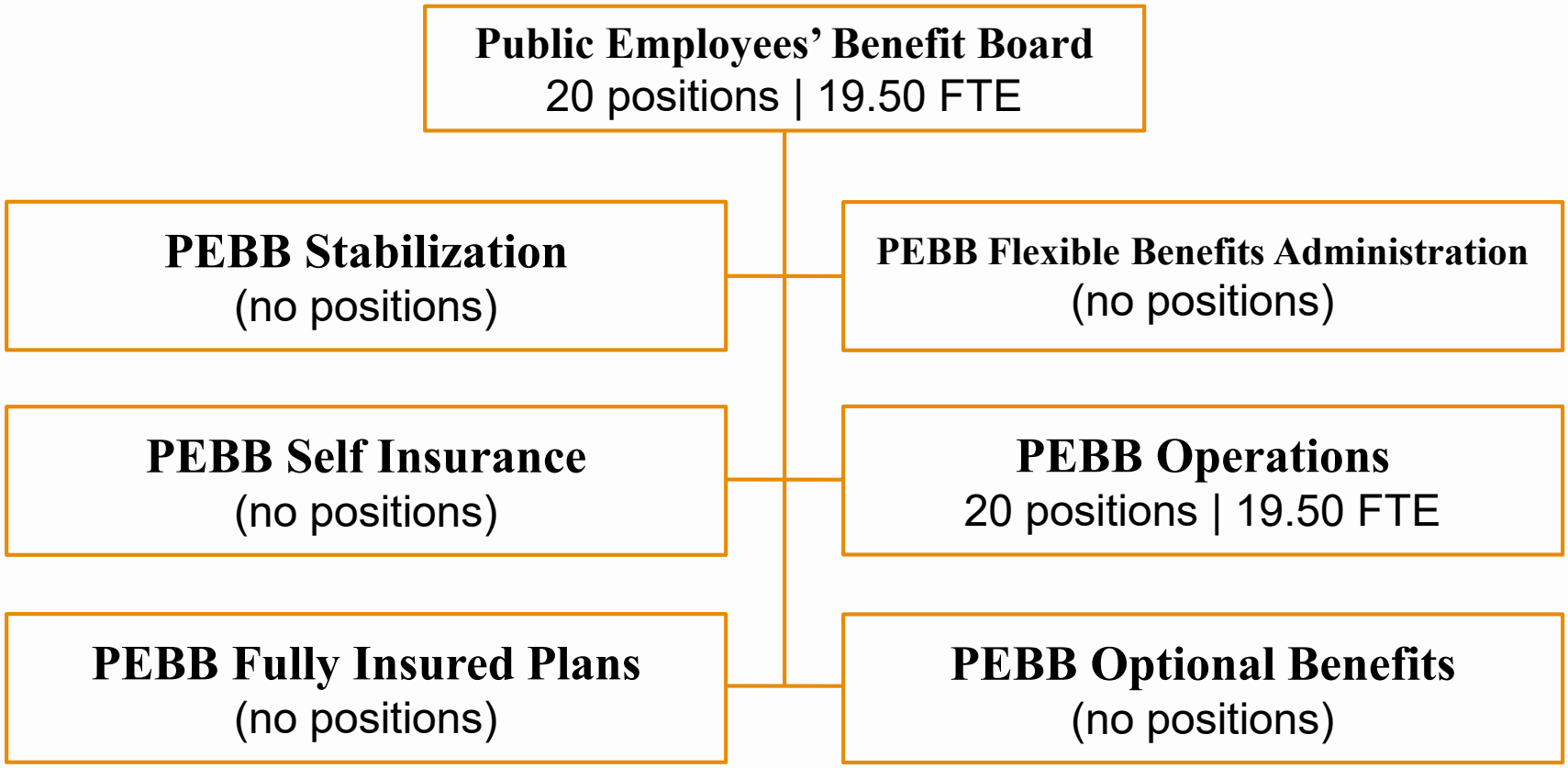
Proposed new laws that apply to the program unit

None.

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

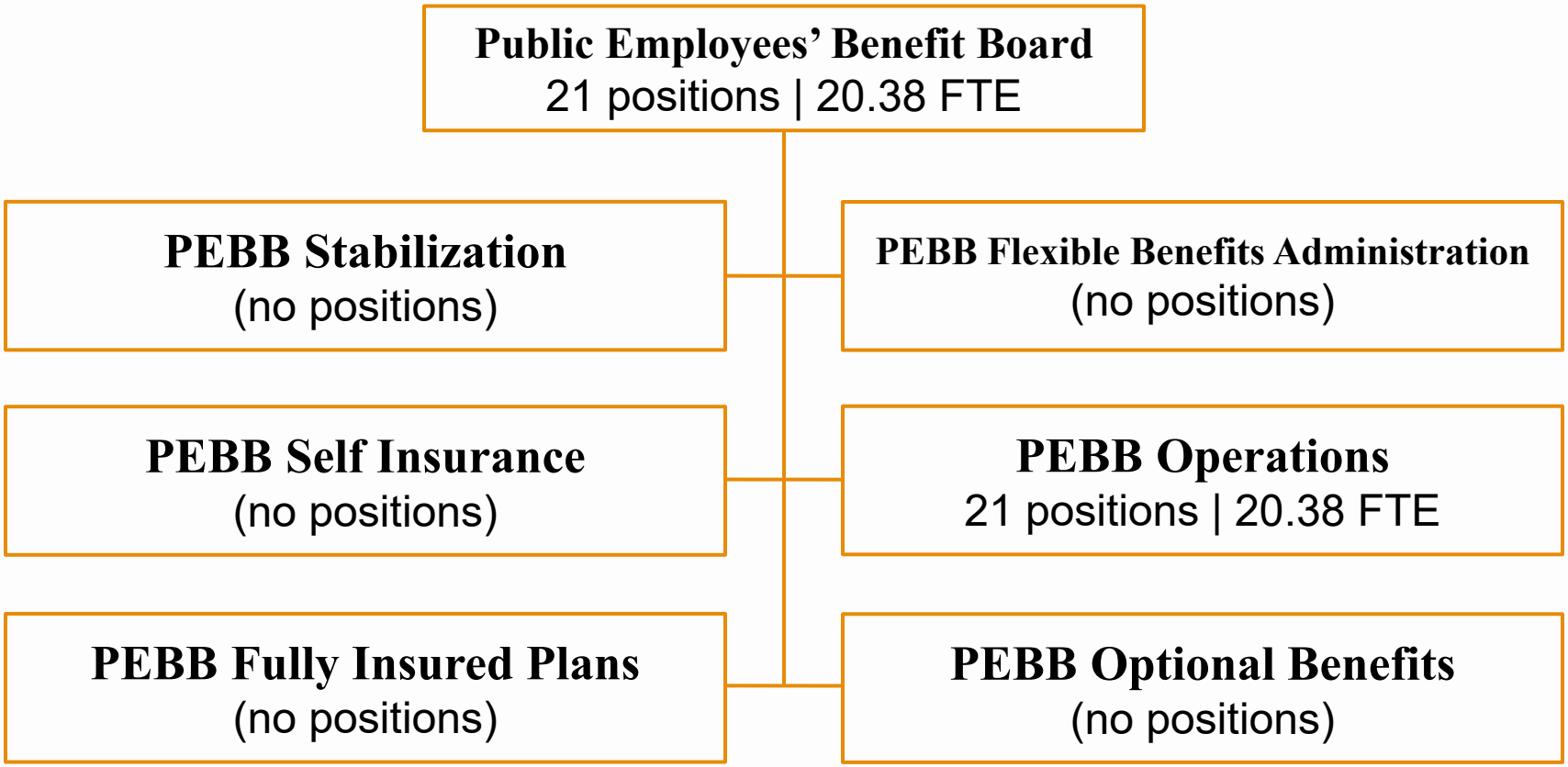
2019-21

Legislatively Approved Budget



Oregon Health Authority

2021-23
Governor's Budget

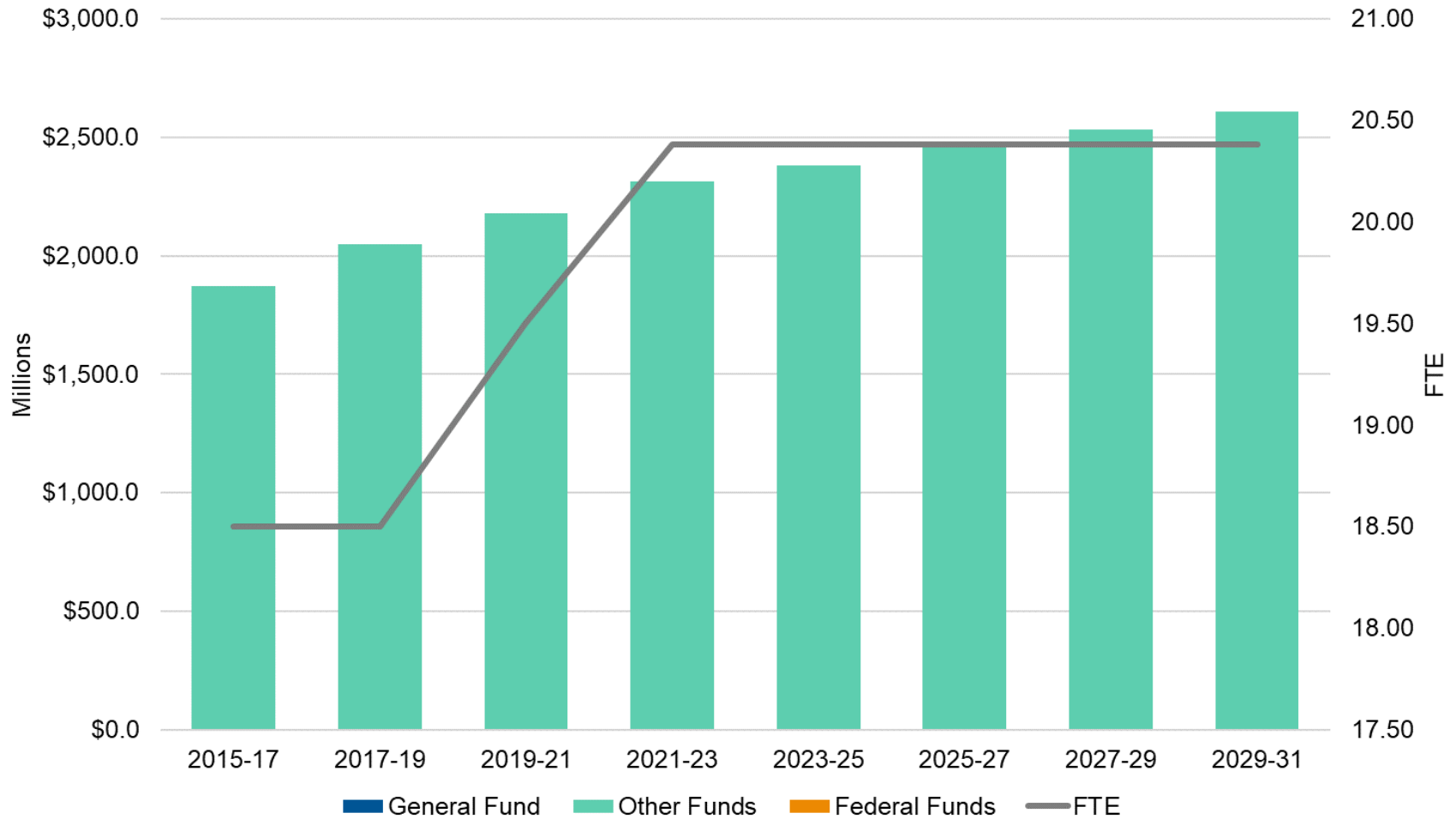


Oregon Health Authority

Oregon Health Authority: Public Employees' Benefit Board

Executive Summary

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



Executive Summary

Division overview

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

Funding request

The 2021-23PEBB 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. It also includes a policy package to fund PEBB's portion of the cost to replace both the PEBB and OEBB benefits management systems. All PEBB expenditures are categorized as Other Funds Limited. PEBB's Stabilization Fund budget expenditure growth is capped at 3.4 percent annually by the Legislature on a per-employee-per-month (PEPM) basis. The 2019-21 Governor's Budget is built on a PEPM basis.

Program descriptions

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

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

Executive Summary

Program justification and link to long-term outcomes

Transforming health care

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

Value-based benefits

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

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

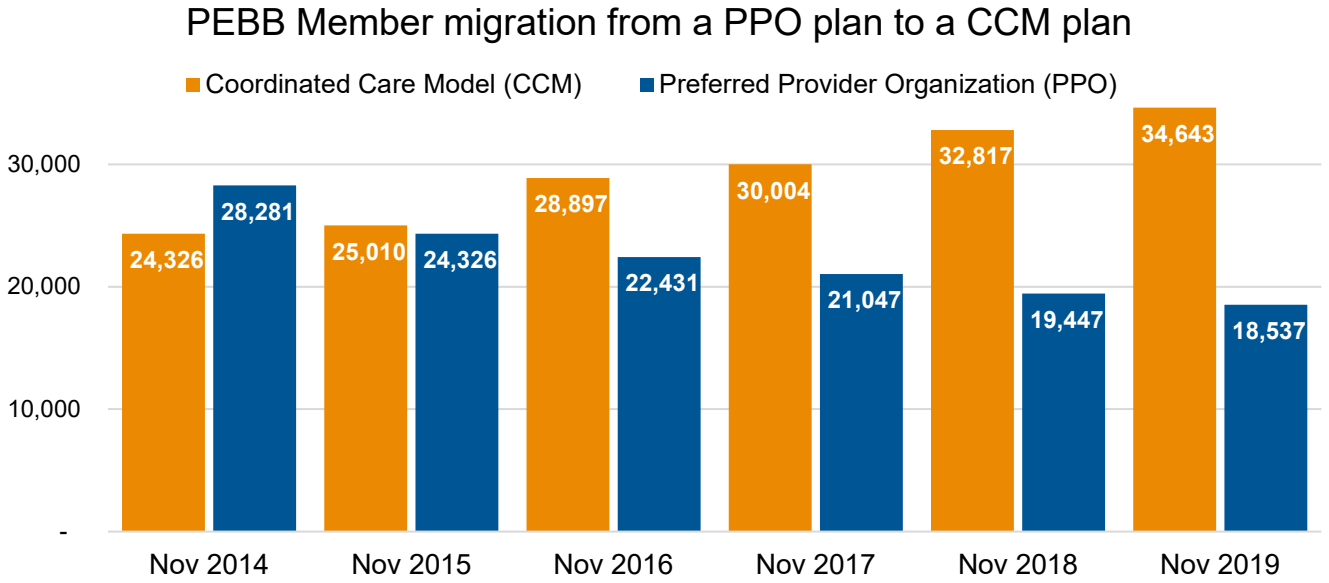
	OEBB	PEBB	CCO
Infrastructure payments	■	■	■
Pay for reporting	■	■	■
Pay for performance	■	■	■
Shared savings with upside risk	■	■	■
Shared savings upside and downside risk	■	■	■
Condition-specific population-based payment			■
Comprehensive population-based payment	■	■	■
Integrated finance and delivery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

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

Executive Summary

Wellness initiatives and promoting member health

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



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.

Executive Summary

PEBB quality measures and fees-at-risk

In the 2021-23 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 Coordinated Care Organizations (CCO), PEBB and OEBB plans, and the Oregon Health Insurance Marketplace.

Program performance

PEBB has met the 3.4 percent overall expenditure increase and annual premium increase "test" nearly every year since 2012 (see below). Fulfilling the growth cap has been done by executing on cost containment strategies and promoting program efficiencies. PEBB face challenges in meeting the 3.4 percent tests as a payer in the commercial market in battling trend, provider market leveraging and the timing of the annual growth cap.

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

Executive Summary

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.

PEBB medical benefit design did not change significantly between 2019 and 2020. PEBB still continues to cover:

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

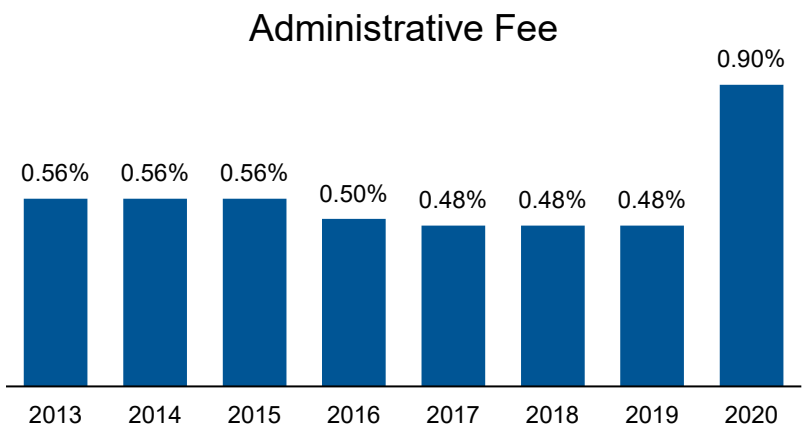
PEBB also offers non-traditional and culturally responsive benefits and services, e.g., the use of doulas and other traditional health workers, Christian Science and Native American healers and alternative care such as acupuncture, massage, naturopathic and spinal manipulation services.

Enabling legislation/program authorization

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

Funding streams

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



Executive Summary

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

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

Significant proposed program changes from 2019-21

Changes from the 2019-21 biennium include two policy packages, #426: PEBB-OEBB Benefit Management System (BMS) and #425: Coordinated Care Model (CCM), which is associated with legislative concept 411.

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

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

Executive Summary

Policy package #425 CCM (LC 26), would align the purchasing power across OEBB, PEBB and other public purchasers.

What does this mean for consumers and taxpayers?

An affordable, stable, predictable health system: Health care costs no longer outpace family and household incomes, freeing up funding for wage growth and other important state services.

Improved quality and population health: The health care system is working together to keep patients healthy and improve the quality of care they receive.

Improved patient experience: All patients have timely access to high quality care. They receive right care at the right time in coordinated system that puts patients in the center.

Local flexibility: Employers have access to sustainable, high value health care with flexibility to provide unique benefit offerings.

What does this mean for providers?

Stable, predictable revenue: By moving from a system that pays for volume of care to one that pays for value, providers will have more stable, predictable revenue that grows within a sustainable rate of growth.

Administrative streamlining and efficiency: By aligning payment models and metrics, providers can spend more time helping their patients and less time on paperwork.

Local flexibility and accountability: The State will set broad expectations but allow local communities to innovate to best meet the goals within a sustainable budget.

Public Employees' Benefit Board

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$0.00	$2,178.48	$0.00	$2,178.48	20	19.5
Governor's Budget 2021-23	$0.00	$2,311.87	$0.00	$2,311.87	21	20.38
Difference	$0.00	$133.39	$0.00	$133.39	1	0.88
Percent Change	N/A	6%	N/A	6%	5%	5%

The 2021-23 Governor's Budget includes $2,312 million Total Funds, which covers current service levels and includes funding to replace the PEBB benefits management system and resources to continue to transform the delivery system in alignment with the coordinated care model.

Activities, programs and issues in the program unit base budget

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

PEBB designs, contracts for and administers health plans, group policies and flexible spending accounts for PEBB members. Approximately More than 140,000 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.

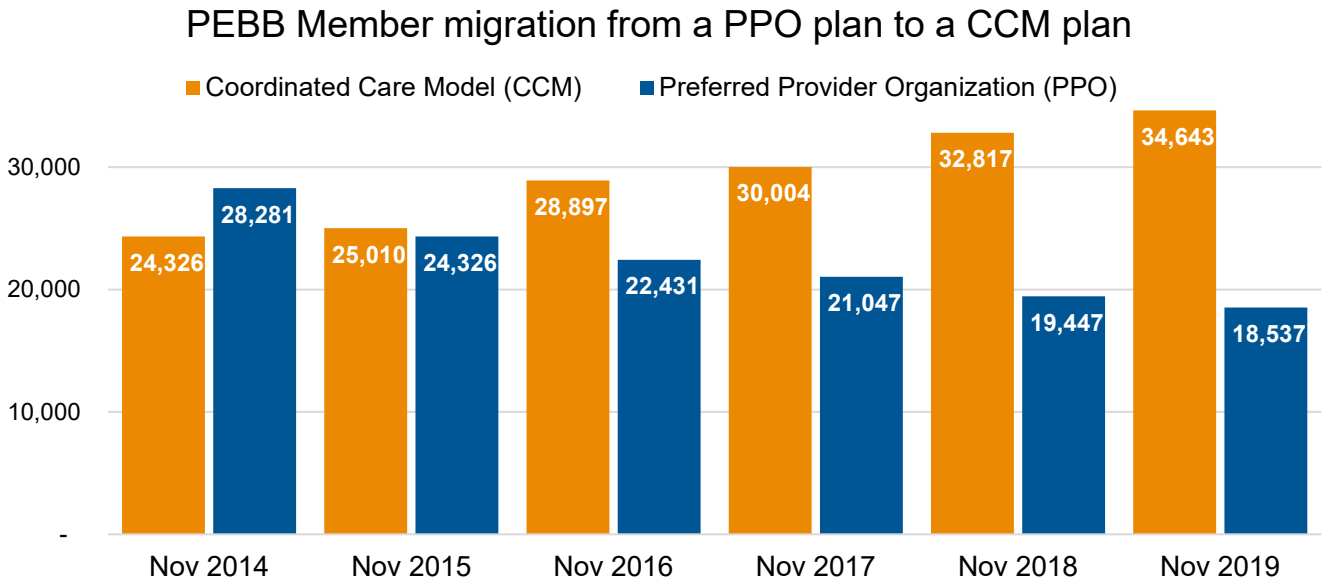
Public Employees' Benefit Board

The PEBB Board serves diverse populations 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 Public Employees' Benefit Board (PEBB) is mandated to redesign the health care delivery system so public employees have access to high quality plans at a lower price, defined in Senate Bill 1067 (2017) as no more than 3.4 percent growth annually. How to stay at or under a 3.4 percent annual growth trend when the Oregon commercial insurance market trend averages 6-7 percent -- which equates to an annual savings requirement of $30 to $40 million -- is without a doubt PEBB biggest challenge.

The PEBB Board has made transforming the health care delivery system a priority and advances this transformation with plans that coordinated 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 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.



PEBB's implementation of coordinated care model plans focuses 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 cost containment programs

Another shared innovation strategy revolves around the use of alternative payment models (APMs) to help control premium costs. 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.

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

Wellness initiatives and promoting member health

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

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

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

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

Public Employees' Benefit Board

PEBB quality measures and fees-at-risk

In the 2021-23 biennium PEBB will continue to include quality measures and performance targets in health plan contracts to support better health, better care, and lower cost. The specific quality measures selected will be based on the Statewide Aligned Quality Measures menu developed by the Health Plan Quality Metrics Committee for 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 growth cap.
- Implementing benefit mandates as required.

Joint PEBB and OEBB Innovation Workgroup

- PEBB and OEBB formed the joint Innovation Workgroup (IWG), made up of PEBB and OEBB board members and legislators to analyze cost drivers, measure access and quality, and explore joint alternative payment models that bring true value and the potential for big savings.

Background information

House Bill 2037 (2019 Legislative Session) Long Term Care:
This bill allows PEBB to make available long-term care insurance plans at the boards' discretion rather than as a statutory requirement. This change aligns all optional plan benefits offered to employees.

House Bill 2266 (2019 Legislative Session) cost containment bill (repealed portions of Senate Bill 1067 (2017). The most significant changes for PEBB are:

- Maintains the "opt-out" incentive for employees.
- Maintains the "double-coverage" option for employees.
- Requires PEBB impose a surcharge for employees who enroll as a subscriber on an OEBB or PEBB plan when already enrolled as a dependent on another OEBB or PEBB plan. The surcharge amount will be decided by the Board.
- PEBB will conduct dependent eligibility reviews, as opposed to a third-party administrator, with the frequency of review based on a consultant's recommendation of commercial best practice.
- Revised the in-network and out-of-network reimbursement cap for hospitals so that the cap does not apply to hospitals outside of the state.
- Requires that PEBB/OEBB report to the Legislature by December 31, 2019 on:
    - Actions, strategies and challenges for meeting the 3.4 percent growth cap.
    - Purchasing power maximization and total cost reduction strategies.
    - Previous and upcoming renewal rates.

Revenue sources and changes

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

Public Employees' Benefit Board

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

Legislative Concept #411 and Policy package #425: Coordinated Care Model (CCM) would align the purchasing power across OEBB, PEBB and other public purchasers.

What does this mean for consumers and taxpayers?

An affordable, stable, predictable health system: Health care costs no longer outpace family and household incomes, freeing up funding for wage growth and other important state services.

Improved quality and population health: The health care system is working together to keep patients healthy and improve the quality of care they receive.

Improved patient experience: All patients have timely access to high quality care. They receive right care at the right time in coordinated system that puts patients in the center.

Local flexibility: Employers have access to sustainable, high value health care with flexibility to provide unique benefit offerings.

What does this mean for providers?

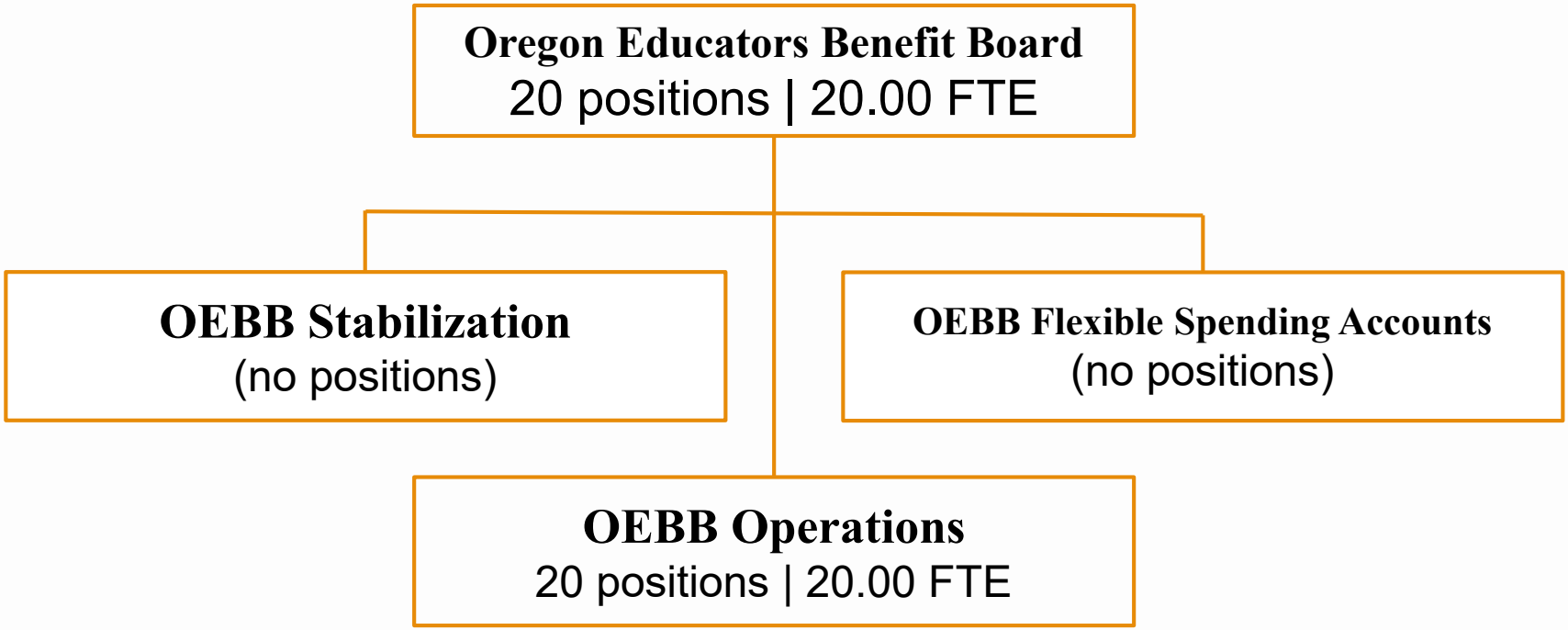
Stable, predictable revenue: By moving from a system that pays for volume of care to one that pays for value, providers would have more stable, predictable revenue that grows within a sustainable rate of growth.

Administrative streamlining and efficiency: By aligning payment models and metrics, providers can spend more time helping their patients and less time on paperwork.

Local flexibility and accountability: The state would set broad expectations but allow local communities to innovate to best meet the goals within a sustainable budget.

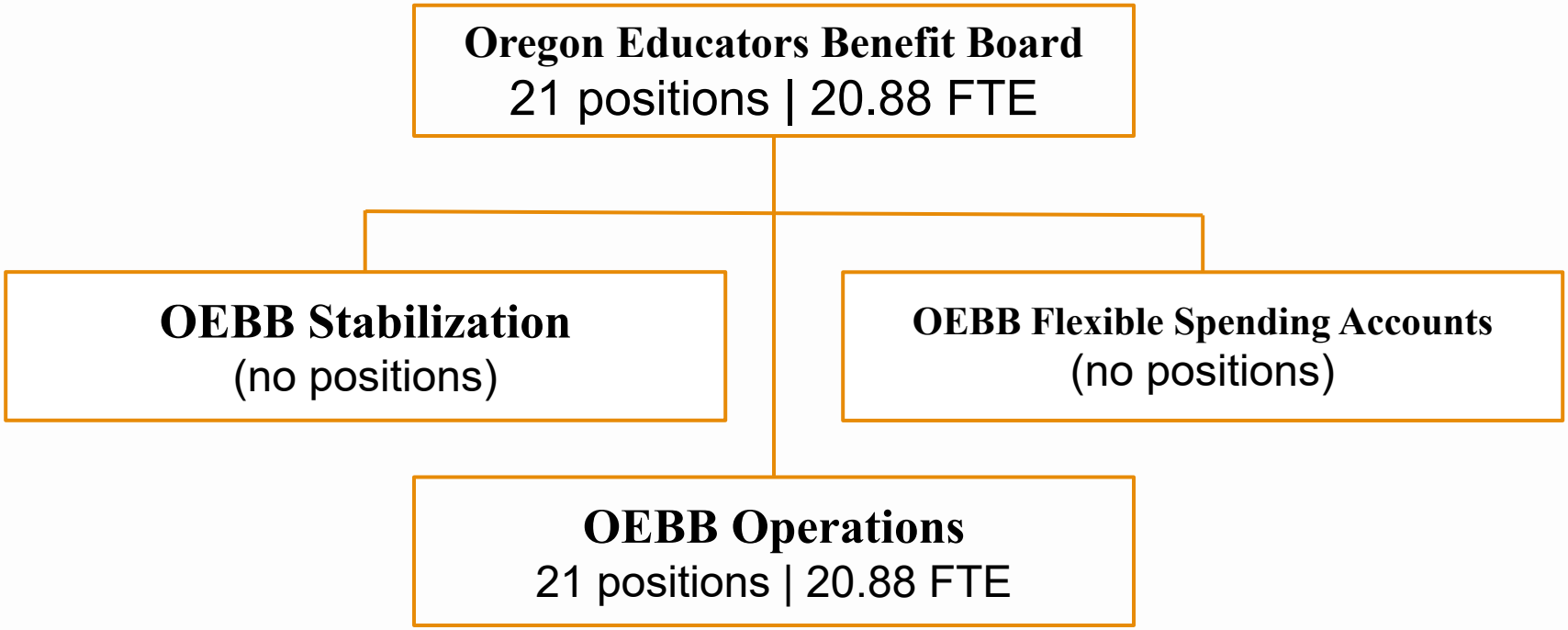
2019-21

Legislatively Approved Budget



Oregon Health Authority

2021-23
Governor's Budget

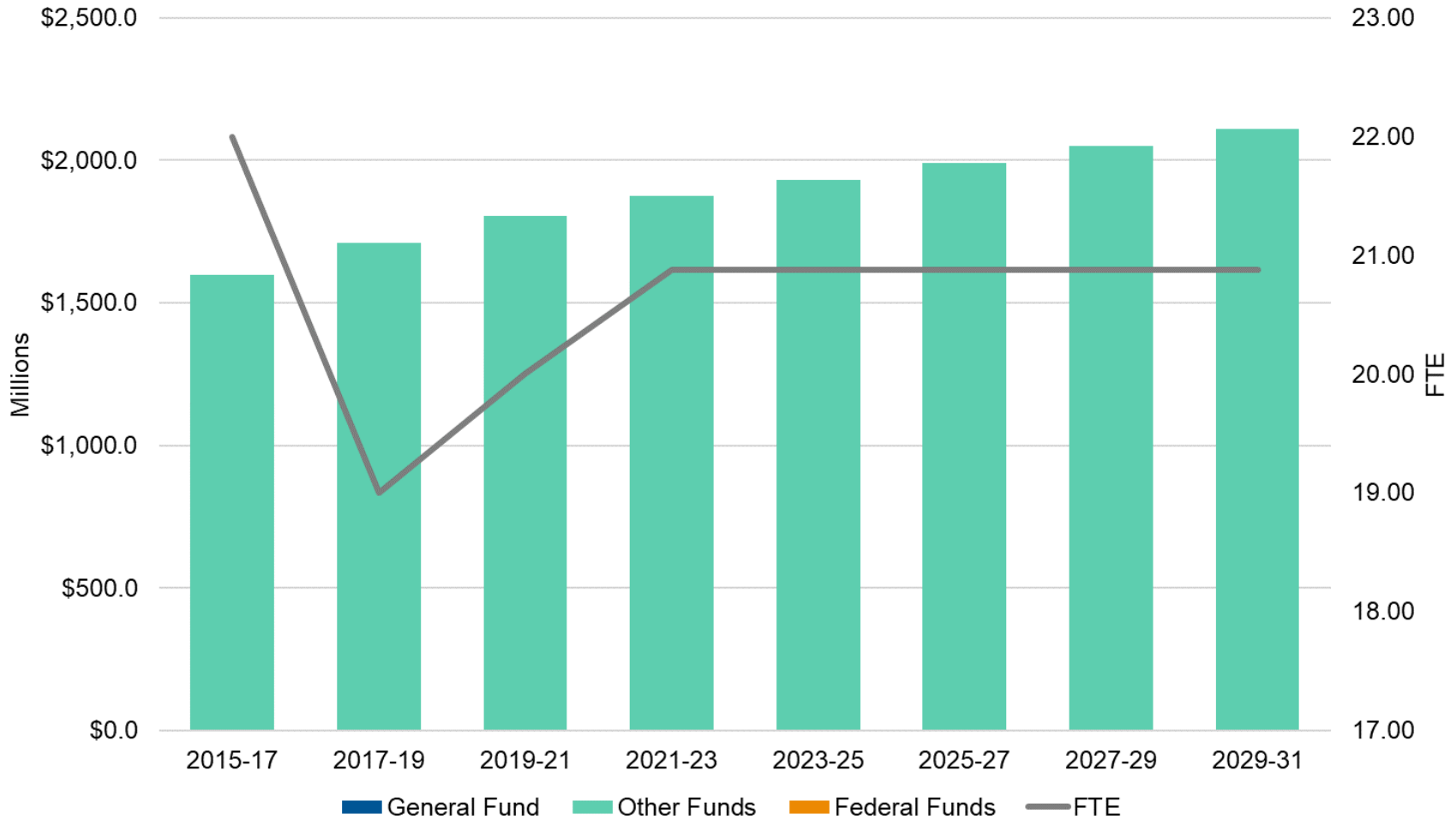


Oregon Health Authority

Oregon Health Authority: Oregon Educators Benefit Board

Executive Summary

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



Executive Summary

Division 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 some counties and special districts. OEBB's plans are designed to be flexible and accommodate the needs of employers and members.

Funding request

The Governor's Budget for OEBB for the 2021-23 biennium continues current service levels, which includes cost growth for OEBB medical premiums at 3.4 percent for both the 2021-2022 and 2022-2023 plan years. The request also includes OEBB's portion of replacement costs for both the OEBB and PEBB benefits management systems. All OEBB expenditures are categorized as Other Funds Limited.

Program descriptions

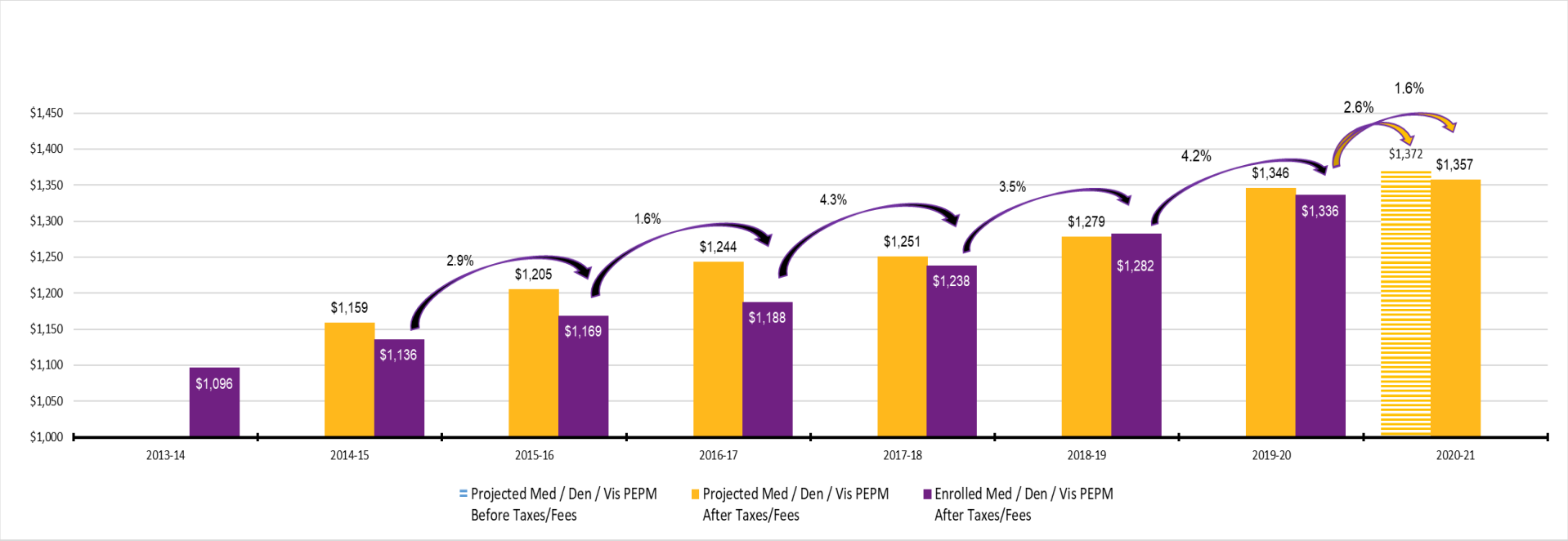
OEBB serves more than 155,000 members (employees, early retirees and their family members) in more than 251 publicly-funded entities throughout Oregon. OEBB serves its members and entities year-round.

The OEBB board designs and maintains a full range of benefit plans for eligible publicly funded entities to offer to their employees 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.

Rising health care costs are a primary cost driver for OEBB. OEBB has recognized and taken steps to provide incentives for appropriate care and condition management through benefit plan design with the goal of containing costs and using alternative payment models to control costs. OEBB strives to keep benefit plans affordable and stable while providing quality care to members. OEBB has managed benefit costs to well below national trend throughout its history and continues to meet a legislatively capped annual 3.4 percent increase on premiums and costs on behalf of members.

Executive Summary

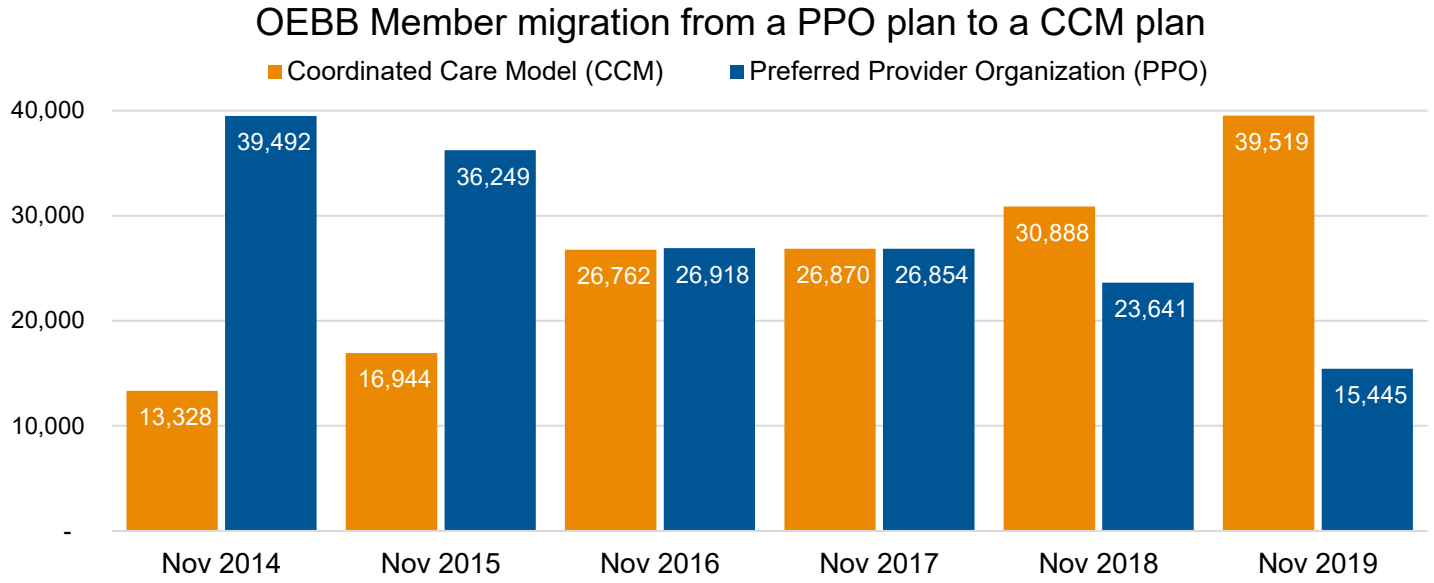
Senate Bill 1067 (2017) established the cost growth cap on OEBB's annual aggregate costs for medical, dental and vision plans combined that should not increase by more than 3.4 percent over prior year costs. This test applies to premium costs excluding the impact of increases or decreases in state or federal premium tax changes. OEBB beat the required test in 2020-21, as aggregate premiums are expected to increase by 2.65 percent before applying the change in federal premium taxes. Because the Affordable Care Act (ACA) premium tax has been discontinued, the projected total change in aggregate OEBB premium is expected to be an increase of 1.58 percent. OEBB has met the legislative test for several years, even as the Commercial Market Insurance trend hovers in the 6 to 7 percent range.



Executive Summary

Program justification and link to long-term outcomes

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



Transforming health care

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

health disparities. In 2018, the boards joined to create a sub-group called the "Joint Innovation Workgroup" consisting of PEBB and OEBB board members as well as state legislators.

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

OEBB quality measures and fees at risk
In the 2021-23 biennium OEBB will continue to include quality measures and performance targets in health plan contracts to support better health, better care, and lower cost. The specific quality measures selected will be based on the Statewide Aligned Quality Measures menu developed by the Health Plan Quality Metrics Committee for Coordinated Care Organizations (CCOs), PEBB and OEBB plans, and the Oregon Health Insurance Marketplace.

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

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 PCP 360 plans, as well as the health care delivery system inherent in the Kaiser Permanente plans.

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.

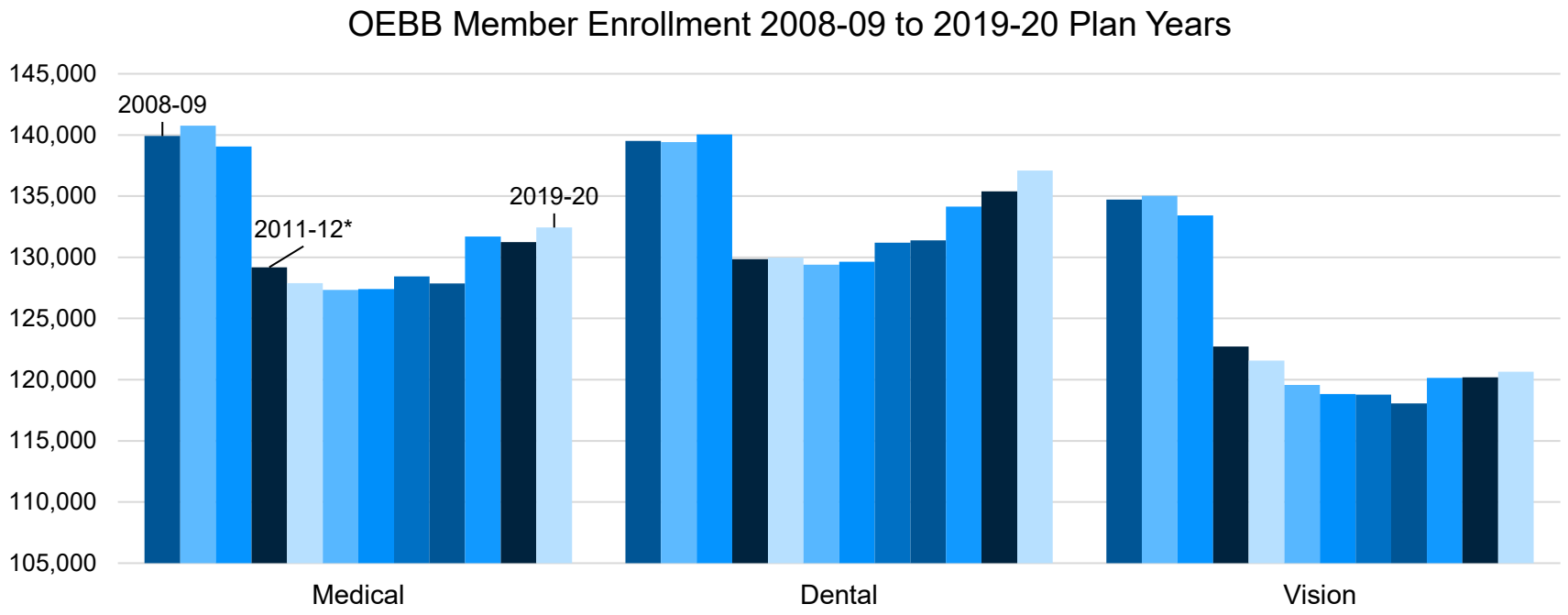
Executive Summary

- Support member wellness and population health.
- Create streamlined operations and organization effectiveness.
- Provide enhanced member outreach and communications.
- Create a financially sustainable organization.

Benefit highlights for the 2020-21 plan year

- OEBB will continue to offer the same medical, dental and vision plans through Moda, Kaiser, Willamette Dental and VSP for the 2020-21 Plan Year. All deductible levels, copayments, coinsurance levels and out-of-pocket maximums will continue.
- All medical plans will include an enhanced virtual telehealth service.
- Moda plans will see some exciting new changes with the implementation of a new member concierge service, Moda360. Moda360 provides OEBB members with specialized service navigators to provide extra assistance to get the care they need, find quality providers, resolve claims or billing issues, schedule appointments or find health care resources. Moda360 includes additional services such as expanded telemedicine, diabetes care programs and enhanced behavioral health services.
- Double Coverage Surcharge – In response to a legislative requirement, OEBB will assess a $5 monthly surcharge for each subscriber who elects to cover a dependent on their OEBB medical plan who is also covered as a subscriber under their own OEBB or Public Employees' Benefit Board (PEBB) medical plan.

Executive Summary



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

Enabling legislation/program authorization

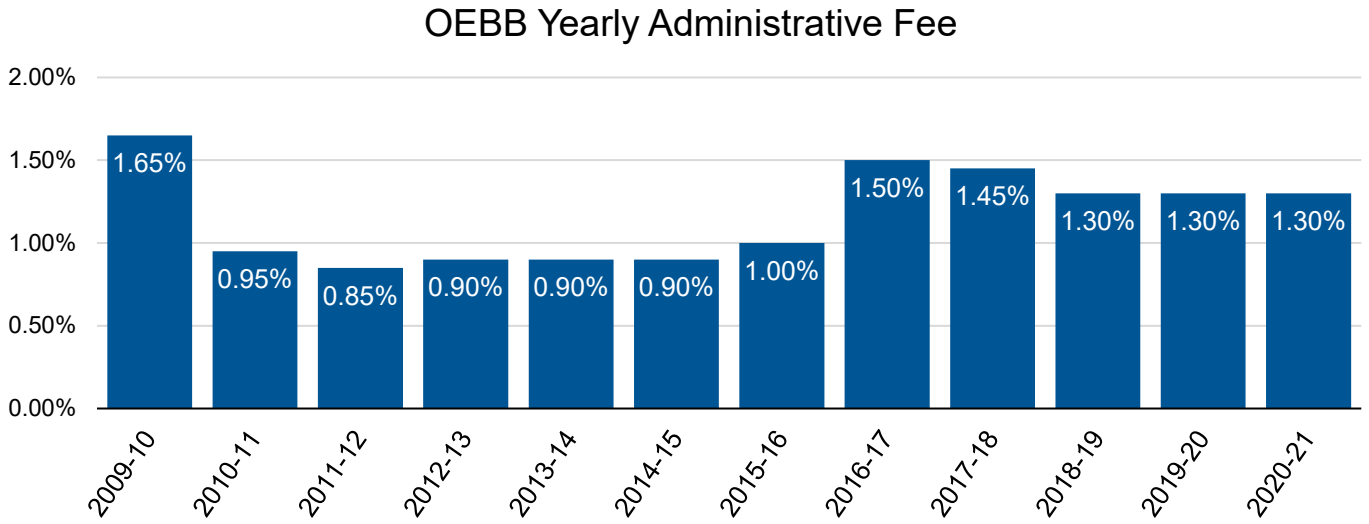
OEBB was established by Senate Bill 426 (2007). House Bill 2279 (2013) expanded participation eligibility to include local governments and special districts. The OEBB board functions and responsibilities are authorized by ORS 243.860 to 243.886.

Funding streams

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

Executive Summary

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



Significant proposed program changes from 2019-21

Changes from the 2019-21 biennium include two policy packages: #426 OEBB-PEBB Benefit Management System (BMS) and #425 Coordinated Care Model (CCM), which is tied to legislative concept 411.

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

- The ability to implement and maintain latest security best practices.
- Mobile app compatibility.
- Compatibility with commonly used browsers, operating systems and devices.
- Flexibility to accommodate business partners' and customers' needs.

Executive Summary

- 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.

Policy package #425 CCM (LC 411) would align the purchasing power across OEBB, PEBB and other public purchasers.

What does this mean for consumers and taxpayers?

- An affordable, stable, predictable health system: Health care costs no longer outpace family and household incomes, freeing up funding for wage growth and other important state services.
- Improved quality and population health: The health care system is working together to keep patients healthy and improve the quality of care they receive.
- Improved patient experience: All patients have timely access to high quality care. They receive right care at the right time in coordinated system that puts patients in the center.
- Local flexibility: Employers have access to sustainable, high value health care with flexibility to provide unique benefit offerings.

What does this mean for providers?

- Stable, predictable revenue: By moving from a system that pays for volume of care to one that pays for value, providers would have more stable, predictable revenue that grows within a sustainable rate of growth.
- Administrative streamlining and efficiency: By aligning payment models and metrics, providers can spend more time helping their patients and less time on paperwork.
- Local flexibility and accountability: The state would set broad expectations but allow local communities to innovate to best meet the goals within a sustainable budget.

Oregon Educators Benefit Board

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$0.00	$1,803.74	$0.00	$1,803.74	20	20
Governor's Budget 2021-23	$0.00	$1,875.28	$0.00	$1,875.28	21	20.88
Difference	$0.00	$71.54	$0.00	$71.54	1	0.88
Percent Change	N/A	4%	N/A	4%	5%	4%

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 approximately 155,000 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 251 employer entities OEBB serves maintains a unique service area, eligibility requirements, cost sharing with employees, and diverse populations. 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.

OEBB was created to eliminate the wide-ranging disparities between health plans offered by school districts and to respond to the rapidly rising costs of health care. House Bill 2279 (2013) expanded participation eligibility to include local governments and special districts. A statewide pool, such as OEBB, creates purchasing power and avoids unstable premium swings

experienced by school districts with volatile claims experience. Streamlining administration and eliminating third-party fees and duplication of work were also large cost savers upon the formation of OEBB. School districts benefit from cost predictability and controlling of expenditures year-over-year. For the 2020-21 Plan Year, 83% of OEBB subscribers will experience a rate change for their medical plan of 2.4% or lower. Twenty-five percent (25%) of OEBB subscribers will have a decrease in medical rates. In addition to OEBB's cost goals, OEBB plans emphasize coordinated care model features. Coordinated care means the member's primary care physician works with specialists, hospitals and other providers in a coordinated fashion to ensure optimal and efficient care for members. All the plan design changes implemented for the 2020-21 Plan Year focus on advancing preventive care and coordinated care principles.

Key components of the OEBB program include:

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

Transforming Health Care

The OEBB board has made transforming the health care delivery system a priority and envisions advancing health care transformation with plans that coordinate care. OEBB has partnered with its "sister program" the Public Employees' Benefit Board (PEBB) in the shared innovation strategy referred to as "Coordinated Care Model" plans. OEBB and PEBB believe the coordinated care model (CCM) is essential for achieving success in managing overall costs. For the 2020-21 plan year, OEBB further enhanced the CCM offering with "health navigators". Health navigators are personal health coaches that provide members with assistance in scheduling appointments, billing questions, claims and appeals, care programs and prior authorizations allowing members to better coordinate their health care. Both boards continue to add these systems of care

throughout the state with a focus on integrated care and reducing health care costs and eliminating health disparities. The boards would like to further pursue plans and providers that use creative and innovative evidence-based practices, specifically in the area of social determinants of health.

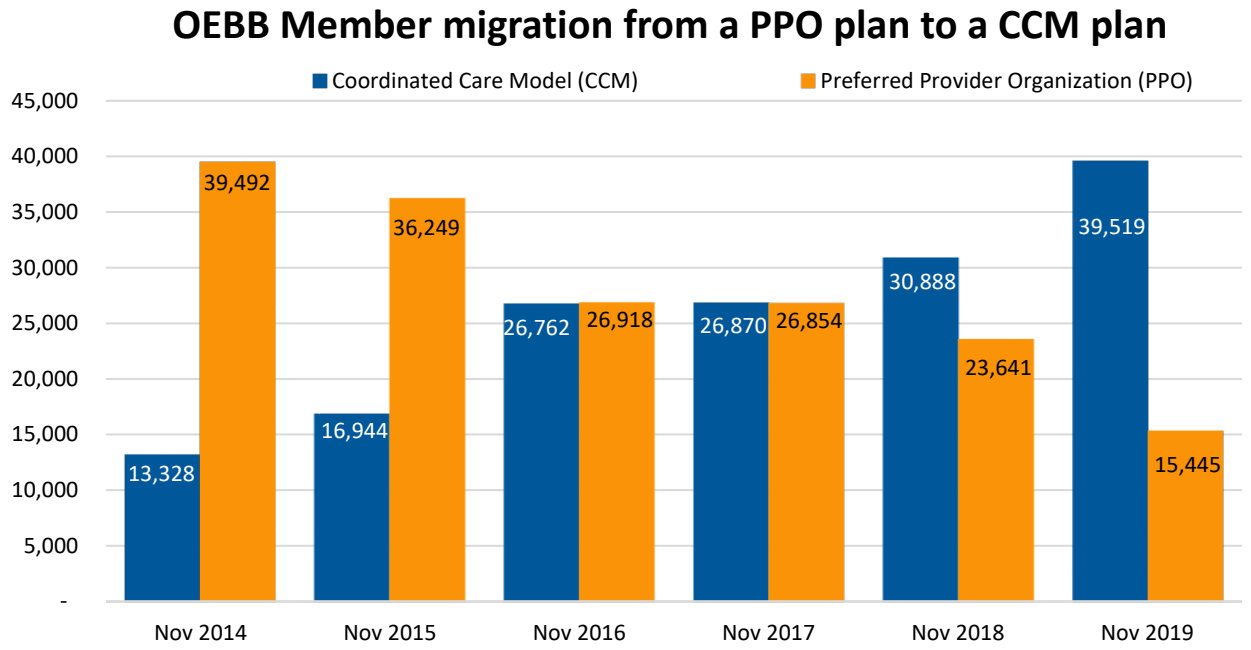
As the board evaluates plan offerings in an annual contract renewal with plans, it focuses on maintaining sustainable, affordable, equitable and high-quality benefit plan options across the entire state. Strategies include:

- Engage employers 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.
- Incentivize coordinate care plans and improve access to culturally-specific services across the state.
- Integrate coordinated, patient-centered care – physical, mental and dental.
- Demonstrate improved health outcomes.
- Embrace alternative payment models.

OEBB also actively engages in OHA committees, including:

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

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



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.

- Additional copays were included to discourage the use of certain procedures and treatments that had less-invasive options that were equally effective.

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

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

OEBB quality measures and fees at risk

In the 2021-23 biennium OEBB will continue to include quality measures and performance targets in health plan contracts to support better health, better care, and lower cost. The specific quality measures selected will be based on the Statewide Aligned Quality Measures menu developed by the Health Plan Quality Metrics Committee for Coordinated Care Organizations (CCO), 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 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.

Oregon Educators Benefit Board

OEBB's carriers strive to beat local trend averages – Coordinated care efforts and advanced plan management features in place with OEBB's carriers and approved by the board have resulted in favorable outcomes. OEBB medical, dental and vision plans have performed better than local plan trends of 7.9%1, according to an annual survey of insured plan trends conducted by Willis Towers Watson. This good performance, as well as the reduction in insurance taxes, has resulted in favorable rate changes for OEBB plans for the 2020-21 Plan Year.

Background information

House Bill 2037 (2019 Legislative Session) Long Term Care:
This bill allows the OEBB board to make available long-term care insurance plans at the boards' discretion rather than as a statutory requirement. This change aligns all optional plan benefits offered to employees.

House Bill 2266 (2019 Legislative Session) cost containment bill (repealed portions of Senate Bill 1067 (2017). The most significant changes for OEBB are:

- Maintains the "opt-out" incentive for employees
- Maintains the "double-coverage" option for employees
- Requires OEBB implement a surcharge for employees who enroll as a subscriber on a PEBB or OEBB plan when already enrolled as a dependent on another PEBB or OEBB plan. The surcharge was determined by the Board to be $5 per month.
- Maintains the dependent eligibility review be complete in OEBB with frequency based on the consultant's recommendation.
- Revises the cap for reimbursement for both in-network and out-of-network hospitals so that it does not apply to hospitals outside of the state.
- Requires that PEBB/OEBB report to the Legislature by 12/31/2019 on:
    - Actions, strategies and challenges for meeting the 3.4% growth cap
    - Purchasing power maximization and total cost reduction strategies

- Previous and upcoming renewal rates

Revenue sources and changes

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

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

Proposed new laws that apply to the program unit

Legislative Concept 411 and Policy Package 425 Coordinated Care Model (CCM):
This policy package will align the purchasing power across PEBB, OEBB and other public purchasers.
COVID-19 has exposed the inequities in Oregon's healthcare system. The state can better leverage the public purchasing power in order to contain costs on a statewide basis. Currently:

- Health care coverage remains insufficient and unaffordable for many. In 2017, 8 percent of families had problems paying medical bills.
- With health insurance coverage at record highs and uncompensated care for providers at record lows, there's an opportunity for Oregon to leverage its purchasing power to contain costs for more Oregonians.
- The PEBB and OEBB boards have taken steps to align on several initiatives with the goal of enhancing their purchasing power. PEBB and OEBB have also merged the administrative staff of both programs into one unit.
- The state however, has not yet maximized the opportunities to fully align benefits and purchasing across other programs and look to expand the purchasing power beyond just PEBB and OEBB.

- Reducing health care costs allows resources to go to wages and other critical investments.
- The result to consumers and taxpayers is a much more sustainable health care system for the entire state, in line with the Triple Aim and the Governor's policy priorities as well as OHA's strategic plan.

The purpose of this policy package is to give the PEBB and OEBB boards more authority on procurement outside the RFP process to meet purchasing needs. This would include the authority for the boards to function as a single board if desired. The composition of one board is yet to be determined.

There is a real potential to leverage purchasing power by aligning financial incentives with other publicly-funded programs to improve care and lower costs across the Oregon Health Plan, public employee programs, the Marketplace and other local governments.

Conceptually, the boards could contract with a plan proposed to the boards outside the RFP process if the plan demonstrates:

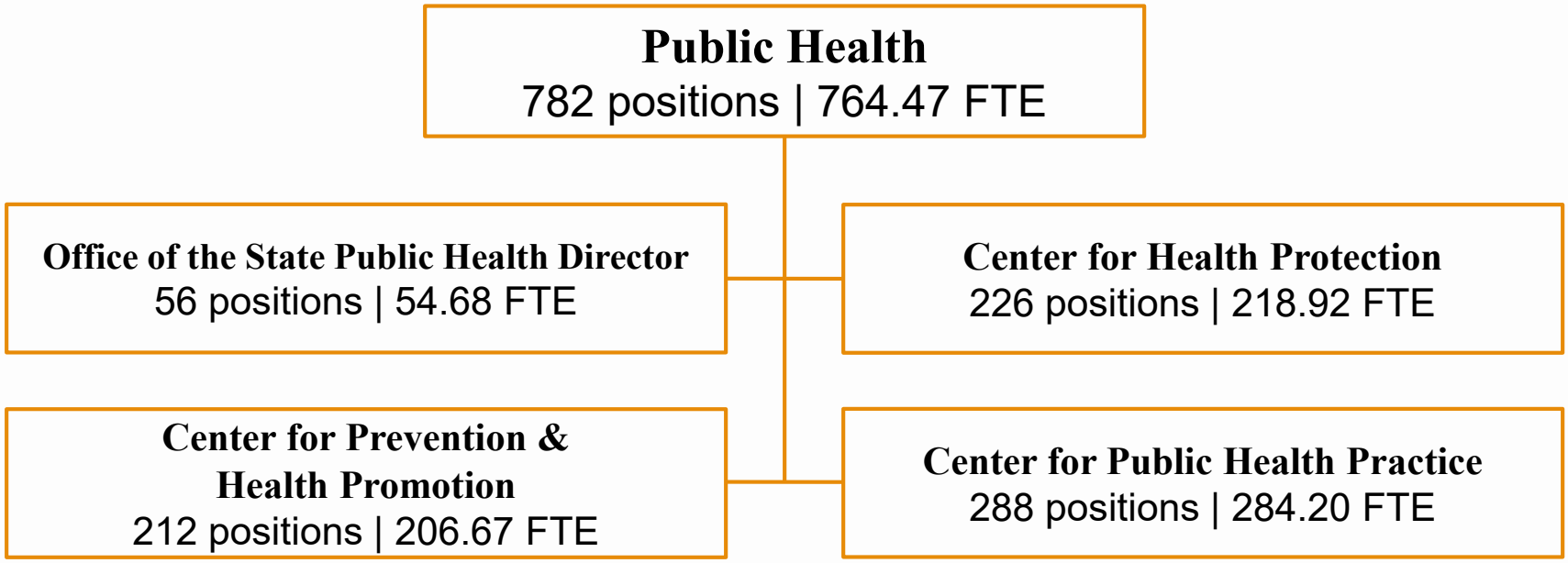
- The plan(s) and its providers are willing to serve all members in state markets (Medicaid, PEBB, OEBB, Marketplace), proportional to the market.
- It will offer unified provider contracts across all state markets that promote the same high standards of access and quality for all patients, regardless of where they obtain their insurance.
- Aligned core set of metrics for access and quality.
- Aligned payment methodologies across all state markets that move providers to shared savings/shared risk and population-based payments.

Policy Package 426 OEBB-PEBB Benefit Management Replacement System
OEBB and PEBB are requesting additional funding to continue with the Benefit Management System (BMS) replacement project. Staff in have finished the system gathering requirements for the new combines benefits management system. Next steps are to submit a Request for Proposal (RFP) for competitive bidding by third party entities able to fulfill the business

need. This new system would allow OEBB and PEBB to modernize all its members' and administrators' user experience. Top modernization goals include:

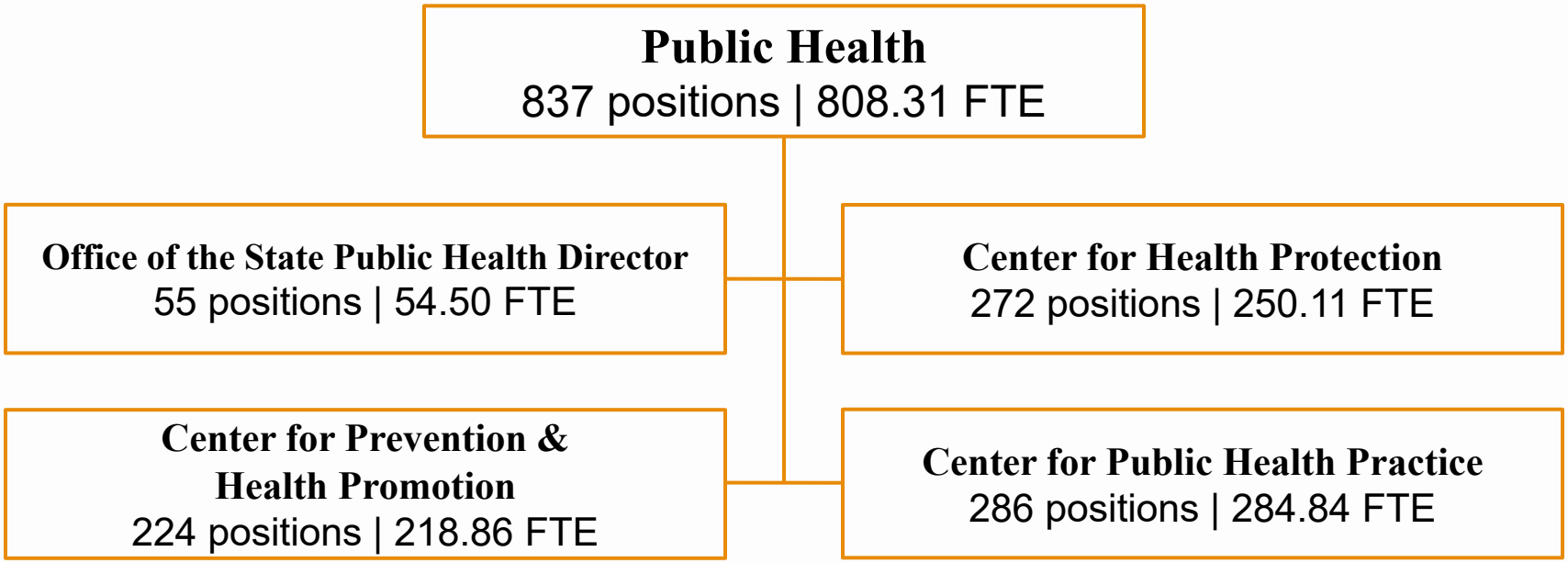
- The ability to implement and maintain latest security best practices.
- Mobile app compatibility.
- Compatibility with commonly used browsers, operating systems and devices.
- Flexibility to accommodate business partners’ and customers’ needs.
- Expanded automated error checking and data validation.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

2019-21
Legislatively Approved Budget



Oregon Health Authority

2021-23
Governor's Budget



Oregon Health Authority

Oregon Health Authority: Public Health Division

Executive Summary

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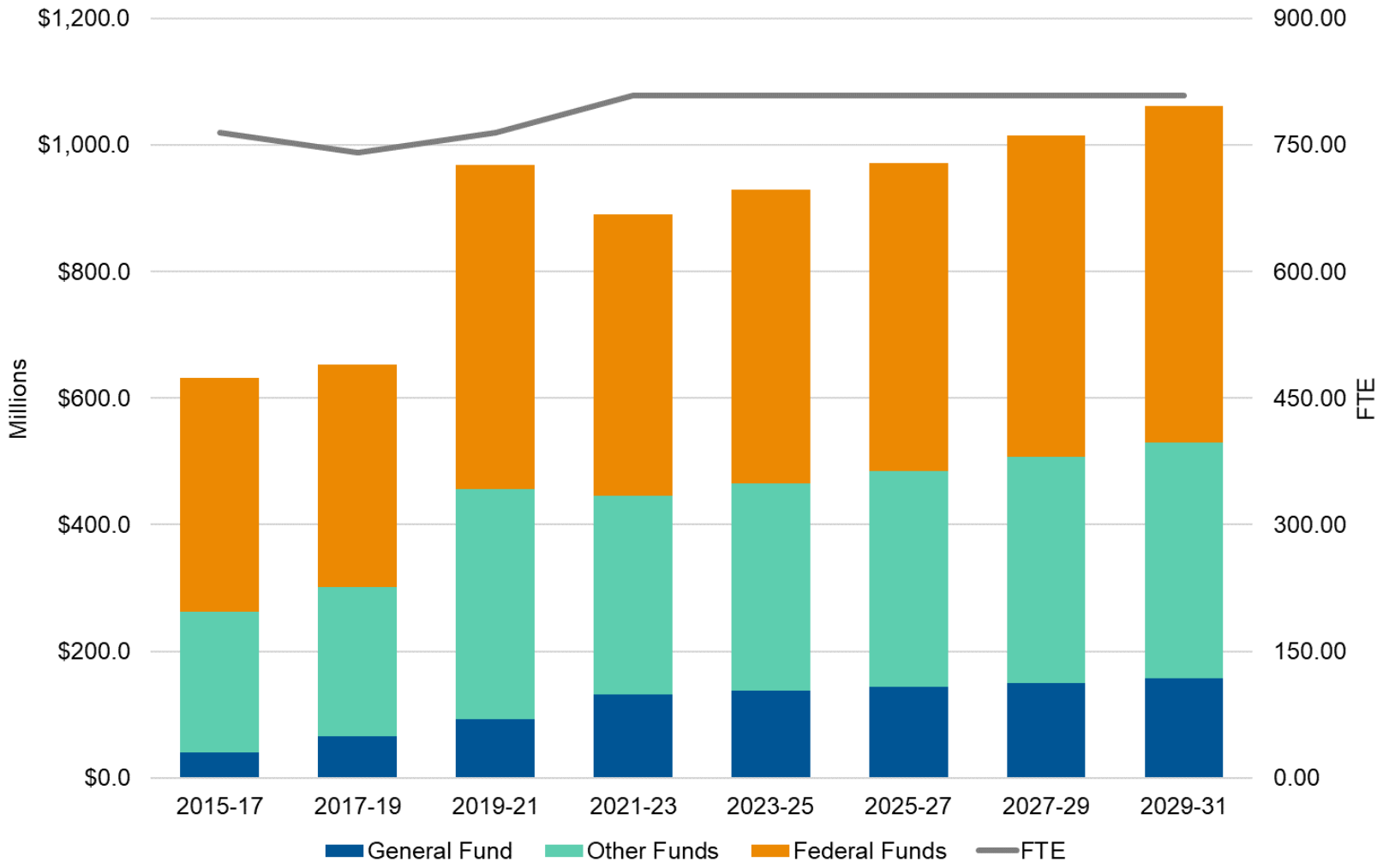

Executive Summary

Division overview

Public health uses equity practice, data, science and best practice to achieve health, improve care and lower or contain health care costs by preventing the leading causes of death, disease and injury in Oregon.

Funding request

The Governor's Budget of $968.5 million Total Funds for Public Health continues funding at the current service level for the 2021-23 biennium as well as policy packages for fee increases and an investment in public health modernization.

Program descriptions

The Public Health Division (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. OHA-PHD is central to achieving OHA's 10-year goal to end health inequities. OHA-PHD provides leadership for the 2020-24 State Health Improvement Plan (SHIP), Healthier Together Oregon. The plan development included state, local, Tribes, and community-based organizations (CBO) working together on the root causes of poor health outcomes, including systemic racism and oppression. Healthier Together Oregon's 62 strategies are encompassed in five priority areas: Institutional bias; Adversity, trauma and toxic stress; Economic drivers of health (including issues related to housing, living wage, food security and transportation); Access to equitable preventive health care; Behavioral health (including mental health and substance use).

The equity-centered, cross-sector strategies included in Healthier Together Oregon are a result of the work the public health system has done to modernize its practice. Oregon's public health system includes tribal and local public health authorities (LPHA), CBO's and OHA-PHD. The public health infrastructure developed as a result of public health modernization has been essential to Oregon's response to COVID-19. Specifically, Oregon has benefited from additional highly qualified state and local epidemiologists to track data, and quickly manage and respond to outbreaks in high risk settings like long-term care facilities, worksites and correctional institutions. The ongoing focus on health equity and cultural responsiveness by the public health system has allowed engagement with community members and CBO's to provide testing, culturally and linguistically responsive communications, and delivery of wraparound services to allow people to safely isolate or quarantine.

Executive Summary

The major cost drivers to Oregon's public health system are the increasing public health threats and a consistent decrease in federal funding.

Program justification and link to long-term outcomes

Public health programs and interventions contribute to reductions in health care costs and improved health outcomes through the prevention of disease and injury. OHA-PHD uses data and culturally and linguistically responsive practices to perform its work. OHA-PHD collects health data to determine what populations and conditions need to be prioritized in order to have the greatest impact, and to evaluate and improve quality and effectiveness of population-based programs and interventions.

Program performance

OHA-PHD has a system of performance management and quality improvement to inform program implementation. Specifically, OHA-PHD collects and reports annually on SHIP health outcome measures, which are also reflected in the Oregon Health Authority Key Performance Measures; public health accountability measures; and OHA-PHD Strategic Plan measures.

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 partners. Federally-funded public health programs are implemented according to federal laws.

Funding streams

For the 2021-23 biennium, the Governor's Budget for OHA-PHD comprises 15 percent General Fund, 50 percent Federal Funds and 35 percent Other Funds. Federal revenue includes entitlement grants such as Medicaid and more than 72 categorical grants. During 2019-21, federal grants remained flat funded.

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As a part of COVID-19 response, OHA-PHD has received over $211 million in funding from federal grants and CARES Act funds to address both the immediate pandemic and long-term strategic planning to create systems to address pandemic and any other future outbreak. At the time of writing, it is unclear what federal funding will be available for 2021-23; Congress has passed the Consolidated Appropriations Act of 2021 with funding to continue public health response activities and vaccine distribution, but the bill has not yet been signed by the President.

OHA-PHD's Other Funds revenue sources include fees for activities in such areas as newborn screening tests; licensing of facilities including hospitals; and statutorily dedicated funds from the Tobacco Use Reduction Account.

Significant proposed program changes from 2019-21

In the 2021-23 biennium, the OHA-PHD is proposing to continue advancements in public health modernization by continuing a focus on health equity and communicable diseases while also investing in environmental health, as the historic wildfire season has called out the importance of climate adaptation and environmental emergency preparedness. COVID-19 has highlighted the critical foundational capabilities and programs necessary to achieve OHA's 10-year goal of eliminating health inequities.

To address the continuing COVID-19 pandemic, the temporary Coronavirus Response and Recovery unit (CRRU) will continue in 2021. CRRU will focus on continued testing, tracing, education, outreach, and communication to slow the spread of the disease as well as shift to assist with the statewide vaccine rollout and support needed to ensure Oregonians are aware and educated about both preventing COVID-19 and getting vaccinated.

In order to sustain the costs of service delivery in these programs, Radiation Protective Services, Cosmetology and Respiratory Therapist and Polysomnographic Technologist Boards, ambulance licensing, Oregon Environmental Laboratory Accreditation Program, and the Prescription Drug Monitoring Program, OHA-PHD is proposing fee changes.

OHA-PHD put forward legislative concepts to address Radiation Protection Services, revising fee authority in statute; Environmental Public Health Lead Paint Contamination Clean-up which will give OHA-PHD authority to require cleanup of homes, schools and day cares contaminated with lead paint; and Emergency Management Services, establishes a new statewide

Executive Summary

Emergency Healthcare Advisory Board and Regional Boards, which will create state and regional plans to ensure optimal care for all time-sensitive emergency health conditions such as trauma, stroke, pediatrics and cardiac disease.

In response to the challenge of limited state revenues largely due to a once-in-a-hundred-year public health emergency, the Governor's Budget includes reductions in these programs: The Oregon Medical Marijuana Program Oregon Cannabis Commission, Women, Infant, and Children USDA/WIC Farmers Market Food Voucher Program; HIV, STD, and TB administrative duties; and Communicable disease modernization for surge support and training.

Office of the State Public Health Director

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$29.47	$109.18	$23.56	$162.22	56	54.68
Governor's Budget 2021-23	$60.05	$7.40	$10.43	$77.87	55	54.50
Difference	$30.58	-$101.78	-$13.14	-$84.34	-1	-0.18
Percent Change	104%	-93%	-56%	-52%	-2%	0%

The Governor's Budget of $77.9 million Total Funds continues funding for the Office of the State Public Health Director programs at the current service level for 2021-23. This budget also includes policy packge #417, $30 million for public health modernization.

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. The work of the office includes providing leadership for the division and governmental public health in health equity and cultural responsiveness. 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.

The Fiscal and Business Operations Unit manages the Oregon Health Authority Public Health Division (OHA-PHD) budget process, fiscal management, legislation, contracts, human resources, building operations, risk and safety, business continuity,

volunteer coordination, quality improvement activities and workforce development. The Operations team leads division wide initiatives that improve the effectiveness of a modern public health system. Focusing on PHD's national accreditation status; providing oversite and coordination across PHD's Health Information Technology projects; guiding PHD's modernization change plan and PHD's quality improvement priorities; guiding the implementation of PHD's Workforce Development plan, with a focus on health equity, and workforce diversity; implementing PHD's Continuity of Operations Plan, safety procedures and practices; and leading OHA-PHD's work on the OHA Performance System.

The Science and Epidemiology Unit includes population health data collection and reporting, program evaluation, clinical aspects of state public health service delivery, and ethical review of public health studies involving human subjects through the OHA-PHD Institutional Review Board. The Science and Epidemiology Unit aligns public health data and collection reporting around REALD and supports community-based approaches to public health data collection by working directly with communities of color and tribal communities to collect, analyze, interpret and report disaggregated public health data that is important to community.

The Policy and Partnerships Unit leads the development and execution of strategic initiatives to improve health equity and cultural responsiveness across governmental public health practice. The unit is responsible for supporting legislative policy strategy and administrative rulemaking and executing division and statewide plans, which support OHA-PHD's nationally-accredited status, including Oregon's State Health Improvement Plan (SHIP) and the OHA-PHD Strategic Plan. The unit cultivates strategic partnerships for a cohesive statewide public health system along with local public health authorities, federally-recognized tribes, community-based organizations, coordinated care organizations and other state agencies. The unit staffs the Public Health Advisory Board, which has adopted the public health system's commitment to leading with racial equity.

The Policy and Partnerships Unit leads efforts to further advance health equity across OHA-PHD by facilitating a division-wide health equity workgroup charged with accomplishing three broad goals: fostering a shared understanding of and will to achieve health equity, cultural responsiveness, and trauma-informed approaches in the Public Health Division; 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; 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 in the health equity workgroup work plan.

The work to accomplish these goals includes identifying gaps in health equity practice through equity assessments and data, 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; finding opportunities to increase the collection of race, ethnicity, language and disability (REALD) data, examining data on the social determinants of health by race, ethnicity and language, gender identity, place, and poverty; and building PHD organizational structures, policies and supports to promote workforce diversity.

The Coronavirus (COVID-19) pandemic has had an impact on the public health system and the core work of the division. PHD has been the leader in all aspects of this event for the state using the Incident Management Team structure. Staffing is comprised of the Health, Security, Preparedness and Response section, the OSPHD staff, and many employees within Public Health and the agency (over 389 public health employees have or are assisting in the event). Throughout the COVID-19 response, every unit within OSPHD has directly supported the COVID-19 response:

- Fiscal and Business Operations has led all COVID-19 financial work to date, including contract management, time coding, tracking all expenditures, FEMA reimbursement and management of federal investments in COVID-19 response.
- Operations has activated the Public Health Division's Continuity of Operations Plan (COOP), organized staffing of the COVID-19 Incident Management Team (IMT), and led the division's transition to remote work during the pandemic.
- Science and Epidemiology has provided scientific leadership for the COVID-19 response through the State Health Officer and State Epidemiologist and through analysis of key COVID-19-related health data.
- The Policy and Partnerships Unit has provided cohesive COVID-19 response support, including administration of COVID-19 investments to local public health authorities, tribes, and established a new program consisting of community engagement staff that manage a statewide network of over 170 community-based organizations to provide culturally and

linguistically responsive community engagement, contact tracing and wraparound services for people affected by COVID-19. The unit has facilitated dozens of COVID-19 related administrative rulemakings and collaborates with the Governor's Office on COVID-19 reopening policy and enforcement.

In response to the extended crisis, the agency developed a temporary COVID-19 Recovery and Response Unit (CRRU). CRRU is a joint effort between Oregon Department of Human Services (ODHS) and OHA. The goal is to successfully prevent the spread and mitigate the impacts of COVID-19 across all Oregon and tribal communities while laying the foundation for future response efforts by integrating and elevating community voices to co-create solutions, share power, and effectively guide the state's approach; centering the state's response in equity and addressing the inequities of the current system and its approach, with a concerted focus on those communities most impacted by historical and contemporary racism and oppression; providing essential and equitable supports and services across all Oregon communities and responding in a coordinated, agile way, that increases impact, maximizes resources, and reduces duplication of efforts.

The CRRU has four key functional areas: Response and Operations which includes clinical epidemiology, surveillance, intervention, investigation, and testing; Community Services Support which liaises with ODHS and OHA programs to ensure coordinated wrap around and support services; Equity and Community Engagement which centers the work of the CRRU in equity and leverages the equity and community engagement efforts across the agencies; and Business Operations which provides the administrative backbone for the unit.

Equity drives policy decisions and program delivery to support communities that systemic racism and oppression impact the most. Inequities in health and well-being for those communities reflect systemic racism, historical injustice and the inequitable distribution of power and resources across Oregon. CRRU is founded on health and service equity to ensure that all communities have equitable access to programs and services provided by ODHS and OHA.

By increasing authentic community participation, building trust between governmental entities and community while ensuring equitable distribution or redistribution of power and resource, the CRRU will help move Oregon toward more equitable outcomes.

Background information

OSPHD works to ensure that decisions and priorities set in Oregon are data-driven, grounded in public health practice and work toward OHA's 10-year goal of eliminating health inequities. 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 coordination with Oregon's local public health authorities, federally recognized tribes and community-based organizations. State public health programs also partner with a range of state and local agencies and organizations, health care providers, insurers, coordinated care organizations, state and federal agencies and the private sector.

Strategic planning and accountability

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 2018, OSPHD published Oregon's second State Health Assessment, which includes a set of quantitative state population health indicators. State population health indicators are updated annually and serve as the backbone for OSPHD's reporting of OHA-PHD's key metrics, including key performance measures, Oregon's State Health Improvement Plan (SHIP) measures, and public health accountability measures. OSPHD continues to implement the REALD law and support the use of data to identify and meaningfully address health inequities. From 2018-2020, OSPHD convened the PartnerSHIP, a multisector charged with guiding the development of the 2020-2024 SHIP. The PartnerSHIP used the State Health Assessment and feedback from communities across Oregon to identify the following five priorities for the 2020-2024 SHIP:

- Institutional bias
- Adversity, trauma and toxic stress
- Economic drivers of health (including issues related to housing, living wage, food security and transportation)
- Access to equitable preventive health care
- Behavioral health (including mental health and substance use)

From Summer 2019 to Summer 2020, the PartnerSHIP subcommittees met to develop goals, strategies and measures for the 2020-24 SHIP, which was named Healthier Together Oregon. This process included 97 individuals representing 62 different organizations and a community engagement process led by culturally-specific organizations across the state to ensure the plan prioritizes the needs of Oregon's diverse communities.

Healthier Together Oregon officially launched in September 2020 through its new website, healthiertogetheroregon.org. Work is underway to seat a new PartnerSHIP that will provide community-based leadership for the plan through 2024. OSPHD has established a cross-OHA Core Group to support implementation of Healthier Together Oregon with the OHA Office of Equity and Inclusion, External Relations, Health Policy and Analytics and Health Systems Divisions. OSPHD partners with the OHA Health Policy and Analytics Division to align implementation of community health improvement plans by local public health authorities, coordinated care organizations and nonprofit hospitals with Healthier Together Oregon so that these plans can also be used to achieve statewide health outcomes.

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

- 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 the 2019-21 biennium, the Legislature added an additional $10 million General Fund investment for public health modernization. In October 2019 OSPHD awarded $10 million of this investment to local public health authorities to:

- Continue to enhance regional infrastructure created during the 2017-19 biennium, including regional epidemiologist positions, data analysis and surge capacity agreements.
- Build local public health authority work related to health equity and cultural responsiveness, leadership and organizational competencies, and communicable disease and environmental health interventions.

OSPHD has also awarded $1.1 million to federally-recognized tribes to:

- Conduct public health modernization assessments and develop public health modernization plans.
- Begin implementation of tribal public health modernization plans.

OSPHD is using the remaining public health modernization General Fund investment to:

- Provide technical assistance and support to local and public health modernization grantees and coordinate statewide communicable disease control efforts.
- Provide staff support and capacity building for health equity and cultural responsiveness.
- Update public health surveillance systems to be co-designed with communities and researchers of color, incorporate new data collection methods and provide more granular levels of data.
- Evaluate the effectiveness of the public health modernization investment, including annual collection and reporting of public health accountability measures.

Office of the State Public Health Director

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

The public health infrastructure developed as a result of public health modernization has been essential to Oregon's response to COVID-19 and low case numbers relative to other states of a similar size and geography. Specifically, Oregon has benefited from additional state and local epidemiologist positions to track data to quickly manage and respond to outbreaks; the Surge Epidemiologist brought on by public health modernization has been leading outbreak investigation and COVID-19 support with the Department of Corrections and Oregon Youth Authority, a critical role for addressing COVID-19 inequities. The ongoing focus on health equity and cultural responsiveness by the public health system has allowed better engagement with community members and community-based organizations. Health equity staff that have been hired by state, local and tribal public health modernization funds have supported the COVID-19 response by applying principles of health equity and community partnership development to the work. Finally, work to prevent communicable disease transmission in high risk settings including long-term care facilities and homeless shelters was already underway across the state before the COVID-19 pandemic hit Oregon, so those relationships have been leveraged to respond to COVID-19.

The Public Health Advisory Board has adopted a health equity policy and procedure to ensure all board decisions promote equity and do not promote or further health inequities; this policy and procedure commits the public health system to leading with race in its pursuit of health equity, The local public health authority funding formula includes several variables related to health equity so that future General Fund resources can be targeted to communities experiencing the greatest burden of poor health outcomes.

Revenue sources and changes

The 2021-23 budget for OSPHD is composed of 77 percent General Fund, 13 percent Federal Funds (primarily through the agency's federally approved cost allocation plan), and 10 percent Other Funds.

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 fund new positions to support the implementation work of modernization, data and collection, and enhancements to critical data systems at the state.

The Legislature appropriated $10 million General Fund in the 2019-21 biennium, building on a $5 million General Fund investment in the previous biennium, to support the ongoing implementation of public health modernization. Most of this new investment funds 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 effective and efficient delivery of public health protections and coordination across the public health system.

In the 19-21 legislative session and a special session in August 2020, a total of $6.995 million was allocated to continue support for local communicable disease outbreak surveillance at the current service level. This General Fund reduced the Oregon Medical Marijuana Program (OMMP) obligation to support the work.

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.

In March 2020, OSPHD received a $5 million General Fund investment in the public health system response to COVID-19, including case investigation. A total of $4 million was allocated to local public health authorities and tribes through amendments to existing contracts. The remainder was allocated to expenses for testing supplies and equipment at the Oregon

State Public Health Laboratory. The Emergency Board subsequently replaced the $4 million of the General Fund investment with Federal Funds made available by the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

In July 2020, OSPHD received $94.2 million in additional funding through the CARES Act to support culturally and linguistically responsive community engagement and education, case investigation, contact tracing and social services and wraparound supports related to isolation and quarantine. These funds are being allocated to all local public health authorities, tribes and a statewide network of over 170 culturally-specific community-based organizations.

Policy package #417 – Public Health Modernization includes an additional $30 million investment to advance health equity and cultural responsiveness, communicable disease control, environmental health and emergency preparedness and response. These funds will support the Public Health Division, local public health authorities, tribes and community-based organizations to eliminate communicable disease-related health inequities, address health inequities that are persistent as a result of climate change, promote health resilience and environmental justice. This investment will support OSPHD in continuing the essential work of community-based organizations as a part of the public health system by providing grant funding and the OSPHD staffing needed for technical assistance and day-to-day support.

Proposed new laws that apply to the program unit

Senate Bill 64 – Public Health Housekeeping includes minor changes to statutes to correspond with program implementation.

House Bill 2073 – Public Health Modernization is a placeholder to accompany policy package #417 – Public Health Modernization. This bill may be used to further refine implementation of public health modernization.

Center for Protection

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$11.60	$39.09	$18.97	$69.65	226	218.92
Governor's Budget 2021-23	$17.80	$47.46	$20.69	$85.95	272	250.11
Difference	$6.20	$8.38	$1.72	$16.30	46	31.19
Percent Change	53%	21%	9%	23%	20%	14%

The 2021-23 Governor's Budget of $86 million Total Funds continues funding for some of the Center for Health Protection programs at the current service level. The budget includes fee changes through policy packages in three sections. The Radiation Protection Services (RPS) policy package #448 ensures that RPS continues conducting radiological health and safety regulatory inspections, issue licenses, and meet emergency response requirements. Policy package #450 for the Emergency Medical Services (EMS) program in Health Care Regulation and Quality Improvement Section includes a fee increase to allow the program to continue to conduct on-site licensing surveys of ambulance agencies and vehicles, and complaint investigations to ensure that ambulance agencies and vehicles provide high-quality and safe services; and the Cosmetology policy package #447 and Respiratory Therapist Boards policy package #452 in the Health Licensing Office both ensure the boards are able to issue licenses to applicants in a timely manner and protect the public from potential health and safety violations.

Activities, programs and issues in the program unit base budget

The Center for Health Protection (CHP) protects the health of individuals and communities by establishing, implementing, and ensuring compliance with regulatory and health-based standards. CHP protects people in Oregon from environmental health hazards including those that may occur in drinking water, through exposure to radiation, in recreational waters, and through food. The center establishes, applies and ensures compliance with critical areas of health care policy, in support of Oregon's triple aim. It requires patient safety efforts and quality improvement activities by health care providers. The center's six sections partner with local public health authorities, communities affected by environmental health hazards, tribes, private practitioners

and medical experts. CHP works through its various programs towards achieving the Oregon Health Authority's 10-year strategic goal to end health inequities. CHP regulatory programs ensure that communities of color and lower-income communities are protected from environmental health hazards and risks. CHP protects communities experiencing health inequities so that they have access to safe drinking water, safe and equitable access to healthcare facilities, emergency services, and to health-related services and professions. Non-regulatory programs in CHP track, assess, and collaborate with community partners to provide outreach and education to vulnerable populations disproportionately exposed to built and natural environmental health risks, such as radon and lead exposure and the effects of climate change.

Radiation Protection Services (RPS) protects workers, patients, and the public from unnecessary and unhealthy radiation exposure. This is accomplished through on-site facility inspections, licensing of radioactive materials, and registration of X-Ray and tanning devices, environmental monitoring, and radio analytical laboratory services. This section provides Oregon's sole public resource for radiation-related incidents. In addition, the section collaborates with licensing boards to ensure operators and workers are properly trained and credentialed.

Drinking Water Services (DWS) ensures the safety of drinking water provided by all public water systems in Oregon. The program administers and enforces state and federal safe drinking water quality standards; prevents contamination of public drinking water systems by protecting drinking water sources; ensures 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, learn and play. EPH works closely with local, state, federal and tribal natural resource management, occupational safety, environmental and other agencies to understand risks to human health posed by changing conditions, policies and practices.

Center for Protection

EPH recognizes that communities of color, lower-income communities, and tribal communities are disproportionately at risk for environmental exposures and prioritizes its work accordingly to address inequities in exposure to environmental health hazards.

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. This includes the timely review of cardholder registry applications and maintaining and ensuring patient confidentiality. The program's compliance and enforcement unit ensure compliance with OMMA and administrative rules by medical marijuana dispensaries, processing sites, growers, and grow sites.

Health Care Regulatory and Quality Improvement (HCRQI) ensures safe and high-quality health care through assessment, education and regulation for health facilities and providers through the Health Facility Licensing and Certification program and the Emergency Medical Services and Trauma Systems (EMS/TS) program. During the COVID Pandemic Response. The section has provided regulatory guidance and flexibility options during the initial surge and again during the reopening. The Health Facility Licensing and Certification program licenses and certifies health care facilities, providers and suppliers in acute care and community-based programs. The EMS/TS program ensures the effectiveness and coordination of the state's emergency medical response system for illness and injury. The program encourages improvements in the emergency care of pediatric patients and regulates systems that provide emergency care to people who experience a sudden illness or traumatic injury.

Health Licensing Office (HLO) is a central licensing and regulatory office that oversees multiple health and related professions. HLO protects the health, safety and rights of Oregon consumers by ensuring that only qualified applicants are authorized to practice. HLO reviews and approves applicant qualification, conducts examinations, inspects thousands of licensed facilities and independent contractors, responds to and investigates consumer complaints, and disciplines licensees who violate state requirements.

Package #098 in the Governor's Budget adds six independent health-related boards to OHA and HLO through program reorganization: Mortuary and Cemetery Board; Board of Naturopathic Medicine; Occupational Therapy Licensing Board;

Board of Medical Imaging; Board of Examiners for Speech-Language Pathology & Audiology; and Veterinary Medical Examining Board.

Center for Health Protection programs are engaged in or working toward health equity and inclusion strategies increasing cultural competency among staff and advisory board members; Providing funding assistance for safe drinking water system construction projects in underserved and economically disadvantaged communities; Leading integration of health equity as a core priority in the Public Health Division's Environmental Health Modernization plan; Reviewing regulatory and compliance procedures to address discrimination issues; Collecting and reporting data that are disaggregated by race, ethnicity, language and disability status (REAL D) and; 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 regulatory oversight for all people in Oregon.

Radiation Protection Services (RPS) licenses or registers more than 14,000 sources of radiation statewide. It routinely inspects those radiation sources in more than 4,200 facilities including hospitals, dental and medical clinics, radiation oncology clinics, tanning salons, and academic and research facilities. Several RPS staff members also supported OHA's state-wide COVID response efforts by serving as contract tracers and in the agency Incident Management Team (IMT) roles.

Drinking Water Services (DWS) regulates nearly 3,400 public water systems statewide. The section certifies 1,700 public water system operators and 1,500 backflow device testers and specialists. Contracts with county health departments and the Oregon Department of Agriculture provide for local regulation of smaller public water systems served by groundwater sources. DWS regulates larger public water systems and those with treatment systems and provides technical assistance to water systems and partners. DWS provides technical expertise and best management practices related to emerging contaminants that may affect drinking water quality, including Harmful Algal Blooms and Per and polyfluoroalkyl substances (PFAS). Additionally, DWS staff participated in OHA's IMT COVID-19 response including contact tracing.

Center for 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. During 2019-21, the program saw increased workloads implementing the Oregon Department of Environmental Quality's new "Cleaner Air Oregon" regulatory program, and in work related to climate change and health. Beginning in March 2020, the program's Food, Pool and Lodging Health and Safety Program assumed a major new workload as the source of technical expertise, rule writing and guidance development, interagency memoranda of understanding development, and liaison to local public health authority environmental health programs for implementation and enforcement of the Governor's Executive Orders related to COVID-19.

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. They regulate clandestine drug lab clean-up (2,100 cleaned up since 1990) and lead-based paint-related activities. Also included is the Toxic-Free Kids program, that regulates hazardous chemical reporting and removal by manufacturers of children's products.

EPH assessment programs evaluate areas of environmental concern to ensure impacts to human health are included in action plans for air quality, contamination from hazardous waste sites, brownfield redevelopment plans, transportation and land use plans, and hazards related to climate change. Assessments and stakeholder engagement activities take into consideration that some communities face greater risks and environmental health inequities.

EPH surveillance programs monitor data on lead poisoning, radon, pesticide exposures, occupational health, domestic well safety, beach safety, harmful algae blooms and other environmental health hazards. EPH direct efforts to 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 both the medical and retail marijuana markets. House Bill 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 continue to decline since legalization of marijuana in 2015.

The continued transition of registered medical facilities to licensed recreational facilities with OLCC has significantly affected revenue and contributed to a decline in registrations. Additionally, the number of patients paying full price for medical cards has decreased as most applicants now pay a reduced fee. Currently approximately 24,015 patients, 9,884 growers, and 8,245 grow sites are registered with OMMP. Additionally, OMMP staff participated in OHA's IMT COVID-19 response including contact tracing and assisted with guidance and enforcement of the Governor's Executive Orders related to COVID-19 and Oregon's re-opening.

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 94 ambulatory surgical centers, 14 birthing centers, 77 dialysis facilities, 713 hemodialysis technicians, 71 home health agencies, 61 hospice agencies, 65 hospitals and hospital nurse staffing programs, 178 in-home care agencies, 104 rural health clinics, and 10 other provider types.

The Health Facilities Planning and Safety unit works to ensure that facilities are safe and effective and meet nationally accepted building standards. This program reviews design and construction plans and issues project approvals for approximately 200 health facility projects annually. 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. This unit also provides review for facilities regulated by the Oregon Department of Human Services.

Emergency Medical Services and Trauma Systems (EMS/TS) Program works with partners and nine advisory boards to monitor and improve the emergency systems of care. The program licenses 136 ambulance service agencies, 740 ambulances, approximately 11,996 Emergency Medical Services Providers (EMSPs): 1,609 Emergency Medical Responders (EMR), 5,357 Emergency Medical Technicians (EMT), 694 EMT-Intermediate, 204 Advanced EMTs and 4,132 Paramedics. It also certifies

all EMT training courses and provides 8,700 hours of continuing education to over 4,000 EMSPs in nearly 200 rural and frontier communities. The Trauma program inspects 45 designated trauma centers.

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 and receives funds to support a contract with Oregon Health and Sciences University for administration of the Oregon Physician's Orders for Life Sustaining Treatment (POLST) Registry.

Health Licensing Office (HLO) works with 16 boards, councils and programs: Art Therapy; Athletic Trainers; Behavior Analysis; Certified Advanced Estheticians; Cosmetology; Denture Technology; Dietitians; Direct Entry Midwifery; Electrologists and Body Art Practitioners; Environmental Health Specialists; Hearing Aid Specialists; Lactation Consultant; Long Term Care Administrators; Music Therapy; Respiratory Therapy and Polysomnography; and Sexual Offense Treatment. In 2019, HLO administered 8,864 examinations, issued 9,105 licenses and registrations, renewed 46,349 licenses and registrations, conducted 6,463 inspections, investigated 362 complaints, and monitored 5,531 facilities and 41,723 licensees. In 2020 HLO staff assisted with guidance and enforcement of the Governor's Executive Orders related to the COVID-19 response and Oregon's re-opening.

Revenue sources and changes

The 2021-23 Center for Health Protection budget comprises 55 percent Other Funds, primarily in the form of fees for services, 24 percent Federal Funds, and 21 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. The last program fee increases were in 2015. RPS has biennial fee increase requests totaling $1.4 million for the three fee-based regulatory programs, including a new x-ray vendor

fee. Without these additional revenues, RPS budget solvency will be threatened in 2021-23, leading to significant program staff and service reductions and breaching of inter-agency agreements.

Drinking Water Services (DWS) receives funding from federal grants, fees and the General Fund. In the 2019-21 biennium DWS received an allocation of $4.4 million from the General Fund. DWS also collects fee revenue from four sources/programs, totaling roughly $4 million per biennium: Backflow Tester/Specialist Certification, Water System Operator Certification, Water System Plan Review fees and Water System Annual Fees. Increases of the Annual Fee are capped at 3 percent per year. Revenue from fees and the General Fund contribute to the required state match for federal grants. DWS receives two federal grants from the Environmental Protection Agency (EPA) which together constitute the largest source of program revenue: The Drinking Water Primacy grant ($3.2 million per biennium) and the Drinking Water State Revolving Fund (DWSRF) capitalization grant. The DWSRF includes support for infrastructure project financing (69 percent) and set asides for specific program functions (31 percent). DWSRF set asides contribute roughly $9 million per biennium to supporting specified program costs.

Environmental Public Health (EPH) receives most of its funding from federal grants and fees, with small amounts of additional funding coming from intergovernmental agreements for collaborative projects with state agency partners and the General Fund. EPH receives Federal Funds revenue from the Centers for Disease Control and Prevention (CDC) grants for Climate and Health, Environmental Public Health Tracking and Childhood Lead Poisoning Prevention. It also receives funding from the National Institute for Occupational Safety and Health 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. In 2020 EPH received a new CDC Environmental Health Data and Capacity grant to bolster the use of environmental health data and support disaster resilience capacity development. EPH receives Other Funds revenues through intergovernmental agreements with county health authorities that collect license fees on OHA's behalf to support foodborne illness, public pool, and tourist facility health and safety activities. OHA health risk assessment and communication work to support the Oregon Department of Environmental Quality's (DEQ) Cleaner Air Oregon industrial air toxics regulatory program is funded through a DEQ-OHA interagency agreement. The Pesticide Exposure Safety and Tracking Program is funded through an interagency agreement with

Oregon Department of Agriculture, while brownfields projects may be funded through Business Oregon. The section also receives a small amount of General Fund to help support its assessment and surveillance efforts, the Toxic Free Kids Act (TFKA) and an Emerging Environmental Health Threats position funded through the legislature's 2019 Public Health Modernization investments. The Governor's Recommended Budget includes general funds to restore a Domestic Well Safety Program that received federal grant funding from 2013 to 2020.

Oregon Medical Marijuana Program (OMMP) section collects fees for issuing medical marijuana cards to qualifying patients and maintains a registry of those patients. The program also collects fees for the registration of grow sites, dispensaries and processing sites and collects a pass-through fee for entities required to use the OLCC cannabis tracking system. Program revenue continues to decline since the legalization of recreational marijuana. In 2019-21 OMMP transferred $1.5 million in revenue to support State Support for Public Health (SSPH), reducing SSPH's General Fund need. Additionally, with the passage of SB 5723 from the 2020 legislative special session, SSPH was funded by General Funds for the remainder of 2019-21. The section also receives $228,000 General Fund, to support the Oregon Cannabis Commission. Revenue impacts from COVID-19 on the state budget resulted in a $69,618 budget cut from this fund.

Health Care Regulation and Quality Improvement (HCRQI) section receives federal funding from the Centers for Medicare and Medicaid Services to perform health facility surveys and certification. Some regulatory work such as Hospital Nurse Staffing and In-home care agencies and is supported by the General Fund. The Health Facility Licensing and Certification program funding sources include fees for licensing and inspection of health care facilities. Emergency Medical Services and Trauma Systems (EMS/TS) program within HCRQI receives federal funding from the Health Resources & Services Administration to administer the Oregon EMS for Children program. In addition 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. HCRQI also receives $1.95 million General Fund as a pass-through to support the Oregon Patient Safety Commission's Early Discussion and Resolution program and receives funds to support a contract with Oregon Health and Sciences University for administration of the Oregon Portable Orders for Life Sustaining-Treatment (POLST) Registry.

Center for Protection

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 have 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

House Bill 2075 and Policy Package #448 — Radiation Protection Services (RPS) would revise fee authority to sustain program funding and operating costs. The LC and POP restructure the RPS X-ray registrant user-fee model, institutes X-ray vendor licensing fees, and implements tanning registrant and radioactive material licensing user-fee increases. Without the revised fee authority and additional revenue, RPS's mission and regulatory obligations are threatened with a large funding gap resulting in significant reductions in regulatory and safety services and staffing. The proposed funding measures will allow the section to maintain current services, administer the new x-ray fee model database, address a growing backlog of facility inspections, and eliminate a funding deficit that would result in inadequate radiation protection and safety for all Oregonians.

House Bill 2077 — Environmental Public Health (EPH) Lead Paint Contamination Clean Up would give OHA authority to require cleanup of homes, schools and day cares contaminated with lead paint. Currently, when a landlord, property manager, school district, or child-care operator has created a risk of exposure to lead paint inside or outside a residence or facility, OHA can levy a civil penalty for failure to implement lead-safe renovation, repair and painting practices spelled out in federal rules the state has incorporated by reference. However, OHA cannot require the responsible party to clean up the property. The LC gives the agency statutory authority to issue a stop-work order for ongoing unsafe work, and to require certain parties responsible for lead-based paint contamination of a residence, school or childcare facility to properly assess and decontaminate the residence or facility.

House Bill 2076 and Policy Package #450 — Health Care Regulation and Quality Improvement (HCRQI) EMS Modernization proposes to create an integrated and comprehensive Emergency Healthcare System into the right care, right

time and right place. The concept establishes a new statewide Emergency Healthcare Advisory Board and Regional Boards, which will create state and regional plans to ensure optimal care for all time-sensitive emergency health conditions. The proposal also includes patient registries for all time-sensitive emergencies and an EMS Mobilization Plan for surge during disasters. Policy package #450 proposes to raise both initial licensure and renewal fees for ambulance service agencies and ambulance vehicles established in ORS 682.047 (1997) and increase biennial revenue by $106,237.

Center for Prevention and Public Health Promotion

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$40.09	$77.60	$249.22	$366.91	212	206.67
Governor's Budget 2021-23	$42.41	$116.72	$262.37	$421.50	224	218.86
Difference	$2.33	$39.12	$13.15	$54.59	12	12.19
Percent Change	6%	50%	5%	15%	6%	6%

The 2021-23 Governor's Budget of $421.5 million Total Funds continues funding for most of the Center for Prevention and Health Promotion programs at the current service level and expands tobacco prevention. The budget includes additional funding to expand the Tobacco Prevention and Education Program (TPEP) through Ballot Measure 108 tax revenue of $40.3 million. Two new program changes are being proposed, a policy package #453 for a fee increase for the Perscription Drug Monitoring Program (PDMP). The fee ensures that PDMP continues as a crucial health care tool that allows prescribers to ensure they are fully informed of the prescription history of their patients when prescribing controlled substances. Additionally, a policy package #408 would establish a strong statewide licensing system for retailers who sell tobacco products and inhalant delivery systems.

Activities, programs and issues in the program unit base budget

The Center for Prevention and Health Promotion's mission is to help Oregon's communities and residents achieve and sustain lifelong health, wellness and safety through partnership, science and policy. The center's work is essential to achieving the triple aim of better health, better care and lower costs and to meeting the OHA ten-year goal of eliminating health inequities. The center has five sections that work to achieve its mission through ensuring the health and well-being of school-aged youth and young adults; preventing child developmental delays; ensuring adolescent health and well-being; provision of adequate nutrition and access to healthy foods; prevention of risks leading to lifelong and costly chronic diseases, including substance use disorders; prevention of injuries, overdose, suicide, toxic stress, violence and unsafe relationships; access to client-centered,

culturally responsive preventive clinical services including reproductive health and breast and cervical cancer screening; oral health across the lifespan.

The center promotes population and community-based strategies to increase capacity for K-12 schools to provide school health services, health education, and be a safe and supportive environment; increase stability and safety in families; increase equitable access to healthy options and preventive health services; decrease the burden of health inequities borne by communities of color and tribal communities by addressing the social determinants of health; increase access to healthy food and increase healthy eating and physical activity for all people in Oregon; reduce overdose and risky prescribing of opioids; reduce suicide; reduce tobacco, alcohol and other drug use; prevent and reduce secondary impacts of COVID-19 and support recovery.

In collaboration with stakeholders, partners and Tribes, the center invests resources to prevent and address health problems and inequities statewide. Those partners and stakeholders include governmental entities, including local public health authorities and community mental health programs; governmental entities, including local public health authorities and community mental health programs; early child care, early learning, primary and secondary education systems; K-12 school systems including school district leaders, school boards, teachers, staff, and administrators. Health care systems and providers (including dental, mental health and primary care systems); substance use disorder treatment programs; emergency departments and hospitals; food systems and anti-hunger organizations; domestic and sexual violence agencies, community-based organizations led by and centering communities of color, tribal communities and other populations experiencing health inequities; Oregon's nine federally-recognized tribes, urban American Indians and Alaska Natives; regional health equity coalitions; aging services; land use and transportation agencies; emergency medical service providers; academic institutions; parents, families and youth; employers; law enforcement; school health providers (i.e. school nurses, school counselors etc).
The center is engaged in addressing numerous upstream social determinants of health which affect health equity and inclusion strategies as reflected in Oregon's State Health Improvement Plan (SHIP). These are: institutional bias; adversity, trauma and toxic stress; economic drivers of health including housing and transportation; access to equitable preventive health care; and behavioral health, including substance use and mental health services.

Background information

The Center for Prevention and Health Promotion has the following five sections that work to achieve its mission:

Adolescent, Genetics and Reproductive Health (AGRH) promotes the health, well-being and quality of life for all people in Oregon through the development and use of evidence-based policies, tools, educational resources, programs and clinical preventive services to support adolescent, sexual and reproductive health across the lifespan. AGRH commits to working towards racial equity by addressing racism, acknowledging implicit bias, and shifting how we do what we do. AGRH:

- Encourages the adoption of evidence-based programs and practices that support positive youth development and promote authentic youth engagement.
- Collaborates with Oregon Department of Education, school districts, educational service districts, and K-12 schools to uplift health services, increase implementation of K-12 health education, survey students, and inform local and state policy development.
- Provides access to essential preventive health services through a statewide network of school-based health centers (SBHCs), reproductive health clinics, school nurses, mental health providers and ScreenWise providers regardless of gender identity, sexual orientation, race, sex, disability or immigration status.
- Reduces breast, cervical and hereditary cancer inequities by supporting equitable access to early detection and surveillance.
- Supports and ensure 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.
- evelops 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.
- Engages collaboratively with partner organizations and community members to inform policies, clinical services and activities that address systemic, structural, and institutional injustices and advance health equity.

- Recognizes the role of trauma and resilience in health behavior and outcomes and create prevention policy and programming that acknowledges trauma and adverse experiences while building on and enhancing developmental strengths and protective factors.
- Uses innovative approaches to respond to emerging or unique needs resulting from a changing health and policy landscape (e.g., Public Charge Rule, COVID-19).
- Funds community-specific organizations that center Black, indigenous, and people of color in addressing structural barriers to care borne from institutional bias, oppression, trauma and toxic stress.

Health Promotion and Chronic Disease Prevention (HPCDP*)* works with communities and tribes to increase the opportunities for all Oregonians, no matter where they live in the state, to eat better, move more, live tobacco-free, drink less alcohol and take charge of their own health. HPCDP does this by nalyzing 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 among populations disproportionately impacted by health inequities.

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:

- Equipping tribes, local public health authorities, and other diverse communities with the strategies, data, guidance and support they need to recognize historic and current injustices, reconcile disproportionate rates of disease and addiction, make the best decisions about sustainable policy solutions for their communities to rectify injustices and reduce tobacco use, alcohol and drug misuse, and increase access to healthy eating and physical activity.
- Funding for local public health authorities, tribes, regional health equity coalitions and coordinated care organizations (CCOs) to redistribute resources and power to work on evidence- and community-based strategies that support health equity.

Center for Prevention and Public Health Promotion

Injury and Violence Prevention (IVPP) prevents injuries and deaths due to violence, suicide, prescription and illicit drug overdoses, motor vehicle crashes, child maltreatment, youth sports concussion, sexual violence, and unintentional injuries. Some strategies include:

- Providing the web-based Prescription Drug Monitoring Program, which serves more than 29,000 prescribers, pharmacists and their delegates to support safe prescribing decisions.
- Promoting opioid prescribing and tapering guidelines and working within CCOs and other health systems to use them to improve patient safety, reduce incidence of opioid use disorder, improve pain care, and reduce overdoses from prescription and illicit opioids.
- Working with health systems, media and insurers to improve pain care and promote non-pharmacological pain care options and supporting this work with public media focusing specifically on culturally responsive messaging and resources for Native Americans/Alaska Natives and other people of color and rural Oregonians.
- Working with pharmacies, employers and community human services organizations to make naloxone rescue universally available to prevent deaths due to opioid overdose.
- Maintaining web-based data dashboards that are interactive, queriable, accessible to the public and contain information from a variety of sources on the topics of opioid and stimulant prescribing, prescription drug overdose and naloxone rescue; attempted and completed suicides; firearm-related mortality, and sexual violence prevention.
- Working with diverse communities, tribal health clinics, and health care and behavioral health care agencies to track suicide attempts and reduce suicide.
- Coordinating the State Child Fatality Review Team to identify systems level changes to reduce child fatalities.
- Evaluating implementation of statewide policies intended to: 1) reduce the burden of sexual violence among youth, 2) reduce the burden of traumatic brain injury among youth participating in sports, and 3) reduce alcohol-related motor vehicle crashes and injuries.

IVPP manages the Oregon Violent Death Reporting System and provides injury surveillance and epidemiologic study of the leading causes of injury. Recent initiatives have made closer to real-time information available to track trends in overdose and suicide attempt to inform COVID-19 response through 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. Data are also used to inform suicide and overdose prevention programming during COVID-19; specific initiatives related to health equity during pandemic response include support for the state naloxone clearinghouse to ensure access to naloxone rescue and provision of suicide prevention mini-grants to enhance LGBTQ+ community cohesion. IVPP is guided by the Oregon Health Policy Board's definition of equity, is committed to establishment of reciprocal relationships with community partners; the equitable distribution of resources and power; and recognizing and responding to historical and contemporary injustices.

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. Our work leads with a social justice, anti-racism lens to identify and focus on historical and current inequities that lead to poor health outcomes. Through partnerships with local public health, Tribes, other state agencies, community-based organizations and health care and early learning providers, MCH serves not only Oregon's population in general, but specific communities where inequities are greatest.

To better understand and identify changing problems and population needs, the program monitors the health of Oregon's pregnant women and families with three-year-old children through the Pregnancy Risk Assessment and Monitoring System (PRAMS) and Early Childhood Health in Oregon (ECHO) surveys; monitors the prevalence of birth anomalies through our Birth Anomalies Surveillance System (BASS) and monitors the state of oral health through the Oregon Oral Health Surveillance System. The program manages data systems for infant hearing screenings, the home visiting system and its programs, and statewide oral health, disaggregating data by race and ethnicity. For example, the Oral Health Unit has implemented 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 injury prevention, positive youth development/anti-bullying, establishing a medical home, transition into

adulthood, reducing toxic stress and trauma, addressing social determinants of health and equity, and provision of culturally and linguistically responsive services. Title V supports activities such as:

- Assessment and monitoring of maternal and child health needs and disparities.
- Policy and program development.
- Workforce development.
- Program assurance through technical assistance and oversight.
- Coordination with state agencies and community partners.
- Systems development to better address the needs of Oregonians, including children and youth with special health needs.
- Statewide and community specific health promotion activities that address historic and current inequities.

MCH has established and launched Oregon's Maternal Mortality and Morbidity Review Committee. This committee examines the root causes of death of women who died during pregnancy up to 365 days post-partum and makes recommendations for system and systemic changes to prevent maternal mortality and morbidity. The Committee is comprised evenly with members from the community with culturally specific expertise and those with clinical expertise. The Committee's first report will be available January 2021.

MCH received supplemental COVID-19 funding for our Rape Prevention and Education/Intimate Partner Violence prevention work to support virtual training and education opportunities and outreach at the community level. In addition, all our Title V work will be framed around health equity and COVID-19 to ensure both are foundational to the strategies and activities.

Maternal and Child Health is also the home for Oregon's universally offered home visiting system. This system works toward ensuring every family of a newborn receives the opportunity to have 1 to 3 nurse home visits during the first few months of the newborn's life. We are prioritizing integration of Community Health Workers into the home visiting care team to better support families with culturally specific services. This also provides an opportunity to connect families with resources and supports around COVID-19. Senate Bill 526 requires OHA to design, implement and sustain a statewide evidence-based nurse home

visiting system to families who choose to accept the service, and requires commercial health benefit plans to pay for this service. We have established telehealth home visiting protocols for use during the COVID-19 pandemic and are working with all payors—public and private—to reimburse for telehealth/remote home visits during emergency.

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 five 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), which encompasses both the WIC FDNP and the Senior FDNP, provides over 60,000 WIC participants and more than 50,000 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.

During the COVID pandemic, working through USDA waivers, Oregon WIC has been providing services remotely. This helps to ensure the safety of WIC participants and WIC staff while maintaining benefits of the program that support the health and wellbeing of young families across Oregon.

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

Revenue sources and changes

The Center for Prevention and Health Promotion revenues include 10 percent General Fund, 38 percent Federal Funds Limited, 24 percent Federal Funds Non-Limited, 18 percent Other Funds Limited, and 10 percent Other Funds Non-Limited. General Fund revenue supports the School-Based Health Centers program and adolescent health promotion, Oregon Contraceptive Care program (1115 family planning Medicaid demonstration waiver), and the Oregon Reproductive Health Equity Act (RHEA) to provide coverage for a full range of reproductive health services, including female sterilization and abortion. General Fund also supports the Youth Suicide Prevention Program. Additionally, general funds support the Family Connects Oregon universally offered home-visiting program and the WIC Farm Direct Nutrition Program food vouchers.

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

- The Centers for Disease Control and Prevention grants for arthritis, cancer, diabetes, heart disease and stroke, obesity, tobacco, sodium, cancer registry.
- Core Injury and Violence Prevention, National Violent Death Reporting System, Overdose Data to Action, Emergency Department Surveillance of Nonfatal Suicide Related Outcomes.
- Promoting Adolescent Health through School-Based HIV/STD Prevention and School-Based Surveillance.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) grants for Youth Suicide Prevention and Early Intervention and Substance Abuse, Prevention and Treatment.
- COVID-19 specific funding from the CDC includes funds for suicide and adverse childhood experiences prevention through and supplemental COVID-19 funding for Rape Prevention and Education and Intimate Partner Violence prevention.

- 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.
- Administration for Children and Families for Personal Responsibility Education Program.
- Centers for Medicare & Medicaid Services (CMS) Meaningful Use HIT/E for Emergency Medical Services (EMS) & Trauma Data Systems and integration of the Prescription Drug Monitoring Program into clinical electronic health record systems.
- Funding to support opioid overdose prevention by means of grants awarded to other programs within the Oregon Health Authority via the SAMHSA State Targeted Response grant (OHA Health Systems Division).

Federal grant award amounts remained flat or declined through the 2019-21 biennium. This trend is expected to continue during the 2021-23 biennium.

The Center's Other Funds revenues include statutorily dedicated funds under the Tobacco Use Reduction Account (TURA), and the Electronic Prescription Monitoring Fund as well as marijuana tax revenues for alcohol and other drug prevention. Cigarette tax revenues resulting from Ballot Measure 108 that are earmarked for public health prevention will improve health equity and address disproportionate rates of commercial tobacco use in specific communities. Dedicated culturally and tribal specific prevention and nicotine addiction treatment programs will help community members quit, prevent youth from starting, reduce tobacco-related death and disease and support local community infrastructure to advance OHA's 10-year goal of eliminating health inequities.

Impact of elimination of the USDA/WIC Farmers Market Food Voucher Program
The elimination of state general funds ($268,075) from Farm Direct Nutrition Program (FDNP) food vouchers makes Oregon ineligible to participate in the USDA Farm Direct Nutrition Program. This will lead to the following economic and health impacts:

- 57,000 WIC participants will not receive the $28 benefit for fresh fruits and vegetables for their families. This results in up to $860,000 in economic loss to local farmers.
- 52,000 senior participants will not receive the $24 benefit for fresh fruits and vegetables. This results in up to $880,000 in economic loss to local farmers.
- In 2020, 690 local farm businesses participated in the FDNP via 85 farmers markets and 210 farm stands in all 36 counties of Oregon.

If the state of Oregon doesn't provide a state match to the WIC FDNP, the state will lose over $750,000 in federal funds. FDNP and SFDNP serves a racially and ethnically diverse low-income population. FDNP and SFDNP connects with participants speaking 82 languages and offers print and translation services through program partner 211info. The elimination of this program that provides access to fresh fruits and vegetables will have adverse health impacts and increase food insecurity among older adults and young families in Oregon and may perpetuate health inequities.

Proposed new laws that apply to the program unit

House Bill 2148 — Flavored Tobacco Sales Prohibition: This legislative concept will reduce the youth appeal of flavored tobacco products, including IDS, and youth access to these products. The legislative concept accomplishes this through two components: A ban on the sale of all flavored tobacco products and IDS. The flavor ban would include mint and menthol, as well as "concept flavors" such as "jazz" and "red", that are popular with young people. A ban on the online and telephonic sales of all tobacco products to Oregon addresses. This would create parity with cigarettes and smokeless tobacco.

House Bill 2071 and Policy Package #408 — Tobacco Retail Licensure: This policy package requires tobacco and inhalant delivery system retailers in Oregon to obtain a license. Retailer licensing fees and any civil money penalties for violations cover the cost of administration and enforcement of the license. This includes retailer education and yearly inspections. OHA estimates there are 4,000 tobacco product and IDS retailers operating brick and mortar locations in the state. Licensing fees would go into effect on the following January 1. This policy package would equip OHA-PHD with new tools to educate retailers about tobacco laws and hold tobacco retailers that sell tobacco illegally to underage persons accountable. It would

support OHA's goal to reduce the burden of tobacco-related disease and death across the state, especially among communities of color and tribal communities.

House Bill 2074 and Policy Package #453 — Prescription Drug Monitoring Program Licensing Fees would change the PDMP fund type to allow comingling with other OHA funds. Increases PDMP user fees paid by each licensing board in order to maintain enough capacity for program operations and database functions. The PDMP fee impacts all licensees regardless of program registration or program use.

Center for Public Health Practice

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$12.03	$119.33	$203.06	$334.41	288	284.2
Governor's Budget 2021-23	$12.09	$123.89	$134.24	$270.23	286	284.84
Difference	$0.07	$4.57	-$68.82	-$64.19	-2	0.64
Percent Change	1%	4%	-34%	-19%	-1%	0%

The 2021-23 Governor's Budget of $270.2 million continues funding for most of the Center for Public Health Practice programs at the current service level. The budget includes policy package #449 to increase fees in the Oregon Environmental Laboratory Accreditation Program (ORELAP). The Laboratory is also included in the modernization policy package #417 to support communicable disease testing at the Oregon State Public Health Laboratory in order to respond to novel strains of disease, natural disasters, foodborne outbreaks and other health emergencies.

Activities, programs and issues in the program unit base budget

The Center for Public Health Practice protects the health of individuals and communities through the prevention and control of infectious diseases, provision of integrated care and treatment for persons living with HIV, issuing Oregon vital records, monitoring population health, and ensuring emergency public health services in natural and human-caused disasters. The center's programs provide many of the essential services in the state public health's Continuity of Operations Plan and have played a key role in Oregon's response to the COVID-19 pandemic. The center is committed to bringing community voice into the design and implementation of interventions to reduce the burden of disease and the impacts of all hazard response and recovery on communities that face systemic and historic bias. The center's work is central to Oregon's achievement of the triple aim, health system transformation and the Oregon Health Authority's 10-year strategic goal to end health inequities.

The center has six sections:

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

Center for Public Health Practice

- 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).

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 the COVID-19 pandemic.

The Center for Public Health Practice delivers core public health services necessary to maintain a healthy population and respond to and recover from disasters. Preventable disease vaccine programs ensure that children are healthy enough to attend school regularly and learn successfully. Its interventions for influenza and foodborne disease outbreaks (e.g., salmonella, hepatitis, E. coli) allow parents to attend work and sustain a healthy economy. The center's HIV/STD and tuberculosis programs work with local partners and the community to prevent and eliminate disease transmission. Its HSPR programs track the surge capacity of hospitals and public health agencies to respond in health emergencies (e.g., COVID-19, floods, wildfires 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.

Center for Public Health Practice

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.
- Conducting health equity impact analyses on new and existing efforts.

Additional program-specific strategies are identified in section narratives.

Background information

Center for Public Health Practice program activities are described below.

Center for Health Statistics is responsible for registering, certifying, amending, and issuing Oregon vital records, including:

- Maintaining approximately 6.5 million vital records for birth, death, marriage, divorce, fetal death.
- Registering 130,000 vital events that occur in Oregon annually.
- Issuing 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 Oregon's modern public health practice framework. 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, healthcare-associated infections and vector-borne diseases. ACDP collaborates with a large array of stakeholders to reduce disease transmission associated with various pathways including food, water, animals, insects, human contact, and 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 use important data to implement strategies to prevent the spread of communicable diseases.

Communicable disease control is a foundational program of Oregon's public health practice framework, and ACDP's work integrates all the foundational capabilities. ACDP identifies and prevents inequities in groups disproportionately affected by communicable disease. ACDP does this by collecting data and intervening on any diseases identified as disproportionately affecting people of color, people with limited English proficiency, people with access and functional needs, and 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. 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 COVID-19 and other 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 intellectual disability or death if undetected.
- Providing highly specialized reference tests that are unavailable elsewhere, especially for diseases of public health significance (e.g., 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 medical, marijuana, environmental, and drug screening laboratories throughout Oregon.

The HIV, Sexually Transmitted Diseases and Tuberculosis section (HST) works collaboratively with local public health authorities, health care providers, community-based organizations 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 HST 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 local public health authorities, immunization providers and local 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 and making these data available to local entities to achieve complete and timely immunization of all people in Oregon.
- Maintaining the federal Vaccines For Children (VFC) entitlement program.

The Immunization section 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 62 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 Boost Oregon coalition, and an equity workgroup that is developing a diversity-based internship for a bachelor- or master-level student in hopes of broadening the diversity of candidates who apply to work with the section.

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 a foundational capability of a modern public health practice framework and is the cornerstone of the HSPR section. HSPR emphasizes cultural responsiveness through partnerships with tribal governments, hospitals and health care systems, emergency medical services, law enforcement, fire and local public health authorities to build community resiliency through emergency preparedness planning, training, exercises and coalition development. These partnerships include funding for health care and public health programs in local and tribal agencies, as well as support for essential public health functions related to communications, laboratory services and communicable disease control. The program works to ensure equitable inclusion of persons with limited English proficiency and other language and access needs in planning activities. Current activities address:

- COVID-19 pandemic.
- 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 2,600 registered licensed health professionals providing 560 hours of emergency services in the past year and participating in 5,120 hours of exercises and 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 changes

The 2021-23 Center for Public Health Practice revenues include 46 percent Other Funds, 4 percent General Fund, and 50 percent Federal Funds.

In response to the COVID-19 pandemic, the center received $113 million of federal funding for a broad range of response activities, including case investigation and contact tracing, laboratory testing, healthcare system infection control capacity, and vaccine distribution.

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.

Center for Public Health Practice

The center's General Fund is used to pay for staff, supplies and equipment necessary to coordinate and deliver services to people in Oregon. The center pays counties to deliver the Vaccines for Children program, using Medicaid matching funds and leveraged by General Fund.

In the HST section, federal funding for HIV, STD and TB programs has remained flat in recent years. Neither the STD nor TB program federal funds can support the increased need for testing/clinical services or support services necessary to control and ensure treatment. 48% of General Fund is allocated for distribution to local public health for HIV prevention, STD and TB testing, contact tracing and treatment. Due to COVID-19 a reduction of $578,597 was taken from HIV, STD and TB administrative duties in the 21-23 budget.

The Ryan White program has available funding due to its pharmacy model. Approximately $ 45 million restricted Other Funds carryover balance from the 2019-21 to 2021-23 biennium is expected. The program obligates the full amount of these restricted Other Funds carryover balance to pay for medical services and medications for persons living with HIV and for projects that support Oregon's initiative that aims to eliminate new HIV infections, End HIV Oregon. End HIV Oregon is a community and OHA developed comprehensive plan that is aligned with the Health and Human Services Ending the HIV Epidemic: A Plan for America and is approved by the CDC and HRSA. The End HIV Oregon initiative has enhanced statewide services to include new HIV early intervention services, increased housing services, enhanced behavioral health capacity, enhanced case management and other supportive services that prevent the transmission of HIV, and improved the health outcomes of persons diagnosed with HIV.

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 Enterprise Services LLC 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 strains the program's ability to meet requirements while maintaining our support

for Oregon counties. In response to the COVID-19 pandemic, Immunizations received $1.7 million to address vaccine campaigns in the influenza season.

The ACDP section receives about $20 million 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 of July 2020, ACDP is receiving approximately $98.9 million dedicated to COVID-19 specific case investigation and disease control across Oregon. General fund reductions will eliminate dedicated capacity for communicable disease surge support. The modernization funds reduced provide dedicated surge support and training to directly help overburdened local public health authorities and tribal health authorities with communicable disease response and prevention. Reductions will limit capacity for ACDP to support efforts at general communicable disease control and overall capacity to eliminate communicable health disparities. Due to COVID-19 a reduction of $371,394 was removed from communicable disease modernization for surge support and training.

The Oregon State Public Health Laboratory's revenues for the 2019-21 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 recent biennia, increasing operating costs have begun to outpace revenues, leading to a variety of efforts to reevaluate OSPHL's fee rates and structures.

OSPHL implemented a fee increase for the newborn screening program 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. Policy package #417, Modernization, includes funding to ensure communicable disease testing is addressed.

Evaluations of additional fee structures will continue in the 2021-23 biennium.

The Center for Health Statistics' revenues include mostly Other Funds, primarily in the form of fees for services, and some Federal Funds, in the form of deliverable-based contracts for timely and accurate birth and death data. Other Funds include payments from state agencies that use vital records information to conduct their business. 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 three federal grants, the Crisis Cooperative Agreement, 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. HSPR is receiving approximately $9.5 million in funds to build capacity for the COVID-19 response across the public health system and with healthcare and community partners.

Proposed new laws that apply to the program unit

None.

Indirect Cost Rate

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$0.00	$18.00	$17.31	$35.31	0	0.00
Governor's Budget 2021-23	$0.00	$18.00	$17.31	$35.31	0	0.00
Difference	$0.00	$0.00	$0.00	$0.00	0	0.00
Percent Change	N/A	0%	0%	0%	N/A	N/A

The 2021-23 Governor's Budget of $35.3 million continues to provide the limitation needed to implement and operate an indirect cost rate for the Public Health Division at the current service level.

Activities, programs and issues in the program unit base budget

As part of pursing the implementation of a division-wide indirect cost rate, Public Health has a Detail Cross-Reference Number (DCR) specific to the indirect cost rate and separate from the program Centers and Office of the State Public Health Director. This functions as budgetary structure to house needed limitation and does not contain any program areas.

The technical accounting entries required to operationalize an indirect cost rate will produce duplicative expenditure data in an internal services fund specific to tracking and reconciling indirect costs assessed to Public Health. Limitation is in Federal Funds and Other Funds to cover the duplicative costs and accommodate the necessary accounting processes. There are no additional "real" expenditures, and the duplicated costs will be excluded from statewide reporting by excluding the internal services fund.

Background information

The Public Health Division currently operates under the Oregon Health Authority's federally approved cost allocation plan for the purpose of allocating indirect costs. As Public Health has a large number of revenue streams (more than 72 categorically dedicated federal grants for the 2021-23 biennium in addition to billable contracts and fee revenues), operationalizing an indirect cost rate will

streamline the funding request process and will provide certainty across funding streams as to how each will be impacted by indirect costs. This will allow Public Health to maximize use of available funding to direct resources in the best manner to achieve positive outcomes for Oregonians and eliminate health inequities across the state.

Public Health has been working to implement a division-wide indirect cost rate, with an initial proposal submitted from the Oregon Office of Financial Services, Cost Allocation Unit to the Department of Health & Human Services, Cost Allocation Services in July of 2018. Public Health has continued work with the Cost Allocation Unit to keep the plan updated as revisions are completed and as negotiations occur with Cost Allocation Services, however, some of that work has slowed as Public Health resources have been prioritized to address the COVID-19 response in 2020.

Revenue sources and changes

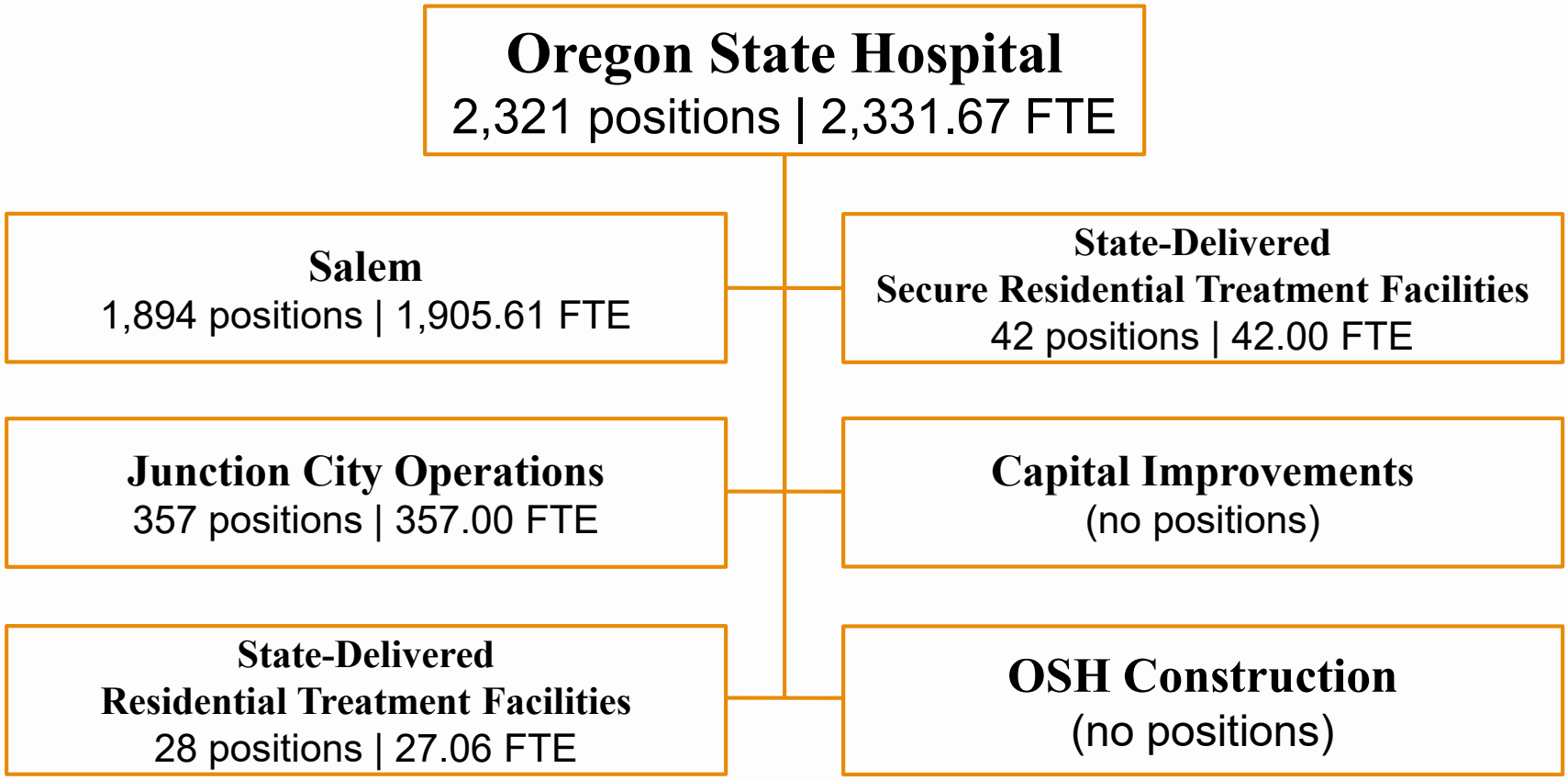
The indirect cost rate DCR limitation is 51 percent Other Funds and 49 percent Federal Funds.

Proposed new laws that apply to the program unit

None.

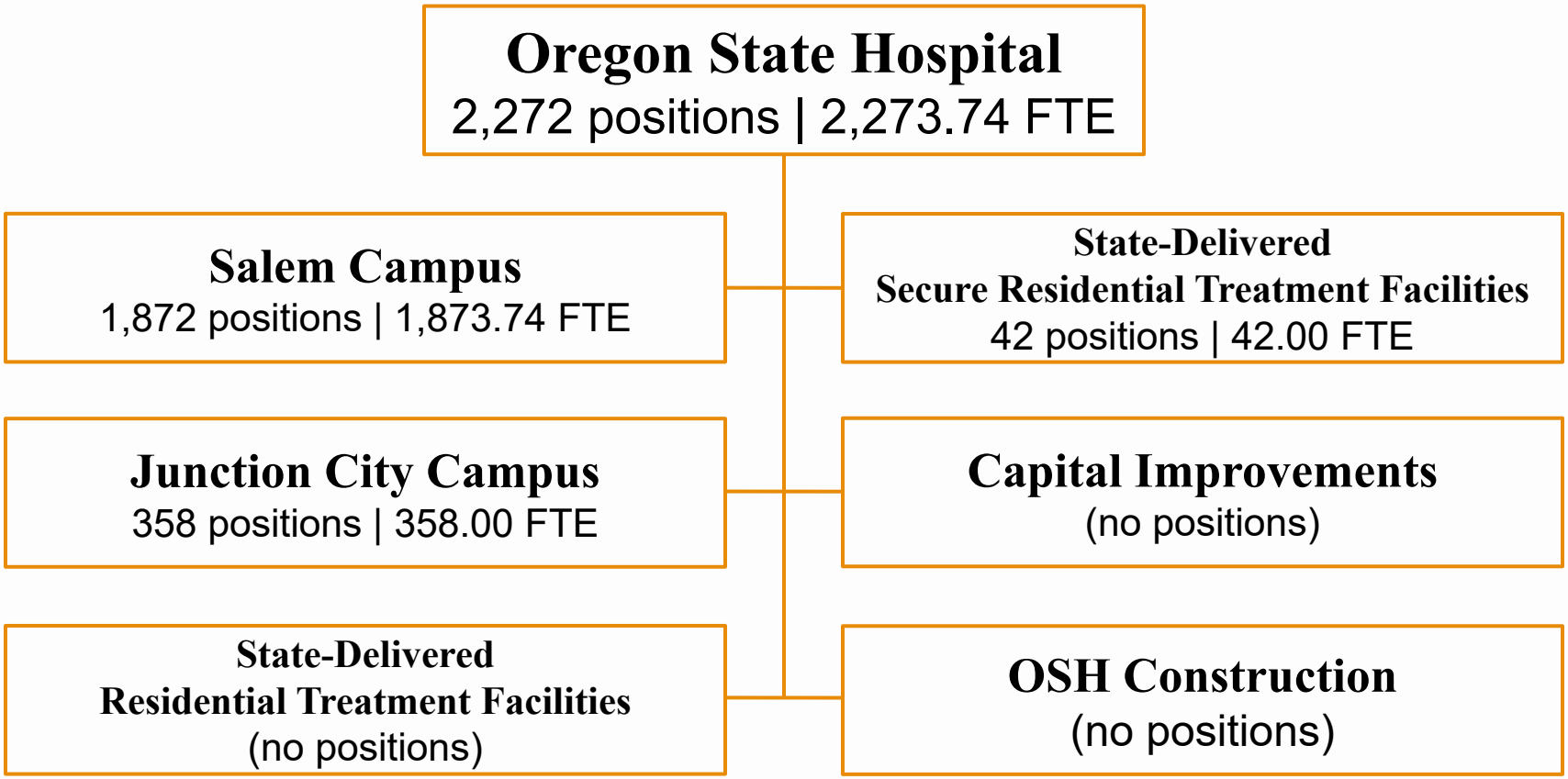
2019-21

Legislatively Approved Budget



Oregon Health Authority

2021-23
Governor's Budget

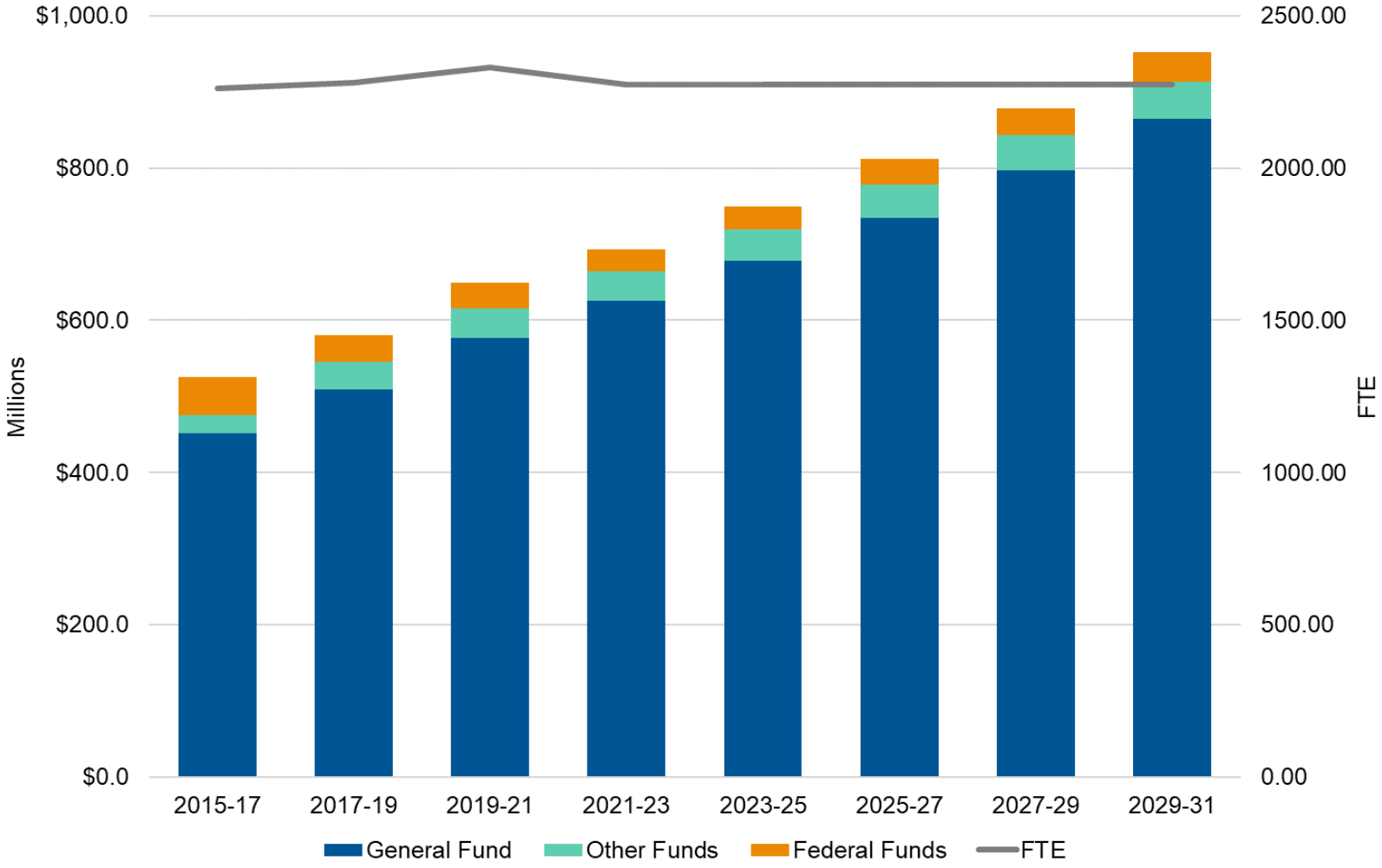


Oregon Health Authority

OREGON HEALTH AUTHORITY: OREGON STATE HOSPITAL

Executive Summary

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



OREGON HEALTH AUTHORITY: OREGON STATE HOSPITAL

Executive Summary

Division overview

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

OSH operates two campuses with the capacity to serve up to 708 Oregonians, with 592 beds in Salem and 100 beds in Junction City. Services are provided 24 hours per day, seven days a week. Oregon's only state-operated secure residential treatment facility also reports to the superintendent of OSH. Pendleton Cottage, a 16-bed facility, is located on the grounds of the former Eastern Oregon Training Center in Pendleton. The secure mental health treatment program provides a community treatment setting for people who need a secure level of care as their first step out of the state hospital.

Funding request

The Governor's Budget of $642.8 million Total Funds for the 2021-23 biennium substantially continues current service levels and investments in facilities, equipment, and technology to preserve the hospital's ability to provide high-quality care as well as address capacity challenges. This budget proposes $4.1 million in General Fund reductions that impact staffing levels in both administrative and patient care areas.

Program descriptions

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

Executive Summary

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

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

Personal Services costs are the main budget driver for the Oregon State Hospital. Salaries, taxes and benefits for staff comprise 86 percent of OSH's 2019-21 Legislatively Approved Budget. Of the 2,309 positions currently budgeted for the Oregon State Hospital, 76 percent are direct-care staff such as nurses, psychiatrists, psychologists, etc. Per ORS 441.154 and ORS 441.155, the staffing plan for OSH is set by the nurse staffing committee, composed of both nurse management and AFSCME-RN union members. The number of staff the hospital needs is based on the level of acuity (the severity of symptoms, direct care needs) and commitment type (civil, guilty except for insanity, aid and assist). Sufficient staffing is key to OSH's ability to provide adequate mental health care, and 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, and appropriate use of seclusion and restraint.

Executive Summary

Program justification and link to long-term outcomes

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

OSH's key goal are:

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

Program performance

OSH uses Lean methodology as the primary foundation for continuous improvement and organizational performance. Through Lean, OSH has a robust system to align and link all the services it provides with organizational goals and desired outcomes. OSH also tracks performance metrics throughout 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, acting and evaluating results.

Executive Summary

Performance System

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

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

Some examples of metrics tracked on the scorecard are:

- Incidents of aggression
- Patient and staff injuries
- Incidents and duration of seclusion and restraint
- Length of stay
- Admissions wait times
- 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 status of our organizational health using the scorecard. QPRs create the discipline to review the status of the routine work (fundamentals) and initiatives (breakthroughs), and to drive problem solving as needed to achieve the goals of the organization.

Executive Summary

Enabling legislation/program authorization

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

Funding streams

The Oregon State Hospital (OSH) budget of $642.8 million is made up primarily of General Fund revenues, 90 percent. OSH generates Other Fund revenue through billing of services to Medicare for eligible patients, 6 percent. Medicaid funds make up the Federal Funds portion of the budget, 4 percent.

Significant proposed program changes from 2021-23

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

OSH Salem campus has continued to make beds available to serve individuals under Aid and Assist orders, focusing on those needing hospital level of care, and ensuring appropriate program and unit designation to address psychiatric acuity, commitment discharge needs and patient-centric care. In the fall of 2019, the OSH Junction City campus activated an additional ten hospital level of care (HLOC) beds for patients under civil commitments. At the same time, two cottages (8 beds/cottage) were opened at the residential treatment facility (RTF) level of care for individuals under civil commitment no longer requiring HLOC. This allowed for additional throughput while individuals were awaiting the availability of residential beds in the community.

Salem Campus

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$477.13	$33.02	$31.97	$542.11	1,894	1,905.61
Governor's Budget 2021-23	$516.76	$32.77	$25.64	$575.16	1,872	1,873.74
Difference	$39.63	-$0.25	-$6.33	$33.06	-22	(31.87)
Percent Change	8%	-1%	-20%	6%	-1%	-2%

The Governor's Budget of $575.16 million Total Funds continues funding for the Oregon State Hospital - Salem Campus services substantially at the current service level for the 2021-23 biennium. This budget includes the following four policy packages proposed for bond financing:

#421 Deferred Maintenance: Critical maintenance projects to prevent equipment or infrastructure failure.

#422 Asset Replacement: Replaces outlived or expiring useful life equipment and assets.

#423 Capital Improvement: Critical infrastructure projects to make the hospital more sustainable and expand useable space.

#433 Technology Modernization: Technical enhancements related to video conferencing updates.

The Governor's Budget also eliminates 16 positions across the Salem campus in both administrative and direct patient service areas, including the psychology department and nursing administration.

Activities, programs and issues in the program unit base budget

Salem Campus detail

- Capacity: 24 units (592 beds)

Salem Campus

- Operating: 24 units (554 beds)
- Population served: civil commitment (includes voluntary commitments by guardian), neuropsychiatric (high medical need), guilty except for insanity (GEI), aid and assist
- Census: 528.3 (Daily average population for 2019)
- Square feet: 1.3 million

Background information

Populations served

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

The Salem campus serves individuals under three different commitment types:

- **Civil** – People who come to Oregon State Hospital through a civil commitment require 24-hour care that is not available through community programs. These patients have been found by the court to be a danger to themselves or others, or unable to provide for their own basic needs – such as health and safety – because of a mental disorder.
- **Guilty Except for Insanity (GEI)** – People who come to Oregon State Hospital who have successfully pleaded Guilty Except for Insanity (GEI) for crimes related to their mental illness. These patients are under the jurisdiction of the Psychiatric Security Review Board.
- **Aid & Assist** – People who come to Oregon State Hospital through a court order under Oregon law (ORS 161.370) for treatment that will help them understand the criminal charges against them and to assist in their own defense.

Treatment programs – Oregon State Hospital serves patients in the program that best meets their treatment and psychiatric acuity needs. Each program is designed to treat a specific segment of our patient population.

Salem Campus

- **Crossroads** – Two units of the Crossroads program provide progressive care services for people who have been civilly committed or voluntarily committed by a guardian. Patients each have an individual treatment care plan and attend treatment mall groups every weekday. These groups are designed to help patients learn how to manage their symptoms and medications, develop coping and recreational skills, budget and manage their money, and plan and prepare meals. Community reintegration is the focus of weekly group trips to community settings. Treatment groups also include educational support, psychotherapy and help for alcohol and drug abuse. A third unit provides progressive care services for people under Aid and Assist court orders. With continued stabilization, patients gain the ability to cooperate with attorneys, understand the charges against them, and participate in their own defense.

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

- **Archways** – The Archways program serves people under Aid and Assist court orders. This program helps patients stabilize, gain the ability to cooperate with attorneys, understand the charges against them, and participate in their own defense. Patients each have individual treatment care plans and attend treatment mall groups every weekday. Treatment groups primarily focus on understanding the court system and learning basic legal terminology. Other treatment groups and resources include a law library, legal assistance, symptom management, anger management, physical fitness, medication management and drug and alcohol education. During their stay, patients are periodically evaluated to determine if they are able, never able or not yet able to stand trial.

- **Harbors** – Four units of the Harbors program provide intensive care services to patients under Aid and Assist orders, and two units provide acute care psychiatric treatment across all commitment types. Patients each have individual treatment care plans and attend treatment mall groups every weekday. Treatment groups are designed to achieve psychiatric stabilization in

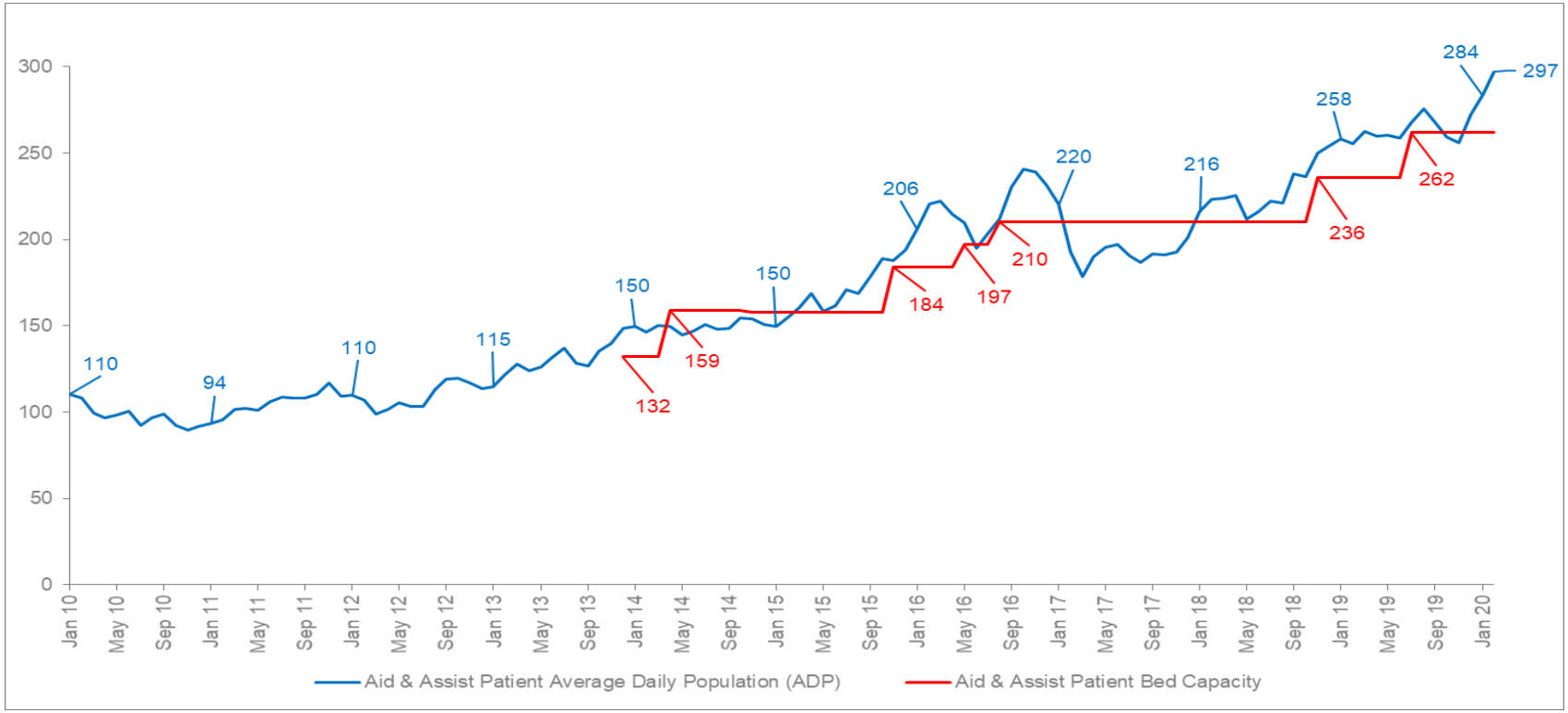
order to transition to lower levels of psychiatric care within the hospital. Treatment groups also focus on symptoms management, medication management, legal skills acquisition, and practicing coping skills.

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

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

Salem Campus

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. The Aid and Assist population at OSH spiked dramatically in October 2018, forcing the hospital to convert a 26-bed civil commitment unit to an Aid and Assist unit. In July 2019, OSH again converted an additional 26-bed civil commitment to and Aid and Assist unit. These unit conversions provided hospital bed capacity to serve people under Aid and Assist orders that are waiting in jail to receive psychiatric care and competency restoration services. The unit conversions also reduced the hospital's capacity to serve people who have been civilly committed after a judge found them to be a danger to themselves or others.



Salem Campus

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

USDOJ/Olmstead

Since 2016, Oregon State Hospital has operated under the Oregon Performance Plan (OPP) that was developed by the Oregon Health Authority and approved by the United States Department of Justice. This plan outlined expectations and measures for ensuring people under civil commitment receive behavioral health services in a community setting when hospital level care was no longer required. The OPP reporting period ended June 2019 and OHA began transitioning to the development of the Behavioral Health Quality Performance Improvement Plan (BHQPIP) for ongoing reporting purposes, continued adherence to metrics established by the OPP, and to further the gains achieved through the OPP by establishing realistic and achievable goals. The BHQPIP is expected to be finalized in 2020-21.

Nurse Staffing

Adequate nurse staffing is fundamental for effective treatment and patient and staff safety at OSH. Per Oregon Revised Statute 441.154 and 441.155, the staffing plan for OSH is set by the Nurse Staffing Committee, composed of both nurse management and AFSCME-RN union members. On average, about 13.4 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, nor does it reflect the absentee rate since the COVID-19 pandemic began. 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 to work overtime. However, even with overtime shifts, the hospital's staffing needs are not always met.

Salem Campus

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

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

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

The prevalence of staff call-outs (unplanned absences) and physician-ordered patient precautions has driven staffing needs well beyond the Nurse Staffing Committee's staffing plan. Historically and currently, OSH has relied on overtime as the primary means to meet staffing needs when direct-care staff are absent and to staff patient acuity/precaution needs. Over the past three years, OSH has averaged 22,594 hours and $880,555 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, she found that: "*This Standard is NOT MET as evidenced by: Observed in Record Review at Oregon State Hospital (2600 Center Street, NE, Salem, OR) site for the Psychiatric Hospital deemed service. In 35 of 112 shifts reviewed, staffing was noted not to meet the organization's expected staffing matrix."*

OSH established a nurse staffing float pool composed of limited duration positions and increased its use of agency contract nursing staff to fill in staffing gaps. These strategies help ensure adequate nurse staffing to provide active treatment, a therapeutic milieu, and a safe environment. The cost for these limited duration (LD) positions and increased nurse agency staffing is not budgeted and has been a driver of shortfalls in 2017-19 and in 2019-21 as the division has only partially afforded to make up costs from its existing budget allocation.

Revenue sources and changes

The Oregon State Hospital Salem Campus receives 90 percent of its funding from the General Fund. Other Funds revenues consisting of service revenues generated through the billing of Medicare and third-party insurance and local revenue from the hospital café, coffee shop, and patient made wood products sales account for 6 percent of the budget. Finally, Federal Funds from Medicaid and Disproportionate Share Hospital (DSH) payments make up the remaining 4 percent.

One of the financial impacts of a shifting population at Oregon State Hospital is lower numbers of patients on Medicare being admitted. This has reduced the collection of Medicare revenue necessitating fund shift adjustments for the 2021-23 biennium. DSH payments have also declined due to adjustments in the Federal Medical Assistance Percentage (FMAP) rate.[1]

[1] Notwithstanding the temporarily enhanced federal match rates due to the COVID-19 public health emergency. At the time of writing, the enhanced rates are not scheduled to continue into the 2021-23 biennium.

Salem Campus

Proposed new laws that apply to the program unit

Senate Bill 72: Aid and Assist Placeholder

The purpose of this placeholder bill is to address unforeseen issues regarding aid and assist during the 2021 session.

Concept Subject: Modify "cost of care" statutes related to Oregon State Hospital to include costs of outpatient services

OSH patients often need to be taken out into the community to receive medically necessary outpatient medical and/or dental services. OSH pays these community provides for the services furnished to OSH patients. Current statute prohibits the cost of this care from being included in the patient's cost of care. Due to this, OSH must take care to exclude from Medicare and Medicaid cost reporting, as well as not being able to pass these costs to patients that can afford to pay them. This legislative concept would amend the cost of care statutes to include the costs of outpatient services provided to OSH patients would allow OSH to be compensated by insurers and patients that can afford to pay for these costs appropriately, as well as reduce the administrative burden of keeping these costs separate from OSH's overall cost of service provision.

State-Delivered Secure Residential Treatment Facility

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$7.15	$0.23	$2.07	$9.45	42	42.00
Governor's Budget 2021-23	$7.82	$0.23	$2.62	$10.67	42	42.00
Difference	$0.67	$0.00	$0.54	$1.22	0	0
Percent Change	9%	0%	26%	13%	0%	0%

The Governor's Budget of $10.7 million Total Funds continues funding for the Oregon State Hospital (OSH) - Pendleton Cottage, a 16-bed state-delivered secure residential treatment facility, at the current service level for the 2021-23 biennium.[1]

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 2018, the facility averaged a 97 percent occupancy rate, with an average daily population of 15.67. The mission of Pendleton Cottage is to help people recover from their mental illness by focusing on positive life experiences, self-confidence and community integration. Pendleton Cottage is often the first step for people transitioning from the state hospital to a life in the community.

Background information

People served

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

[1] Note: This program unit will be impacted by the funding in the OSH Capital Construction budget for some critical deferred maintenance projects in policy package #421.

State-Delivered Secure Residential Treatment Facility

Treatment philosophy

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

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

Pendleton Cottage services

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

Facility

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

State-Delivered Secure Residential Treatment 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 individuals 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 changes

Revenue sources for Pendleton Cottage include 73 percent General Fund. Other Funds revenues consisting primarily of private payment Room and Board, with additional revenues for Veteran's transportation reimbursement and meal tickets, account for 2 percent of the budget. Federal Funds revenue make up the remaining 25 percent and consist of the federal match of Medicaid claim billing. The change from per diem to fee for service billing has resulted in a minor increase in Federal Funds revenue and is represented in the 2021-23 fund shift adjustment.

Proposed new laws that apply to the program unit

None.

Junction City Campus

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$84.62	$5.15	$0.00	$89.77	357	357.00
Governor's Rec. 2021-23	$93.79	$5.33	$0.14	$99.25	358	358.00
Difference	$9.17	$0.17	$0.14	$9.48	1	1.00
Percent Change	11%	3%	2264050%	11%	0%	0%

The Governor's Budget of $99.3 million Total Funds continues funding for Oregon State Hospital - Junction City Campus at the current service level for 2021-23.

Activities, programs and issues in the program unit base budget

Junction City Campus Detail

- Capacity – 6 units, (150 beds)
- Operating – 4 units, (96 beds)
- Populations served – civil commitment (includes voluntary commitments by guardian), guilty except for insanity (GEI)
- Census – 90.7 (Daily average population for 2019)
- Square feet – 220,000

Background information

Populations Served

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

Junction City Campus

The Junction City campus serves individuals under two 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. A subset of this population is called *Voluntary by Guardian*. Working through the court system, legal guardians may commit their wards who meet civil commitment criteria.
- **Guilty Except for Insanity (GEI)** – Oregon State Hospital serves patients who have successfully pleaded Guilty Except for Insanity (GEI) for crimes related to their mental illness. These patients are under the jurisdiction of the Psychiatric Security Review Board.

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

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

Revenue sources and changes

The Junction City campus of the Oregon State Hospital receives 10 percent of its funding from the General Fund and 62 percent Federal Funds. Other Fund revenues comprise the remaining 28 percent of funding, which consist of service revenues generated through the billing of Medicare and third-party insurance as well as local revenues derived from the hospital café and coffee shop.

Junction City Campus

Proposed new laws that apply to the program unit

None.

Junction City Residential Treatment Facility

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$7.04	$0.00	$0.00	$7.04	28	27.06
Governor's Budget 2021-23	$6.61	$0.00	$0.00	$6.61	0	0.00
Difference	-$0.43	$0.00	$0.00	-$0.43	-28	-27.06
Percent Change	-6%	N/A	N/A	-6%	-100%	-100%

The Governor's Budget of $6.6 million General Fund continues funding at current service level for the Junction City Residential Treatment Facility.

Activities, programs and issues in the program unit base budget

The Junction City Residential Treatment Facility (RTF), named Rivers Run, comprises two eight-bed suites on the Junction City Campus. The program currently serves people under civil commitments and people with voluntary and voluntary by guardian status who no longer need hospital level of care and are awaiting transition to a community placement.

Rivers Run services feature skills building (cooking, activities of daily living, navigating public transportation, etc.) and group treatment (substance use treatment, symptom management, etc.) focused on preparing people to successfully transition from the highly structured State Hospital environment to an integrated home in the community. Discharge planning for individuals at the Oregon State Hospital begins at admission. Rivers Run continues the transition planning while providing people an opportunity to build skills living in a home-like environment of increased choice and autonomy while maintaining safety with the support of the hospital next door. The Rivers Run staff work with residents and their support network – family members, friends, peers, and community partners – to help them build the skills they need to discharge to the least-restrictive and most-integrated setting possible.

Junction City Residential Treatment Facility

Background information

Oregon continues to experience an unanticipated increase in numbers of defendants who have been deemed unable to aid and assist in their own defense. Most of these defendants receive competency restoration services at the Oregon State Hospital. Oregon Health Authority opened this residential treatment facility (RTF) in the fall of 2019 as part of a strategy to make more hospital beds available to serve the increasing number of people under aid and assist orders being directed to Oregon State Hospital's Salem campus. This strategy included creating space for transitioning patients under civil commitment served at the Salem Campus to Junction City to open capacity at the Salem Campus to service people under aid and assist orders.

The Rivers Run program, a 16-bed Residential Treatment Facility (RTF) consisting of two 8-bed suites, was created to provide a system for patient throughput allowing people immediate access to lower levels of care while waiting for a permanent placement in the community.

Revenue sources and changes

This program is funded in Governor's Budget by General Fund for the 2021-23 biennium.

Proposed new laws that apply to the program unit

None.

Capital Construction Projects

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$0.00	$0.00	$0.00	$0.00	0	0.00
Governor's Rec 2021-23	$12.62	$0.00	$0.00	$12.62	0	0.00
Difference	$12.62	$0.00	$0.00	$12.62	0	0.00
Percent Change	N/A	N/A	N/A	N/A	N/A	N/A

The Governor's Budget funds Capital Construction Projects at Oregon State Hospital $12.6 million Total Funds to be bond financed. This budget includes funding for four policy packages:

#421 Deferred Maintenance: Critical maintenance projects to prevent equipment or infrastructure failure.

#422 Asset Replacement: Replaces outlived or expiring useful life equipment and assets.

#423 Capital Improvement: Critical infrastructure projects to make the hospital more sustainable and expand useable space.

#433 Technology Modernization: Video conferencing updates related to overall accessibility, functionality and ease of use.

Activities, programs and issues in the program unit base budget

The Capital Construction Project addresses four areas of concern within the Oregon State Hospital as a system. Deferred Maintenance funds allow the hospital to maintain equipment and infrastructure in advance of failure on the Salem and Pendleton campuses. Capital Asset Replacement funds large expenditure lifecycle equipment replacement on the Salem and Junction City campuses. Capital Improvement funds projects to make the Salem campus more self-sustainable, expand available office space within existing buildings, and re-purpose space to enhance treatment capability. Technology Modernization funds an update to video conferencing equipment at OSH that has become obsolete.

Capital Construction Projects

Background information

Oregon State Hospital (OSH) campuses have unfunded maintenance and construction projects that could result in health and safety issues for staff and patients if not resolved. Good stewardship of the state's resources is at the forefront of the building maintenance program at OSH to proactively maintain the state's assets and ensure compliance with Joint Commission and Centers for Medicare and Medicaid Services (CMS). Maintaining critical operational continuity and providing 24-hour hospital level of care to patients needing intensive psychiatric treatment for severe and persistent mental illness is part of the mission of the Oregon Health Authority and Oregon State Hospital.

Revenue sources and changes

The Governor's Budget for this program unit is 100 percent General Fund for the 2021-23 biennium.

Proposed new laws that apply to the program unit

None.

Oregon State Hospital Capital Construction/Acquisition

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$0.00	$0.00	$0.00	$0.00	0	0.00
Governor's Budget 2021-23	$0.00	$12.62	$0.00	$12.62	0	0.00
Difference	$0.00	$12.62	$0.00	$12.62	0	0.00
Percent Change	N/A	N/A	N/A	N/A	N/A	N/A

Overview

The Oregon State Hospital proposes four capital construction/acquisition projects for the 2021-23 biennium: Well Water Treatment Facility (policy package #423), Additional Office Space (policy package #423), Deferred Maintenance (policy package #421), and Automated Dispensing Cabinets (policy package #422). All projects would be financed with Article XI-Q Bonds issued October 2021 (May 2022 for Additional Office Space).

Project costs and purpose

The costs described below are for the 2021-23 biennium. Following each project's implementation plan, all bond issuance is expected to occur during the 2021-23 biennium, with no additional financing required in future biennia. Debt service would extend into the 2029-31 biennium and would be funded with General Fund.

The **Well Water Treatment Facility** project is expected to cost $5.0 million, which includes approximately $4.5 million for project costs, $62,000 for bond issuance, and $484,000 for debt service, as estimated by the Department of Administrative Services (DAS). This would fund the construction of a well water treatment facility and potable water storage tanks to provide a backup water supply to the hospital in the event of disruption of contamination of the city water supply. OSH has one single point of connection to city water that is fed through a 1950's era 10" steel underground pipe. This leaves the hospital vulnerable to a complete loss of domestic water and water for sanitation including flushing toilets. Loss of water could also shut down

critical systems such as cooling which would then lead to overheating server rooms that could damage or require shutting down essential technology systems and access control.

The **Additional Office Space** project is expected to cost $1.9 million, which includes approximately $1.7 million for project costs, $41,000 for bond issuance, and $158,000 for debt service, as estimated by DAS. This would fund the construction of a second floor in an area that currently has existing "ceiling" space. The project would add 2,700 square feet of office space within the secure perimeter to accommodate 32 staff and include a conference room, copy room, and unisex toilet room.

The **Deferred Maintenance** project is expected to cost $1.6 million, which includes approximately $1.4 million for project costs, $40,000 for bond issuance, and $192,000 for debt service, as estimated by DAS. This project would address current large expenditure deferred maintenance in advance of equipment and infrastructure failure. Funding for deferred maintenance would ensure maintenance of the facility to the highest standard and avoid more costly future maintenance, align with regulatory compliance and stewardship of the state's assets, and result in a safe and secure treatment and work environment.

The **Automated Dispensing Cabinets** project is expected to cost $3.6 million, which includes approximately $3.5 million for project costs, $55,000 for bond issuance, and $474,000 for debt service, as estimated by DAS. Automated dispensing cabinets (ADC) are the method by which drugs are dispensed at the state hospital. They are integrated with electronic health records and control access to medications at the individual patient level to ensure patients receive the correct medication, in the proper dosage, at the right time. This project would replace 41 ADCs deployed throughout patient care areas on the Salem and Junction City campuses. The computers in each cabinet use the Windows 7 operating system, which is no longer supported by Microsoft or the Office of Information Services. Replacing the ADCs would address security risks related to using equipment without product support and avoid needing to immediately hire additional pharmacists and pharmacy assistants to manually provide medication to OSH patients.

ESTIMATED PROJECT COST

		$	% Project Cost	$/GSF
DIRECT CONSTRUCTION COSTS				
1	Building Cost Estimate	$ 1,385,300		
2	Site Cost Estimate (20 Ft beyond building footprint)			
3	**TOTAL DIRECT CONSTRUCTION COSTS**	$ 1,385,300	100%	$ -
INDIRECT CONSTRUCTION COSTS				
4	Owner Equipment / Furnishings / Special Systems			
5	Construction Related Permits & Fees			
6	Other Indirect Construction Costs Including 1% Art, 1.5% Renewable Energy and other state or unique regulatory requirements not in hard costs			
7	Architectural, Engineering Consultants			
8	Other Design and PM Costs	$ -		
9	**TOTAL INDIRECT COSTS**	$ -	$ -	$ -
10	**OWNER'S PROJECT CONTINGENCY** insert %			
		$	**% Project Cost**	**$/GSF**
	TOTAL PROJECT COST	$ 1,385,300	100%	$ -

Major Construction/Acquisition Project Narrative

Note: *Complete a separate form for each project*

Agency: 443	Oregon Health Authority - Oregon State Hospital	Priority (Agency #):	3	Schedule	
		Cost Estimate	Cost Est.Date	Start Date	Est. Completion
Project Name:	Potable water treatment and storage facility	$ 4,492,750		Nov 2021	Oct 2022
		GSF	# Stories	Land Use/Zoning Satisfied	
Address/Location:	2600 Center St NE, Salem, OR 97301			Y	N

Funding Source(s): Show the distribution of dollars by funding source for the full project cost.	General Fund	Lottery	Other	Federal
	$ -		$ 4,492,750	

Description of Agency Business/Master Plan and Project Purpose/Problem to be Corrected
OSH is an entirely self-contained facility except for backup water. OSH has one single point of connection to city water that is fed through a 1950's era 10" steel underground pipe. This leaves the hospital vulnerable to a complete loss of domestic water and water for sanitation including flushing toilets. In May of 2018 the City of Salem water supply was contaminated with Cyanotoxins from an algae bloom in Detroit lake and issued a water advisory for at risk individuals.OSH took immediate steps to provide bottled water to all patients and staff since many of our patients and staff could be in the vulnerable categories and all of their medical histories are not known and we needed to ensure that there was a safe source of potable water. We also had to provide thousands of gallons of potable water for cooking patient meals. The total cost of the event to the hospital was $81,882.00. The installation of a backup water system would also provide for sanitation in the event of a disruption of city water that could occur due to multiple reasons including contamination, waterline repairs and or replacement and an earthquake event that could leave the hospital without water for an extended period. Loss of water for sanitation in a secure facility with 620 psychiatric patients and corresponding staff 24-7 would be catastrophic. Loss of water could also shut down critical systems such as cooling which would then lead to overheating server rooms that could damage or require shutting down critical computer systems.

Project Scope and Alternatives Considered
OSH commissioned the services of Affiliated Engineers NW, Inc in 2018 to complete a concept study, preliminary engineering and cost estimate and the study recommends a below grade water storage system in the non-historical area to the SE of the main campus supplemented by the existing well (with significant upgrades) at an estimated total construction cost of $4,380,000. A blackwater storage system was also studied but is a more expensive proposition and meets a less-likely need. The estimated construction cost for this system is $6,330,000 and is only recommended if OSH feels strongly that it meets a likely need. OSH is requesting funding for the potable water treatment and storage facility

ESTIMATED PROJECT COST

		$	% Project Cost	$/GSF
DIRECT CONSTRUCTION COSTS				
1	Building Cost Estimate	$ 4,492,750		
2	Site Cost Estimate (20 Ft beyond building footprint)			
3	**TOTAL DIRECT CONSTRUCTION COSTS**	$ 4,492,750	100%	$ -
INDIRECT CONSTRUCTION COSTS				
4	Owner Equipment / Furnishings / Special Systems			
5	Construction Related Permits & Fees			
6	Other Indirect Construction Costs Including 1% Art, 1.5% Renewable Energy and other state or unique regulatory requirements not in hard costs			
7	Architectural, Engineering Consultants			
8	Other Design and PM Costs	$ -		
9	**TOTAL INDIRECT COSTS**	$ -	$ -	$ -
10	**OWNER'S PROJECT CONTINGENCY** insert %			
		$	**% Project Cost**	**$/GSF**
	TOTAL PROJECT COST	$ 4,492,750	100%	$ -

Major Construction/Acquisition Project Narrative

Note: *Complete a separate form for each project*

Agency: 443	OHA - Oregon State Hospital	Priority (Agency #):	4	Schedule	
		Cost Estimate	Cost Est.Date	Start Date	Est. Completion
Project Name:	Renovation to increase office space	$ 1,733,586		Aug 2022	Jul 2023
		GSF	# Stories	Land Use/Zoning Satisfied	
Address/Location:	2600 Center St NE, Salem, OR 97301	2700		Y	N

Funding Source(s): Show the distribution of dollars by funding source for the full project cost.	General Fund	Lottery	Other	Federal
			$ 1,733,586	

Description of Agency Business/Master Plan and Project Purpose/Problem to be Corrected
The hospital has identified an administrative and program staff space shortage and have had to move staff and programs to the cottages on campus and have identified future space needs requiring additional staff space. OSH proposes the conversion of empty, useable overhead space in a storage area to a second floor. This new second floor would be designated for and built as additional office space to meet current and future needs.

Project Scope and Alternatives Considered
OSH Commissioned SRG architects to perform a feasibility study and budget proposal to infill an existing space within the secure perimeter that would add 2700 square feet of office space that would accommodate 32 staff and include a conference room, copy room, and unisex toilet room.

ESTIMATED PROJECT COST

		$	% Project Cost	$/GSF
DIRECT CONSTRUCTION COSTS				
1	Building Cost Estimate	$ 1,733,586	100%	$ 642
2	Site Cost Estimate (20 Ft beyond building footprint)			
3	**TOTAL DIRECT CONSTRUCTION COSTS**	$ 1,733,586	100%	$ 642
INDIRECT CONSTRUCTION COSTS				
4	Owner Equipment / Furnishings / Special Systems			
5	Construction Related Permits & Fees			
6	Other Indirect Construction Costs Including 1% Art, 1.5% Renewable Energy and other state or unique regulatory requirements not in hard costs			
7	Architectural, Engineering Consultants			
8	Other Design and PM Costs			
9	**TOTAL INDIRECT COSTS**	$ -	0%	$ -
10	**OWNER'S PROJECT CONTINGENCY** insert %			
		$	**% Project Cost**	**$/GSF**
	TOTAL PROJECT COST	$ 1,733,586	100%	$ 642

Capital Financing Six-Year Forecast Summary 2021-23

Agency: OHA - Oregon State Hospital

Agency #: 443

Provide amounts of agency financing needs for the 2021-23 biennium, by expected use and repayment source. Include proposed project amounts only (do not include debt service from either previously issued debt or from new debt issuance).

Use of Bond Proceeds	Bond Type: General Obligation Bonds	Bond Type: Revenue Bonds	Totals by Repayment Source	
Major Construction / Acquisition Projects				
General Fund Repayment	$ 11,724,386	$	$ 11,724,386	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Major Construction	$ 11,724,386	$ -	$ 11,724,386	
Equipment/Technology Projects over $500,000				
General Fund Repayment	$ 898,500	$	$ 898,500	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Equipment/Technology	$ 898,500	$ -	$ 898,500	
Debt Issuance for Loans and Grants				
General Fund Repayment	$ 272,114	$	$ 272,114	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Loans and Grants	$ 272,114	$ -	$ 272,114	
Total All Debt Issuance				
General Fund Repayment	$ 12,895,000	$ -	$ 12,895,000	GF
Lottery Funds Repayment	-	-	-	LF
Other Funds Repayment	-	-	-	OF
Federal Funds Repayment	-	-	-	FF
Grand Total 2021-23	$ 12,895,000	$ -	$ 12,895,000	

Capital Financing Six-Year Forecast Summary 2023-25

Agency: OHA - Oregon State Hospital

Agency #: 443

Provide amounts of agency financing needs for the 2023-25 biennium, by expected use and repayment source. Include proposed project amounts only (do not include debt service from either previously issued debt or from new debt issuance).

Use of Bond Proceeds	Bond Type: General Obligation Bonds	Bond Type: Revenue Bonds	Totals by Repayment Source	
Major Construction / Acquisition Projects				
General Fund Repayment	$	$	$ -	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Major Construction	$ -	$ -	$ -	
Equipment/Technology Projects over $500,000				
General Fund Repayment	$	$	$ -	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Equipment/Technology	$ -	$ -	$ -	
Debt Issuance for Loans and Grants				
General Fund Repayment	$	$	$ -	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Loans and Grants	$ -	$ -	$ -	
Total All Debt Issuance				
General Fund Repayment	$ -	$ -	$ -	GF
Lottery Funds Repayment	-	-	-	LF
Other Funds Repayment	-	-	-	OF
Federal Funds Repayment	-	-	-	FF
Grand Total 2023-25	$ -	$ -	$ -	

Capital Financing Six-Year Forecast Summary 2025-27

Agency: OHA - Oregon State Hospital

Agency #: 443

Provide amounts of agency financing needs for the 2025-27 biennium, by expected use and repayment source. Include proposed project amounts only (do not include debt service from either previously issued debt or from new debt issuance).

Use of Bond Proceeds	Bond Type: General Obligation Bonds	Bond Type: Revenue Bonds	Totals by Repayment Source	
Major Construction / Acquisition Projects				
General Fund Repayment	$	$	$ -	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Major Construction	$ -	$ -	$ -	
Equipment/Technology Projects over $500,000				
General Fund Repayment	$	$	$ -	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Equipment/Technology	$ -	$ -	$ -	
Debt Issuance for Loans and Grants				
General Fund Repayment	$	$	$ -	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Loans and Grants	$ -	$ -	$ -	
Total All Debt Issuance				
General Fund Repayment	$ -	$ -	$ -	GF
Lottery Funds Repayment	-	-	-	LF
Other Funds Repayment	-	-	-	OF
Federal Funds Repayment	-	-	-	FF
Grand Total 2025-27	$ -	$ -	$ -	

Major Construction/Acquisition 10-Year Plan, Lease Plans, Disposals

2021-23 Biennium

Agency Name: OHA - Oregon State Hospital

Proposed New Construction or Acquisition - *Complete for 5 Biennia*

Biennium	Priority	Concept/Project Name	Description	GSF	Position Count	General Fund	Other Funds	Lottery Funds	Federal Funds	Estimated Cost/Total Funds
2021-23	1	Deferred Maintenance	**Salem and Pendleton construction or renovation projects to restore infrastructure**	883,816	1928	1,385,300	-	-	-	1,385,300
2021-23	2	Automated Dispensing Cabinets	**Replacement of medication dispensing equipment**	1,081,858	2242	3,500,000	-	-	-	3,500,000
2021-23	3	Water Treatment	**Potable water treatment and storage facility**	861,858	1886	4,492,750	-	-	-	4,492,750
2021-23	4	Office Renovation	**Renovation to increase office space**	861,858	1886	1,733,586	-	-	-	1,733,586
2023-25										-
2025-27										-
2027-29										-
2029-31										-

Proposed Lease Changes over 10,000 RSF - *Complete for 5 Biennia*

Biennium		Location	Description/Use	Term in Years	Total RSF[2] +/- (added or eliminated)	USF[3]	Position Count[1]	Biennial $ Rent/RSF[2]	Biennial $ O&M[4]/RSF[2] not included in base rent payment	Total Cost / Biennium
					A	B	C	D	E	(D+E)*A
2021-23										-
2023-25										-
2025-27										-
2027-29										-
2029-31										-

Planned Disposal of Owned Facility

Biennium		Facility Name	Description
21-23		Pendleton	Demolition of Building #108 ($100,000)

Definitions:

Position Count: **1** Total Legislatively Approved Budget (LAB) Position Count assigned to (home location) each building or lease as applicable.

RSF **2** Rentable SF per BOMA definition. The total usable area plus a pro-rated allocation of the floor and building common areas within a building.

USF **3** Usable Square Feet per BOMA definition for office/administrative uses. Area of a floor occupiable by a tenant where personnel or furniture are normally housed plus building amenity areas that are convertible to occupant area and not required by code or for the operations of a building. If not known, estimate the percentage.

O&M **4** Total Operations and Maintenance Costs for facilities including all maintenance, utilities and janitorial.

Facilities Maintenance

Key drivers of facility needs and measuring demand

Oregon State Hospital is subject to standards set by the Centers for Medicaid and Medicare Services (CMS) and reviewed and accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). In addition to standard repair and maintenance of buildings and equipment, the hospital may be required to meet more stringent facilities requirements as determined by those governing bodies. These will be related to patient and staff safety, such as anti-ligature efforts.

The occupancy of the hospital is primarily determined by the judicial system. Periodic legislative changes impact the types and number of patients to be admitted to OSH. Depending on the changes in law, this can drive an increase or decrease to the facility demand, partially determined by the level of care required for new patient admissions and the associated adaptation of existing hospital space. Space requirements are therefore fluid. The measurement of space is done through monitoring of legislative and regulatory requirements, with associated increases or decreases to staffing dependent on shifting requirements and the needs of the patients.

Challenges over next 10 years

- Construction or renovation to ensure efficient hospital utilization and sustainability.
- Lifecycle replacement of high value equipment and assets.
- Responding to regulatory changes requiring facility improvements.
- Ensuring a 5- and 10-year equipment replacement cycle is maintained.
- Funding to develop life cycle costing, and budget for life cycles in advance of equipment breakdown.
- Ensure upgrades are made to equipment to extend life cycles.
- Above standard wear and tear of a facility partially occupied by persons not invested in long term facility care.

What is needed to meet challenges

- Receive budgetary funding adequate to meet these challenges.
- Ensure related technology resources are adequate and available.
- Update and maintain associated maintenance software.

Facilities Summary Report

2021-23 Biennium

Agency Name: **Oregon Health Authority**

Owned Facilities Over $1 million — **FY 2020 DATA**

Number of Facilities	21			
Current Replacement Value $ (CRV)	$ 501,259,117	Source	Risk	Risk or FCA
Gross Square Feet (GSF)	*927,733*			
Usable Square Feet (USF)	*675,451*	*Estimate/Actual*	*72.8*	% USF/GSF
Occupants Position Count (PC)	2284	**USF/PC**		

Owned Facilities Under $1 million

Number of Facilities	29
CRV	$ 9,995,456
GSF	64,967

Leased Facilities 0

Total Rentable SF			
Biennual Lease Cost			
Additional Costs for Lease Properties (O&M)			
Usable Square Feet (USF)	*Estimate/Actual*		% RSF/GSF
Occupants Position Count (PC)	**USF/PC**		

Definitions

CRV Current Replacement Value Reported to Risk ***or Calculated Replacment Value Reported from Facility Conditions Assessment (FCA)***

RSF Rentable SF per BOMA definition. The total usable area plus a pro-rated allocation of the floor and building common areas within a building.

USF Usable Square Feet per BOMA definition. Area of a floor occupiable by a tenant where personnel or furniture are normally housed plus building amenity areas that are convertible to occupant area and not required by code or for the operations of a building.
If not known, estimate precentage.

PC Legislatively Approved Budget (LAB) Position Count

O&M Total Operations and Maintenance Costs for facilities including all maintenence, utilities and janatorial.

Report

2021-23 Biennium

Agency Name: Oregon Health Authority

Facilities Operations and Maintenance (O&M) Budget

	2017-19 Actual	2019-21 LAB	2021-23 Budgeted	2023-25 Projected
Personal Service (Maintenance)	$11,657,322	$12,534,656	$13,798,776	$15,190,383
Services & Supplies (Maintenance)	$5,465,104	$4,431,279	$4,621,824	$4,820,562
O&M $/GSF (Maintenance)	$17.25	$17.09	$18.56	
Personal Service (Utilties & Janitorial)	$10,374,119	$11,815,663	$13,007,273	$14,319,056
Services & Supplies (Utilties & Janitorial)	$3,697,589	$3,932,636	$4,101,739	$4,278,114
O&M $/GSF (Utilities & Janitorial)	$14.18	$15.86	$17.23	

	General Fund	Lottery Fund	Other Funds	Federal Funds
O&M Estimated Fund Split %	90%		6%	4%

Non-PICS = .00725

Short and Long Term Deferred Maintenance Plan for Facilities Value Over $1M

	Current Value (2019)	Ten Year Projection	2021-23 Budgeted	2023-25 Projected
riorities 1-3 - Currently, Potentially and Not Yet Critical	$17,326,312	$15,355,356	$10,343,356	$10,225,091
priority 4 - Seismic & Natural Hazard				
Priority 5 - Moderization	$8,120,000	$8,120,000	$6,020,000	
Total Priority Need	$ 25,446,312.00	$ 23,475,356.00	$ 16,363,356.00	$ 10,225,091.46
Facility Condition Index (Need/CRV)	3.389%	3.00%	1.37%	1.00%

Assets Over $1M CRV	$501,259,117

Process/Software for routine maintenance (O&M)	
Process/Software for deferred maintenance/renewal	
Process for funding facilities maintenance	

STATE OF OREGON

DEPARTMENT OF ADMINISTRATIVE SERVICES

DATE: August 18, 2020

TO: Karen Jamieson

FROM: Rhonda Nelson, DAS CFO, Capital Finance Analyst

SUBJECT: **2021-23 XI-Q Request for Equipment Replacement**

The following information is intended to assist you in preparing an Agency Request Budget that incorporates funding for the Equipment Replacement project as outlined in your request dated May 15, 2020. In preparing the following estimate, we anticipated an October 2021 XI-Q bond sale (see attached estimated debt service & COI schedule for further details).

If you decide to move forward with this project a policy package will be required. The policy package should include the project costs, issuance costs and any 2021-23 debt service. Consult with your assigned Chief Financial Office (CFO) Analyst to determine the appropriate packages.

Category	Appropriated Fund	ORBITS Compt Srce #	Amount
Project Proceeds			
Revenue	3020 OF Capital Construction	0555 (GF Bonds)	$898,500
Expense - Capital Outlay	3020 OF Capital Construction	5XXX (Capital)	$898,500
Cost of Issuance			
Revenue	3400 OF Limited	0555 (GF Bonds)	$36,500
Expense - S&S	3400 OF Limited	4650 (Other S&S)	$36,500
Debt Service: 2021-23			
Revenue	8030 GF Debt Service	0050 (GF Appropriation)	$157,588
Expense - Principal	8030 GF Debt Service	7100 (Principal-Bonds)	$125,000
Expense - Interest	8030 GF Debt Service	7150 (Interest-Bonds)	$32,588

Over the life of the financing, your agency will be responsible for on-going financing costs such as fiscal agent fees, arbitrage calculation fees and an assessment for Oregon State Treasury (OST) Debt Management Division. The non-OST financial costs are estimated at $3,000/year for each bond sale. OST financial costs can be found in the Price List under OST assessments.

Please email me at Rhonda.nelson@oregon.gov or call me at (503) 378-8927 if you need additional information.

Attachment: Estimated Debt Service & COI Schedule

cc: Patrick Heath

Oregon State Hospital Capital Construction/Acquisition

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$0.00	$0.00	$0.00	$0.00	0	0.00
Governor's Budget 2021-23	$0.00	$12.62	$0.00	$12.62	0	0.00
Difference	$0.00	$12.62	$0.00	$12.62	0	0.00
Percent Change	N/A	N/A	N/A	N/A	N/A	N/A

Overview

The Oregon State Hospital proposes four capital construction/acquisition projects for the 2021-23 biennium: Well Water Treatment Facility (policy package #423), Additional Office Space (policy package #423), Deferred Maintenance (policy package #421), and Automated Dispensing Cabinets (policy package #422). All projects would be financed with Article XI-Q Bonds issued October 2021 (May 2022 for Additional Office Space).

Project costs and purpose

The costs described below are for the 2021-23 biennium. Following each project's implementation plan, all bond issuance is expected to occur during the 2021-23 biennium, with no additional financing required in future biennia. Debt service would extend into the 2029-31 biennium and would be funded with General Fund.

The **Well Water Treatment Facility** project is expected to cost $5.0 million, which includes approximately $4.5 million for project costs, $62,000 for bond issuance, and $484,000 for debt service, as estimated by the Department of Administrative Services (DAS). This would fund the construction of a well water treatment facility and potable water storage tanks to provide a backup water supply to the hospital in the event of disruption of contamination of the city water supply. OSH has one single point of connection to city water that is fed through a 1950's era 10" steel underground pipe. This leaves the hospital vulnerable to a complete loss of domestic water and water for sanitation including flushing toilets. Loss of water could also shut down

critical systems such as cooling which would then lead to overheating server rooms that could damage or require shutting down essential technology systems and access control.

The **Additional Office Space** project is expected to cost $1.9 million, which includes approximately $1.7 million for project costs, $41,000 for bond issuance, and $158,000 for debt service, as estimated by DAS. This would fund the construction of a second floor in an area that currently has existing "ceiling" space. The project would add 2,700 square feet of office space within the secure perimeter to accommodate 32 staff and include a conference room, copy room, and unisex toilet room.

The **Deferred Maintenance** project is expected to cost $1.6 million, which includes approximately $1.4 million for project costs, $40,000 for bond issuance, and $192,000 for debt service, as estimated by DAS. This project would address current large expenditure deferred maintenance in advance of equipment and infrastructure failure. Funding for deferred maintenance would ensure maintenance of the facility to the highest standard and avoid more costly future maintenance, align with regulatory compliance and stewardship of the state's assets, and result in a safe and secure treatment and work environment.

The **Automated Dispensing Cabinets** project is expected to cost $3.6 million, which includes approximately $3.5 million for project costs, $55,000 for bond issuance, and $474,000 for debt service, as estimated by DAS. Automated dispensing cabinets (ADC) are the method by which drugs are dispensed at the state hospital. They are integrated with electronic health records and control access to medications at the individual patient level to ensure patients receive the correct medication, in the proper dosage, at the right time. This project would replace 41 ADCs deployed throughout patient care areas on the Salem and Junction City campuses. The computers in each cabinet use the Windows 7 operating system, which is no longer supported by Microsoft or the Office of Information Services. Replacing the ADCs would address security risks related to using equipment without product support and avoid needing to immediately hire additional pharmacists and pharmacy assistants to manually provide medication to OSH patients.

2021-23 Oregon Health Authority — Governor's Budget Policy Packages (POPs)

Temp. POP #	Lead Program Area	Policy Package Title	Description	General Fund	Lottery Funds	Other Funds	Federal Funds	Total Funds	POS	FTE	Due to an audit?
070	HPA	**Health IT Programs Shortfall**	This policy package removes positions and reduces Federal Funds expenditure limitation to align with revenues available at the current service level for the Oregon Health Authority's (OHA) Health IT Programs. These programs have been funded by a 90 percent Federal Funds match from the Health Information Technology for Economic and Clinical Health (HITECH) Act, which sunsets in 2021. Without funding to backfill the reduction in Federal Funds revenue, OHA will end health IT programs and eliminate eight full-time positions.	$ -	$ -	$ -	$ (17,543,925)	$ (17,543,925)	(8)	(8.00)	No
070	PH	**Public Health Revenue Shortfalls**	This Pkg 070 is a combination of 8 separate, fee-related Pkg 070 revenue reductions which also have POP buy-backs: Tobacco Tax (no POP buyback), Ambulance License Fees (POP 450), RPS Radioactive Material Licensing (POP 448), ORELAP (POP 449), HLO RT (POP 452), PDMP (POP 453), HLO Cosmotology (POP 447), and Home Health Agencies Licnesing (POP 451).	$ -	$ -	$ (5,208,300)	$ -	$ (5,208,300)	-	-	No
070	HSD	**HSD Revenue Shortfalls**	The 21-23 Lottery Forecast from June 2020 predicts that Lottery Revenue distributions to the Health Systems Division will be less than originally budgeted and approved in the 19-21 LAB Lottery Revenue budget.		$ (1,184,459)			$ (1,184,459)	-	-	
402	CS, SAEC	**Strategic/Structural Health Equity Innovation and Implementation**	The Oregon Health Authority has limited capacity to complete current baseline equity and inclusion work for agency and Oregon, specifically related to health system transformation. This policy package not only addresses current structural and resource deficits but is also necessary to meet the needs of the agency to fulfill the 10-year strategic goal of eliminating health inequities in Oregon, including strategic planning development and implementation.	$ 5,825,829	$ -	$ 509,764	$ 946,685	$ 7,282,278	17	15.08	No
403	HSD	**Indian Managed Care Entity**	Establish and support Indian Managed Care Entities at the request of Oregon's Federally recognized Tribes, which would provide critical care coordination services to American Indian/Alaska Native enrollees in the Oregon Health Plan.	$ 1,365,071	$ -	$ -	$ 10,731,035	$ 12,096,106	-	-	No
404	CS, SAEC	**Tribal Traditional Health Worker**	This policy package would fund the creation of a sixth, separate Traditional Health Worker category for Indian Health Care Providers (IHCP) which would allow the Oregon Tribes and Urban Indian Health Program to develop a program to use in their communities. This would include developing curriculum, training staff, and certification. Once certified, IHCPs would be able to receive Medicaid reimbursement recognizing tribal based practices and other culturally specific services under this new worker type. Approval of the new provider type would occur via the State Plan Amendment process.	$ 171,706	$ -	$ 15,025	$ 27,901	$ 214,632	1	0.88	No
407	HSD	**Operate Fee-For-Service Like a CCO**	This policy package would fund nine new positions to improve the Oregon Health Plan (OHP) fee-for-service (FFS) program operations and address several identified program gaps by aligning the fee-for-service delivery system with that of a coordinated care organization. The adverse effect of not funding this package is that program gaps will persist, OHP members in FFS will continue to have a health plan that is inferior to CCO plans, and important policy work, such as fee schedule and rule updates, will continue to be delayed. Avoidable problems with OHP payment to providers will continue to occur.	$ 11,057,223	$ -	$ -	$ 18,467,168	$ 29,524,391	9	6.75	No

2021-23 Oregon Health Authority — Governor's Budget Policy Packages (POPs)

Temp. POP #	Lead Program Area	Policy Package Title	Description	General Fund	Lottery Funds	Other Funds	Federal Funds	Total Funds	POS	FTE	Due to an audit?
408	PH	**Tobacco Retail Licensure**	Tobacco is the leading preventable cause of death and disease in Oregon, costing the state $2.9 billion and nearly 8,000 lives every year. Moreover, the burden of tobacco use is not distributed evenly, falling heavily on Oregonians with low incomes, African Americans, Native Americans and Alaska Natives, and those who identify as LGBTQ+. This policy package would establish a strong statewide licensing system for retailers that sell tobacco products and inhalant delivery systems. It would equip OHA-PHD with new tools to educate retailers about tobacco laws, and – critically – to hold tobacco retailers that sell tobacco illegally accountable. Without statewide tobacco retail licensure, Oregon cannot robustly enforce tobacco laws such as the minimum legal sales age. A retail license could make it easier to enforce other tobacco sales laws such as tax collection compliance, counterfeit product sales, and compliance with federal laws (for example, no single cigarette sales or self-service displays of tobacco products).	$ -	$ -	$ 2,078,226	$ -	$ 2,078,226	12	7.86	No
409	HSD, HPA	**Community Behavioral Health Services**	Requests funding to implement strategies and recommendations from the Governor's Behavioral Health Advisory Council and the Governor's Racial Justice Council to improve the behavioral health system for adults and transition-aged youth who experience serious mental illness and co-occurring substance use disorders.	$ 47,720,999	$ -	$ -	$ 3,775,229	$ 51,496,228	5	4.01	No
411	HSD, HPA	**Community Mental Health Aid and Assist**	The number of people sentenced under "Aid and Assist" laws has doubled over the past five years. Oregon has traditionally relied on OSH as the primary resource to meet the service needs of these people. Recent capacity challenges have been so great that the state fell into a period of non-compliance with the US Federal Court of Appeals ruling (Mink Order) that requires OSH to admit people committed under ORS 161.370 within 7 days of a signed judge's order. Local law enforcement, jails and EDs are consistently reporting stresses on their systems as well as frustration with the lack of effective service options. This package includes funding and positions to contract with community providers to open additional secure residential treatment facilities and increase community services to meet the immediate needs of people who have been arrested and court-ordered for services under Oregon's "Aid and Assist" laws; ensure better coordination between courts, OSH and community mental health and substance use disorder service providers for people who have intensive behavioral health service needs; and a comprehensive evaluation to better understand the root causes for the increases and identify long-term strategies to improve services and outcomes. If this package is not funded, communities would not have the resources needed to provide proper services for people sentenced under "Aid and Assist" orders and OSH Aid and Assist admissions would continue beyond current capacity.	$ 19,268,531	$ -	$ -	$ 3,376,104	$ 22,644,635	6	4.50	No

2021-23 Oregon Health Authority – Governor's Budget Policy Packages (POPs)

Temp. POP #	Lead Program Area	Policy Package Title	Description	General Fund	Lottery Funds	Other Funds	Federal Funds	Total Funds	POS	FTE	Due to an audit?
417	PH	**Public Health Modernization**	Since 2013, Oregon has been on a path to fundamentally shift its practice to ensure essential public health protections are in place for all Oregonians through equitable, outcomes-driven and accountable services. The groundwork laid through initial investments in public health modernization have been critical to Oregon's management of the COVID-19 pandemic. However, the COVID-19 response has highlighted continued gaps in the public health system, specifically centering all work in health equity and cultural responsiveness so that we can end health inequities by 2030. This policy package supports implementation of key public health programs in state, local and tribal public health authorities and communities and creates mechanisms for increased accountability for health outcomes. Not funding this policy package risks OHA's ability to ensure basic public health protections guaranteed in statute are available to every person in Oregon, risks continuing health inequities, and challenges OHA in continuing to meet the deliverables and timelines prescribed in House Bill 3100 (2015).	$ 30,000,000	$ -	$ -	$ -	$ 30,000,000	-	-	No
421	OSH, SAEC	**Deferred Maintenance**	The Salem campus of the Oregon State Hospital consists of 1.2 million square feet of buildings and interior court yards and has a Current Replacement Value (CRV) as reported to the Capital Advisory Board (CPAB) of $363,275,131. This makes the Oregon State Hospital among the highest replacement value of any single facility owned by the state. The Pendleton cottage facility has a current replacement value of $2,785,898 and is presenting considerable deferred maintenance due to the age of the campus. Funding the requested deferred maintenance requests would eliminate the current critical deferred maintenance needs for the Salem and Pendleton campuses and maximize the lifespan of the state's investment and public trust.	$ 191,943	$ -	$ 1,425,000	$ -	$ 1,616,943	-	-	No
422	OSH, SAEC	**Asset Replacement**	The Oregon State Hospital Salem facility began construction in 2009, was completed in 2011 and is over 10 years old. The Junction City facility is now over 5 years old. As aging occurs, much of the expendable property and capital assets in operation have outlived or have soon expiring useful lives. Replacement of these items is necessary to provide a safe and secure environment for patients and staff, as well as maintain critical continuity of hospital operations.	$ 621,906	$ -	$ 4,429,599	$ -	$ 5,051,505	-	-	No
423	OSH, SAEC	**Oregon State Hospital Capital Improvement**	The Oregon State Hospital (OSH) Salem Campus is the primary state psychiatric facility serving some of Oregon's most vulnerable populations. OSH has identified three critical capital improvement projects that would provide: A self-sustainable facility that could maintain a safe and secure environment of care throughout loss of city water and or contamination of city water such as the 2018 cyanotoxin event; expanded staff space by building a second floor within an existing area; and enhanced treatment capability by repurposing existing space.	$ 719,932	$ -	$ 6,980,000	$ -	$ 7,699,932	-	-	No

2021-23 Oregon Health Authority — Governor's Budget Policy Packages (POPs)

Temp. POP #	Lead Program Area	Policy Package Title	Description	General Fund	Lottery Funds	Other Funds	Federal Funds	Total Funds	POS	FTE	Due to an audit?
425	PEBB/OEBB	**Aligning Purchasing Power Across PEBB/OEBB and Other Public Purchasers**	One of the most important levers OHA has for spreading change across the healthcare marketplace is aligning the state's purchasing power across PEBB and OEBB along with other public purchasers. This policy package provides a pathway to expand PEBB and OEBB's statewide enrollment footprint of 300,000 covered lives. It allows for additional special procurement authority for joint purchasing initiatives and adds resources to continue to transform the delivery systems in alignment with coordinated care organizations (CCO) and the coordinated care model. Both boards have fully committed to advancing the coordinated care model and exploring innovative, long-term solutions to stay under a 3.4 percent annual trend cap. Under their current legal structures, the boards' procurement authority does not allow for the flexibility needed to directly contract with plans who can meet specific criteria as determined by the boards, without issuing a request for proposal. This policy package will grant expanded procurement authority to explore opportunities in innovation as they are presented to the boards.	$ -	$ -	$ 1,570,708	$ -	$ 1,570,708	2	1.76	No
426	PEBB/OEBB	**Benefit Management System Replacement Project for PEBB/OEBB**	The current benefit management systems (BMS) used by the Oregon Educators Benefit Board (OEBB) and Public Employees' Benefit Board (PEBB) no longer support all current business needs since their respective introductions in 2008 and 2003. OEBB and PEBB, along with the OEBB and PEBB boards, are seeking to integrate the administration and support of the two systems, with improved user experience and customer care, into a single platform to meet the legislative direction provided under Senate Bill 1067 (2017). Not prioritizing and supporting a replacement effort for the current system will result in the continued use of end-of-lifecycle technology that is fragmented, non-standard, difficult to support, and is not scalable. Approximately 300,000 covered lives would be at risk for benefits interruption if a replacement system is not identified and procured prior to the expiration of existing vendor support in 2022.	$ -	$ -	$ 8,182,928	$ -	$ 8,182,928	-	-	OHA
427	HPA	**Oregon State Option & Coverage Stabilization**	This policy package would enable the Oregon Health Authority (OHA) to refine the details of health insurance reforms that would be intended to increase access to health insurance while reducing premiums paid by consumers, potentially through a public option or a "Medicaid buy-in" plan as envisioned by Senate Bill 770 (2019).	$ 200,000	$ -	$ -	$ -	$ 200,000	-	-	No
429	HPA	**Statewide Value-based Payment Adoption, Alignment, and Infrastructure**	To leverage the OHA's leadership role in establishing a statewide value-based payment (VBP) roadmap and requisite technical assistance infrastructure to support increased adoption and alignment of VBP across Oregon.	$ 946,781	$ -	$ -	$ 605,319	$ 1,552,100	1	0.88	No

2021-23 Oregon Health Authority – Governor's Budget Policy Packages (POPs)

Temp. POP #	Lead Program Area	Policy Package Title	Description	General Fund	Lottery Funds	Other Funds	Federal Funds	Total Funds	POS	FTE	Due to an audit?
431	HSD	**Substance Use Disorder 1115 Waiver State Plan Amendment**	Oregon has submitted a substance use disorder (SUD) 1115 Waiver and will shortly submit a state plan amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) to support an enhanced full continuum of care delivery system for individuals with SUD. If the waiver and corresponding SPA are approved, the Oregon Health Authority (OHA) would be able to utilize additional Medicaid dollars to pay for residential treatment for more Oregonians with SUD. If approved, this would provide the supports needed to prevent and treat SUD and sustain long-term recovery, including crisis intervention, outreach and education to help individuals in recovery find and keep housing. This policy package would staff the SUD waiver implementation and would provide funds to contract for an evaluation to measure the effectiveness of the implementation process and waiver at creating desired outcomes.	$ 11,511,910	$ -	$ -	$ 106,509,066	$ 118,020,976	1	1.00	No
433	OSH, SAEC	**Technology Modernization**	This technology modernization package replaces videoconferencing equipment at the Oregon State Hospital, primarily related to hearing rooms.	$ 10,180	$ -	$ 60,401	$ -	$ 70,581	-	-	SOS
436	HPA	**Pharmacy Omnibus**	This policy package equips the Oregon Health Authority (OHA) with staffing and clarified statutory authority to support and manage pharmacy purchasing in a collaborative and innovative manner. Without this policy package, OHA will be limited in its ability to effectively innovate and keep pace with the dynamic and quickly evolving pharmacy marketplace and supply chain.	$ 939,262	$ -	$ (75,215)	$ (23,183)	$ 840,864	4	3.52	No
437	HPA	**Strengthen Purchasing Power of the Marketplace**	This policy package would move the health insurance Marketplace from the Department of Consumer and Business Services (DCBS) to the Oregon Health Authority (OHA), creating greater opportunities for aligned policy, which would utilize all state levers to maximize opportunities for greater alignment in pursuit of the triple-aim.	$ 2,616,499	$ -	$ 16,276,637	$ -	$ 18,893,136	-	-	No
207	Shared, SAEC	**Maintenance & Operations of Provider Time Capture**	The Oregon Department of Human Services and Oregon Health Authority in-home care programs need a system that will increase program integrity and comply with the federal 21st Century CURES Act for Electronic Visit Verification System and the U.S. Department of Labor Fair Labor Standards Act. This would be done with a time, attendance and payment system for the program's Home Care Workers and Personal Support Workers. The drivers for this work include a need for: 1. Improved timeliness and accuracy of data 2. Improved compliance with federal, state, and bargaining requirements 3. Increased efficiency and internal controls 4. Decreased duplication of efforts across agencies 5. HCW/PSW to accurately and timely report services provided across programs 6. Decrease dependency on outdated legacy systems This policy package would implement ongoing maintenance and enhancements that build upon a base system implemented in the 2021-23 biennium that would result in an integrated solution that meets the 21st Century Cures Act criteria and helps protect vulnerable Oregonians.	$ 58,615	$ -	$ 824,214	$ 18,246	$ 901,075	3	3.00	No

2021-23 Oregon Health Authority — Governor's Budget Policy Packages (POPs)

Temp. POP #	Lead Program Area	Policy Package Title	Description	General Fund	Lottery Funds	Other Funds	Federal Funds	Total Funds	POS	FTE	Due to an audit?
447	PH	**Board of Cosmetology**	The Board of Cosmetology licensing fees must be increased to cover the cost of licensing and regulating the board's professionals and protecting the public. The board's current fees cannot sustain the program. Revenue and expense forecasts predict the board to slip into a budget deficit in 2020 that will continue in 2021-23. Without an increase in fees, the Health Licensing Office (HLO) will not be able to issue licenses to applicants in a timely manner and protect the public from potential health and safety violations. This would have an extremely negative impact on this board and HLO. In addition, the Legislature's mandate to protect the public would be compromised.	$ -	$ -	$ 1,562,547	$ -	$ 1,562,547	-	-	No
448	PH	**Radiation Protection Services Fee Increase**	Ensures Radiation Protection Services (RPS) can continue providing adequate radiation health and safety of Oregonians by creating 2021-23 financial stability and adequate biennia funding through user-fee increases. Without additional revenues, RPS budget solvency will be threatened, leading to significant program staff and service reductions resulting in increased potential for harmful radiation exposure and injury to patients, workers and the public; and breaching of inter-agency agreements.	$ -	$ -	$ 1,408,249	$ -	$ 1,408,249	3	2.25	No
449	PH	**Oregon Environmental Laboratory Accreditation Program (ORELAP)**	The Oregon Environmental Laboratory Accreditation Program (ORELAP) was established in 1999 and is statutorily mandated. ORELAP accredits Oregon drinking water, environmental and cannabis laboratories based on international standards to ensure laboratories are in compliance with federal and state regulations. ORELAP is a fee-based program and is experiencing a budgetary shortfall. This policy package will support a fee increase and an update to the ORELAP fee structure for simplification and to ensure fees are appropriate for the work required to perform laboratory accreditations of differing complexity. A fee increase is needed to ensure ORELAP can provide timely and quality accreditations that meet established standards and regulatory requirements to best serve ORELAP's clients and protect the health of all Oregonians.	$ -	$ -	$ 896,094	$ -	$ 896,094	-	-	No
450	PH	**EMS Modernization**	The Health Care Regulation and Quality Improvement section regulates both ambulance service agencies and vehicles to ensure the quality and safety of services provided to Oregonians. Revenues generated from current fees no longer support the cost of associated regulatory work. Pursuant to ORS 682.085, the program conducts on-site licensing surveys of ambulance agencies and vehicles, and complaint investigations to ensure that ambulance agencies and vehicles provide high-quality and safe services and comply with associated state licensing regulations. Failure to increase fees would jeopardize the program's ability to meet its licensing requirements which may jeopardize the quality of available emergency and nonemergency care and place patients and Emergency Medical Services providers at risk. It would also threaten the ability to maintain a fiscally sustainable budget, which is necessary to meet the agency's overall fiscal and operational goals.	$ -	$ -	$ 106,237	$ -	$ 106,237	-	-	No

2021-23 Oregon Health Authority — Governor's Budget Policy Packages (POPs)

Temp. POP #	Lead Program Area	Policy Package Title	Description	General Fund	Lottery Funds	Other Funds	Federal Funds	Total Funds	POS	FTE	Due to an audit?
451	PH	**Home Health Agencies Licensing Fees**	This policy package increases home health agency licensure fees to support existing regulatory and complaint investigation activities and to ensure the quality of client care provided by home health agencies. Failure to approve the fee increase would jeopardize the program's ability to meet its statutory obligations including on-site initial and relicensure survey and complaint investigation requirements and may place persons at increased risk of unsafe or ineffective care. It would also jeopardize the program's ability to maintain a fiscally sustainable budget, which is necessary for the program to meet the agency's overall fiscal and operational goals.	$ -	$ -	$ 51,265	$ -	$ 51,265	-	-	No
452	PH	**Respiratory Therapist and Polysomnographic Technologist Licensing Board**	The Respiratory Therapist and Polysomnographic Technologist Licensing Board licensing fees must be increased to cover the cost of licensing and regulating the board's professionals and protecting the public. Without the increased revenue, the Health Licensing Office (HLO) will have insufficient staff to process applications timely and license practitioners to begin working in Oregon. HLO would also have insufficient staff to investigate complaints received relating to practitioners not following the regulating rules and statutes.	$ -	$ -	$ 232,342	$ -	$ 232,342	-	-	No
453	PH	**Prescription Drug Monitoring Licensing Fees**	Increase fees paid by each healthcare licensee to fund the Prescription Drug Monitoring Program (PDMP). Funding is necessary in order to maintain sufficient capacity for program operations and database functions. The PDMP fee impacts all licensees regardless of program registration or program use. If alternate funding is not made available, the quality of the Oregon PDMP will decrease as the number of staff is decreased and emerging evidence-based services are not implemented. This will result in decreased PDMP use by prescribers and pharmacists and less informed prescribing.	$ -	$ -	$ 657,936	$ -	$ 657,936	-	-	No
		TOTALS		**$ 133,226,387**	**$ (1,184,459)**	**$ 41,983,657**	**$ 126,889,645**	**$ 300,915,230**	**56**	**43.49**	

Oregon Health Authority
2021-23 Policy Package

Division:	Health Policy & Analytics
Program:	Office of Health Information Technology
Policy package title:	Health IT Programs Shortfall
Policy package number:	070
Related legislation:	None

Summary statement:

This policy package removes positions and reduces Federal Funds expenditure limitation to align with revenues available at the current service level for the Oregon Health Authority's (OHA) Health IT Programs. These programs have been funded by a 90 percent Federal Funds match from the Health Information Technology for Economic and Clinical Health (HITECH) Act, which sunsets in 2021. Without funding to backfill the reduction in Federal Funds revenue, OHA will end health IT programs and eliminate eight full-time positions.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$0**	**($17,543,925)**	**($17,543,925)**	**(8)**	**(8.00)**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

This policy package is required by the Department of Administrative Services (DAS) to reduce Federal Funds expenditure limitation and positions to align the Oregon Health Authority's (OHA) budget with revenues available at the current service level. OHA's Health IT Programs have been funded by a 90 percent Federal Funds match from the Health Information Technology for Economic and Clinical Health (HITECH) Act, which sunsets in 2021. Without funding to backfill the reduction in Federal Funds revenue, OHA will end health IT programs and eliminate eight full-time positions.

2. What would this policy package buy and how and when would it be implemented?

This policy package reduces Federal Funds expenditure limitation to align with the projected Office of Health IT base budget. Health IT Programs currently operating under 90/10 HITECH match will be cut or reduced to operate within base budget with lower federal matching rates (75, 50, or 39 percent federal match depending on the work performed) for both staff and contracts.

Changes in federal match rates affects 25 positions and most Office of Health IT contracts. However, without replacement funding, OHA will eliminate or reduce the following programs and staff and use its base budget to cover remaining staff and contracts at the lower federal match rates:

- The Oregon Provider Directory will be eliminated.
- The Clinical Quality Metrics Registry will be eliminated
- HIT Commons will be reduced.
- Medicaid PreManage subscription will be reduced.
- Eight positions will be eliminated.

Here is further information about these programs:

- OHA launched the **Oregon Provider Directory (OPD)** in 2019 to centralize the collection and improve the overall quality of provider data (e.g., race and ethnicity, provider specialties, practice location, contact information, affiliations, etc.). Healthcare organizations, including OHA/DHS stakeholders and providers, face significant challenges and costs in managing provider directories and having a single source of truth for provider data. They can use the OPD to advance operational efficiencies, care coordination and health information exchange, and analytics, network management, and accountability efforts. As a statewide directory, the OPD includes more than 10,000 organization records and 130,000 provider records and is in process of rolling out its initial use cases. The OPD provides an interoperable, statewide infrastructure needed for unifying the collection of provider data from multiple sources, providing one place to access high quality provider data. *This policy package removes federal funding limitation and 8 positions due to reductions in federal funding match that begin in October 2021. This reduction will eliminate the Oregon Provider Directory program.*
- OHA launched the **Clinical Quality Metrics Registry (CQMR)** in 2019, which collected electronic clinical quality metrics data for Oregon's Medicaid program and also supported reporting for two federal health IT and quality programs, the Merit-based Incentive Payment System (MIPS) and the Comprehensive Primary Care Plus (CPC+) program. The vision for the CQMR was to provide the statewide infrastructure needed to ensure quality in the Medicaid program and to support aligned reporting, administrative efficiencies, and reduced reporting burdens for providers. Because of changing federal regulations related to electronic health records, the CQMR's planned glide path to patient-level quality data is no longer viable. During this transitional period for national standards, the CQMR service has been suspended as of the end of 2020. *This policy package removes federal funding limitation and 8 positions due to reductions in federal funding match that begin in October 2021. This will eliminate the budget that preserves the CQMR program in suspension, effectively eliminating the CQMR program.*

- OHA and the Oregon Health Leadership Council launched **the HIT Commons**, a public/private partnership, to provide long-term sustainability for statewide health IT efforts. The HIT Commons governs two initiatives:
    - **EDie/PreManage (aka Collective Platform):** EDie connects all Oregon hospitals and provides emergency rooms with critical, concise information about patients who are high utilizers of emergency department (ED) services and patients with complex care needs. PreManage, a companion service to EDie, brings real-time hospital event notifications from EDie to participating CCOs, health plans, providers, and OHA/DHS programs who subscribe to receive real-time information when their patient, member, or client has a hospital event in any hospital in Oregon or Washington.
        - All of Oregon's eligible hospitals have made their ED and inpatient data available in EDie, adding Oregon's data to the data from Washington and other states. In 2019, Oregon's Skilled Nursing Facilities (SNFs) were able to join EDie, and today over half of SNFs in Oregon participate.
        - Today, all CCOs and major health plans are subscribed to PreManage, most of whom extend this service to their key contracted physical, behavioral and oral health clinics. Today, a majority of Oregon's Patient-Centered Primary Care Home clinics, over one-third of licensed behavioral health agencies, and four of nine Tribes' tribal clinics participate, as well as all of Oregon's Dental Care Organizations.
    - **The Oregon PDMP Integration Initiative,** launched in 2018, 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.
    - **Planning for statewide Community Information Exchanges** that bring critical data and infrastructure to connect health care and culturally specific social service agencies across Oregon's communities.
    - *This policy package removes federal funding limitation and 8 positions due to reductions in federal funding match that begin in October 2021. This will reduce OHA's support for the HIT Commons.*

- OHA supports the **Medicaid PreManage program**, which supports CCOs, Tribal clinics, OHA/DHS programs and others. OHA/DHS programs also use PreManage – including Medicaid and behavioral health staff coordinating care, Oregon State Hospital teams, DHS long-term services and supports program staff including all Type B Area Agency on Aging and Aging & People with Disability District offices, and DHS Intellectual & Developmental Disability program staff and contractors. *This policy package removes federal funding limitation and 8 positions due to reductions in federal funding match that begin in October 2021. This will significantly reduce OHA's Medicaid PreManage subscription.*

3. How does this policy package further OHA's mission and align with its strategic plan?

This policy package is required by DAS to reduce Federal Fund expenditure limitation and to reduce positions.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

Not applicable.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

Not applicable.

7. What are the long-term desired outcomes?

Not applicable.

8. What would be the adverse effects of not funding this policy package?

Not applicable.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

Some of the cost associated with transitioning to lower federal match rates will be accommodated by reducing scope and focusing on only the most essential work. Still, critical health IT programs and staff will be eliminated without additional GF to sustain these existing programs and the significant time and resources invested in them.

Prioritization for this policy package: Without additional funding in 2021-23, OHA has made difficult decisions about what work would remain with only base General Fund at lower rates of federal match. In making these decisions, OHA prioritized work required by federal, state or contract requirements, and prioritized the staff needed to support that work. Priorities include:

- Statutorily mandated work related to the Health IT Oversight Council (HITOC).
- Managing CCO 2.0 health IT contractual requirements.
- Completing and wrapping up the federal Medicaid Electronic Health Record Incentive Program.

OHA reviewed the remaining budget with the goal of retaining services under OHA's statutorily required Oregon Health IT Program. Oregon Health IT Program services each include significant contractor and vendor

costs, which are eligible for 75/25 federal matching funds after 90/10 HITECH funding ends. Although all services within the Oregon HIT Program are operational, the remaining General Fund was insufficient to retain either the Oregon Provider Directory (OPD) or the Clinical Quality Metrics Registry (CQMR) programs due to the contractor costs. Only the HIT Commons and Medicaid PreManage programs could be retained under reduced funding.

10. What alternatives were considered and what were the reasons for rejecting them?

OHA provided information to DAS and the Governor's office on the additional GF needed to sustain existing work, but ultimately new funding was not included in the Governor's Budget given other urgent priorities and reduced revenue available. This policy package is required by DAS to reduce Federal Fund expenditure limitation and positions.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

OHA, ODHS, tribal clinics, local public health agencies, and other contracted organizations like CCOs and Medicaid Fee for Service care coordination entities (KEPRO and CareOregon) currently benefit from participation in OHA's Medicaid PreManage program and OHA's support for the HIT Commons, which will be reduced and require some organizations to take on additional costs (without the benefit of 75% federal match).

13. What other agencies, programs or stakeholders are collaborating on this policy package?

OHA's health IT programs support all Oregon health care stakeholders, as well as OHA and ODHS programs. In particular, OHA has the support of the following stakeholders for work impacted by this package:

- Health plans and CCOs, including CCO Oregon, Dental Care Organizations
- Hospitals and health systems, including OAHHS
- Oregon Health Leadership Council and its committees
- HIT Commons Governance Board and various committees
- Providers and many provider associations including OMA, OPCA, Office of Rural Health and others
- Behavioral Health agencies and associations including AOCMHP
- Social services and Community Information Exchange stakeholders including 211info
- Technology and data quality partners such as Comagine, Reliance eHealth Collaborative, OCHIN
- Oregon retail pharmacies
- Skilled Nursing Facilities

In addition to OHA stakeholders, OHA's Office of Health IT (OHIT) has coordinated with ODHS executives and programs to ensure the value of HIT Programs support ODHS.

- HIT Commons and OHIT staff provide subject matter expertise on Health IT and technical assistance to ODHS programs including Type B Area Agency on Aging, Aging and People with Disabilities, Intellectual and Developmental Disabilities, Child Welfare staff and local offices or contractors (AAA, Brokerages) related to OHA's Medicaid PreManage program. This tool enables ODHS programs to view hospital and emergency department admit and discharge data on ODHS clients, which is used for managing residential and long-term care placements, identifying quality and abuse concerns, and managing effective ODHS programs.

- HIT Commons and OHIT staff also support social determinants of health work across ODHS with Community Information Exchange planning efforts, which would ultimately support electronic referrals and resource look-up for social services statewide.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

.

Health IT programs, policies, governance and coordination are critical for supporting populations impacted by health inequities. Health IT plays several critical roles directly and indirectly in this area:

- HIT Commons and Medicaid PreManage programs support all CCOs, health plans and hospitals across Oregon, as well as patient-centered primary care homes, safety net clinics, tribal clinics, behavioral and oral health providers to ensure that individuals at risk of high-utilization of ED/hospitalization do not fall through the cracks of a disconnected health care system. Providers and CCOs instead have the benefit of data and tools needed to manage and coordinate care for these high-risk populations, including many that typically face disparities due to racism and other social factors.
- Oregon communities are leading the way to addressing social determinants of health through new Community Information Exchanges, which connect CCOs, health plans, hospitals and health care providers to social services. These technology platforms provide social service resource directories, closed loop referrals to social services, and data and analytics capabilities that have unprecedented ability to support vulnerable populations and help target local and statewide investments. HIT Commons work to plan and coordinate statewide Community Information Exchanges bring critical data and infrastructure to connect health care and culturally specific social service agencies across Oregon's communities.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

- Data on race, ethnicity, language and disability can be sourced and shared from health IT systems, including electronic health records and via health information exchange tools.
- Population management tools supported by state health IT strategies and programs allow CCOs, health plans, and providers to assess quality of care and target resources to individuals facing the greatest need and barriers and demonstrate the impact of programs on populations including those facing inequities.
- Health IT subject matter expertise and leadership under HITOC is critical to ensure that Oregon's health system transformation efforts are supported by the data and infrastructure needed to achieve health equity and address barriers for populations facing inequities. HITOC coordinates with the Health Equity Committee as well as OHA programs seeking to improve REALD data and leverage technology.
- The OPD can help identify culturally appropriate care by providing statewide data on providers' race/ethnicity/language characteristics, as well as information about specialty focus areas (like expertise working with specific populations) and information about facility accommodations for physical disabilities. It also contains location information that can identify where there may be gaps or capacity/access issues across the state to populations impacted by health inequities.

Staffing and fiscal impact

Implementation date(s): July 1, 2021

End date (if applicable): Not applicable

15. What assumptions affect the pricing of this policy package?

The enhanced federal match from the HITECH Act sunsets in 2021.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

No.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

No.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

The following existing positions will be eliminated:

- One (1) Executive Support Specialist 2 position
- One (1) Research Analyst 3 position
- One (1) Research Analyst 4 position
- Two (2) Operations and Policy Analyst 2 positions
- Two (2) Operations and Policy Analyst 3 positions
- One (1) Operations and Policy Analyst 4 position

20. What are the start-up and one-time costs?

None.

21. What are the ongoing costs?

Not applicable. This policy package is required by DAS to reduce Federal Fund expenditure limitation and positions.

For transparency, OHA is providing the table below, which represents the costs associated with each program/body of work under the Office of Health IT. In particular:

- **Program or Body of Work:** Program name or body of work under the Office of Health IT that shows the contract and staff associated with specific work.
- **FF/GF match rate:** Federal Funds match rate for work associated with the program category.
- **Contract:** Type of contract associated with the program or body of work.
- **Contract Total Funds with 070 package:** Total contract costs associated with the program or body of work, assuming 070 package, with additional information about the reduction from the full funding to maintain the program work.
- **Contract General Funds with 070 package:** General Fund portion of contract costs associated with the program or body of work, assuming 070 package, with additional information about the reduction from the full funding to maintain the program work.
- **Gap in GF Funding needed to maintain program work:** Difference between Contract General funds with 070 package and full GF funding to maintain program work.

Program or Body of Work	FF/GF match rate*	Contract	Contract Total Funds with 070 package	Contract General Funds with 070 package	Gap in GF Funding needed to maintain program work
HIT Policy/ HITOC work & CCO 2.0 work	Blended and 39/61	Strategic Consultants	$80,000 *(reduced from $210,000)*	$28,000 *(reduced from $69,000)*	$41,000 contracts GF
Oregon Provider Directory**	75/25, 90/10 for enhancements	Vendors	$0 *(reduced from $6,007,038)*	$0 *(reduced from $1,077,560)*	$1,077,560 contracts GF (plus ~$200,000 GF associated with minimal LD staff)
Clinical Quality Metrics Registry** – *cost to hold CQMR in suspension*	100% GF	Vendors	$0 *(reduced from $98,000)*	$0 *(reduced from $98,000)*	$98,000 contracts GF
HIT Commons**	75/25 (90/10 for development)	Governance, coordination, planning, TA	$590,000 *(reduced from $1,225,000)*	$262,500 *(reduced from $480,000)*	$217,500 contracts GF
Medicaid PreManage Program**	75/25 ongoing	Collective Medical Technologies	$1,370,272 *(reduced from $2,830,418)*	$342,568 *(reduced from $707,608)*	$365,040 contracts GF
Medicaid EHR Incentive Program (program will end in 2021-23)	90/10	DXC vendor for MAPIR application	$200,000 *(no reduction)*	$20,000 *(no reduction)*	$0

* Blended rates include a mix of 75/25 (related to IT programs like HIT Commons, OPD, CQMR), 50/50 (Medicaid Admin match), and some are 39/61 (for statewide health policy-related work that is partially 50/50 matched).
** Policy Package 070 removes federal funding allocation and 8 positions associated with reductions in federal funding match that begin in October 2021. OPD and CQMR programs would end, the HIT Commons and Medicaid PreManage programs would be reduced, and 8 FTE would be eliminated.

22. What are the potential savings?

Not applicable. This package is required by DAS to reduce Federal Fund expenditure limitation and positions.

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

The Federal Funds reduced are due to the end of the 90 percent Federal Funds match from the HITECH Act.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	($938,791)		($1,252,417)	($2,191,211)	(8)	(8.00)
Services & Supplies	($174,826)		($15,162,255)	($15,337,081)		
Capital Outlay						
Special Payments	$1,113,617		($1,129,253)	($15,633)		
Other						
Total	**$0**	**$0**	**($17,543,925)**	**($17,543,925)**	**(8)**	**(8.00)**

Fiscal impact by program

	HPA Office of Health Information Technology	HPA Office of Business Operations		Total
General Fund				**$0**
Other Funds				**$0**
Federal Funds	($17,218,785)	($325,140)		**($17,543,925)**
Total Funds	($17,218,785)	($325,140)		**($17,543,925)**
Positions	(6)	(2)		**(8)**
FTE	(6.00)	(2.00)		**(8.00)**

Oregon Health Authority
2021-23 Policy Package

Division:	Central Services
Program:	Equity and Inclusion Division
Policy package title:	Strategic/Structural Health Equity Innovation and Implementation
Policy package number:	402
Related legislation:	HB 2087 #37 Health Care Interpreter; SB 70 Regional Health Equity Coalitions

Summary statement:

The Oregon Health Authority has limited capacity to complete current baseline equity and inclusion work for agency and Oregon, specifically related to health system transformation. This policy package not only addresses current structural and resource deficits but is also necessary to meet the needs of the agency to fulfill the 10-year strategic goal of eliminating health inequities in Oregon, including strategic planning development and implementation.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$5,825,829**	**$ 509,764**	**$ 946,685**	**$7,282,278**	**17**	**15.08**

Oregon Health Authority: 2021-23 Policy Package

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

The Oregon Health Authority has systemic capacity limitations which have impeded equity and inclusion driven work related to health system transformation. Without a more robust infrastructure to address social and health inequities and achieve health equity for communities disadvantaged by historical and structural racism, OHA will not meet agency initiatives or fulfill its mission to provide better health for all. OHA will fail to reach its 10-year strategic goal of eliminating health inequities in Oregon and populations of people in Oregon will continue to suffer preventable illness, chronic illness and premature death.

The problem of working without sufficient resources and the clear mandate to achieve greater health equity in Oregon health and health care delivery is longstanding. While the need for health equity work continues to grow in scope, visibility and priority, it is ultimately confined and constricted by an ongoing lack of resources. This POP literally implements a component of OHA's recently adopted definition of health equity, by seeking to redistribute resources and power within OHA to address health inequity and deliver on the Governor's long-range goal to achieve improved health equity.

Hence, this POP addresses current structural and resource deficits within OHA and connects the agency's new and evolving initiatives for addressing the COVID-19 pandemic and furthering health care reforms with innovative community engagement strategies as developed by the Equity and Inclusion Division, Community Partner Outreach Program (CPOP) and Tribal Affairs. Additionally, the disparate impact of COVID-19 has only intensified the need for a robust and interconnected OHA resource for strategic community engagement with impacted communities in order to inform:

- The state's long-term response to the COVID-19 pandemic

- The state's strategies for addressing structural health inequities more broadly, as reflected in CCO 2.0 policy goals, the 2021 State Health Improvement Plan, and the state's 2022 1115 waiver.

2. What would this policy package buy and how and when would it be implemented?

The policy package is an investment in infrastructure within the Equity and Inclusion division, including positions, position classification realignment and programmatic funding. It would first right-size the division and positions to meet current demands and build the infrastructure needed to support the agency's fulfillment of the 10-year goal to eliminate health inequities in Oregon. This policy package addresses that infrastructure-gap through additional positions, the reclassification of current management positions and additional programmatic funds. All are necessary to enhance the current infrastructure of the Equity and Inclusion division by deepening the bench to include more people to do the work. The work under this policy package is immediately implementable because of existing structure in the OHA Equity and Inclusion division.

This POP buys critical resources needed for the Equity and Inclusion division which is responsible to lead the work necessary to operationalize the ***health equity definition*** adopted by the Oregon Health Policy Board and OHA in October 2019:

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

The principles of the health equity definition must be integrated as an essential part of OHA's strategic plan framework including but not limited to ongoing community engagement on new policies and programs in the next 1115 Waiver; CCO 2.0 implementation and 3.0 development; public health modernization; the State Health Improvement Plan implementation and COVID-19 stabilization and sustainability work to come. This undertaking requires more staff with the capacity to develop expertise in ongoing health care transformation, public health modernization and COVID response and recovery within OHA. The agency also requires further development of both innovation, as well as the expansion of existing innovative strategies and programs. This includes the development and tracking of metrics and REALD data, health equity, non-discrimination and ADA policy and practice, culturally responsive community engagement and the expansion of Regional Health Equity Coalitions and Language Access, Health Care Interpreters and Traditional Health Worker programs. This work is necessary to develop capacity and operationalization across multiple divisions of the agency and the state, and right-size that capacity to meet the 10-year goal of the agency and the Governor's goals related to health equity.

Right-size Equity and Inclusion Division:

This policy package adds the following ten positions: one Research Analyst 3, three Operations & Policy Analyst 3 positions, two Operations & Policy Analyst 4 positions, two Program Analyst 3 positions, one Program Analyst 4 position, and one Executive Support Specialist 2 position. This request does not preclude the identification of additional positions that could work as specific liaisons with or be embedded in behavioral health, communications, Human Resources training and development, and the Ombud's program.

Add New and Right-size Managerial Positions:

This policy package adds two managerial positions: a Health Equity Innovation/Implementation Manager (PEM F) and an Operations Deputy (PEM E), and reclassifies two existing management positions to PEM F and reclassification of the Equity and Inclusion Director to PEM H.

Community Engagement:

In addition to rightsizing, the policy package also buys increased expertise in community engagement and outreach capacity. Community engagement and outreach is not only communication but is a practice-based expertise related to health equity which includes outreach, engagement, development and follow-up in a continuous loop of communication. OHA has a unique opportunity and responsibility to engage and form more effective partnerships with communities to identify, analyze, research and address policy and systemic barriers to guide effective implementation of strategic priorities. Investing in continuous and meaningful community engagement is essential to build trust and relationships with communities that experience the greatest health inequities due to structural and institutionalized oppression and racism. These include communities of color, people with disabilities, LGBTQ communities, immigrants, refugees, people with limited English proficiency, Tribes, and communities at the intersection of these identities. Additionally, it is critical that OHA shift away from models where interactions with communities are transactional and largely occur when the agency needs input, information or feedback for initiative-specific purposes. This model creates long-lasting barriers and mistrust. Instead, the agency needs to develop models for continuous community engagement capable of building long-term trust and relationships with communities.

Specifically, this policy package adds one of each the following five positions: Operations & Policy Analyst 1, Operations & Policy Analyst 3, Operations & Policy Analyst 4, one Program Manager 3, one Program Analyst 3, and one Administrative Specialist 2. These positions will bring a specific expertise in equity-focused community engagement and policy development and will coordinate across the entire agency and all divisions.

3. How does this policy package further OHA's mission and align with its strategic plan?

With Health Equity as its core value, the Oregon Health Authority has embarked on a strategic planning process to identify priorities and achieve the goal of improving the health of all people in Oregon. In that context, OHA has a unique opportunity and responsibility to engage and form partnerships with communities to address policy and

systems barriers and guide effective implementation of its strategic priorities. This policy package is imperative to the development and implementation of the OHA strategic plan and the 10-year goal of eliminating health inequities in Oregon. It creates the internal programmatic, resource, operational and staffing capacity to support the development and implementation of the strategic plan and necessary community engagement. In addition, the policy package also generates staffing expertise in both the evolving content of OHA's health system transformation and COVID-19 response and recovery strategies, as well as innovative and robust community engagement initiatives as implemented by the Equity and Inclusion division in partnership with Community Partner Outreach Program. As a result, OHA will have the infrastructure to make meaningful progress toward its 10-year goal of eliminating health inequities, addressing health disparities and achieving health equity in populations and communities most impacted by health inequities. Overall, the requested resources will enable OHA to better understand the full context of population-specific health inequities and meaningfully advance health equity in Oregon.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

This policy package ensures and sustains capacity for strategic and structural health equity innovation and implementation to achieve OHA's 10-year goal of eliminating health inequities in Oregon. To that end, OHA will develop a set of measures to drive efforts to reduce health inequities. The measures will align with five-year goals currently under development to inform and align with the broader set of 10-year strategic plan measures. There are also several process and outcome measures developed as part of the OHA Performance System. For this purpose, measures used to evaluate the success of this policy package will include existing indicators, indexes, and

composite measures as well as those that will be developed to provide clear direction, spur actions and reflect progress toward achieving health equity. The measures will be broadly focused in the following areas:

- Understanding and addressing the social determinants of health and health equity including structural drivers such as systemic racism and oppression.
- Developing, implementing and investing in continuous and meaningful community engagement to build trust and relationships with communities impacted by the greatest health inequities.
- Identifying and prioritizing community needs, and ultimately developing additional innovative and sustainable solutions to achieve health equity in all communities across the state.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

Yes. It is closely connected with the purpose of the OHA Performance System, which is to increase effectiveness in OHA's work to transform health and health care for the people of Oregon. The OHA Performance System is a framework that identifies and improves processes that will ultimately increase effectiveness in accomplishing the strategic goals, mission and values of the agency. Health Equity has been identified as a core value for the agency and therefore, Equity and Inclusion as a key goal has been woven throughout the outcomes and core operating and supporting processes in the OHA Performance System. This policy package will help OHA reach that desired outcome of health equity as an actively pursued value and goal across the agency and the state, including for example the expansion of the Regional Health Equity Coalition program. The Performance System, by identifying processes and measures, will help work toward that outcome and evaluate progress.

7. What are the long-term desired outcomes?

- Development and implementation of the community engagement work for the strategic plan and ongoing community engagement work for the agency.

- Development and implementation of the OHA strategic plan, including five-year goals and 10-year goal of the strategic plan.
- Expansion of Regional Health Equity Coalitions.
- Expanded capacity to support research and analysis in support of health equity programmatic and engagement needs and to connect across divisions within OHA to bridge health care reform initiatives and community engagement strategies.
- The elimination of health inequities in Oregon by 2030/31.
- Long-term savings to the overall health delivery system as health inequities are eliminated over the 10-year period.

8. What would be the adverse effects of not funding this policy package?

The problem of working without sufficient resources but the clear mandate to achieve greater health equity in Oregon health delivery is a long and historical one. While the need for this kind of work continues to grow in scope, visibility and priority, it is ultimately confined and constricted by a lack of sufficient resources. This policy package literally implements a component of OHA's recently adopted definition of health equity, by seeking to redistribute resources and power within OHA and the state to address health inequity and deliver on the Governor's long-range goal to achieve improved health equity. Therefore, without additional resources, it will be very difficult, if not impossible, to fully operationalize the fundamentals of the health equity definition within the agency and across the state. The lack of additional resources will also hinder the development of organizational and shared ownership of health equity as an actively pursued value and will ultimately prevent OHA from fully actualizing the 10-year goal to eliminate inequities in Oregon's health system.

This policy package is also significant for the communities facing inequities as communities will have opportunities to engage and share the barriers and challenges they experience. This will help the agency to better understand population-specific inequities. As a result, creative and sustainable solutions will be created to more

meaningfully address the conditions and needs that impact people's capacity to be healthy across the state. To make this meaningful with a significant equity impact, sustained, long-term efforts with dedicated fiscal investment are needed. Hence, without the additional resources through this policy package there will be a detrimental effect on OHA's ability to address health equity challenges at the community level.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

Over multiple biennia, the Equity and Inclusion division has reprioritized work and has reallocated two positions to support work related to health equity innovation within health system transformation. Focus areas for these positions include development of an Oregon-grown measure of health equity for CCO incentivization and CCO 2.0 contractual deliverable guidance and related support that focuses on newly mandated CCO contractual obligations related to health equity.

In 2016 the division worked with a LEAN specialist to apply LEAN practices to the work and structure. Recommendations were applied along with results of an operational assessment in 2015, by outside consultants. In 2019, community engagement work was assessed by an external consultant. Additionally, two staff members of the division were reassigned and dedicated almost exclusively to develop, plan and coordinate the agency's Community Engagement events/sessions for the 10-year strategic plan. This has worked short-term but is not sustainable medium to long-term.

10. What alternatives were considered and what were the reasons for rejecting them?

In 2015, under previous agency administration, seven positions were eliminated. Since then the division has reprioritized work and pursued efficiencies as described above, but unfortunately continues to lack sufficient capacity to meet current needs. Staff have been working in overdrive. With OHA's adoption of the 10-year goal to

eliminate health inequities, there are no viable alternatives except to invest the additional funds described in this policy package.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

While statute changes are not inherently required to implement this policy package, programs related to Traditional Health Workers, Health Care Interpreters, Race, Ethnicity, Language and Disability data collection and Regional Health Equity Coalitions would benefit from legislation that strengthens existing standards and requirements.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

Strengthening community engagement, Regional Health Equity Coalitions (RHECs) and Traditional Health Worker (THW) programs will enhance resources for Tribal Governments. It also Increases opportunities for local/county governments and health system, including coordinated care organizations (CCOs) to partner with RHECs and offer technical assistance and training to build capacity around health equity and the social determinants of health.

For example, a RHEC-capacity building grant to Warm Springs Confederated Tribes has successfully shown that additional RHECs run by Tribal Governments can enhance equity work with Tribes. Additionally, the ongoing collaboration between the division and Tribal Governments has resulted in the identification of a potential new THW worker category specific within the Tribes where there will also be additional benefit.

Another example is when Mid-Columbia Health Equity Advocates (MCHEA) successfully advocated to County Commissioners for a county ID card for all community members regardless of barriers related to age, housing

transportation, immigration status and cost. Having an official ID improves access to basic services and helps make law enforcement interactions less frightening.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

The Equity and Inclusion division is collaborating with the Health Policy and Analytics (HPA) division and the Oregon Health Authority Leadership Team.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

This policy package is solely focused on achieving health equity and equitable health outcomes for priority populations that are most disadvantaged by historical and contemporary racism and oppression, which are the root causes of health inequities. This policy package advances the operationalization of the agency's health equity definition and advancement toward the 10-year goal to eliminate health inequities.

Staffing and fiscal impact

Implementation date(s): July 1, 2021

End date (if applicable): None

15. What assumptions affect the pricing of this policy package?

The assumption that health equity and the 10-year agency goal are indeed priorities for the agency and the state.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

No, all aspects of the policy package fit within existing responsibilities of the agency including compliance with state and federal law, the current mission of the agency and the 10-year goal of the agency's strategic plan.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

No.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No, our work is not delivered in a caseload or service unit context.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

This policy package would establish 17 permanent, full-time positions:

- Research Analyst 3, Research and Analytics
- Operations & Policy Analyst 4, Accessibility Coordinator
- Operations & Policy Analyst 3, Public Investigator
- Operations & Policy Analyst 4, Regional Health Equity Coalition Lead (based on expansion Legislation)
- Program Analyst 3, Regional Health Equity Coalition (based on expansion Legislation)
- Program Analyst 4, Traditional Health Worker program
- Program Analyst 3, Health Care Interpreter program

- Operations & Policy Analyst 3, Strategic Coaching and Technical Assistance
- Executive Support Specialist 2
- Principle Executive Manager E, Operations Deputy

Reclassed Positions:

- Two Principle Executive Manager E positions to Principle Executive Manager F positions
- One Principle Executive Manager G to Principle Executive Manager H

Community Engagement:

- Operations & Policy Analyst 3
- Operations & Policy Analyst 4
- Administrative Specialist 2
- Project Manager 3
- Program Analyst 3
- Operations & Policy Analyst 1

20. What are the start-up and one-time costs?

None.

21. What are the ongoing costs?

All costs are ongoing, as they are staffing and programmatic in nature.

22. What are the potential savings?

Savings will be long-term to the health delivery system.

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

Funding for personal services in OHA Central Services, including the Equity and Inclusion division, are determined by an agency-wide cost allocation methodology. The budgeted funding splits are as follows, General Fund at 80 percent, Other Funds at 7 percent and Federal Funds at 13 percent. Federal funding sources include primarily Medicaid matching funds and other federal grants.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$2,584,791	$ 226,183	$ 420,040	$3,231,014	17	15.08
Services & Supplies	$3,241,038	$283,581	$526,645	$4,051,264		
Capital Outlay						
Special Payments						
Other						
Total	**$5,825,829**	**$509,764**	**$ 946,685**	**$7,282,278**	**17**	**15.08**

Fiscal impact by program

	Central Services				Total
General Fund	$5,825,829				**$5,825,829**
Other Funds	$ 509,764				**$ 509,764**
Federal Funds	$ 946,685				**$ 946,685**
Total Funds	$7,282,278				**$7,282,278**
Positions	17				**17**
FTE	15.08				**15.08**

Oregon Health Authority
2021-23 Policy Package

Division:	Health Systems Division
Program:	Medicaid, Tribal Affairs
Policy package title:	Indian Managed Care Entities
Policy package number:	403
Related legislation:	None

Summary statement:

Establish and support Indian Managed Care Entities at the request of Oregon's Federally recognized Tribes, which would provide critical care coordination services to American Indian/Alaska Native enrollees in the Oregon Health Plan.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$1,365,071**	**$0**	**$10,731,035**	**$12,096,106**	**0**	**0.00**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

In September 2018, during formal tribal consultation for the development of CCO 2.0, representatives of Oregon's nine Federally recognized tribes and urban Indian health program made a formal written request to OHA Leadership. This request was to assist in the creation of Indian Managed Care Entities (IMCEs), which would provide critical care coordination services to American Indian/Alaska Native (AI/AN) enrollees in the Oregon Health Plan. Section 1932(h) of the Social Security Act and federal regulations at 42 CFR §438.14 gives the state the authority to create Indian Health Care Entities. These IMCEs, when approved by the Centers for Medicare and Medicaid Services (CMS) via state plan amendment, would be the very first IMCEs in the nation. Other states and tribes have explored developing IMCEs but to date none have been created.

Work has continued since September 2018 in partnership with tribal health directors and staff to develop this proposal and move toward implementation. This vital priority requires a significant dedication of staff time, expertise, and agency resources across many different divisions and units. As of June 2020, four Tribes and the urban Indian health program are moving forward with establishing a total of five IMCEs, however ongoing effort, technical assistance, and resources are required to support implementation of these five IMCEs, as well as an additional four IMCEs that may move forward if these Tribes also decided to join this initiative.

The IMCEs are a non-risk-based program where Indian health care entities may provide managed care services as a Primary Care Case Management model and receive a Primary Care Case Management payment on a Per Member Per Month basis. Tribes are anticipated to receive 100 percent Federal Funds, and the urban Indian health program would be anticipated at a minimum to receive federal matching funds based on their clients' enrollment. A State Plan Amendment will be submitted. Federal matching funds is based on approval of that

SPA. This program will assist in reducing health disparities by ensuring the delivery and sustainability of coordinated, culturally responsive health care for American Indians and Alaska Natives.

2. What would this policy package buy and how and when would it be implemented?

OHA would procure technical assistance for the Tribes and urban Indian health program in designing and implementing the IMCE program in their health clinics. We are currently receiving technical assistance from two contractors – this request for continued technical assistance would continue this support through 2021-2023. Although it is not known precisely when we would receive CMS approval and have OHA implementation ready to support IMCEs, this request for assistance would ensure OHA is supporting the preparation necessary to establishing this program.

OHA would also ensure each IMCE receives their full Per Member Per Month (PMPM) payment for each AI/AN patient enrolled in the IMCE, regardless of the level of federal financial participation. It is likely that this program will be in place and making PMPM payments to IMCEs in 2021.

3. How does this policy package further OHA's mission and align with its strategic plan?

This proposal would further the triple aim of better health, better care, and lower costs by supporting IMCEs to deliver and coordinate, culturally responsive health care for their tribal populations served. This proposal would also help achieve the agency's goal of eliminating health disparities within ten years by improving the delivery and availability of health services that are limited to AI/AN OHP members, who are disproportionally fee-for-service and experience a dearth of specialty care and limited care coordination services. Full funding of this initiative would help further the Governor's goal of ensuring that we fully integrate health equity, tribal, and racial justice into our focus on social determinants of health.

All IMCEs will perform, at minimum, the following six functions:

- Provision of Telephonic or Face-To-Face Case Management
- Development of Enrollee Care Plans
- Provision of Enrollee Outreach and Education Activities
- Operation of a Customer Service Call Center
- Implementation of Quality Improvement Activities Including Administering Satisfaction Surveys
- Conduct Outcome Measurement and Provide Outcome Reports to OHA

Additional services may be provided at the option of the IMCE. By allowing tribal members to receive culturally responsive care coordination services from tribes and the urban Indian health program, from a nurse practitioner or physician assistant, and arranging transportation and arranging for services on site, this would allow tribal members to access health care while remaining connected to their community. Additionally, this program would provide funding for the Tribes and urban Indian health program to hire professional level staff to assist in on-site coordination of patient care.

By further integrating health care delivery for tribal members, this would also allow for Federal reimbursement for tribal based practices, which are culturally responsive services that have demonstrated effectiveness in improving health outcomes in tribal communities.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

The technical assistance is designed to help the Tribes stand up their IMCEs, so success would be measured by the timely and successful establishment of this program. Successful delivery of the technical assistance to Tribes would result in the establishment of IMCEs that meet the Tribes' community needs. Successful technical assistance to OHA would result in the successful submission and acceptance of the State Plan Amendment by CMS to establish the program. The benefits of this program would manifest as reduced health disparities among AI/AN. By honoring this request by tribes, it reinforces the agencies commitment to our government to government relationship.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

Yes. Within the OHA Performance System, "Health Equity" and "Partnership" have been identified as core values for the agency and "Equity and Inclusion" and "Effective Partnerships" as key goals have been woven throughout the outcomes, core operating and supporting processes in the OHA Performance System. This policy package would help OHA reach the desired outcomes of health equity and effective partnership by ensuring Oregon's AI/AN OHP members receive effective and culturally responsive health care.

Specifically, this policy package is closely tied to the "Engaging Community Stakeholders, Members and Partners" core process, which includes the following sub-processes:

- Building and maintaining relationships.
- Understanding, assessing, and responding to needs, concerns, and issues.
- Integrating inclusive and culturally responsive practice.

IMCEs also support the "Improving Clinical and Population Health" core process, which includes the following sub-processes:

- Evaluating and applying evidence of health service effectiveness, accessibility, and quality.
- Delivering coordinated, high quality and culturally responsive health services.
- Coordinating care.
- Providing technical assistance and improving quality of services and systems.

There is also a specific measure that tracks OHA's compliance with the Tribal Consultation and Urban Indian Health Confer Policy. Since this request was received during consultation it is important, we follow through to the best of our ability.

7. What are the long-term desired outcomes?

Implementing this policy package would help maintain good partnerships between the Oregon Health Authority and the nine Federally recognized Tribes. Moreover, this policy package will compensate the Tribes and urban Indian health program for providing culturally responsive care coordination services for the American Indian/Alaska Native community. Culturally responsive services coordinated by Tribes, including tribal based practices, have a demonstrated efficacy in Native communities and will help to reduce health disparities among AI/AN Oregonians. Ultimately, this will result in better health, better care, and lower costs for healthcare for Oregon's AI/AN OHP-members.

8. What would be the adverse effects of not funding this policy package?

Failure to fund this package would result in OHA continuing to move forward with honoring the Tribes' request, although without the necessary financial supports and technical assistance to ensure successful

implementation. Moreover, without additional support for Per Member Per Month payments, there will an impact on General Fund revenues that will create budget challenges as a result of the COVID-19 pandemic.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

OHA is moving forward with this project in partnership with the nine Federally recognized Tribes, the urban Indian health program, and our consultants and contractors. This policy package would provide financial support for this effort to ensure success.

10. What alternatives were considered and what were the reasons for rejecting them?

Not applicable. OHA Leadership accepted the Tribes' request to develop and implement this proposal.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

The four tribal governments and urban Indian program will be initially involved in implementing this program. The remaining five tribal governments may choose to implement later. This policy package would help maintain good relations between Oregon and the nine Federally recognized Tribes. OHA Leadership has committed resources to the implementation and success of the Tribes' proposal, and the successful implementation of this policy package will increase trust and improve the government to government

relationship between the Tribes and the state. Failure or delay in successfully implementing this proposal would strain these important relationships.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

No.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

This proposal would help to improve the health status and reduce health disparities among the Oregon's AI/AN communities. Compensating Tribes for care coordination of tribal members would ensure that tribal members are directed to culturally responsive and tribal-based practices, which are shown to improve health outcomes in tribal communities.

Staffing and fiscal impact

Implementation date(s): July 1, 2021

End date (if applicable): Not applicable

15. What assumptions affect the pricing of this policy package?

The assumptions used for the pricing are:

- Four Tribes and the urban Indian health program, also known as the Native American Rehabilitation Association (NARA), would participate in the implementation of the initial IMCEs.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

- The enrollment methodology for IMCEs is currently being developed by the tribes and urban Indian health program, and federal financial participation for these enrollees' care coordination services is currently unknown and will be subject to CMS input and review. This IMCE proposal is the first in the nation, and IMCE proposals have never been submitted to CMS, so there is uncertainty about the precise details of federal approval. Therefore, this pricing assumes IMCEs established by the Tribes would receive PMPM payments funded at 100 percent federal match, just as Medicaid services do. The IMCE established by the Urban Indian Health Program would receive a blended rate comprised of General Fund and Federal Funds. These assumptions cover the 2021-23 biennium.
- The total members were based on the number of Tribal FFS clients as of March 2020.
- The per member per month (PMPM) cost is $39.65. The PMPM calculation used a blend of the average salaries of a doctor, physician's assistant, nurse practitioner, and nurse midwife in Oregon to determine staffing costs of $35.75, with an assumption that one full-time IMCE staff person could coordinate the care of 500 members. The PMPM would include $3.90 for a 24-hour nursing triage line.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

OHA's Health Systems Division would be responsible for contracting with the Tribes and consultants, calculating and dispersing payments to Tribes, developing technical assistance and policy guidance and regulations, and facilitating member communication and enrollment in the IMCEs.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

System changes to MMIS to issue payments and enroll patients would need to be developed and automated, which would require additional resources. It may be necessary to create new business processes and procedures

to allow Enrollment/Eligibility staff to honor requests for enrollment in an IMCE. This may request additional funding for system changes and staff support.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

This policy package would not impact the OHP caseload but would impact services for a portion of OHP members. A portion of the estimated 12,153 AI/AN fee-for-service population would be enrolled in the IMCEs, depending on a methodology determined by the Tribes and urban Indian health program. The number of enrolled patients is likely to range from 5,000 to 10,000 AI/AN OHP members. OHP members enrolled in IMCEs would receive culturally responsive care coordination services.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

Existing HSD Medicaid staff would be responsible for the operation of this program.

20. What are the start-up and one-time costs?

The one-time costs would be $532,000 Total Funds ($243,000 General Fund). This includes consulting on how to implement an IMCE ($150,000 General Fund) and 24 months of care coordination to the Tribes and NARA until the IMCEs were up and running ($70,000 General Fund). It also includes an additional one-time cost of approximately $92,000 Total Funds to make updates to the Medicaid Management Information System that modifies the current enrollment and capitation processes for the IMCEs ($23,000 General Fund).

21. What are the ongoing costs?

The ongoing costs would be PMPM payments to IMCEs for AI/AN patients. General Fund for NARA and General Fund for a contractor to provide care coordination until the IMCEs are fully established and operational.

22. What are the potential savings?

Improvements in health outcomes and reduction in health disparities for AI/AN OHP members would result in additional health savings for OHA.

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

Total funds would be approximately $1.4 million General Fund and $10.7 million Federal Funds. The four federally-recognized Tribes would receive 100 percent Federal Funds. NARA's funds would be a blended rate of 72.45 percent Federal Funds and 27.55 percent General Fund. The contracting costs would be split 50-50 between General Fund and Federal Funds. The contracting costs of DXC would be split 75 percent Federal Funds and 25 percent General Fund.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services						
Services & Supplies	$242,967	$0	$288,900	$531,867		
Capital Outlay						
Special Payments	$1,122,104	$0	$10,442,135	$11,564,239		
Other						
Total	**$1,365,071**	**$0**	**$10,731,035**	**$12,096,106**	**0**	**0.00**

Fiscal impact by program

	HSD Medicaid	HSD Admin.			**Total**
General Fund	$ 1,122,104	$ 242,967			**$ 1,365,071**
Other Funds	$0	$0			**$0**
Federal Funds	$ 10,442,135	$ 288,900			**$10,731,035**
Total Funds	$ 11,564,239	$ 531,867			**$12,096,106**
Positions	0	0			**0**
FTE	0.00	0.00			**0.00**

Oregon Health Authority
2021-23 Policy Package

Division:	Central Services
Program:	Equity & Inclusion Division, Tribal Affairs
Policy package title:	Tribal Traditional Health Worker
Policy package number:	404
Related legislation:	House Bill 2088

Summary statement:

This policy package would fund the creation of a sixth, separate Traditional Health Worker category for Indian Health Care Providers (IHCP) which would allow the Oregon Tribes and Urban Indian Health Program to develop a program to use in their communities. This would include developing curriculum, training staff, and certification. Once certified, IHCPs would be able to receive Medicaid reimbursement recognizing tribal based practices and other culturally specific services under this new worker type. Approval of the new provider type would occur via the State Plan Amendment process.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$171,706**	**$15,025**	**$27,901**	**$214,632**	**1**	**0.88**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

Indian Health Care Providers (IHCPs) provide critical health services to their tribal members, families and communities. Traditional Health Workers (THWs) are community members who also understand health issues and the health care system and are uniquely positioned to work with communities to identify and address the underlying causes of health problems. THWs became formally recognized as a valued element of community health through Oregon's healthcare transformation efforts. Some of the IHCPs and current tribal-based practices do not currently fit within the five existing THW categories.

2. What would this policy package buy and how and when would it be implemented?

This policy package would fund one full-time position for the Equity and Inclusion Division (OEI) to create and administer this new program, and its ongoing work. Partnering closely with Tribal Affairs, Health Systems Division Tribal Liaisons and the Tribal Health Programs, the position would support the process to develop a curriculum, organize trainings, update the THW registry, assist in the application process and provide technical assistance for certification moving forward. The position would assist in contracting with an organization to create the curriculum in partnership with Oregon Tribes and Urban Indian Health Program and funding to support tribal representatives to be trained in the new curriculum. To date, one curriculum and training specific to Family Support Specialists has been created for tribal communities by Oregon tribal representatives with support from OEI and Tribal Affairs. It was a good first step to create something that could be built upon. Now we would like to continue to honor the tribes' request and expand this important work. Additional funding to support this work would be for the 2021-23 biennium.

3. How does this policy package further OHA's mission and align with its strategic plan?

This proposal would help achieve the agency's goal of eliminating health disparities within ten years. American Indians and Alaska Natives (AI/AN) experience some of the most significant health disparities among Oregonians, a direct result of colonization, termination, and relocation. Funding this initiative would help further the Governor's goal of ensuring OHA fully integrate health equity, tribal, and racial justice into its focus on social determinants of health. This proposal would further the triple aim of better health, better care, and lower costs by ensuring the delivery of culturally responsive health care for American Indians and Alaska Natives.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

Success of this program will be measured by the increase in utilization of traditional health workers in tribal communities and the culturally relevant services they provide to assist in reducing health disparities in tribal communities.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

Within the OHA Performance System, "Health Equity" has been identified as a core value for the agency and "Equity and Inclusion" as a key goal has been woven throughout the outcomes, core operating and supporting processes in the OHA Performance System. This policy package would help OHA reach the desired outcome

of health equity by ensuring Oregon's Native OHP members receive effective and culturally responsive health care.

Specifically, this policy package supports the "Engaging Community Stakeholders, Members and Partners" core process, which includes the following sub-processes:

- Understanding, assessing, and responding to needs, concerns, and issues.
- Integrating inclusive and culturally responsive practice.

Tribal Traditional Health Workers would also support the "Improving Clinical and Population Health" core process, which includes the following sub-processes:

- Delivering coordinated, high quality and culturally responsive health services.
- Coordinating care.

7. What are the long-term desired outcomes?

Long term outcomes would include increased access to culturally specific health care services along with reducing adverse health outcomes within tribal communities.

8. What would be the adverse effects of not funding this policy package?

If this package goes unfunded it would be very difficult to implement this new program as we do not currently have the staff to take on this additional work that has been requested by Oregon tribal representatives. The ongoing disproportionality and over representation of American Indian/Alaska Natives health disparities will continue.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

This concept was originally developed by an Oregon Tribal Member working in their tribal clinic. Tribal Affairs has been supporting the concept by collaborating with tribal representatives and the Equity and Inclusion Division to create the Family Preservation Training. This curriculum was written for tribal communities by tribal members as a training for Family Support Specialists in collaboration with the Oregon Family Support Network and with support from the Northwest Portland Area Indian Health Board. Although still a new program it has been utilized in several Oregon Tribal communities with success. Building on that success is one reason OHA would like to expand the idea to create a Tribal Traditional Health Worker category to address the additional ongoing issues IHCPs face with their services not fitting in the existing THW model.

10. What alternatives were considered and what were the reasons for rejecting them?

Continue utilizing the current Traditional Health Worker categories. This does not meet all the needs for Tribal Health Programs.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

Yes, House Bill 2088 (2021) would amend ORS 414.665 Section 1 to add: "(f) A tribal traditional health worker".

It would also amend ORS 414.025 to add the definition of tribal traditional health worker:

"**Tribal traditional health worker**" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 (Traditional health workers utilized by coordinated care organizations) and who: (a) Has expertise or experience in tribal health;

(b) Works in a tribal or urban Indian community, either for pay or as a volunteer in association with a local health care system;
(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves;
(d) Assists members of the community to improve their health, including physical, behavioral, and oral health, and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;
(e) Provides health education and information that is culturally appropriate to the individuals being served;
(f) Assists community residents in receiving the care they need;
(g) May give peer counseling and guidance on health behaviors; and
(h) May provide direct services including tribal-based practices.

The LC would also amend ORS 413.600 Section 2(a) to add: "(f) tribal traditional health workers, as defined in ORS 414.025".

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

Tribal Governments would see an increase in the workforce of culturally specific health care workers and an increase in Medicaid reimbursement for these services as many of these services are currently not eligible for reimbursement.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

OHA Tribal Affairs, OHA Equity and Inclusion Division, OHA Tribal Liaisons, Oregon Tribes and the Urban Indian Health Program. Tribal Based Practices are also a strategic pillar in the Oregon Tribal Behavioral Health Strategic Plan, supported by the Alcohol and Drug Policy Commission Strategic Plan and the Governor's Behavioral Health Advisory Council.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

American Indians and Alaska Natives (AI/AN) continue to be impacted by health inequities due to historical and intergenerational trauma. Tribal Health Programs provide culturally specific health services that have demonstrated efficacy in tribal communities, which assists in achieving health equity. OHA would be honoring the government to government relationship to support Tribal Governments to create programs that best meet the needs of their people. This proposal would improve the health of American Indians and Alaska Natives and appropriately reimburse the tribes for health services they have provided to their communities for generations.

Staffing and fiscal impact

Implementation date(s): July 1, 2021

End date (if applicable): Not applicable.

15. What assumptions affect the pricing of this policy package?

The assumption that health equity and the 10-year agency goal are indeed priorities for the agency and the state.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

Yes, the Equity and Inclusion Division and OHA Tribal Affairs and Tribal Liaisons will be responsible for creating this new program. Working closely with the Tribal Health Programs to create a curriculum, organize trainings, make updates to the THW registry, assist in the application process, and provide technical assistance for certification moving forward and Medicaid reimbursement.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

No.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

This policy package would not impact the Oregon Health Plan caseload but would result in an increase in services to patients/clients served by Indian Health Care Providers.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

This proposal requests one new permanent, full-time Program Analyst 3 position for the Equity and Inclusion Division to create this new focus of the THW program.

20. What are the start-up and one-time costs?

Not applicable.

21. What are the ongoing costs?

All costs are ongoing, as they are staffing and programmatic in nature.

22. What are the potential savings?

OHA may realize long-term savings due to more cost-effective, high-quality care being delivered to OHP members.

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

Funding for personal services in OHA Central Services, including the Equity and Inclusion Division, are determined by an agency-wide cost allocation methodology. The budgeted funding splits are as follows, General Fund at 80 percent, Other Funds at 7 percent and Federal Funds at 13 percent. Federal funding sources include Medicaid matching funds and other federal grants.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$141,292	$ 12,364	$ 22,960	$176,616	1	0.88
Services & Supplies	$30,414	$2,661	$4,941	$38,016		
Capital Outlay						
Special Payments						
Other						
Total	**$171,706**	**$ 15,025**	**$ 27,901**	**$214,632**	**1**	**0.88**

Oregon Health Authority: 2021-23 Policy Package

	Central Services Office of Equity & Inclusion	Central Services COO/CFO	Central Services SAEC	**Total**
General Fund	$150,477	$544	$20,685	**$171,706**
Other Funds	$13,168	$47	$1,810	**$ 15,025**
Federal Funds	$24,451	$89	$3,361	**$ 27,901**
Total Funds	$188,096	$680	$25,856	**$214,632**
Positions	1	0	0	**1**
FTE	0.88	0.00	0.00	**0.88**

Oregon Health Authority
2021-23 Policy Package

Division:	Health Systems Division
Program:	Medicaid
Policy package title:	Operate FFS Like a CCO
Policy package number:	407
Related legislation:	None

Summary statement:

This policy package would fund nine new positions to improve the Oregon Health Plan (OHP) fee-for-service (FFS) program operations and address several identified program gaps by aligning the fee-for-service delivery system with that of a coordinated care organization. The adverse effect of not funding this package is that program gaps will persist, OHP members in FFS will continue to have a health plan that is inferior to CCO plans, and important policy work, such as fee schedule and rule updates, will continue to be delayed. Avoidable problems with OHP payment to providers will continue to occur.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$11,057,223**	**$0**	**$18,467,168**	**$29,524,391**	**9**	**6.75**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

While the vast majority of Oregon Health Plan (OHP) members are enrolled in a coordinated care organization (CCO), which is a network of all types of health care providers who work together in their local communities, approximately 100,000 OHP members' benefits are administered by the Oregon Health Authority (OHA) through a fee-for-service (FFS) program, also known as Open Card. CCOs improve health outcomes and lower costs by focusing on prevention and helping people manage chronic conditions, like diabetes, which in turn helps reduce unnecessary emergency room visits. Though FFS members are eligible for the same OHP benefits, they do not receive the same level of coordinated care as those enrolled in CCOs. CCO enrollees benefit from CCO staff working with providers in innovative ways to improve the quality and coordination of healthcare. Due to its current level of staffing, the FFS program is unable to devote necessary staff time to working with providers on behalf of members in this way.

To assure the same level of service and care coordination provided to CCO members and better meet the needs of OHP members in FFS, the state must transform the FFS program to operate like a CCO. Due to a lack of resources, including adequate staffing, the state is not currently equipped to transform the FFS program to operate like a CCO. In its role as a FFS delivery system, OHA issues detailed guidance on tens of thousands of medical services covered by OHP. The state does this through administrative rules, by publishing guidance documents and fee schedules, creating forms, developing operations procedures for staff, answering questions, and providing technical assistance. This work will continue and expand as the FFS program transforms to operate like a CCO. Health Plans, and the state in this role, must be nimble and continually update rates and coverage details. The state's ability to meet this need is hampered by its current staffing levels as described below. As a result, providers serving OHP FFS members are often left operating with outdated inaccurate policy details. It is not uncommon for policies to be 3 to 5 years out of date. Out of date rules and policies for

FFS are problematic for the entire Medicaid system because FFS serves as the floor against which CCOs are measured. This can make it difficult for the agency to ensure that CCOs are providing high quality care for their enrollees. Additionally, there are known gaps in FFS programs impacting FFS members that the agency needs funding to solve. These challenges stem from significant changes made to the Medicaid program at the state and federal level over the last few years. These changes have made the Medicaid program much larger and more complex but have not been accompanied by increased investment and additional staffing to manage that complexity and growth. The biggest driver of increased complexity has been the Affordable Care Act expansion in 2014, which more than doubled the Medicaid population served in Oregon. The state went from serving approximately 400,000 individuals to more than 1,000,000- an increase of more than 600,000 members. With the creation of CCOs in 2012, it was assumed that the vast majority of Medicaid enrollees would be served by CCOs. While that has held true, there is still a significant number of Medicaid recipients enrolled in the FFS program. The number enrolled is approximately 100,000 members making the FFS program the third largest "plan" in Oregon. Experience has shown that the FFS program will remain sizeable and will require investment and attention to ensure its members receive the same level of care coordination as CCO members.

2. What would this policy package buy and how and when would it be implemented?

The policy package includes nine additional staff and funding to address several identified program gaps.

Staff:

The nine positions include a Physician Specialist, a Manager, and an Operations and Policy Analyst 4 (OPA4) to lead the transformation work that this package would fund. The physician and the manager would provide direction and oversight for the entire FFS program and focus on health equity, robust care coordination and improved access to services for the FFS populations. In operating the FFS program, OHA must frequently consider unique the medical circumstances of its members. There is more work than can be covered by existing

MD and managers as OHA moves into new and transformative areas of health care. The OPA4 staff would focus on the FFS Medicaid behavior health services to ensure they are well coordinated with non-Medicaid programs and members' needs are being met.

The other six positions are Operations and Policy Analyst 1 positions (OPA1), a Research Analyst, and a Fiscal Analyst. These positions are to perform critical program maintenance work and provide technical assistance related to coverage and billing within the FFS Medicaid programs. Investing in these additional staff will allow the current professional-level program leads to focus on health outcomes for members in their respective program areas. This will allow existing staff to work at the top of their classification and manage their program areas to best and efficiently meet the needs of the FFS members.

Program gaps:

- Increase rates for Enteral/Parenteral Nutrition and IV supplies. Providers report that rates for these supplies are too low to cover their expenses and as a result they limit the number of FFS OHP members they serve. This package would address this problem by increasing rates to match providers' acquisition costs for these supplies.
- Fund the use of the Lifecourse model in our behavioral health programs. Lifecourse model is designed to capture an individual's experiences, social determinants of health, culture, goals, wants and needs to effectively plan services and supports needed to achieve and maintain a level of independence in their life. Lifecourse model is used in identifying these and other areas in a shared decision-making effort toward person-centered service planning. The goal is for the individual to control and own the details and decisions with regard to the direction of their life. The cost for this is in the staffing described above. It is an example of how we could use our regulatory authority to drive transformation in the FFS program. But to do so we need staff to conduct the oversight and monitoring activities.

- Add transition services and services to assist in obtaining or maintaining employment to the 1915i State Plan and adjust the criteria so additional members will be eligible for 1915i services to meet their needs. Transition services are vital for members to step down from higher levels of support toward independence. To effectively transition, individuals must maintain the skills acquired in higher levels of supports. Transition services are used to educate incoming service providers about successful services and techniques to aid maintenance. Funding would be to cover new services and for increased utilization when more members are eligible for existing services.
- Adding in-home settings as a service location for BRS. Funding is in part included in the staffing increase above to develop and oversee a new in-home service program. This new in-home service program would be used for children returning to their biological home after receiving BRS or residential services, providing needed parent education and services for skill maintenance. Additionally, this service would function as a diversion for those children at risk of out-of-home placement due to behavioral concerns or involvement with juvenile justice. Funding would also be needed because there would likely be some increase in the number of clients in addition to those BRS clients served with the addition of this service location.
- Increase rates in the ABA program. Access to ABA services is below what we expect in the FFS program. Low rates are likely a factor and needs to be addressed to properly serve our members.
- Study delivery of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) for FFS eligible children. EPSDT is a set of federal requirements governing Medicaid coverage for children. From the federal perspective Oregon's program is compliant however this benefit is not well understood by members and providers in Oregon. Funding for this study is included in the staffing above. The study would likely result in OAR revisions, new guidance and FAQs aimed at program improvement.
- Change the payment model for interpreter services in the FFS program. Currently interpreter services are considered a practice expense for FFS providers. This means that OHA has very little influence over the

quality of these services and providers are incentivized to reduce these expenses as much as possible. This package would fund OHP to pay directly for interpreter services in the FFS program. This model is exactly how all CCOs fund these services and it gives them a powerful lever to ensure members receive quality service. OHA needs this lever for the FFS program so it can better serve its limited English-speaking members and reduce health inequities for this vulnerable population.

3. How does this policy package further OHA's mission and align with its strategic plan?

This policy package would allow FFS program staff to focus strategically on ensuring access to quality health care for the FFS population by identifying and addressing gaps. All program areas will benefit but the funding will particularly benefit behavioral health services for the FFS population.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

Many processes and program details are expected to improve with funding for this package but the most important measure would be improved health outcomes for FFS members. Improved health outcomes would be seen in improvement for FFS using the same metrics used for CCOs. Improvement on these metrics would show that OHA has successfully transformed FFS to operate like a CCO.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

Yes. Improving Clinical & Population Health and Developing, Implementing, and Managing Programs are core process for HSD in OHA's Performance System. The Medicaid programs included in this policy package are among the most consequential programs managed by HSD and they are designed to improve the health of Oregonians.

7. What are the long-term desired outcomes?

The long-term desired outcome is for the FFS program's performance to keep pace with CCOs on the same metrics. Particularly metrics measuring health outcomes in the OHP population. The FFS program needs to be operated to drive toward the same outcomes we expect of our CCOs.

8. What would be the adverse effects of not funding this policy package?

HSD will continue to make tough prioritization decisions as we are today. Some important work will be delayed and health disparities will persist unaddressed and some even unidentified. HSD will not be able to operate the FFS to the standards that we expect of our CCOs and OHP FFS members will continue to receive services through a program inferior to CCOs.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

FFS managers actively and strategically assign work and juggle priorities with the staff that we have. We use our discretionary funds to purchase reference materials, computer software, and staff training to enhance efficiency. Despite these efforts this often means doubling up program work for staff and choosing to delay important projects.

10. What alternatives were considered and what were the reasons for rejecting them?

An alternative would be to petition the Federal government to allow the state to end the FFS program and transition all OHP members into CCOs. This alternative is appropriate for approximately 90% of OHP members and OHA continues to work on increasing this percentage however federal law and other considerations, including state law, necessitate that the FFS program will continue to exist. For example, the agency must allow Native Americans the choice to have a FFS program. Individuals with dual Medicare-Medicaid eligibility also have the right to choose to be enrolled in a CCO or the FFS Program.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

Some tribal and local government agencies are providers in the FFS network. They would see improved service to their members as a result of more robust care coordination and increased access to providers

13. What other agencies, programs or stakeholders are collaborating on this policy package?

All providers in the OHP FFS network would benefit from this policy package, but none are collaborating with us on this package.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

This policy package would have a direct positive impact for populations with in the FFS membership who are impacted by health inequities because HSD would have staff that can focus on identifying and addressing these needs. Staff would rebuild the FFS program and transform services to be accountable and responsive to member's needs.

Staffing and fiscal impact

Implementation date(s): January 1, 2022

End date (if applicable): Not applicable.

15. What assumptions affect the pricing of this policy package?

E/P IV – Pricing was based on total claims less reimbursed amounts. Rates has not been adjusted for years and experienced a reduction in 2015.

Transition Services - $1,800 rate is based on similar APD Services and 173 count represents statewide behavioral health tier 2 capacity.

Interpretive Services - American Sign Language (ASL) & Non-English (N-E) projected cost per claim is $60. Services for CCO population are covered under the capitation payment. Utilization expected to be at 70 percent for the first 12 months from initial implementation and 100 percent thereafter.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

BRS Home - Community Step Down Proctor is chosen as a base rate as it consists of costs required for the home as a service location. Parent training only therefore proctors in the rates have been removed as foster parents will not be trained. Rate set at $110.98 per day with services anticipated to be 3 times per week for 8 weeks. Projected annual count of 2,700 annually.

ABA Rates – Increase procedure codes 97153 ($44) and 97155 ($52) to $55 per hour. This estimate is representative of the potential annual cost of CCO rates if the fee schedule increase is implemented. The actual CCO cost impact may differ depending on the timing of the increase as well as actual CCO experience.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

All program areas in HSD's FFS program would have new responsibilities to monitor health outcomes and member experience. The program would be rebuilt to be responsive to these identified needs by adjusting and improving.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

No.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

This policy package would fund client caseloads or services increases in two program areas.

Transition Services: Funding would cover services for 260 additional members added to the caseload and new services to assist members in obtaining/maintaining employment.

BRS: Funding would cover 2,700 additional members added to the caseload and add a new service location.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

This policy package would establish nine permanent, full-time positions.

- One Physician Specialist to provide clinical direction and expertise to inform the administration of the FFS program.
- One Principle Executive Manager G position to oversees all FFS operations and focus on delivering on the promise of health care transformation for FFS members.
- One Operations and Policy Analyst 4 position for the behavioral health program. This analyst would lead the complex coordination between our team, the Non-Medicaid behavioral health team, and various teams under ODHS.
- Four Operations and Policy Analyst 1 positions to take over program maintenance tasks currently done by Operations and Policy Analyst 3-level staff; one for hospital, one for behavioral health, one for DME, and one shared for several other programs. The primary duties for these staff would be to keep rates and billing code details current and accurate in MMIS, maintain our Fee Schedules and guidance documents and receive and process documents from providers as part of our oversight and compliance activities.
- One Research Analyst 3 to conduct complex data quarries, to build tools to automate data processes, and to provide data related technical assistance to our team on topics that are highly specific to our work.
- One Fiscal Analyst 3 to lead in-house rate development the FFS team does in coordination with the Actuarial Services Unit. This is primarily for dental and behavioral health programs. It also includes select

services in many other programs in which rates are not set in reference to CMS rates and must be developed in-house.

20. What are the start-up and one-time costs?

None.

21. What are the ongoing costs?

The nine positions would be permanent and would create ongoing costs. Funding to fill program gaps in the following areas would add services to the OHP benefit, increase rates, or increase utilization of existing services. These would be on-going costs.

- Increase rates for Enteral/Parenteral Nutrition and IV supplies.
- Add transition services and services to the OHP benefit.
- Add in-home settings as a service location for BRS to allow additional utilization of this service.
- Increase rates in the ABA program.
- Change the payment model for interpreter services in the FFS program. Payment for these services would be a new and ongoing cost.

22. What are the potential savings?

No savings are anticipated.

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

General Fund and Federal Funds.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$715,728		$840,188	$1,555,916	9	6.75
Services & Supplies	$153,794		$180,502	$334,296		
Capital Outlay						
Special Payments	$10,187,701		$17,446,478	$27,634,179		
Other						
Total	**$11,057,223**		**$18,467,168**	**$29,524,391**	**9**	**6.75**

Fiscal impact by program

	HSD Medicaid	HSD Program Support & Administration	**Total**
General Fund	$10,187,701	$869,522	**$11,057,223**
Other Funds	$0	$0	**$0**
Federal Funds	$17,446,478	$1,020,690	**$18,467,168**
Total Funds	$27,634,179	$1,890,212	**$29,524,391**
Positions	0	9	**9**
FTE	0.00	6.75	**6.75**

Oregon Health Authority
2021-23 Policy Package

Division:	Public Health Division (PHD)
Program:	Health Promotion and Chronic Disease Prevention
Policy package title:	Tobacco Retail Licensure
Policy package number:	408
Related legislation:	House Bill 2071 (2021)

Summary statement:

Tobacco is the leading preventable cause of death and disease in Oregon, costing the state $2.9 billion and nearly 8,000 lives every year. Moreover, the burden of tobacco use is not distributed evenly, falling heavily on Oregonians with low incomes, African Americans, Native Americans and Alaska Natives, and those who identify as LGBTQ+. This policy package would establish a strong statewide licensing system for retailers that sell tobacco products and inhalant delivery systems. It would equip OHA-PHD with new tools to educate retailers about tobacco laws, and – critically – to hold tobacco retailers that sell tobacco illegally accountable. Without statewide tobacco retail licensure, Oregon cannot robustly enforce tobacco laws such as the minimum legal sales age. A retail license could make it easier to enforce other tobacco sales laws such as tax collection compliance, counterfeit product sales, and compliance with federal laws (for example, no single cigarette sales or self-service displays of tobacco products).

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$2,078,226**	**$0**	**$2,078,226**	**12**	**7.86**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

Tobacco use remains the top preventable cause of death and disability in Oregon and costs the state $2.9 billion each year in medical costs and lost productivity. Addiction to nicotine nearly always starts in adolescence: Nine out of ten adults who smoke started smoking before turning 18. In 2019, 16 percent of Oregon tobacco retailers illegally sold a tobacco product (cigarette, e-cigarette or little cigar/cigarillos) to a person under the age of 21. The rapid increase of e-cigarette use by youth has contributed to the highest overall high school tobacco use rates since the year 2000. Currently 1 in 4 Oregon high schoolers uses e-cigarettes or other vaping products. Keeping these products out of the hands of children has the potential to prevent a generation addicted to nicotine.

In Oregon, there is no state license required to sell tobacco products or inhalant delivery systems (IDS). Without a state license, the state is missing key tools to enforce the tobacco minimum legal sales age and implement other tobacco sales laws that could prevent youth tobacco use. Regional variation in tobacco licensing exists across Oregon. As of February 2020, two counties have fully implemented tobacco licensure policies with license fees sufficient to cover administration and enforcement. In other jurisdictions, the licensing program policies and associated fees are currently insufficient to allow for implementation of the program. This results in regional inequities, where children in communities most impacted by tobacco use and industry targeting – particularly Native American and Alaska Native, Latino, and rural Oregonians – do not benefit from a basic level of protection provided by Tobacco Retail Licensure (TRL).

Without a state-wide licensure system, state and local governments do not know exactly who is selling tobacco products and IDS. The recent public health emergency E-cigarette or Vaping Associated Lung Injury (EVALI) made clear that the state was unable to fully identify and reach all tobacco retailers in Oregon for immediate education and enforcement of Executive Order 19-09. Executive Order 19-09 enacted a temporary ban on the

sale of flavored vaping products as well as other sources or additives identified in cased of vaping-related lung injury or death. This was a learning opportunity of the value of licensing for effective policy enforcement.

TRL is also a mechanism to hold retail store owners accountable for illegally selling tobacco to underage persons and for breaking other tobacco laws. Currently, most enforcement action for illegal tobacco sales to minors is taken on a store clerk, which means there is little incentive for retail store owners or managers to reduce illegal sales. Retail stores that regularly sell to underaged persons are well known by youth who seek tobacco. These stores become regular sources of tobacco products for youth at risk of nicotine addiction. This complicates enforcement of underage sales inspections and other tobacco retail laws.

2. What would this policy package buy and how and when would it be implemented?

TRL creates a mechanism to hold retail store owners accountable for selling tobacco illegally to underage persons and for breaking other tobacco laws. This policy package requires tobacco and IDS retailers in Oregon to obtain a license. Retailer licensing fees and any civil money penalties for violations cover the cost of administration and enforcement of the license. This includes retailer education and yearly inspections. OHA estimates that there are 4,000 tobacco product and IDS retailers operating brick and mortar locations in the state. The cost of an annual license is estimated to be between $250-$500 and would go into effect on January 1, 2022.

OHA estimates that administration and enforcement of the license would require 11 permanent positions (4 starting September 2021 and 7 starting January 2022) and 1 limited duration position lasting one year (starting September 2021). This estimate assumes OHA conducts enforcement across the entire state. However, the policy package allows for local jurisdictions to opt into responsibility for enforcement of the state law, and OHA expects some counties will take this option. Licensing costs and cost of administration will depend on the

level of enforcement taken on by local jurisdictions. The program estimates $215,817 for initial one-time costs and $1,862,410 in ongoing costs, which would be covered by program fees.

3. How does this policy package further OHA's mission and align with its strategic plan?

Tobacco use remains the top preventable cause of death and disability in Oregon. Addiction to nicotine nearly always often starts in adolescence: nine out of ten adults who smoke started smoking before turning 18. Due to aggressive targeting by the tobacco industry, rates of youth tobacco use are highest among youth who are lower income, Native American, African American, or LGBTQ+. A tobacco retail license would have the greatest benefit for groups targeted by the tobacco industry and would benefit communities living with historic and current injustices.

This policy package supports OHA's mission by helping prevent youth tobacco addiction and helping create healthier communities throughout Oregon. It provides a foundational expectation that sales to youth will not be tolerated throughout Oregon, including areas unlikely to adopt tobacco retail policies locally. Additionally, this policy package ensures the equitable enforcement of tobacco laws by holding tobacco retailers responsible for ensuring employees have the skills and tools necessary to abide by laws, creating sustainable change in the workplace for low-wage workers.

Tobacco use costs Oregon about $2.9 billion each year in medical costs and lost productivity. Strong TRL coupled with effective enforcement can reduce youth tobacco use, saving the state significant resources; a step toward achieving the health care triple aim. In addition, tobacco retail licensing can be a foundation for state or local retail policies that would further reduce tobacco use. This means a stronger foundation to rectify injustices and reconcile disproportionate rates of disease and addiction.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

Key indicators of success for this policy package include decreased rate of illegal tobacco sales to minors, fewer youth reporting that tobacco and e-cigarettes are easy to get in Oregon, and ultimately, lower rates of youth tobacco use. In 2019, 16 percent of Oregon tobacco retailers made an illegal tobacco sale to an underage person, and violation rates were higher for products popular with youth. One in five tobacco retailers sold e-cigarettes illegally, and one in four sold cigarillos illegally to underage persons. Rates of 11th grade e-cigarette use in Oregon increased 80 percent from 2017 to 2019, from 13 percent to 23percent. Enforcement of a strong tobacco retail license, paired with other tobacco control interventions, are expected to decrease youth tobacco use.

OHA can also measure the success of this policy package by measuring the number of local policies that build on statewide TRL to further decrease youth tobacco use. The Tobacco Prevention and Education Program (TPEP) funds every Local and Tribal Public Health Authority in Oregon to decrease youth tobacco initiation and support individuals who are attempting to quit. Local TPEP programs will be able to build on a state TRL with other interventions to address tobacco retailer density, price promotions, and other interventions that can reduce youth use and improve health equity. Local initiatives and success would indicate redistribution of resources and power to communities experiencing the health effects of injustice.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

Yes. The percent of Oregonians living in a jurisdiction requiring tobacco retail licensure is an OHA-PHD Public Health Accountability Metric. This policy package directly relates to this metric as passing a state tobacco retail license would provide 100 percent coverage to all communities in Oregon.

In addition, reduced adult and youth tobacco use, which are long-term desired outcomes for this policy package, are also included in multiple performance indicators for OHA-PHD. This policy package will help achieve the Public Health Accountability Metric to reduce youth and adult tobacco use, address tobacco use as a priority area from the 2015-2020 State Health Improvement Plan, and improve the OHA-PHD's Health Indicators for current cigarette smoking prevalence and cigarette packs sold per capita. Rates of tobacco use among all adults and among Medicaid recipients are OHA Key Performance Measures.

7. What are the long-term desired outcomes?

When used to enforce effective policies, licensing can reduce the number of Oregon children and young adults who become addicted to tobacco, help current tobacco users quit, and reduce health care costs for the State of Oregon. Further, decreasing tobacco-related health disparities is an example of addressing injustices related to tobacco industry targeting and a lack of protections for populations disproportionately impacted by health inequities.

A strong retail license system creates a straightforward way to track businesses that sell tobacco products and IDS and manage enforcement of tobacco laws, such as the minimum legal sales age of 21. Laws that prohibit sales to underage persons are important but are not enough on their own to keep kids from using tobacco and nicotine products. To prevent youth initiation of tobacco and e-cigarettes, Oregon needs a comprehensive

approach that holds retailers accountable for illegal sales. A license provides an expectation of retailers statewide that illegal sales to youth will not be tolerated. This concept sets in motion an effective tool for reducing the number of Oregon children and young adults who become addicted to nicotine.

8. What would be the adverse effects of not funding this policy package?

Historically, the tobacco industry has aggressively marketed tobacco products to specific cultural and ethnic groups. This perpetuates historic and current injustices, exacerbates health disparities, and disproportionately harms communities of color, resulting in higher rates of disease and death. Additionally, rates of youth tobacco use are highest among youth who are lower income, Native American, African American, or LGBTQ+. If Oregon does not implement a state tobacco retail license, these disparities will continue. This package will help OHA achieve the 10-year strategic goal of eliminating health inequities. Implementing a state license protects all Oregonian youth, including those in rural areas not currently protected by tobacco retail policies.

Oregon is one of only eight states that does not require tobacco retailers to have a license. Without a state tobacco license, there is no official centralized list of active tobacco retailers and no system in place for effective retailer training and outreach. Without statewide tobacco retail licensure, Oregon cannot robustly enforce tobacco laws such as the minimum legal sales age. In addition, a retail license could make it easier to enforce other tobacco sales laws such as tax collection compliance, counterfeit product sales, and compliance with federal laws (for example, no single cigarette sales or self-service displays of tobacco products).

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

Related Tobacco Retailer Licensing concepts were considered by the Oregon Legislature in prior sessions, obtained support, but never fully cleared the legislative process. Most recently, Senate Bill 1577 in the 2020

legislative session gained significant momentum in response to the EVALI and youth vaping crisis. However, the bill stalled with other legislation at the end of the session.

Local momentum has also built in recent years for this policy package. OHA provides grant funding to local public health authorities to work on tobacco prevention and control policies such as TRL.

In the last five years:

a. Five counties and 12 cities have passed TRL policies for their jurisdiction.
b. As of February 2020, two counties have fully implemented their policies with license fees sufficient to cover administration and enforcement. In other jurisdictions, the licensing program policies and associated fees are currently insufficient to allow for implementation of the program.

10. What alternatives were considered and what were the reasons for rejecting them?

OHA has funded local public health authorities for evidence-based tobacco prevention policies, and many are actively pursuing TRL. Still, the pace of protection of youth and communities through adoption of local TRL policies has been slow. This local policy adoption framework results in protections for only a portion of Oregon youth, and still more youth live in communities with only limited regulation of tobacco retailers. In addition, not all local policies adequately fund enforcement. If every jurisdiction created independent local TRL policies of varying strengths, the patchwork of policies could be complicated for retailers, community, and enforcement agencies to navigate and less protective for youth overall. This concept provides a baseline level of protection and still allows local communities to move farther based on local knowledge and experience.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

Yes. House Bill 2071 (2021) resulting from an OHA legislative concept would amend current statute to both "Tobacco Products" and "Inhalant Delivery Systems (IDS)." Both are defined in Oregon statute and therefore relevant statutes related to taxation of tobacco products, tobacco sales requirements and related issues may need to be revised (ORS 431A.178 and 431A.183; repealing ORS 431A.180).

OHA recommended basing the language for House Bill 2071 on statute language developed **Senate Bill 1577B engrossed from the 2020 legislative session**. If passed, the bill would accomplish the following:

- Create a state-wide Tobacco Retailer License (TRL) system whereby any retailer would need to purchase a license to sell tobacco or inhalant delivery system products.
- Provide the State with the authority to penalize licensees not operating in compliance and establish a clear graduated system of accountability for retailers that sell illegally to underage persons, including license suspension and possible revocation.
- Allow local jurisdictions the authority to enforce the state TRL requirements, if so desired.
- Simplify enforcement of administrative tax laws and other state and local tobacco regulations.
- Administer TRL fees that would allow for sustainable administration and enforcement of the program by covering regular inspection and enforcement.
- Allow local communities to adopt stronger tobacco retail regulations, if desired.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

House Bill 2071 allows for local jurisdictions to opt into responsibility for enforcement of the state law and OHA expects some counties will take this option. Tribal lands and sales are sovereign and not affected by this legislation. While several jurisdictions have adopted a local TRL, only two counties are operating fully and have license fees sufficient to enforce the policy. It is likely that cities and counties that adopt a local TRL would develop agreements with the state to determine appropriate local licensing fee and jurisdictional enforcement.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

Department of Revenue and Department of Justice have been consulted and provided feedback on the TRL policy package. Both agencies would play a collaborative role in the enforcement and administration of a statewide Tobacco Retailer License.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

Historically, the tobacco industry has aggressively marketed tobacco products to specific cultural and ethnic groups. This perpetuates disparities in tobacco-caused disease and death and disproportionately harms communities of color that have experienced and continue to experience injustices. Additionally, rates of youth tobacco use are highest among youth who are lower income, Native American, African American, or LGBTQ+. If Oregon does not implement a state tobacco retail license that begins to rectify injustices through providing basic protections, these health disparities will continue. This package will help OHA achieve the 10-year strategic goal of eliminating health inequities. Implementing a state license protects all Oregonian youth, including those in rural areas not currently protected by tobacco retail policies.

Regional variation in tobacco licensing exists across Oregon. As of February 2020, two counties have fully implemented their policies with license fees sufficient to cover administration and enforcement. In other jurisdictions, the licensing program policies and associated fees are currently insufficient to allow for implementation of the program. Children in communities most impacted by highest rates of tobacco use,

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

particularly Native American and Latino Oregonians, do not benefit from a basic level of protection through TRL.

Statewide legislation will promote equity by ensuring that all Oregon children are better protected from harmful tobacco products in the retail environment. Retail stores that sell to underaged persons are well known by youth who seek tobacco. These stores become regular sources of tobacco products for youth at risk of nicotine addiction.

Staffing and fiscal impact

Implementation date(s): September 1, 2021

End date (if applicable): Ongoing

15. What assumptions affect the pricing of this policy package?

The pricing of this policy package assumes the state would be responsible for implementing the TRL until we know more about which counties are willing or able to administer their own program. The pricing also assumes the number of tobacco retailers remains constant from past years, irrespective of economic changes, and that the youth sales age violation rate is consistent with current rates. OHA-PHD and the Department of Revenue may also find new retail locations once there is a licensing requirement, but that is not accounted for in this policy package.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

The new responsibilities for OHA would be to set up and operate a program to enforce a retailer licensing program for tobacco product and IDS sales. OHA would provide technical assistance to local public health authorities (LPHA) regarding the regulation of the retail sale of tobacco products and inhalant delivery systems.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

OHA would purchase a license and user access for licensing software with a tobacco module. The software would:

- Include a tobacco retail licensing-specific module.
- Include a list of licensed tobacco and inhalant delivery system retailers (imported and updated from the licensing program at the DOR).
- Provide for entry, tracking and reporting of data collected from annual enforcement inspections for youth purchase programs.
- Provide for entry, tracking and reporting of annual inspections of all tobacco product and IDS retailers for compliance with the licensing program's laws and rules.
- Provide for online citizen complaints regarding compliance with the licensing program's laws and rules or for when a citizen sees a retailer selling without a license.

Licensing fees and penalties collected from tobacco product and inhalant delivery system retailers for licensure would cover the cost of administration, education and enforcement of the licensing program.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

To implement this policy, the following new staff would be required:

3 Inspectors (Compliance Specialist 3) at full-time, who would: conduct licensing requirement inspections in retailers, conduct underage compliance inspection at retailers, oversee student office workers, document inspections and report results. (Hire date January 2022)

3 Student Office Workers at part-time, who would: accompany Compliance Specialists on underage compliance inspections and provide documentation and testimony, as necessary. (Hire date January 2022)

1 Program Manager (Principal Executive/Manager D) at full-time, who would: manage program staff, oversee program development and ongoing support, and manage program budget. (Hire date January 2022)

1 Training coordinator (Program Analyst 2) at full-time, who would: support ongoing technical assistance to local public health authorities and OHA inspection staff, develop training for staff, and train staff for inspections. (Hire date September 2021)

1 Data analyst (Research Analyst 3) at full-time who would: coordinate, analyze and aggregate data collated through the database system, assess the effectiveness of state and local programs for regulating the retail sale of tobacco and IDS products, and create reports. (Hire date September 2021)

1 Policy and program coordinator (Program Analyst 3) at full-time who would: oversee program activities, including development of inspection protocol, training and ongoing support, provide policy direction including

required rulemaking, coordinate with Department of Justice, and oversee technical assistance to local public health authorities. (Hire date September 2021)

1 Operations support staff (Administrative Specialist 1) at part-time, who would: provide general support, support hiring and onboarding staff, and provide administrative duties such as mailings to retailers and web support. (Hire date September 2021)

1 Communications Specialist (Program Analyst 3) at for a 1-year limited duration who would: develop materials for educational outreach to retailers and oversee media-related work such as website, print ads and earned media. (Hire date September 2021)

20. What are the start-up and one-time costs?

$0.2 million - For initial costs for setting up the program include hiring and new staff; developing processes and procedures for the program; creating intergovernmental agreements with the Department of Revenue (DOR) and LPHA for data sharing and coordination; purchase of an electronic database system; analyzing and aggregating data; and creating reports. Other initial costs are for communications related expenses including website updates, print ads, earned media, and educational outreach to retailers including mailings.

21. What are the ongoing costs?

$1.7 million - Ongoing costs to implement enforcement include annual sales to underage persons inspections and annual licensing requirement inspections. Licensing requirement inspections also include enforcement of the flavored IDS product ban. To ensure consistent administration and enforcement, OHA expects to conduct 9,200 inspections annually assuming a 15 percent retailer violation rate. Other ongoing costs are for maintenance of the database system (annual renewal), ongoing training costs and legal support from the Department of Justice (DOJ) for the imposition of civil penalties and contested case hearings. They also

include communications to retailers, especially small business owners and those with limited English proficiency, who might need more support to comply with the policy.

22. What are the potential savings?

There are potential efficiencies in staff time spent on compiling and verifying retailer locations as this process would be greatly simplified through a license requirement. We anticipate this staff time would be reallocated to tobacco prevention and cessation activities.

In the longer term, there may be savings in health care costs and other tobacco-related costs to the state through reductions in tobacco use. These benefits would especially accrue to communities of color that are affected most by the lack of current protections.

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

OHA estimates $2.1 million Other Funds, 12 positions (7.86 FTE).

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services		$1,445,303		$1,445,303	12	7.86
Services & Supplies		$632,923		$632,923		
Capital Outlay		$0		$0		
Special Payments		$0		$0		
Other		$0		$0		
Total	**$0**	**$2,078,226**	**$0**	**$2,078,226**	**12**	**7.86**

Fiscal impact by program

	Center for Prevention and Health Promotion				Total
General Fund	$0				**$0**
Other Funds	$2,078,226				**$2,078,226**
Federal Funds	$0				**$0**
Total Funds	$2,078,226				**$2,078,226**
Positions	12				**12**
FTE	7.86				**7.86**

Oregon Health Authority
2021-23 Policy Package

Division:	Health Systems Division
Program:	Behavioral Health
Policy package title:	Community Behavioral Health Services
Policy package number:	409
Related legislation:	Senate Bill 67 (2021), House Bill 2086

Summary statement:

Requests funding to implement strategies and recommendations from the Governor's Behavioral Health Advisory Council and the Governor's Racial Justice Council to improve the behavioral health system for adults and transition-aged youth who experience serious mental illness and co-occurring substance use disorders.

- Funds community-based services and supports to increase access to peer delivered services, promote culturally responsive practice, and build capacity.
- Provides funds for provider and student incentives to build Oregon's health care workforce, including behavioral health providers, in underserved communities.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$47,720,999**	**$0**	**$3,775,229**	**$51,496,228**	**5**	**4.01**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

Oregon's fragmented behavioral health systems inadequately address the unique needs of Oregonians with serious and complex behavioral health conditions. This has led to high rates of serious mental illness, substance use disorders and suicides.

- People with behavioral health challenges have untreated physical health conditions, resulting in an average life expectancy for people with serious mental illness that is 20 years less than those without.
- There are insufficient community supports available to those who seek behavioral health care but do not desire or require a hospital or emergency department level of intervention.
- Some individuals are uncomfortable and will not seek treatment with traditional clinical facilities due to unmet cultural needs, systemic racism, or historical trauma related to health care.
- There is a statewide workforce shortage for all behavioral health provider types, including Traditional Health Workers, licensed and unlicensed providers, and prescribers.

These circumstances leave many Oregonians unwilling or unable to access care until they reach a crisis point, sometimes requiring intervention by law enforcement, crisis response teams, or hospital emergency departments.

Executive Order 19-06, issued by Governor Kate Brown on October 18, 2019, established the Behavioral Health Advisory Council to form strategies and recommendations to improve the behavioral health system for adults and transition-age youth (ages 14 to 25) who experience serious mental illness and co-occurring substance use disorders. In September 2020, the Governor established the Racial Justice Council to institutionalize racial justice into the way the State of Oregon conducts business. The ongoing work of the Behavioral Health Advisory Council was aligned with the Racial Justice Council to provide a racial equity-centered action plan for Oregon's behavioral health system. The joint recommendations include concrete

actions, policies and potential investments needed to preserve and improve services and supports in Oregon's behavioral health system.

OHA proposes this policy package to stabilize the current system and address existing issues with capacity and consistency in services across the state. Specifically, this policy package would:

- Fund the three priority areas identified by the council:
  - Behavioral health programs and services: Expand capacity of person-centered, community-based behavioral health care in Oregon.
  - Behavioral health workforce: Make investments to develop a robust behavioral health workforce to address health inequities.
  - Community-based living: Make investments to expand and sustain Oregon's residential and community-based living environments and provide supports to help individuals recover and live in their community.

In addition to addressing the systemic changes required to support preventive, responsive, community-based care throughout Oregon, OHA proposes this policy package to address the issues described below that contribute a significant negative impact to the behavioral health of underserved populations.

Youth and Young Adults

Young adults in transition (ages 14 to 25) are underserved across the continuum of care. They are also at a developmentally unique time in their lives with significant social, emotional, physical, and cognitive changes taking place. Due to significant differences across the state in access and service availability, many young people are at high risk of failed transition into independent adulthood. Research shows that young adults in transition have high rates of serious mental health concerns with the lowest rates of engagement in mental health services. Furthermore, many young adults previously engaged as children (age 0-18) in the behavioral

health system disengage during the transition to the adult behavioral health system. Some studies show disengagement rates as high as 80 percent.

Oregon's current behavioral health system is not sufficiently equipped to respond to the unique developmental needs of this demographic, or to provide timely treatment for youth at recommended levels of care. Oregon has seven Residential Treatment Homes (RTH) with a total of 34 beds that serve this population. Between February 2019 and February 2020, OHA received more than 125 referrals to these homes. This is far more referrals than the current residential system can support. Three Oregon counties provide intensive services to this population, and each county can only support 35 to 40 young people at any one time.

Over the past five years, Oregon has seen a decrease in mental health residential and subacute beds, including at the Psychiatric Residential Treatment Facility (PRTF) level of care[1], which serves ages 6 to 18. Oregon has three types of licensed PRTF facilities, including Psychiatric Residential Treatment Services (PRTS) facilities. In 2019, OHA and DHS performed a joint capacity study that indicated Oregon needs an additional 47 beds at the PRTS level of care to support children with intense mental health needs. Approximately 245,000 children and youth in this age group are covered by the Oregon Health Plan (OHP) at any point in time, which equates to 0.6 beds of PRTS capacity for every 1,000 children on OHP. OHP coordinated care organizations (CCOs) must cover PRTS as a required element of the CCO benefit package. This means CCOs must demonstrate that the services, or some equivalent substitute, are available for all who need it as demonstrated by federal medical criteria. Among in-state PRTS providers who contract with commercial insurance carriers and OHP CCOs, OHA estimates that 25 percent of PRTS beds are occupied by children on commercial insurance and the remaining 75 percent are occupied by children on OHP (of which roughly 20 percent are children in the child welfare system)[2].

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[1] PRTF is a federal designation of services offered at a non-hospital facility that is accredited by a national accreditation agency such as the Joint Commission on Accreditation of Healthcare Organizations (JAHCO) and the Commission on Accreditation of Rehabilitation Facilities (CARF), directed by a physician, and provides active treatment that is likely to benefit a youth. *42 CFR 441.151 through 42 CFR 441.182.*

[2] These numbers do not reflect children served in out-of-state PRTS programs.

2. What would this policy package buy and how and when would it be implemented?

Behavioral health system priorities
Component 1: Peer Respite Care
Component 2: Staffing to implement the Alcohol and Drug Policy Commission (ADPC) Strategic Plan
Component 3: Increased Medicaid funding to support underserved populations
Component 4: Workforce development and retention in underserved communities

Youth and young adult supports
Component 5: Expand Young Adult in Transition Residential System
Component 6: Develop Psychiatric Residential Treatment Services Capacity

Expanding community-based programs and services

Component 1: Peer Respite Care:
Peer-run respite centers provide culturally informed, voluntary, short-term support in a home-like setting to adults who are experiencing acute mental health or emotional distress. OHA would use $2.4 million General Fund to implement and pilot three non-clinical peer-run respite centers, including a culturally and linguistically specific program designed to provide services and supports to communities of color and/or tribal communities. These pilot centers would be operated by contracted peer run organizations and staffed by state-certified Peer Support Specialists or Peer Wellness Specialists. Using data gathered from this pilot program and model best practices, OHA would design program fidelity and evaluation standards, provide oversight and technical assistance to pilot sites, and help programs develop strategies for recruitment and retention of a culturally diverse workforce.

Component 2: Staffing to implement the Alcohol and Drug Policy Commission (ADPC) Strategic Plan:

The 2020-2025 ADPC Strategic Plan identifies several priority strategies and activities to address the primary structural and other factors that have impeded Oregon's ability to prevent, treat, and help its people recover from substance misuse and SUDs. The plan's goals include:

- Implement a statewide system that ensures that substance misuse policies, practices, investments, and efforts are effective and result in healthy and thriving individuals and communities.
- Increase the impact of substance misuse prevention strategies across the lifespan.
- Increase rapid access to effective SUD treatment across the lifespan.
- Increase access to recovery supports across the lifespan.

Implementing the plan is a vital step in moving toward a full continuum of care in Oregon's behavioral health system. To do this, this policy package requests $0.2 million General Fund and position authority for an ADPC Inventory and Implementation Project Director (OPA 4) and an ADPC Inventory and Implementation Coordinator (OPA 3).

The two positions would focus on the ADPC work and support OHA efforts to align funding sources and task forces with the ADPC Strategic Plan approved by the Governor. Work would include providing funding, guidance, technical assistance, and development support to the substance use disorder continuum of care.

Component 3: Increased Medicaid funding to support underserved populations

This component includes dedicated funding for fee-for-service Medicaid reimbursement of behavioral health services to underserved populations:

- $10.1 million for integrated treatment of co-occurring disorders: Mental health and substance abuse treatment services are provided separately throughout much of the state, in many cases using separate funding streams. As a result, individuals must navigate both systems and may not receive adequate care. Some of these services are currently billable for people with a mental health diagnosis but not for people with substance use disorder. Others pay a lower rate for substance use disorder treatment for similar services provided by clinicians with similar credentials. To encourage an integrated care model and

address financial barriers to treatment, funds would cover reimbursement at an enhanced rate for services provided to treat co-occurring MH and SUD disorders. The enhanced rate would be effective July 1, 2022, upon federal approval of amending Oregon's Medicaid State Plan to add treatment of co-occurring disorder as a covered benefit.

- $0.5 million to fund services provided by tribal-based practices and fund support for Tribal Behavioral Health Workforce.

Component 4: Workforce development and retention in underserved communities

The behavioral health workforce shortage impacts Oregon's ability to address health inequities. American Indian/Alaska Native populations have higher rates of substance use disorder, post-traumatic stress disorder, and suicide. The Black community has higher rates of anxiety and depression coupled with lack of access to appropriate and culturally responsive behavioral health care. And, the number of Latinx providers of behavioral health services does not reflect the population needing service, particularly in northeast and southern Oregon. To begin to develop a behavioral health professional workforce that is culturally responsive and more closely reflects the communities it serves, OHA would use $22 million General Fund to:

- Pay for additional Bachelor's and Master's level education, certification and/or licensure in behavioral health fields.
- Expand incentives for THWs/CHWs (including Peer Support Specialists) to reduce the demand on licensed providers and provide a more culturally-balanced clinic support team.
- Increase loan repayment and forgiveness opportunities for behavioral health providers in communities with workforce shortages, especially providers of color.
- Offer retention bonuses post-graduation and post-licensure for behavioral health professionals.
- Provide other incentives, including but not limited to housing assistance and tax credits; sign-on bonuses; part-time and flex time; professional development and professional satisfaction initiatives to prevent burnout; and childcare for both behavioral health and some medical professionals.

- Work with four-year institutions and community colleges to fund program slots for behavioral health students from ethnically/racially and socioeconomically diverse backgrounds, prioritizing students who are going to specialize in pediatric/early childhood behavioral health.
- Provide loan or grant funding for practices to be able to hire more providers to meet the need than their existing revenue base may support, including funding for bi-directionally placing behavioral health and medical professionals in each other's respective practice environments.
- Provide targeted outreach and scholarships for students of color to go into the BH professions, prioritizing students who are going to specialize in pediatric/early childhood behavioral health.
- Offer financial and non-financial incentives for clinics to model their practice environments to be supportive of clinicians from ethnically/racially/socio-economically diverse backgrounds and more culturally responsive, including subsidizing employment for such professionals.
- Offer organizations funding to support training for behavioral health professionals to acquire elevated skills and remain with an organization over time. Prioritize health professionals who specialize in pediatric/early childhood behavioral health.

In addition, OHA would provide $5.5 million to work with the K-12 system, particularly Career and Technical Education (CTE) and career pathway programs, along with groups including Area Health Education Centers (AHECs), regional Workforce Boards, and others to better attract students to enter the medical and behavioral health fields.

These investments would help OHA reach the goal of having a workforce across Oregon that better reflects the population it serves. Moreover, these workforce incentives would better prepare OHA to meet the demand of new initiatives that increase access to services, including: Measure 110, the 988 national crisis line, and efforts to stand up the Oregon Behavioral Health Access System. To ensure equitable distribution of these funds, OHA and its Office of Equity and Inclusion will partner with Oregon's Federally Recognized Tribes, communities of color, and key partners.

Youth and young adult supports

To increase capacity and supports for youth and young adults across Oregon's behavioral health system, OHA is requesting General Fund for the following components:

Component 8: Expand Young Adult in Transition Residential System:

OHA would use $7.5 million to:

- Provide $3 million in one-time startup and development funding to add three 5-bed Residential Treatment Homes (RTH) to serve Oregon's young adult population (ages 17.5 to 25), increasing capacity by 15 beds.
- Add $4 million for fee-for-service Medicaid reimbursement and $500,000 for General Fund only reimbursement of YAT residential services.

The RTHs would provide the same services and supports Oregon's current seven homes provide, including but not limited to 24-hour supervision and support; access to therapy and medication management; skill development; access to supported education and employment; recreational and social activities. Skill development would focus on:

- Self-managing emotions and mental health symptoms
- Money and household management
- Nutrition and physical health needs
- Personal hygiene, clothing care, and grooming
- Communication skills for social, health care, and community resources

Ongoing costs to support these additional facilities would include:

- Medicaid reimbursement for monthly standardized rate service payments, and daily to weekly rehabilitation needs such as therapy, skills training, and medication management for Medicaid-eligible residents.

- Non-Medicaid reimbursement for services and supports such as Person Incidental Funds and Room and Board for those with no income, and service payments for residents not eligible for Medicaid or commercial insurance.

OHA would implement this expansion through a request for proposal process and would consider location when awarding the contract to expand accessibility to underserved or unserved areas and help young people stay closer to their support networks. OHA anticipates a 15- to 24-month implementation timeline with 6 to 12 months for the RFP and contract process, and 9 to 12 months for building construction and/or renovation. The new homes would be available for services no sooner than late 2022.

Component 9: Develop Psychiatric Residential Treatment Services Capacity:
OHA would use $7.5 million for:

- Ongoing support and capacity infrastructure to sustain a comprehensive continuum of care for children's mental health with a focus on intensive inpatient and residential programs.
- Addressing immediate PRTS capacity shortages by adding 47 new PRTS beds in the 2021-23 biennium and remaining capacity needs in future biennia. In 2021-23, OHA would use a request for proposals process to shape expectations for the new beds, and work with Oregon providers to develop smaller therapeutic settings with an average length of stay of 10 to 12 weeks. The beds would serve approximately 200 children with complex behavioral health needs per year. In future biennia, funds would be used to augment, upgrade, and maintain existing PRTS capacity to create environments that are trauma informed, support positive outcomes (e.g., reduction in restraints and seclusions), and improve the quality of treatment.

3. How does this policy package further OHA's mission and align with its strategic plan?

To further OHA's mission to ensure that all people and communities can achieve optimum physical, mental, and social well-being through partnerships, prevention, and access to quality, affordable health care, this policy package:

- Ensures all Oregon communities have capacity to upstream programs that offer community-based behavioral health care and manage crisis situations to prevent unnecessary ED or justice involvement.
- Corrects inequities in Oregon's current residential treatment capacity for children and young adults.
- Increases funding to providers in underserved populations.
- Helps to build a culturally diverse behavioral health workforce.

Each requested investment in this policy package furthers and builds on the last five years of behavioral health work group, task force, and committee recommendations, including:

- The 2015-2018 Behavioral Health Strategic Plan.
- The ADPC Strategic Plan.
- Behavioral Health Collaborative Recommendations.
- The Farley Center workforce report and recommendations.
- The Oregon Native American Behavioral Health Collaborative's[3] 2019 Tribal Behavioral Health Strategic Plan.
- The goals, principles and recommendations of the Governor's Behavioral Health Advisory Council and Racial Justice Council Health Equity Committee.

Disjointed and siloed behavioral health systems disproportionately impact communities of color, the tribes and AI/AN population, non-English speakers, people who are unhoused, persons with disabilities, and LGBTQ+

[3] The Oregon Native American Behavioral Health Collaborative includes representatives from Oregon's nine federally recognized tribes, the Native American Rehabilitation Association, the Northwest Portland Area Indian Health Board, the Oregon Health Authority and the Oregon Department of Human Services Tribal Affairs.

communities. Complex access points are exacerbated by a lack of culturally responsive services and representative providers, historical trauma related to health care, and implicit bias. To help achieve OHA's health equity goals, the programs and services in this policy package are designed to address these disparities.

- Peer respite models seek to provide culturally and linguistically responsive services, regardless of one's ability to pay.
- Peer services can help individuals overcome fear and stigma with traditional clinic-based services by meeting people where they are and helping them to avoid crisis.
- The Workforce Incentive Fund would incentivize the recruitment and retention of providers from communities of color and tribal communities, and those who are culturally and linguistically responsive to the communities they serve, including rural residents and people facing systemic health inequities.
- Promoting behavioral health care access through Tribal Based Practices and Traditional Health Workers (Peer Support Specialists, Peer Wellness Specialists and Youth Support Specialists) would further increase support for culturally responsive care in tribal communities (see more in question 7).

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

This proposal describes many items related to youth, young adults, community services and the behavioral health workforce. The items in this policy option package can be grouped into three categories:

1. Expansion of services to increase the number of persons served (capacity).
2. Providing funds for strategic plans.
3. Improving the service infrastructure.

Each of the proposed items can be measured through assessment of one or more relevant criteria:
a) Establishing well-defined milestones, deliverables and target dates in a clear implementation plan.
b) Measuring increased capacity.
c) Documented outcomes for individuals and/or improvement in the service delivery infrastructure.

The table below identifies the type of measures for each policy option item. In general milestones would be reported in the first year of funding, capacity increases in the second year and outcomes in the third.

Policy package component	Milestones-Y1	Capacity-Y2	Outcomes-Y3
Expand Young Adult in Transition residential system	X	X	
Develop Psychiatric Residential Treatment Services capacity	X	X	
Peer run respite pilot	X	X	X
Fund components of the Tribal Behavioral Health Strategic plan	X	X	X
Implement the ADPC strategic plan	X		
Payment methodology to fund treatment of SUD/MH	X		
Incentive fund for behavioral health workforce	X	X	X

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

The behavioral health system investments requested in this package support the following 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. **30-day illicit drug use among 6th graders** - Percentage of 6th graders who have used illicit drugs in the past 30 days.
4. **30-day alcohol use among 6th graders** - Percentage of 6th graders who have used alcohol in the past 30 days.
5. **30-day illicit drug use among 8th graders** - Percentage of 8th graders who have used illicit drugs in the past 30 days.
6. **30-day alcohol use among 8th graders** - Percentage of 8th graders who have used alcohol in the past 30 days.
7. **30-day illicit drug use among 11th graders** - Percentage of 11th graders who have used illicit drugs in the past 30 days.
8. **30-day alcohol use among 11th graders** - Percentage of 11th graders who have used alcohol in the past 30 days.
23. **Rate of tobacco use (population)** - Rate of tobacco use among adults.
24. **Rate of tobacco use (Medicaid)** - Percentage of CCO enrollees who currently smoke cigarettes or use tobacco every day or some days.

7. What are the long-term desired outcomes?

These proposals are aimed at improving behavioral health services for people in Oregon by expanding services, increasing the workforce and improving access to residential services.

For youth and young adults, the policy package aims to improve the mental, social, and emotional wellbeing of youth and young adults across Oregon by increasing youth-oriented behavioral health service capacity.

- Increased residential treatment capacity would significantly decrease the wait time for accessing needed services. Timely access to care would in turn decrease the use of higher levels of care, including acute psychiatric units and the Oregon State Hospital, as well as decrease the risk of encounters with the criminal justice system and homelessness.
- Increased PRTS capacity also ensures timely access to quality, appropriate care in Oregon, with continued family supports.
- Equitable access to the right service at the right time for the right duration.

This policy package creates lower cost, person-centered, trauma-informed, and culturally responsive alternatives to emergency room visits or hospitalization for individuals experiencing mental or emotional distress.

- For individuals who do not need a hospital level or emergency department level of support, the peer-run respite concept would fill a gap in the continuum of care for adults who are not comfortable engaging services in traditional treatment settings.
- Funding, technical assistance, training, and education for meaningful and responsive tribal-based services would provide greater sustainability and integration of tribal/urban care providers in the state's behavioral health transformation efforts.
- Behavioral health workforce incentives and investments will add culturally responsive workforce capacity that reinforces access to culturally responsive behavioral health care in communities of color and tribal communities.

8. What would be the adverse effects of not funding this policy package?

Not funding this policy package would maintain the status quo for behavioral health in Oregon.

- Young adults would continue to experience insufficient access to residential behavioral health care.
- Implementation of the Tribal Strategic Plan and the ADPC would be at risk.
- The behavioral health workforce shortage would continue.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

To support services to Youth and Young Adults, OHA activities include:

- Residential rate standardization: To make residential payments equitable across Oregon, OHA moved RTH funding to a Medicaid-funded standardized rate model. OHA has encouraged existing providers to open additional service locations, but they would need additional funds for development. OHA also analyzed existing funds for capacity building, but funding is not currently available to establish additional capacity at this level of care.
- PRTS beds: Twenty-five beds are currently in development through Mental Health Block Grant funding. As of May 2020, seven additional beds have been added. OHA has drafted an RFP to post as funds are identified.

To help build community-based behavioral health programs and services, OHA activities include the Tribal Behavioral Health Strategic Plan, the Alcohol and Drug Policy Commission (ADPC) Strategic Plan, and a behavioral health workforce recruitment and retention plan.

Tribal Behavioral Health Strategic Plan: The plan is in various stages of implementation. For example, Senate Bill 134 (2019) authorized OHA to develop uniform contracting standards that accept and consider tribal-based practice for mental health and substance use prevention, counseling and treatment as equivalent to evidence-based practices. The bill also allows for Medicaid coverage, subject to approval by the Centers for Medicare and Medicaid Services (CMS), of "tribal-based practices for mental health and substance abuse prevention, counseling, and treatment services for members who are Native American or Alaska Native as equivalent to evidence-based practice for purposes of meeting standards of care and shall reimburse for those tribal-based practices." However, additional funding is necessary to fully implement all provisions of the bill.

Alcohol and Drug Policy Commission (ADPC) Strategic Plan: The 2019 and 2020 legislative sessions directed OHA and the ADPC to complete a statewide inventory of substance use disorder services across the continuum of care and implement a strategic plan. While the ADPC completed its strategic plan in February 2020, the work to implement the plan requires at least five to six years, and a full-time position to complete the objectives and timelines established by the Governor and the Legislature.

Behavioral Health Workforce: Oregon completed an analysis of the current behavioral health workforce and developed a recruitment and retention strategy. The analysis detailed a shortage of behavioral health workforce by all provider types throughout the state, with a maldistribution between urban and rural regions. The recruitment and retention plan focused increasing the workforce, including ensuring a diverse workforce and expanded language access, training and curriculum recommendations to ensure a qualified workforce, and strategies to retain the workforce such as loan repayment and increased wages.

10. What alternatives were considered and what were the reasons for rejecting them?

OHA has been working with partners and stakeholders to identify options for many years. This policy package was developed by looking at national standards and best practices. OHA worked closely with the Governor's Behavioral Health Advisory Council, which considered several alternative policy and funding proposals. This proposal represents ideas that emerged as front runners in group deliberations.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

OHA put forward legislative concept placeholders (Senate Bill 67, House Bill 2086) for the Governor's Behavioral Health Advisory Council and treatment of co-occurring disorders.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

Tribes would benefit from the new programs, technical assistance, workforce incentives and service delivery models offered in this policy package. The peer-run respite centers, increased participation by peers in service delivery models, and the Workforce Inventive Fund each address the need for culturally responsive care in communities of color. The increased Medicaid funding for tribal health practices also supports the 2019 Tribal Behavioral Health Strategic Plan.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

The Governor's Behavioral Health Advisory Council and Racial Justice Council were instrumental in informing this policy package.

The 47-member Behavioral Health Advisory Council represents a broad range of perspectives and experiences in Oregon's behavioral health system, including CCOs, Certified Community Behavioral Health Centers, Community Mental Health Programs, state legislators, MDs, judges, sheriffs, consumers, advocates for communities of color and tribal leaders. The council also invited adult and young adult consumers to participate in and inform the development of policies.

The Racial Justice Health Equity Committee included stakeholders and community leaders across Oregon who provided recommendations on prioritizing initiatives that increase racial justice and equity. The Committee specifically recommended additional investment in behavioral health workforce diversification.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[4] or equitable health outcomes?

[4] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

The Governor's Behavioral Health Advisory Council adopted OHA's Health Equity Statement as their overall vision of health equity in behavioral health and supported principles that strive for a behavioral health system that is simpler to access, more responsive to individuals' needs, and produces more meaningful outcomes. Furthermore, these proposals attempt to support the behavioral health system given the impacts of COVID-19. Underlying health conditions, homelessness, and inconsistent access to the health system leave many with behavioral health issues particularly vulnerable to the health and health system impacts of COVID-19. What's more, social isolation and financial instability could trigger worsening symptoms or crises.

Staffing and fiscal impact

Implementation date(s):	Various, see specific component
End date (if applicable):	Various, see specific component

15. What assumptions affect the pricing of this policy package?

Component #1 Peer Respite Care: Assumes legislative approval to continue the program in 2021-23 for the 18 months priced for House Bill 2831 (2019).

Component #3 Increased Medicaid funding to support underserved communities: Assumed 10 percent of all 2019 OHP fee-for-service outpatient behavioral health claims were for services through Tribes and NARA, and this would remain consistent in 2021-23. For non-Medicaid services, 15 percent would be General Fund for Tribal claims and 51 percent would be General Fund for NARA claims. Claim costs assume MEI of 1.9 percent from 2020 to 2023, and a 5 percent increase in utilization of tribal-based practices from 2020 to 2023.

Component #4 Workforce development and retention in underserved communities: Work would be performed by OHA's Primary Care Office.

Component #5 Expand Young Adults in Transition Residential System: Current YAT/RTH capacity and program staffing, with two facilities in the Portland Metro area. Adjusted 2015 construction and equipment estimates for inflation at 3.4 percent per year through 2021.

- Assumes 90 percent of clients would be Medicaid-eligible at standard Title XIX match rate.
- Assumes 10 percent of clients would be General Fund only with room and board.
- Costs are estimated at approximately $0.4 million per RTH facility.
- Includes 20 percent contingency amount for construction.
- Assumed five 2-week periods for salaries and training to get the facilities up and running to equal 3 months.
- Includes 30 percent contingency amount for facility equipment.
- Property costs are not included because there are too many unknown variables.

Component #6 Develop PRTS:

- Assumes ongoing costs per bed of $125,000 for 47 new beds ($5.9 million) of which 25 percent would be contracted for outside of OHA or DHS services (e.g., through commercial insurers). Of the 75 percent contracted by OHA and DHS, 80 percent would be allocated to OHA and 20 percent to DHS. This would result in $3.5 million in ongoing costs for OHA.
- Assumes construction or renovation for added capacity of eight facilities serving 5 clients would cost approximately $500,000.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

Yes. Below are the components that would require new responsibilities.

- Peer-Run Respite: The proposal would require OHA to develop a pilot program, technical assistance and guidance, contractual agreements, and oversight and evaluation of a new program.

- Staffing the ADPC Strategic Plan: Implementation would require new work to coordinate agency resources to implement pieces of the ADPC strategic plan.
- Workforce Incentive Fund: Implementation would require new work to develop plans for the allocation of the funding, application procedures, distribution and administration for the funding and oversight and monitoring.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

No.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Yes. See below for service population expansions for each program where applicable:

- Peer Respite: Access will increase geographically; the caseload impact is indeterminable at this time.
- Workforce Fund: The increase to the number of providers in the field is indeterminable at this time.
- Expansion of Young Adult Residential: Add 15 beds to serve young adults ages 17.5 to 25.
- Expansion of Psychiatric Residential Treatment Services: Adds 47 beds to serve youth ages 6 to18.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

This policy package includes the following five permanent, full-time positions to support several components of this request:

Component	Classification	Pos.	FTE
#1: Peer Respite Care	Operations and Policy Analyst 3	1	0.88
#2: ADPC Strategic Plan Staffing	Operations and Policy Analyst 3 Operations and Policy Analyst 4	2	1.50
#3: Increased Medicaid funding to support underserved populations	Operations and Policy Analyst 3	1	0.75
#4: Workforce development & retention in underserved communities	Operations and Policy Analyst 3	1	1.0
Total		**5**	**4.13**

20. What are the start-up and one-time costs?

- Component #8: Young Adults in Transition Residential: Construction and initial equipment costs ($3 million General Fund).

21. What are the ongoing costs?

Except for the construction costs described above, this policy package would be ongoing. For the 2021-23 biennium, ongoing costs would be $44.7 million General Fund and $3.8 million Federal Funds, totaling $48.5 million Total Funds. Please see question #23 for costs by component.

22. What are the potential savings?

There are no measurable savings.

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

This policy package would be funded with General Fund and federal Medicaid matching funds.

Component	General Fund	Federal Funds	Total Funds	Pos.	FTE
#1: Peer Respite Care	$2.4	$0.0	$2.4	1	0.88
#2: ADPC Strategic Plan Staffing	$0.2	$0.2	$0.4	2	1.50
#3: Increased Medicaid funding to support underserved populations	$10.6	$1.1	$11.6	1	0.75
#4: Workforce development & retention in underserved communities	$22.0	$0.0	$22.0	1	1.00
#5: Expand young adult in transition residential system	$5.0 ($3 one-time)	$2.5	$7.5 ($3 one-time)		
#6: Develop psychiatric residential treatment services capacity	$7.5	$0.0	$7.5		
Total	**$47.7**	**$3.8**	**$51.5**	**5.0**	**4.01**

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$589,984		$406,398	$996,382	5	4.01
Services & Supplies	$409,952		$178,632	$588,584		
Capital Outlay						
Special Payments	$46,721,063		$3,190,199	$49,911,262		
Other						
Total	**$47,720,999**	**$0**	**$3,775,229**	**$51,496,228**	**5**	**4.01**

Fiscal impact by program

	HSD Medicaid	HSD Non-Medicaid	HSD Admin	HPA	**Total**
General Fund	$1,502,952	$23,439,747	$778,300	$22,000,000	**$47,720,999**
Other Funds	$0	$0	$0	$0	**$0**
Federal Funds	$3,190,199	$0	$585,030	$0	**$3,775,229**
Total Funds	$4,693,151	$23,439,747	$1,363,330	$22,000,000	**$51,496,228**
Positions	0	0	4	1	**5**
FTE	0.00	0.00	3.13	0.88	**4.01**

Oregon Health Authority
2021-23 Policy Package

Division:	Health Systems Division
Program:	Behavioral Health Non-Medicaid
Policy package title:	Community Mental Health Aid and Assist
Policy package #:	411
Related legislation:	None
Summary statement:	The number of people sentenced under "Aid and Assist" laws has doubled over the past five years. Oregon has traditionally relied on Oregon State Hospital (OSH) as the primary resource to meet the service needs of these people. Recent capacity challenges have been so great that the state fell into a period of non-compliance with the US Federal Court of Appeals ruling (Mink Order) that requires OSH to admit people committed under ORS 161.370 within 7 days of a signed judge's order. Local law enforcement, jails and emergency departments are consistently reporting stresses on their systems as well as frustration with the lack of effective service options. This policy package includes funding and positions to contract with community providers to open additional secure residential treatment facilities (SRTFs) and increase community services to meet the immediate needs of people who have been arrested and court-ordered for services under Oregon's "Aid and Assist" laws; ensure better coordination between courts, OSH and community mental health and substance use disorder service providers for people who have intensive behavioral health service needs; and a comprehensive evaluation to better understand the root causes for the increases and identify long-term strategies to improve services and outcomes. If this package is not funded, communities would not have the resources needed to provide proper services for people sentenced under "Aid and Assist" orders and OSH Aid and Assist admissions would continue beyond current capacity.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$19,268,531**	**$0**	**$3,376,104**	**$22,644,635**	**6**	**4.50**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

This policy package would ensure the needs of people sentenced under Oregon's "Aid and Assist" laws are met (Oregon Revised Statute 161.370). At the local level, law enforcement, jails and emergency departments are consistently reporting stresses on their systems as well as frustration with the lack of effective options to serve this population. The Oregon State Hospital (OSH) has seen a doubling of Aid and Assist admissions over the past 5 years that has shown little indication of abating. The resulting OSH capacity challenges have been so great that the state fell into a period of non-compliance in the past year with the U.S. Federal Court of Appeals ruling (Mink Order) that requires OSH to admit people committed under ORS 161.370 within 7 days of a signed judge's order.

This package would invest in community-based interventions that would help address the following barriers to the state's compliance:

Insufficient resources for counties to meet the growing need for services. A recent review by Oregon Health Authority (OHA) staff and Community Mental Health programs found no Oregon counties receive enough funding to support the growing need for services. This issue has been growing over the past several biennia. In 2015, OHA provided new funding to targeted counties. While funds allocated to those targeted counties successfully met the need at the time, they are now insufficient due to continued growth in county caseloads. Funding allocated to the remaining counties, unfortunately, did not meet the need at the time.

Aid and Assist is not budgeted as a mandated population. While people under aid and assist orders are considered a "mandated population" because they are under a court order to receive treatment, the mandated caseload financial formula never included them. This formula is used in determining the Continuing Service Level Budget for community mental health programs. OHA, under a 2019 budget note, has been working with

the Legislative Fiscal Office (LFO), the Department of Administrative Services (DAS) Chief Financial Office (CFO), OSH, and Community Mental Health Programs to improve forecasting and definitions when determining how to integrate budgeting for all mandated caseloads in the community mental health continuing service level budgeting process. Because this is not part of the calculation, fluctuations in the caseload are not reflected in OHA's budget development.

Lack of access to the proper level of treatment for people under aid and assist orders. In 2019, the Oregon legislature passed Senate Bill 24, which requires restorations be provided in community-based settings if hospital level of care is not needed. The bill helped reduce the rate of increased Aid and Assist admissions to OSH, but admissions continue to grow. In addition, demand for aid and assist restoration services in communities is also growing.

Capacity issues at the Oregon State Hospital. There are insufficient community resources to support people who are ready to be discharged from Oregon State Hospital. This creates backlogs and limits OSH's capacity for timely admissions of people who need hospital level of care.

Insufficient state-level support and expertise to coordinate intensive behavioral health services across courts, State Hospital and in communities. Providing additional community-focused aid and assist restoration services in Oregon represents a significant change in orientation, practice and resource allocation. OHA is not currently resourced or structured to effectively assist communities in developing needed capacity and practices.

2. What would this policy package buy and how and when would it be implemented?

Creation of an "Intensive Services Unit"– Staff in this new unit would provide robust clinical and systems support to communities for people who are clinically complex and multi-system involved. By reorganizing

existing staff and investing in the new positions, OHA would improve system accountability and outcomes for individuals and communities. The "Intensive Services Unit" would provide oversight and coordination of community-based behavioral services delivered as a result of an encounter with the judicial system through ORS Chapters 161 and 426, as well as focus on getting services to people before they are arrested. Specifically, the new unit would coordinate and improve communications with the courts, law enforcement, corrections, the state hospital, community treatment programs, and housing, to ensure people with intensive behavioral health treatment needs can access the proper levels of treatment.

Behavioral Health Community Residential Investments

This policy package would fund the development of three 16-bed facilities for a total of 48 Secure Residential Treatment Facility (SRTF) beds to ensure capacity is available where and when needed. Developing and building this capacity requires time to complete design, siting, contracting, construction activities, and staff recruitment and training at the facilities. The facilities would start serving clients approximately six months after construction is complete. Moreover, this policy package would support facility investments needed to bring existing facilities up to current requirements and start-up costs including staff recruitment and training, supplies, utilities and maintenance, as well as SRTF services and client forensic evaluations. One SRTF would be ready for clients in January 2023 and the other two SRTFs would be ready for clients in July 2023.

Development of Community Care Coordination Supports

This package would fund community support services and the development of an equitable model for allocating funding to counties to provide restoration services for each person who requires community-based services under ORS 161.370. Services include legal skills training, community case coordination, community consultations with the courts, behavioral health treatment, local data collection, and coordination of services for county's residents at OSH under ORS 161.370. OHA anticipates this capacity would be available on January 1, 2022.

Evaluation of demand drivers and capacity needs
OHA would assess the root causes behind the increases in the number of people under aid and assist orders and people found guilty except for insanity. The assessment would consider both individual drivers and systemic issues. Systemic issues could be connected to sentencing patterns, transiency, location geographically, or services provided prior to system engagement, recidivism, clinical profiles – including co-occurring substance use disorders, overlaps between the various commitment populations and other critical areas. Identifying individual and systemic drivers of increasing aid and assist orders would help the state and local communities find long-term solutions that ultimately result in better outcomes. This work would begin as soon as possible, which could be as early as July 1, 2021.

3. How does this policy package further OHA's mission and align with its strategic plan?

The mission of the Oregon Heath Authority is helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality affordable health care. Additionally, OHA's strategic plan aims to eliminate health inequities in Oregon. A disproportionate share of patients admitted to the Oregon State Hospital (OSH) are people of color compared to Oregon's population. This disparity exists across all service types but is especially pronounced for people under aid and assist orders: Oregon's non-white population is 15.6 percent, but more than 27 percent of people admitted under aid and assist are non-white. Further, Oregon's Black population represents 1.9 percent of Oregon's population, but is 9.4 percent of the Aid and Assist population. The staffing and evaluation components of this package would allow OHA to gain a better understanding of the underlying issues creating this inequity and to make program improvements to address those causes and ultimately eliminate the inequities.

This policy package would allow each county to develop the service continuum necessary to support transitions of people from the state hospital back to their home communities as soon as hospital level of care is no longer needed. Further, the package would improve OHA's ability to remain in compliance with the 2003 U.S. Court of Appeals decision, which requires proper and timely behavioral health services for people who have been

arrested and await trial. Finally, this package would allow OHA to focus on service delivery and timing for people who have intensive behavioral health service needs, so that fewer people would be arrested and ordered to treatment under ORS 161.370.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

None.

Quantifying results

5. How will OHA measure the success of this policy package?

OHA would measure and expect more timely discharges from the Oregon State Hospital (OSH) once individuals no longer need hospital level of care to result from improved community resources. OHA anticipates more timely discharges from OSH would lead to a cascade of positive, measurable impacts:

- More capacity at OSH and reduce the risk of failing to meet the 7-day admission requirement for people ordered to OSH under ORS 161.370.
- Less frequent limits on admissions to OSH for people who are Civilly Committed.
- Reductions in the length of time and number of people who await admission to the state hospital from local acute care facilities and other locations.
- More people receive services in the most appropriate setting as they are directed to community services sooner once they no longer require a hospital level of care.
- Specifically, more people under aid and assist orders, in each county, would receive services in the community. This will be measured through data that OHA collects from counties through OHA's MOTS system. Staff and evaluation from this package would allow OHA to monitor and ensure contract compliance regarding data completeness and accuracy.

Additionally, in the long-term, this policy package would reduce health inequities. The funding and staff from this package would focus programs and interventions to reduce arrest rates for people who have intensive behavioral health service needs. Evaluation resources from this package would allow OHA to perform special studies in conjunction with the Oregon State Police to evaluate overall arrest patterns for people with intensive behavioral health service needs.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

No.

7. What are the long-term desired outcomes?

- Equitable and adequate access to community restoration, legal skills training, and treatment services for individuals who have been ordered to treatment through ORS 161.370 who do not need hospital level of care.
- Ongoing compliance with 2003 U.S. Court of Appeals decision, which requires admission to the Oregon State Hospital within seven days of an order for competence determination identified in ORS 161.365 and ORS 161.370 to determine an individual's fitness to proceed in their own defense.
- Reductions in the rate of arrest, and concomitant reductions in ORS 161.370 court orders, for people with mental illness, particularly those with intensive service needs and persons of color. Those reductions would be the result of people having access to appropriate behavioral health services at the appropriate time.

8. What would be the adverse effects of not funding this policy package?

- People with intensive behavioral health treatment would likely continue to have unmet treatment needs that result in arrest, homelessness, and other undesired outcomes.

- People with intensive behavioral health treatment needs, who are disproportionately people of color, would continue to be served in less appropriate, and often more expensive, treatment settings.
- Continued unequitable distribution of resources available for community-based restoration and treatment services.
- Oregon may not meet the 2003 U.S. Court of Appeals Requirements of 7-day admissions to OSH for people ordered under ORS 161.370.
- Oregon may not meet 1999 U.S. Supreme Court Olmstead Requirements of placements for individuals in the least restrictive environments.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

For the 2017-19 biennium, OHA received funding for targeted communities to enhance crisis response systems and address community needs for the Aid and Assist population. The 2019-21 biennial budget included funding for OHA to open additional community resources to serve regional community needs for housing, behavioral health treatment, legal skills training to ready people for court, and to coordinate resources and needs for individuals. As a result of that package, OHA contracted with Northwest Regional Reentry Center, Lane County, Multnomah County and Coos County. All of those efforts have been helpful, but the needs are statewide and continue to exceed available resources. Additionally, Senate Bill 24 (2019) requires increased community consultation and local service provision. Oregon State Hospital has reconfigured resources to prioritize admissions for people under ORS 161.370 orders.

Beginning in summer of 2019, OHA staff have redoubled efforts to coordinate with community programs to prioritize discharges from OSH for people who no longer need hospital level of care. Clinical coordination occurs between staff of Oregon State Hospital, the HSD Office of Behavioral Health Services and community

providers. Limited community resources have frustrated efforts to provide appropriate services and housing for people to return to community settings. These efforts continue to be a top priority for the division.

10. What alternatives were considered and what were the reasons for rejecting them?

In 2003, the U.S. Court of Appeals ruled that people who are court-ordered for service to Oregon State Hospital under ORS 161.370 must be admitted within 7 days of the court order. OHA frequently struggles to meet that requirement and would be in a stronger position when more appropriate community capacity is available to expedite discharges for people who no longer need hospital level of care. The alternatives to the investments in this package include increasing capacity at OSH or violating the court order. Increased capacity at the state hospital could help, up to a point. However, it would be more expensive and may not be the most appropriate level of care. If OSH capacity is used for people who do not need hospital level of care, it limits access to hospital level of care for other people who need it. Substantial increases to state hospital capacity would not be supported by client advocates or statewide mental health programs.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

None.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

- Community Mental Health Programs would have resources to provide aid and assist services in their community for individuals who do not need a hospital level of care.
- OHA staff would remain in contact with Oregon Housing and Community Services to coordinate opportunities to enhance housing options for this group of people who are often houseless.

- The staffing that results from this package would allow OHA to better coordinate with the courts, corrections systems and law enforcement agencies to identify community-based treatment alternatives and better methods to engage with people with intensive behavioral health service needs prior to arrest.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

Oregon State Hospital, Association of Community Mental Health Programs, Community Mental Health Programs, community crisis programs, local Courts and Jails.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

Current data show tremendous health inequities for persons with intensive behavioral health needs. As mentioned above, 15.6 percent Oregon's population is non-white, but over 27 percent of people admitted under aid and assist are non-white. Further, Oregon's Black population represents 1.9 percent of Oregon's population, but is 9.4 percent of the Aid and Assist population at OSH. The staffing and evaluation funded through this package would help OHA identify root causes to this inequity and develop policies and adjust programs to eliminate this inequity.

Currently, for people who have been arrested and are determined by a court to be unable to aid and assist in their own defense, community-based restoration and treatment services are not available in every county. This policy package would provide investments so that each county would receive a base level of funding for community-based restoration and treatment services targeted for people who have been committed under ORS

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

161.370. This would create a more equitable distribution of those resources so that people who have been arrested have equitable access to restorative services and legal skills training when needed.

Staffing and fiscal impact

Implementation date(s): July 1, 2021

End date (if applicable): Ongoing

15. What assumptions affect the pricing of this policy package?

- Numbers of individuals needing restoration services in the community and needing hospital level of care, with an assumption of a 20 percent increase in services occurring in the community setting verses OSH.
- Required services needing to be provided, making up the case rate and reporting requirements.
- Median case rate includes 6.92 percent inflation.
- Four percent of clients served at SRTFs are Non-Medicaid eligible.
- All new SRTFs assumed to be in the Portland Metro area.
- One SRTF would ready for clients for the last six months of 2021-23. The other two facilities would be ready July 2023.
- The acuity of the people in the beds will also affect pricing.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

OHA would create an Intensive Service Unit to provide enhanced program development, program evaluation, subject matter expertise, technical assistance, contract development and administration, and utilization management for services provided to Oregon's mandated populations.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

None.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

This policy package would impact the Civil Commitment, Guilty Except for Insanity, Aid and Assist (both those served at OSH and in the community) caseloads. Improved management of services for individuals under aid and assist orders is expected to shift services from OSH to the community level for those who do not require a hospital level of care. This shift may stabilize, and possibly reduce, the Aid and Assist caseload served at OSH and increase the number of people under aid and assist orders served in the community. Further, as access to and coordination of care for individuals with intensive behavioral health care needs improves, OHA anticipates a reduction in the number of arrests of those individuals and therefore the number of individuals with intensive behavioral health care needs under aid and assist orders.

As Aid and Assist caseloads stabilize and/or reduce, OSH would have capacity to admit more patients under civil commitment, reducing the length of time and number of people who await admission to the state hospital from local acute care facilities and other locations.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

This package includes six new permanent, full-time positions, priced at 18 months for the 2021-23 biennium.

Intensive Community Services Director – Principle Executive Manager G
The position would direct the full range of community based behavioral health services for people who have entered treatment through Oregon's court systems under ORS 161 and 426.

Court and Corrections Liaison – Operations and Policy Analyst 4
This position would serve as liaison between the Office of Behavioral Health Services and the court system, including judges, district attorneys, and defenders, and the correctional system. This person would focus specifically on the planning, policy and program recommendations for people who have entered the behavioral health system through Oregon's courts as a result of civil commitment, guilty except for insanity, aid and assist, or magistrate hold. The person in this position would identify program policy development needs, including administrative, legislative and funding changes to improve the effectiveness of the services and service delivery system.

Clinical Technical Assistance for Intensive Community Programs – Operations and Policy Analyst 4
This position would serve as clinical expert and treatment liaison between the Office of Behavioral Health Services Intensive Services Unit and the various treatment milieus, including Oregon State Hospital, community treatment programs, and correctional systems. This person would focus specifically on the planning, policy and program recommendations for people who have entered the behavioral health system through Oregon's courts as a result of civil commitment, guilty except for insanity, aid and assist, or magistrate hold. The person in this position would identify program policy development needs, including administrative, legislative and funding changes to improve the effectiveness of the clinical and treatment services and service delivery system. The person in this position would engage stakeholders statewide to improve systems, support policy and program development and collect feedback and work to achieve consensus.

Oregon State Hospital Social Work Liaison – Operations and Policy Analyst 3
The primary purpose of this position would be to serve as liaison and facilitate collaboration between the Office of Behavioral Health Services, community mental health programs, coordinated care organizations, residential treatment providers and the Oregon State Hospital social workers to coordinate admission and discharge planning for people at Oregon State Hospital. This person would focus specifically on the planning, policy, system performance, and program recommendations for people who have entered the behavioral health system through Oregon's courts as a result of civil commitment, guilty except for insanity, aid and assist, or magistrate hold. The person in this position would identify program policy development needs, including administrative, legislative and funding changes to improve the effectiveness of the services and service delivery system. The person in this position would engage a stakeholders to improve systems, support policy and program development and collect feedback and work to achieve consensus.

Co-occurring Treatment Services Specialist – Operations and Policy Analyst 3
This position would to provide leadership, coordination and oversight regarding co-occurring substance use disorder and mental illness within the behavioral health treatment service and delivery systems as they pertain to people who have entered the system through Oregon's courts as a result of civil commitment, guilty except for insanity, aid and assist, or magistrate hold. The employee would focus specifically on policy analysis, evaluates operational issues, project management through implementation of specialized programs and service delivery. The employee would also take the lead in developing improved case management systems and collaborates with physical and public health agencies in addressing issues of coordinated care for these individuals. Staff with specialized clinical and system management skill are necessary in order to appropriately place and maintain these individuals, in community settings.

Research Analyst 4
This position would organize, collect, and analyze data and information about people who utilize intensive behavioral health services to help identify trends, evaluate programs, and determine root causes behind trends.

OHA anticipates five existing positions would also become part of the Intensive Services Unit: three Operations and Policy Analyst 3 positions and two Compliance Specialist 3 positions.

20. What are the start-up and one-time costs?

The one-time costs would be for three 16-bed Secure Residential Treatment Facilities ($7.6 million General Fund) and start-up costs for the facilities ($6.0 million General Fund). The evaluation of demand drivers and capacity needs would be contracted through Program Design and Evaluation Services (PDES) for an estimated one-time cost of $0.5 million General Fund.

21. What are the ongoing costs?

The ongoing costs are OHA staff, community restoration costs, forensic costs, Oregon State Hospital case rate costs, and SRTF per diem rates for 48 clients.

22. What are the potential savings?

No savings are anticipated due to current forecast projections indicating OSH would continue to have capacity issues with the current number of beds available and the projected needs of the three mandated populations; civil commitment, guilty except for insanity and aid and assist.

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

A projected amount of $5.4 million Total Funds in Special Payments is attributed to Medicaid client payments, which receive federal matching funds. The federal match rate applied to these payments is a blended average of the 2021-23 biennium FMAP rates.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$1,064,411			$1,064,411	6	4.50
Services & Supplies	$206,318			$206,318		
Capital Outlay	$7,612,914			$7,612,914		
Special Payments	$10,384,888		$3,376,104	$13,760,992		
Other						
Total	**$19,268,531**	**$0**	**$3,376,104**	**$22,644,635**	**6**	**4.50**

Fiscal impact by program

	HSD Program Support & Administration	HSD Medicaid	HSD Non-Medicaid	Health Policy & Analytics	**Total**
General Fund	$1,079,099	$2,379,424	$15,618,378	$191,630	**$19,268,531**
Other Funds	$0	$0	$0	$0	**$0**
Federal Funds	$0	$3,376,104	$0	$0	**$3,376,104**
Total Funds	$1,079,009	$5,755,528	$15,618,378	$191,630	**$22,644,635**
Positions	5	0	0	1	**6**
FTE	3.75	0.00	0.00	0.75	**4.50**

Oregon Health Authority
2021-23 Policy Package

Division:	Public Health Division
Program:	Office of the State Public Health Director
Policy package title:	Public Health Modernization
Policy package number:	417
Related legislation:	HB 2073 (2021); HB 2348 (2013); HB 3100 (2015); HB 2310 (2017); SB 253 (2019)
Summary statement:	Since 2013, Oregon has been on a path to fundamentally shift its practice to ensure essential public health protections are in place for all Oregonians through equitable, outcomes-driven and accountable services. The groundwork laid through initial investments in public health modernization have been critical to Oregon's management of the COVID-19 pandemic. However, the COVID-19 response has highlighted continued gaps in the public health system, specifically centering all work in health equity and cultural responsiveness so that we can end health inequities by 2030. This policy package supports implementation of key public health programs in state, local and tribal public health authorities and communities and creates mechanisms for increased accountability for health outcomes. Not funding this policy package risks OHA's ability to ensure basic public health protections guaranteed in statute are available to every person in Oregon, risks continuing health inequities, and challenges OHA in continuing to meet the deliverables and timelines prescribed in House Bill 3100 (2015).

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$30,000,000**	**$0**	**$0**	**$30,000,000**	**0**	**0.00**

Oregon Health Authority: 2021-23 Policy Package

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

The landscape for public health has changed dramatically in recent years as the way that we live, travel, work and recreate has created a series of new and increasingly complex public health issues. These are the circumstances that led to the rapid spread of COVID-19, creating an international pandemic not seen on such a scale in the last 100 years since the 1918 influenza pandemic. At the same time, the COVID-19 pandemic immediately exacerbated widespread existing health inequities borne by systemic racism and oppression. COVID-19 has disproportionately impacted communities of color, low wage workers and individuals in congregate settings like correctional facilities and long-term care facilities. The impacts of historical and contemporary injustices leading to health inequities will require years of a committed public health response and recovery that is co-created with communities. OHA's 10-year goal is to end health inequities and OHA-PHD is central to achieving that goal for Oregonians.

This policy package considers this context and builds upon previous investments in public health modernization made in the 2017-19 and 2019-21 biennia to center the public health system fully in equity. The demands on Oregon's public health system have continued to increase and will do so in the future as the secondary and tertiary impacts of COVID-19 come to the fore. These immediate health needs are encapsulated with ongoing environmental health risks such as wildfire due to climate change. These compounding health needs require a public health system that is equity-driven, community-based and nimble.

Recognizing the need for a robust public health system to support Oregon's health system transformation and achievement of the Triple Aim, in 2013 the Oregon legislature set a charge to develop a public health system for the future. In 2016, all state and local public health authorities completed a robust 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 center equity and be culturally and linguistically responsive to health and

community needs, proactively measure and mitigate environmental impacts to human health, manage new communicable disease outbreaks and collect and report public health data that is needed to solve new public health problems. Furthermore, the 2016 public health modernization assessment found a $210,000,000 additional biennial need for state and local public health authorities to fully accomplish statutory responsibilities. This policy package supports implementation of the key public health priorities selected by the Oregon Public Health Advisory Board for the 2021-23 biennium, which include health equity, community partnership development, leadership, communications, assessment and epidemiology, communicable disease control, environmental health, emergency preparedness and response and policy and planning.

2. What would this policy package buy and how and when would it be implemented?

This policy package would build critical public health capacity across state, local and tribal public health authorities and community-based organizations.

Investments in public health modernization ensure the equitable distribution or redistribution of resources and power and recognize, reconcile and rectify historical and contemporary injustices. Within the following three priorities for funding, interventions will be co-created with communities most impacted by health inequities.

1. Strengthen and expand communicable disease and environmental health emergency preparedness, and the public health system and communities' ability to respond.
2. Protect communities from acute and communicable diseases through prevention initiatives that address health inequities.
3. Protect communities from environmental health threats from climate change through public health interventions that support equitable climate adaptation.

These special payments must be an ongoing biennial investment in the public health system which is necessary to protect the health of every person in Oregon. Previous public health initiatives have demonstrated that when funds are not sustained, rates of diseases increase, and communities of color bear a disproportionate burden of those impacts. OHA anticipates that communicable diseases and environmental health threats will not be solved in the 2021-23 biennium and the public health system must remain vigilant to address these needs.

Further details about each of the special payments is as follows:

- Local public health authorities: Local public health authorities will be responsible for centering all of their local interventions on equity, including workforce diversity, partnership with community-based organizations and internal and external organizational policy changes that shift power to community. Local public health authorities will build upon previous investments in communicable disease control to provide comprehensive communicable disease surveillance, investigation, interventions and evaluation. Local public health authorities will also be responsible for assessing and mitigating environmental risks to human health, including those associated with climate change, focusing on those communities most at risk of the adverse effects of environmental health risks to their health. In order to do this work, local public health authorities must apply outcomes from the COVID-19 response to bolster local emergency preparedness and response systems, which underpin the success of communicable disease and environmental health interventions. Local public health authorities will be funded through the funding formula developed with the Public Health Advisory Board, which will be submitted to Legislative Fiscal Office per ORS 431.380. The local public health authority funding formula not only addresses all statutory requirements, but also includes demographic factors like population diversity, income and education level, language other than English spoken at home which are designed to provide more resources to more diverse counties. At the level included in this policy package, local public health authorities will also receive incentive payments when they meet accountability measure targets for their jurisdiction and matching funds for county investment in public health services.

- Tribal public health authorities: In accordance with OHA's Tribal Consultation and Urban Indian Program Confer Policy, OHA will fund Tribes using the methodology to which they agree for work in the following areas: health equity and cultural responsiveness, communicable disease control, environmental health and emergency preparedness and response. Funded work for Tribes will help address areas of need based on the 2019-21 Tribal public health modernization assessment process. Funding allocation to Tribes is determined through the Tribal Consultation and Urban Indian Program Confer Policy.
- Community-based organizations: OHA will utilize an existing partnership network of community-based organizations to fund additional work across the state that advances health equity and cultural responsiveness within the public health system while centering equity in OHA and local public health authority communicable disease control, environmental health and emergency preparedness and response interventions. Community-based organizations will submit proposed budgets and work plans for the objectives included in this policy package. OHA will select community-based organizations across the state that also represent the cultural and linguistic diversity of Oregon's population.

A modern public health system is equipped with a set of skills and tools – sometimes referred to as foundational capabilities – that are the pillars for how the public health system protects people from health threats and achieves health for all.

The following seven foundational capabilities achieve the communicable disease and environmental health goals listed above and make progress toward an equitable Oregon.

- Health equity and cultural responsiveness: Ensure public health programs are co-created with communities and public health programs are culturally and linguistically competent so that we can end health inequities by 2030.

- Assessment and epidemiology: Analyze data to understand emerging trends for communicable disease and environmental health threats; make data readily available to communities and partners who rely on the information and use data to implement culturally and linguistically responsive interventions.
- Community partnership development: Leverage coordinated care organizations, government agencies and other partners to increase the impact of public health modernization work in communities.
- Emergency preparedness and response: Work with communities and partners to prepare for, respond to and recover from public health threats and emergencies, while ensuring populations most at risk are at the center of planning efforts.
- Leadership and organizational competencies: Develop the public health workforce to be better equipped to nimbly respond to new public health threats; use performance management and quality improvement to ensure public health interventions improve outcomes; spread capacity from public health modernization across public health program areas.
- Communications: Ensure timely risk communications and proactive communications that are culturally and linguistically responsive.
- Policy and planning: Engage with partners, stakeholders and communities to develop and implement policy solutions that are responsive to community needs.

At a broad level, the Public Health Division (OHA-PHD) would convene local and tribal public health authorities, community-based organizations, state agencies and representatives from other sectors to develop evidence-based plans for the prioritization and implementation of funded work to mitigate the highest risk impacts to human health across the state.

The specific work included in this policy package is as follows:

OHA-PHD would provide leadership for a community-based and equity-centered approach to public health in Oregon; manage local and tribal public health authority contracts and grants to community-based organizations; maintain and annually report on public health accountability measures; enhance public health and health care data exchange; collect and report population health data for the public health system and its partners; convene partners to develop and implement a framework for using data to identify leading environmental risks to human health and corresponding plans to mitigate risks; and coordinate acute and communicable disease outbreak investigations, including communicable disease testing at the Oregon State Public Health Laboratory.

This policy package includes continuing the recently formed community engagement unit within the Office of the State Public Health Director to manage community-based organization contracts and provide direct partnership and co-creation of health interventions with community. This unit will both manage funds from this policy package for community-based organizations and create the supportive structure within the Public Health Division for other public health programs to work directly with community-based organizations. This package would similarly build out staff within the Environmental Public Health and Center for Public Health Practice to lead state-level interventions and ensure a robust and cohesive public health system.

Local public health authorities would plan for and implement interventions to monitor environmental health risks within communities; convene local stakeholders to develop, exercise and implement emergency preparedness plans; co-create health-related interventions with the community; train clinic staff in culturally and linguistically responsive and evidence-based quality improvement activities; track cases of acute and communicable diseases to ensure individuals and their partners receive treatment to curb the spread of disease; 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 would convene local stakeholders to develop, exercise and implement emergency preparedness plans; co-create health-related interventions with the community; track cases of acute and communicable diseases and implement strategies to prevent the spread of disease; implement strategies to improve access to meaningful Tribal public health data to inform planning and decision-making, and involve communities in the development and execution of health-related interventions.

Community-based organizations would co-create culturally and linguistically responsive public health interventions to ensure alignment with goals to eliminate health inequities and support community resilience and recovery.

3. How does this policy package further OHA's mission and align with its strategic plan?

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. Indeed, ensuring the public health system is appropriately equipped to protect human health has been a leading priority for OHA since 2015.

OHA's strategic plan goal is to eliminate health inequities by 2030. This policy package would shift Oregon's public health system to be community-based and equity-centered in order to achieve OHA's ten-year goal. This policy package would create critical infrastructure within the Public Health Division and with community-based organizations that are essential to centering public health work on equitable outcomes.

This funding supports Governor Brown's priority for building a more equitable Oregon by equipping state, local and tribal public health authorities and community-based organizations with capacity and resources to identify and respond to physical and environmental health needs in the community.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

OHA will measure the success of this POP through achievement of established public health accountability metrics, which are collected and reported annually. At the proposed funding level, OHA-PHD would provide incentive payments to local public health authorities based on their achievement of process measures established within the funded areas, specifically related to immunization quality improvement efforts, contact investigations for sexually transmitted infections, participation in local transportation and land use planning decision-making and achievement of drinking water quality indicators.

OHA will also be able to measure the success of this POP through health indicators identified, analyzed and interpreted with communities of color through community-specific data collection efforts that began with the 2019-21 legislative investment in public health modernization.

This policy package also includes resources for a robust evaluation by OHA-PHD and local and tribal public health authorities on the successes being realized and where the public health system can improve service delivery to create greater efficiencies and accountability.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

This policy package supports several activated Tier 1 OHA performance measures, including:

- Health indicator reporting
- REAL-D implementation
- Timeliness of translations during emerging public health events
- Continuity of Operations Plans

At the Tier 2 level, this policy package supports the following activated OHA-PHD performance measures:

- Tribal representative engagement in public health advisory teams
- Representation of those affected in an advisory capacity
- Staff registered in the Health Alert Network

In this biennium, OHA-PHD will continue to align its performance measures with the work included in this policy package.

7. What are the long-term desired outcomes?

The long-term outcomes for this policy package are to eliminate health inequities by working with communities to equitably distribute or redistribute resources and power and recognizing, reconciling and rectifying historical and contemporary injustices. This work would include ongoing engagement of state, local and tribal public health leaders to co-create public health programs with communities. In the medium term, this policy package would reduce the burden of environmental and communicable disease-related health issues by focusing on the root causes of environmental health and communicable diseases. Short term, it would equip state, local, tribal

and community health agencies to apply the foundational capabilities for governmental public health in such a way that centers equity across all health issues.

8. What would be the adverse effects of not funding this policy package?

If this package is not funded, Oregon's governmental public health system would struggle to address the ongoing health and social impacts of COVID-19 on communities. Although Oregon's public health system was able to respond quickly to COVID-19, it fell short of delivering equitable outcomes for communities of color and tribal communities. Not funding for this POP will exacerbate inequities in health outcomes and work against OHA's ten-year goal. Not funding this policy package would risk the Public Health Division's long-term relationships with communities of color and community-based organizations by failing to uphold the request for sustained funding for their critical work.

Without the support of this policy package, OHA-PHD will likely be in the ongoing position of responding to individual crises rather than being able to work with partners to prevent them in the first place. Not funding this POP leaves the public health system in a position where it will be unable to respond to multiple simultaneous public health crises.

Should this POP not be funded, Oregon can anticipate disparities in the level of public health service available at the local level, particularly as local government budgets struggle to keep up with budget shortfalls as a result of the current recession. This would mean Oregonians would lack essential public health protections based on where they live.

The current focus on gaining efficiencies and improving effectiveness in public health service delivery would subside because there would little incentive to continue working regionally and to focus on delivering outcomes for the community. Recent transitions in local public health service delivery have shown that without sufficient

resources, local governments are more likely to cut, privatize or transfer public health authority to OHA-PHD 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

9. What actions have occurred to resolve the issue prior to requesting a policy package?

In the 2019-21 biennium, OHA-PHD leveraged federal grants and restructured existing positions to the extent possible to augment the programs implemented with the $15.6 million legislative investment in public health modernization. However, the impact of this investment is expected to be proportional to the size of the investment. The Oregon legislature expects the public health system to fully implement its statutory responsibilities, and the current investment will not support expansion of the work needed in health equity, community partnership development, leadership, communications, assessment and epidemiology, communicable disease control, environmental health, emergency preparedness and response and policy and planning.

10. What alternatives were considered and what were the reasons for rejecting them?

OHA-PHD has explored whether federal funding might be available for this work. Based on the way federal public health funds are appropriated by Congress, there is not an immediate option for federal funding for the level of investment needed to implement public health modernization in Oregon. Furthermore, federal financial supports for the areas funded by this POP are likely to continue to or begin to decline as a result of the recession and prior efforts to limit public health spending. Outside of this policy package, OHA will continue to align its funding streams to further support public health modernization to the extent possible based on federal funding restrictions.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

OHA-PHD put forward a legislative concept placeholder, House Bill 2073 (2021), for any changes that may need to be made to statute to support this work.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

This policy package would primarily invest in local and tribal public health authorities so they can carry out their public health responsibilities related to health equity, community partnership development, leadership, communications, assessment and epidemiology, communicable disease control, environmental health, emergency preparedness and response and policy and planning. This policy package would also invest for the first time in community-based organizations to co-create public health interventions grounded in equity. In order for OHA-PHD's work funded in this policy package to be successful, OHA-PHD will collaborate with several state agencies and the sectors they support, including the Oregon Department of Corrections, Oregon Youth Authority, Department of Environmental Quality, Department of Education, Oregon Department of Agriculture, Oregon Department of Transportation, and the Oregon Department of Land Conservation and Development.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

The direction of this policy package 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. Community-based organizations and advocacy organizations will be engaged in developing equity-driven goals for the public health system.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

In the 2016 statewide public health modernization assessment, the most significant gap across state and local public health authorities was in the system's ability to achieve health equity. Although significant work on health equity began with the initial investments in public health modernization, the COVID-19 pandemic has revealed that there must be a fundamental shift in public health practice in order to rectify grave injustices in health outcomes that have been exacerbated by the disproportionate impact of COVID-19 on communities of color.

This package places equity at the center of a modern public health system by funding state, local and tribal public health authorities and community-based organizations to co-create public health interventions. It would provide funding to local and tribal public health authorities through a funding formula that directs greater resources into communities of color, low income communities, rural communities and communities that speak a language other than English at home.

This policy package would specifically address inequities in outcomes related to environmental health threats and communicable diseases and fosters a resilient public health system through investment in foundational public health capabilities.

Staffing and fiscal impact

Implementation date(s): July 1, 2021

End date (if applicable): Not applicable

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

15. What assumptions affect the pricing of this policy package?

The key assumption is that Public Health would be fully funded to address the needs of Oregonians through this policy package. The division would have enough revenue to address outbreaks, prevention, and inequities in outcomes for state and local work.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

Public Health

OHA-PHD would be responsible for overseeing all contracts and grants in this policy package in addition to implementing the state-level public health functions needed to improve health outcomes related to health equity, community partnership development, leadership, communications, assessment and epidemiology, communicable disease control, environmental health, emergency preparedness and response and policy and planning.

Equity and Inclusion

The Equity and Inclusion Division would provide content expertise to OHA-PHD to ensure alignment and benefit of health equity work in the community and would consult on community engagement, REAL+D and health equity training initiatives.

Health Policy and Analytics

Staff in Health Policy and Analytics would provide consultation to OHA-PHD on opportunities to align public health accountability metrics with CCO incentive metrics.

Office of Information Services

The Office of Information Services would 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 it can be used for program and policy decision-making.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

This policy package includes funding and a new position for the Office of Information Services (OIS). OIS has been consulted throughout the development of this policy package.

18. 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.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

This package includes the 13 permanent, full-time positions listed below, priced at 24 months, that would require position authority and General Fund.

Establishing the Community Engagement unit:

- One Principal Executive Manager D
- Eight Operations and Policy Analyst 2
- One Fiscal Analyst 2

In addition, positions to support the division and center work:

- One Operations and Policy Analyst 3
- One Operations and Policy Analyst 4
- One Epidemiologist 2

This package also includes General Fund for two existing positions so these staff can perform work essential to modernization that cannot be charged to a federal grant. These positions would not require position authority. The FTE amounts below represent the portion of the positions transitioning to General Fund at 24 months.

- One Principal Executive Manager D, 0.75 FTE
- One Principal Executive Manager F, 0.5 FTE

20. What are the start-up and one-time costs?

Epidemiologist positions would require statistical analysis software and ongoing software license renewals.

21. What are the ongoing costs?

Ongoing costs are associated with the continued operation and implementation of the work specifically:

- Personnel services for 13 new positions including a new Community Engagement Unit which totals ($1.9million) and two existing staff, all services and supply expenses and equipment for state priorities for a grand total of $5.8 million.
- Special payments, which fund local public health authorities, Tribes and community-based organizations for local staff dedicated to the ongoing work included in this policy package. Local public health authorities will receive $15,438,000; Tribes, $2,178,000; and community-based organizations $6,537,000, totaling $24,153,000.

22. What are the potential savings?

A robust childhood immunization program prevents direct and indirect costs from illness, hospitalizations and deaths over the course of lifetimes. For the national cohort of children born between 1994 (when the national Vaccines for Children program was established) and 2013, childhood immunizations prevented an estimated 322 million illnesses, 21 million hospitalization, and 732,000 deaths at a net savings of $295 billion in direct costs and $1.38 trillion in societal costs.[2] Oregon's public health system ensures widespread and culturally appropriate access to childhood immunizations, a rigorous system for immunization requirements in schools, and provider engagement in quality improvement.

According to work that Lane County and PeaceHealth completed with their 2017-19 public health modernization investment, administering roughly eight pneumococcal vaccines per week could prevent 250 pneumonias; avoid 50 pneumonia-related hospitalizations; and save $500,000 in direct hospital costs. 745 vaccines were delivered over twelve months to high-risk adults prior to hospital discharge, a 3% administration rate. They showed the following improvements:

- On average, 16 people were vaccinated per week, indicating that the **clinical savings** accrued at a much higher rate than the minimum estimate.
- Of those ages 19-64 that were administered vaccination, about 70% were covered by public healthcare insurance, indicating that this intervention has been instrumental in **improving preventative care access for low-income high-risk adults**.
- The percentage of vaccinated high-risk adult patients increased by 12% (from 58% to 70%) at the participating hospital sites.

Cost of one preventable case of Tetanus in Oregon: In 2017, for the first time in 30 years, a six-year-old Oregonian who had received no immunizations cut his forehead while playing outdoors. Six days later, after a

[2] https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6316a4.htm

series of symptoms the last of which was breathing difficulty, his parents called 911 and the boy was air-transported to the hospital. The boy subsequently received a diagnosis of tetanus and required approximately eight weeks of inpatient care, followed by rehabilitation care, before he was back to normal activities. With a price tag of $811,929 for inpatient costs alone, this preventable illness cost 72 times more than the average pediatric hospital stay.[3]

An investment in the prevention of disease and disability is proven to yield significant savings to Medicaid and other payers by decreasing the need for costly health care. Indeed, just a 10 percent increase in per capita public health spending in Oregon would result in:

- 15 fewer infant deaths annually
- 16 fewer diabetes deaths annually
- 202 fewer heart disease deaths annually

Looking at serious bacterial infections (SBI) related to injection drug use, the total cost of IDU-related SBIs in 2018 was $150 million. That same investment could:

- Support the recovery of 25,000 patients with opioid use disorder (OUD) with buprenorphine for one year (a year's worth of buprenorphine is about $6000 per patient) or of 2,500 patients for 10 years.
- Support the operating costs of 150 syringe service programs (SSPs) for one year (a year's worth of SSP operating costs is about $100,000) or 15 SSPs for 10 years.

A study of SSP legalization showed that SSP prevented thousands of HIV infections over a 10-year period in Philadelphia and Baltimore:[4]

[3] Guzman-Cottrill JA, Lancioni C, Eriksson C, Cho Y, Liko J. *Notes from the Field:* Tetanus in an Unvaccinated Child — Oregon, 2017. MMWR Morb Mortal Wkly Rep 2019;68:231–232. DOI: http://dx.doi.org/10.15585/mmwr.mm6809a3.
[4] https://journals.lww.com/jaids/Fulltext/2019/12012/Using_Interrupted_Time_Series_Analysis_to_Measure.14.aspx

Based on an investment of $250,000 in Oregon to address sexually transmitted diseases STI:

- 11 fewer cases of syphilis including congenital syphilis
- 106 fewer cases of gonorrhea
- 301 fewer cases of chlamydia
- An estimated decrease in direct to the healthcare system of $463,100 due to decreases in STD morbidity.

According to the Centers for Disease Control, syringe exchange programs (work many local public health authorities have and will focus on through public health modernization) was estimated in New York City to have:

- Created a one-year savings to the government of $1,300 to $3,000 per client.
- Another cost-effectiveness analysis estimated that expanding access to clean syringes through an additional annual U.S. investment of $10 million would result in:
  - 194 HIV infections averted in one year
  - A lifetime treatment cost savings of $75.8M
  - A return on investment of $7.58 for every $1 spent

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

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services						
Services & Supplies						
Capital Outlay						
Special Payments	$30,000,000			$30,000,000		
Other						
Total	**$30,000,000**	**$0**	**$0**	**$30,000,000**	**0**	**0.00**

Fiscal impact by program

	Office of the State Public Health Director				**Total**
General Fund	$30,000,000				**$30,000,000**
Other Funds	$0				**$0**
Federal Funds	$0				**$0**
Total Funds	$30,000,000				**$30,000,000**
Positions	0				**0**
FTE	0.00				**0.00**

Oregon Health Authority
2021-23 Policy Package

Division:	Oregon State Hospital
Program:	Salem Campus and Pendleton Cottage (State Delivered SRTFs)
Policy package title:	Deferred Maintenance
Policy package number:	421
Related legislation:	None

Summary statement:

The Salem campus of the Oregon State Hospital consists of 1.2 million square feet of buildings and interior court yards and has a Current Replacement Value (CRV) as reported to the Capital Advisory Board (CPAB) of $363,275,131. This makes the Oregon State Hospital among the highest replacement value of any single facility owned by the state. The Pendleton cottage facility has a current replacement value of $2,785,898 and is presenting considerable deferred maintenance due to the age of the campus. Funding the requested deferred maintenance requests would eliminate the current critical deferred maintenance needs for the Salem and Pendleton campuses and maximize the lifespan of the state's investment and public trust.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$191,943**	**$1,425,000**	**$0**	**$1,616,943**	**0**	**0.00**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

Oregon State Hospital (OSH) campuses in Salem and Pendleton have unfunded deferred maintenance that could result in health and safety issues for staff and patients if not resolved. Good stewardship of the state's resources is at the forefront of the building maintenance program at OSH to proactively maintain the state's assets and ensure compliance with Joint Commission and Centers for Medicare and Medicaid Services (CMS). We have seen the results of years of deferring maintenance resulting in loss of accreditation and deplorable conditions in the old hospital that was eventually demolished.

Maintaining critical operational continuity and providing 24-hour hospital level of care to patients needing intensive psychiatric treatment for severe and persistent mental illness is part of the mission of the Oregon Health Authority and Oregon State Hospital. Deferring critical maintenance is not an option in a hospital facility and can result in higher costs to replace or repair systems under emergency situations, health and safety issues for patients and staff, and loss of accreditation and CMS reimbursement.

2. What would this policy package buy and how and when would it be implemented?

This package would address current large expenditure deferred maintenance in advance of equipment and infrastructure failure. Funding for deferred maintenance would ensure maintenance of the facility to the highest standard and avoid more costly future maintenance, align with regulatory compliance and stewardship of the state's assets, and result in a safe and secure treatment and work environment.

Implementation would follow the normal state of Oregon procurement processes for deferred maintenance projects with the list of projects and components identified below in the "start-up and one-time costs" section.

3. How does this policy package further OHA's mission and align with its strategic plan?

OSH strives to achieve the highest standards and outcomes in all aspects of our work. Good stewardship of the public trust and the public dollar includes maintaining the facility to the highest standards and making regulatory and infrastructure improvements to meet the needs of patients and staff. OSH serves one of the most marginalized populations, the mentally ill. Maintaining well-kept and functioning treatment environments for these individuals contributes towards OHA's mission of ensuring all people and communities can achieve optimum physical, mental, and social well-being through partnerships, prevention, and access to quality, affordable health care; and aligns with the OHA strategic plan of eliminating health inequities.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No. Prior to this request, the OSH Salem and Junction City campuses are the only state-owned facilities that do not have any current substantial "Deferred Maintenance" as reported annually to the Capital Projects Advisory Board (CPAB) and cited in the March 2020 Secretary of State audit. Funding for this package would ensure maintenance of the facility and avoid more costly future maintenance, while maintaining regulatory compliance and excellence in stewardship of the State's assets.

Quantifying results

5. How will OHA measure the success of this policy package?

Measurements of success would include:

- Reporting to the Capital Projects Advisory Board
- Continued compliance with regulatory requirements as surveyed by the Joint Commission.
- Continued compliance with Fire/Life safety and building codes.
- Lower security risks to patients and staff

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

No.

7. What are the long-term desired outcomes?

Lower future maintenance costs, operational sustainability and continued compliance with regulatory requirements and good stewardship of state assets to provide a safe and therapeutic environment of care to some of Oregon's most vulnerable populations, as well as a safe work environment for staff.

8. What would be the adverse effects of not funding this policy package?

- Possible loss of accreditation from the Joint Commission and loss of CMS reimbursement.
- Noncompliance with state regulatory requirements.
- Inability to provide adequate treatment support infrastructure.
- Higher future maintenance costs.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

OSH uses a computerized maintenance management software system that lists every piece of equipment and assigns manufacture recommended preventative maintenance schedules. OSH is actively monitoring and performing preventative and predictive maintenance according to manufacturer's recommendations on all assets and equipment. This policy package would fund large expenditure projects not in the normal operating budget.

10. What alternatives were considered and what were the reasons for rejecting them?

Where possible, operations have treated scenarios as break/fix to restore to usable state. However, this continued deferral can no longer restore some infrastructure to operationality without greater attention. One example is the sidewalks on the Pendleton campus.

Deferring critical maintenance is the current option in use, however this is not a viable option in a hospital facility and results in higher costs to replace or repair systems under emergency situations posing significant health and safety issues for patients and staff. Deterioration of the infrastructure also poses the risk of loss of accreditation and CMS funding.

11. Does this policy package require any changes to existing statute(s) or require a new statute?

No.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

None.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

None.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

The investment in critical maintenance helps ensure a safe, secure and therapeutic environment for treating some of Oregon's most vulnerable populations.

Staffing and fiscal impact

Implementation date(s): January 2022

End date (if applicable): June 2025

15. What assumptions affect the pricing of this policy package?

Estimates are rough order of magnitude (ROM) and may vary slightly from actual expenses as the standard procurement processes are followed.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

No.

17. Will there be new responsibilities for or an impact on Shared Services?

No.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No. Although infrastructure for services provided would be improved.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

This package would utilize the Limited Duration Construction Project Manager 2 position included within policy package #423, if that package is also approved. Current OSH staff associated with specific trade skills would be utilized where possible.

20. What are the start-up and one-time costs?

Construction or renovation project components and approximate costs:

1. Salem backflow preventer system, $250,000
2. Pendleton concrete sidewalk replacement, $100,000
3. Pendleton building demolish, $100,000
4. Pendleton parking lot construction, $200,000
5. Salem security cameras and switches, $600,000

Total deferred maintenance construction projects: $1.39 million, which includes a percentage of a Limited Duration project manager position over 2 biennia.

21. What are the ongoing costs?

Projects within this package are self-contained. When completed, minor upkeep and maintenance may be necessary, but is not deemed significant.

22. What are the potential savings?

No budgetary savings are expected as a result of this package. However, efficiency would be gained in the overall environment of care being improved by the projects funded by this policy package.

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

This deferred maintenance package requested XI-Q Bond financing, including a portion of the limited duration Project Manager position, representing the amount of time that position would spend on the projects related to this package. Bond financing at the par amount (cost of bond plus bond issuance) is $1.43 million, with an additional $62,000 in interest for the 2021-23 biennium.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services						
Services & Supplies		$39,700		$39,700		
Capital Outlay		$1,385,300		$1,385,300		
Special Payments						
Debt Service	$191,943			$191,943		
Total	**$191,943**	**$1,425,000**	**$0**	**$1,616,493**	**0**	**0.00**

Fiscal impact by unit

	OSH Capital Construction	Debt Service	State Assessments & Enterprise-wide Costs	**Total**
General Fund		$191,943		**$191,943**
Other Funds	$1,385,300		$39,700	**$1,425,000**
Federal Funds				**$0**
Total Funds	$1,385,300	$191,943	$39,700	**$1,616,493**
Positions				**0**
FTE				**0.00**

Oregon Health Authority
2021-23 Policy Package

Division:	Oregon State Hospital
Program:	Oregon State Hospital Operations
Policy package title:	Asset Replacement
Policy package number:	422
Related legislation:	None.

Summary statement:

The Oregon State Hospital (OSH) Salem facility began construction in 2009, was completed in 2011 and is over 10 years old. The Junction City facility is now over 5 years old. As aging occurs, much of the expendable property and capital assets in operation have outlived or have soon expiring useful lives. Replacement of these items is necessary to provide a safe and secure environment for patients and staff, as well as maintain critical continuity of hospital operations.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$621,906**	**$4,429,599**	**$0**	**$5,051,505**	**0**	**0.00**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

OSH campuses in Salem and Junction City have a considerable volume of depreciable assets at or near the end of their useful lifecycle that must be replaced to maintain critical operational continuity and provide 24-hour hospital level of care to patients needing intensive psychiatric treatment for severe and persistent mental illness.

Lifecycle replacement of equipment is part of the requirement for accreditation by the Joint Commission and for Medicare reimbursement through the Centers for Medicare and Medicaid Services. Much of the existing equipment was purchased at the time of hospital opening, while other pieces were transferred from the old facility. This equipment has experienced the wear and tear of a production environment and is requiring upkeep or replacement beyond existing budget resources.

OSH completed a very successful survey of the facility from the Joint Commission in 2017 in which OSH was recognized as one of the leading psychiatric hospitals in the nation and was encouraged to seek national recognition through the Malcolm Baldrige National Quality Award. Having gained the recognition and achieved the standard of service for that recognition, this package would help to ensure that OSH does not deteriorate patient care or the condition of the facility.

2. What would this policy package buy and how and when would it be implemented?

This package would address immediate large expenditure equipment lifecycle replacement in advance of equipment breakdown. As a one-time package, it would essentially re-start the lifespan cycle for the needed equipment. Funding for asset lifecycle replacement would ensure maintenance of the facility to the highest

standard and avoid more costly future maintenance. It will comply with regulatory requirements and stewardship of the state's assets, for a safe and secure environment with optimal treatment services.

Implementation would follow the normal state of Oregon procurement processes for depreciable asset replacement and use in-house trades staff to install most equipment.

Specific equipment requests are listed in the "one-time or start-up costs" below.

3. How does this policy package further OHA's mission and align with its strategic plan?

OSH strives to achieve the highest standards and outcomes in all aspects of our work. Good stewardship of the public trust and the public dollar includes maintaining the facility to the highest standards and making regulatory and infrastructure improvements to meet the needs of patients and staff contributing towards OHA's mission of ensuring all people and communities can achieve optimum physical, mental, and social well-being through partnerships, prevention, and access to quality, affordable health care.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

The expected lifecycle for hospital assets has been determined by the consensus of experienced representatives from the leading appraisal companies and respected hospitals and health care systems as published in the 2018 edition of *Estimated Useful Lives of Depreciable Hospital Assets* by the American Hospital Association.

Replacement of equipment is part of the expectation of accreditation by the Joint Commission and for the Centers for Medicare and Medicaid Services reimbursement.

Measurements of success would include:

- Continued compliance with regulatory requirements as surveyed by the Joint Commission.
- Continued compliance with food safety standards.
- Continued compliance with OSHA regulations.
- Continued compliance with Fire/Life safety codes.
- Lower security risks to patients and staff.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

This package is indirectly related to treatment outcomes and, in many cases, directly related to environment of care. It is not directly related to KPMs.

7. What are the long-term desired outcomes?

Continued compliance with regulatory requirements and good stewardship of state assets to provide a safe and therapeutic environment of care to some of Oregon's most vulnerable populations.

8. What would be the adverse effects of not funding this policy package?

- Possible loss of accreditation from the Joint Commission and loss of CMS reimbursement.
- Noncompliance with state regulatory requirements.
- Inability to provide adequate infrastructure to support treatment.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

OSH has attempted to use budgetary resources to resolve lifecycle issues in a break/fix capacity, as budget constraints did not allow a resolution for the quantity of items in need of replacement. A preventative maintenance plan has been established to include lifecycle equipment replacement schedules projected out 25 years to predict future lifecycle funding needs.

10. What alternatives were considered and what were the reasons for rejecting them?

There are no viable alternatives to lifecycle asset replacement and preventative maintenance replacement.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

None.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

None.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

The replacement of critical depreciable assets helps ensure a safe, secure and therapeutic environment for treating some of Oregon's most vulnerable populations.

Staffing and fiscal impact

Implementation date(s): September 2021

End date (if applicable): June 2023

15. What assumptions affect the pricing of this policy package?

Standard procurement practices may impact purchasing and some implementation dates. Assets that are eligible for Bond financing are priced at par amounts (the cost of the bond with issuance).

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

No new responsibilities.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

No.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

No staff positions are needed for this package. If policy package #423 for Capital Improvements is accepted, the limited duration Project Manager within that package may be utilized to assist in equipment planning and deployment within this package.

20. What are the start-up and one-time costs?

One-time costs total $4.34 million, as specified in the below list:

Salem Campus			
Asset	**Qty**	**Est. Cost**	**Total**
Court room mics and recording system		$15,000	**$15,000**
Sensory room music sound system replacement		$20,000	**$20,000**
Dental - Cavitron ultrasonic		$6,170	**$6,170**
Dental - X-Ray prosensor intra-oral, large		$5,999	**$5,999**
Dental - Autoclave (sterilizers) (2 @ $6K each)		$12,000	**$12,000**
Dental - Dental chairs	4	$18,000	**$72,000**
Worker's Comp information system replacement	1	$26,500	**$26,500**
Commercial Mower/Grounds equipment		$75,000	**$75,000**
Warehouse forklift	1	$20,000	**$20,000**
Rationale Oven Small- for satellite kitchens	2	$13,200	**$26,400**

Kitchen Grills	2	$6,500	**$13,000**
Salem Automated Dispensing Cabinets	34	$83,333	**$2,833,324**
Total Salem Campus:			**$3,125,393**
Junction City Campus			
Asset	**Qty**	**Est. Cost**	**Total**
Flat Top (Café 48")	1	$5,300	**$5,300**
Servers for Lenel access control, ONSSi camera system and PLS touch screens	1	$195,000	**$192,000**
Rational Oven	2	$45,000	**$90,000**
Steam Kettle	2	$22,000	**$44,000**
Blodget 40G Tilt Skillet	1	$24,000	**$24,000**
Turbo Chef	1	$14,000	**$14,000**
Air Curtain Merchandiser Grab N Go cooler	1	$6,100	**$6,100**
Blast Chiller	1	$40,000	**$40,000**
Deep Fryer	1	$23,000	**$23,000**
Hobart Dishwasher	1	$43,000	**$43,000**
Hustler Mower	1	$13,000	**$13,000**
Blodget Gas Oven Stack Unit (Elite)	1	$21,000	**$21,000**
DDC server & software	1	$33,000	**$33,000**
JC Automated Dispensing Cabinets	8	$83,333	**$666,664**
Total Junction City Campus:			**$1,215,064**

21. What are the ongoing costs?

Equipment replacement is a one-time expense.

22. What are the potential savings?

This package would not result in any direct savings but would prevent over-spending on emergency repairs.

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

OSH is seeking XI-Q Bond Financing for the capital assets present in this request, the par amount (cost of the bond with the cost of the bond issuance) for the eligible assets is $4.4 million, with associated interest in 2021-23 of $186,000.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services						
Services & Supplies		$89,142		$89,142		
Capital Outlay		$4,340,457		$4,340,457		
Special Payments						
Debt Service	$621,906			$621,906		
Total	**$621,906**	**$4,429,599**	**$0**	**$5,051,505**	**0**	**0.00**

Fiscal impact by program

	OSH Capital Construction	State Assessments and Enterprise-wide Costs	Debt Service	**Total**
General Fund	$0	$0	$621,906	**$621,906**
Other Funds	$4,340,457	$89,142	$0	**$4,429,599**
Federal Funds	$0	$0	$0	**$0**
Total Funds	$4,340,457	$89,142	$621,906	**$5,051,505**
Positions	0	0	0	**0**
FTE	0.00	0.00	0.00	**0.00**

Oregon Health Authority
2021-23 Policy Package

Division:	Oregon State Hospital
Program:	Salem Campus
Policy package title:	Oregon State Hospital Capital Improvement
Policy package number:	423
Related legislation:	None

Summary statement:

The Oregon State Hospital (OSH) Salem Campus is the primary state psychiatric facility serving some of Oregon's most vulnerable populations. OSH has identified three critical capital improvement projects that would provide:

- A self-sustainable facility that could maintain a safe and secure environment of care throughout loss of city water and or contamination of city water such as the 2018 cyanotoxin event.
- Expanded staff space by building a second floor within an existing area.
- Enhanced treatment capability by repurposing existing space.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$719,932**	**$6,980,000**	**$0**	**$7,699,932**	**0**	**0.00**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

This policy package would provide capital improvement investment to the Oregon State Hospital (OSH) to fund high priority infrastructure projects determined critical to hospital operations. The primary issues addressed within this package are:

1. **The ability for the hospital to sustain itself in the event of a catastrophe or other emergent situation**. OSH currently has emergency generators capable of supplying power to the entire facility indefinitely and a propane backup system to provide heating and cooking fuel in the event of curtailment of natural gas. This package would include a backup water supply to provide drinking water or water for sanitation in the event of supply contamination such as the recent Cyanotoxin contamination in 2018 or disruption in the city water supply. As evidenced by the COVID-19 pandemic, we must be prepared to adapt to emergency situations that impact the health and safety of a population essentially restricted to a single confined area. The Oregon State Hospital Salem campus has the capacity for 592 patients, resulting in a minimum of 725 people on the campus during any one shift, with a maximum of over 1,600 staff, visitors, and/or vendors. Loss of water for an extended time at the Oregon State Hospital could result in significant medical and sanitary issues and, if sustained, could eventually result in equipment and critical technology failure.

2. **Providing additional program space within the secure perimeter of the hospital** in order to both move staff out of the non-ADA compliant residential cottages on campus into the hospital as well as providing additional treatment space for staff to interact with patients directly on the units.

2. What would this policy package buy and how and when would it be implemented?

This package requests funding and approval for three distinct projects, all located on the Salem campus. These projects include the following, in order of priority:

1. Construction of a well water treatment facility and potable water storage tanks would provide a backup water supply to the hospital in the event of disruption or contamination of the city water supply. OSH is an entirely self-contained facility except for backup water. OSH has backup generators that provide electricity for the entire facility during a power outage event and has a backup propane system for heating and cooking during the event of a loss of natural gas. OSH has one single point of connection to city water that is fed through a 1950's era 10" steel underground pipe. This leaves the hospital vulnerable to a complete loss of domestic water and water for sanitation including flushing toilets.

   Loss of water could also shut down critical systems such as cooling which would then lead to overheating server rooms that could damage or require shutting down essential technology systems and access control. OSH is requesting funding for a potable water treatment and storage facility on the Salem campus to remove these concerns.

   Estimated cost: $4,380,000

2. The hospital has an identified administrative and program staff space shortage in the secure perimeter where treatment staff can be close to the patients and the milieu allowing them to build greater professional understanding and collaboration with other treatment team members. Current conditions require the placement of staff and programs in non-ADA compliant cottages located on the campus. To address this space need, OSH commissioned SRG architects to perform a feasibility study and budget proposal to infill an existing space within the secure perimeter that would add 2,700 square feet of office space. This package would accommodate 32 staff and include a conference room, copy room, and unisex toilet room by constructing a second floor into an area that currently has existing "ceiling" space.

   Estimated cost: $1,643,386

3. The hospital has identified a need to repurpose the existing therapy tub rooms on the units that are no longer used for patients due to ligature risks. The hospital proposes to remodel the existing 24 tub rooms to create additional treatment space for staff to interact with patients. This space is currently planned to be used for Interdisciplinary Teams (IDTs) to be able to meet with and treat patients.

   Estimated cost: $500,000

   To support the success of these projects, a limited duration (LD) Construction Project Manager 2 is requested to assist in the oversight and management of the projects above. OSH is also proposing Deferred Maintenance projects, as presented in the associated Oregon Health Authority policy package #421. This additional support is needed to ensure project management capacity is resourced at the right level for the projects in both packages. The current OSH Operations Director has over 25 years of experience in construction, construction management and state government construction contracting and will be providing direct oversight of the projects and of this position.

Implementation timelines of the items in this package would vary from project to project. Generally, the procurement process and the initiation of hiring for the LD position would determine the respective start dates.

3. How does this policy package further OHA's mission and align with its strategic plan?

OHA's mission of achieving optimum physical, mental and social well-being is at the forefront of all that OSH does. Implementation of this policy package ensures the steadiness of that mission and increased sustainability and flexibility through:

- Self-sufficiency and a safe water supply in the event of a disruption in city water for any reason.
- Safe and ADA compliant environment for patients and staff.

- Additional space providing for both current and future needs of staff and clinical treatment programs that directly and indirectly support Hope, Safety and Recovery for patients at the Oregon State Hospital.
- Continuity of operations and resource efficiency leading to improved business rigor.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

- Success of the installation of a backup water supply to the hospital would be measured by the safety and reliability of our water supply.
- Success of the additional space would be measured by workspace utilization. Currently, some workspaces are over-crowded or non-ADA compliant.
- Success of the repurposing of existing space would be measured by standard treatment protocols and the potential for enhanced treatment.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

This package supports the OHA performance measures related to continuity of operations (1ASP2.7) and managing OHA workforce safety and security (1ASP3.9).

7. What are the long-term desired outcomes?

The primary long-term desired outcomes are that OSH has the capability to provide care during and through the course of an external emergent situation, and that the hospital has appropriate space to provide treatment to patients and conduct business.

8. What would be the adverse effects of not funding this policy package?

Critical system shut down: OSH has one source for domestic water supplied by the City of Salem. In the event of a complete loss of city water supply, OSH would lose all ability to provide critical sanitation including flushing toilets. Loss of sanitation for any amount of time could prove to be catastrophic in a psychiatric hospital setting. Additionally, OSH provides over 2,500 meals a day to patients and loss of domestic water will have a severe impact on the ability to provide for nutritional needs of patients.

Staff have been moved to the residential cottages on the hospital grounds due to lack of administrative and program space within the secure perimeter of the hospital. Adequate ADA compliance is not feasible in the residential cottages and having staff working outside the secure perimeter of the hospital creates issues with access to hospital infrastructure and programming. Given the circumstances of the COVID-19 pandemic, possible OSHA complaints due to inadequate social distancing in some workspaces may result.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

Discussion with the city has occurred to supply options for the water situation. Currently, the only existing option is one of self-sustainability. OSH has completed a preliminary engineering study, design and engineer's cost estimate to verify feasibility of using the existing well to support backup water needs for the hospital.

OSH has attempted to redeploy staff and reimagine available working space as needs have emerged. In some cases, this has led to non-ideal usage of space that fills a need but does so in a less efficient capacity, or without options for social distancing, now a critical element in our environment. Preliminary design and engineer's cost estimates were completed for the additional office space project to help OSH acquire the central office space it needs.

10. What alternatives were considered and what were the reasons for rejecting them?

OSH considered adding an additional point of connection to city water from Center Street. The City of Salem system development charges (SDCs) exceed $750,000 to connect to Center Street, OSH determined that although this option would provide some insurance for loss of water due to line breakage on 24th Street, it would not provide self-sustainability and do nothing to protect from contamination of the city water supply.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

None.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

None.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

The investment in capital improvement helps ensure a safe, secure and therapeutic environment for treating some of Oregon's most vulnerable populations and provide infrastructure improvements to ensure OSH is a self-sustaining facility that can provide necessary health and sanitation in the event of city water contamination or shutdowns due to system failures or catastrophic events such as earthquakes.

Staffing and fiscal impact

Implementation date(s): November 2021

End date (if applicable): Estimated November 2023

15. What assumptions affect the pricing of this policy package?

Estimates are rough order of magnitude (ROM) and may vary slightly from actual expenses as the standard procurement processes are followed. Pricing of the LD position is assumed to be a portion of both of the next two biennia. Bond financing par amounts (the project cost plus the cost of the bond issuance, or the cost of the bond at maturity) are used for package total.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

No.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

No.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No. Although infrastructure for services provided would be improved, which may improve the efficiency of those services.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

One full-time, limited duration Construction Project Manager 2 position (0.88 FTE for 2021-23). Current OSH staff associated with specific trades would be utilized where possible.

20. What are the start-up and one-time costs?

This package is entirely project related, one-time expense.

21. What are the ongoing costs?

The limited duration position is expected to extend into the 2023-25 biennium to encompass the scope of the projects being managed. The cost for the position is expected to total $201,675 for the 2021-23 biennium and $229,643 for the 2023-25 biennium.

Of recurring expenditures, the water storage project is expected to require $6,000 per biennium, or $250 per month, for monthly water quality testing and routine maintenance following the implementation of the project.

22. What are the potential savings?

No savings are anticipated.

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

XI-Q bond financing is being requested for the entirety of this package, including the position.
The water treatment project would have a par amount (cost of project plus bond issuance) of $4.55 million, with 2021-23 interest of $234,000.
The addition of second floor office space would have a par amount of $1.8 million, and interest of $58,000.
The remodel of therapy tub rooms would have a par amount of $650,000, and interest of $18,000.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services						
Services & Supplies		$140,914		$140,914		
Capital Outlay		$6,839,086		$6,839,086		
Special Payments						
Other	$719,932			$719,933		
Total	**$719,932**	**$6,980,000**	**$0**	**$7,699,932**	**0**	**0.00**

Oregon Health Authority: 2021-23 Policy Package

	OSH Capital Construction	State Assessments & Enterprise-wide Costs	Debt Service	Total
General Fund	$0	$0	$719,932	**$719,932**
Other Funds	$6,839,086	$140,914	$0	**$6,980,000**
Federal Funds	$0	$0	$0	**$0**
Total Funds	$6,839,086	$860,847	$719,932	**$7,699,933**
Positions	0	0	0	**0**
FTE	0.00	0.00	0.00	**0.00**

Oregon Health Authority
2021-23 Policy Package

Division:	Health Policy & Analytics
Program:	Public Employees' Benefit Board and Oregon Educators Benefit Board
Policy package title:	Aligning Purchasing Power Across PEBB/OEBB and Other Public Purchasers
Policy package number:	425
Related legislation:	House Bill 2083

Summary statement:

One of the most important levers OHA has for spreading change across the healthcare marketplace is aligning the state's purchasing power across PEBB and OEBB along with other public purchasers. This policy package provides a pathway to expand PEBB and OEBB's statewide enrollment footprint of 300,000 covered lives. It allows for additional special procurement authority for joint purchasing initiatives and adds resources to continue to transform the delivery systems in alignment with coordinated care organizations (CCO) and the coordinated care model. Both boards have fully committed to advancing the coordinated care model and exploring innovative, long-term solutions to stay under a 3.4 percent annual trend cap. Under their current legal structures, the boards' procurement authority does not allow for the flexibility needed to directly contract with plans who can meet specific criteria as determined by the boards, without issuing a request for proposal. This policy package will grant expanded procurement authority to explore opportunities in innovation as they are presented to the boards.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$1,570,708**	**$0**	**$1,570,708**	**2**	**1.76**

Oregon Health Authority: 2021-23 Policy Package

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

Over the next two years, Health Policy and Analytics (HPA) expects to be responding to the enormous disruption of COVID-19 by adopting targeted policy and program changes that stabilize the health system and coverage and allow us to rebuild a more sustainable and equitable system for the longer term. One of the most important levers we have for spreading change across markets is aligning the state's purchasing power across PEBB/OEBB and other public purchasers. COVID-19 has exposed the inequities in Oregon's healthcare system. The state can better leverage the public purchasing power in order to contain costs on a statewide basis. Currently:

- Health care coverage remains insufficient and unaffordable for many. In 2017, eight percent of families had problems paying medical bills.
- With health insurance coverage at record highs and uncompensated care for providers at record lows, there is opportunity for Oregon to leverage its purchasing power to contain costs for more Oregonians.
- The PEBB and OEBB boards have taken steps to align on several initiatives with the goal of enhancing their purchasing power. PEBB and OEBB have already merged the administrative staff of both programs into one unit.
- The state, however, has not yet maximized the opportunities to fully align benefits and purchasing across other programs and expand the purchasing power beyond PEBB and OEBB.
- Reducing health care costs allows resources to go to wages and other critical investments.

The purpose of this policy package is to give the PEBB and OEBB boards more authority on procurement outside of the Request for Proposal (RFP) process to meet purchasing needs. The boards are often not able to act when innovative ideas are brought to them without conducting an arduous RFP process that can extend over one year. The current procurement authority within the PEBB and OEBB legal structures does not grant

the flexibility to directly contract with plans who can meet the specific criteria as determined by the boards when sought. This policy package and accompanying legislative concept would include the authority for the boards to function as a single board if desired.

By starting with the merger of the PEBB and OEBB benefit boards, there is potential to align financial incentives with other publicly-funded programs to improve care and lower costs across the Oregon Health Plan, public employee programs, the Marketplace and other local governments.

Conceptually, with expanded procurement authority the board could contract with an insurance plan outside of the RFP process if the plan demonstrates:

- Its providers are willing to serve all members in state markets (Medicaid, PEBB, OEBB, Marketplace), proportional to the market.
- It will offer unified provider contracts across all state markets that promote the same high standards of access and quality for all patients, regardless of where they obtain insurance.
- An aligned core set of metrics for access and quality.
- Aligned payment methodologies across all state markets that move providers to shared savings/shared risk and population-based incentive payments.
- It will accept global budget (capitation) payments from the state for all lives covered across state markets. It would be willing to contract for a global budget model that is budget-neutral, with blended rates across markets, with an annual growth rate at or below the statewide cost growth target, as established in Senate Bill 889 (2019). Plans would be free to negotiate rates with providers.
- It is willing to offer plans to any new employers that join PEBB and OEBB, with a willingness to provide varying benefits and cost-sharing structures within the plan that do not interfere with collective bargaining agreements.

2. What would this policy package buy and how and when would it be implemented?

This policy package and accompanying legislative concept (House Bill 2083) would provide the legal resources ($300,000 Other Funds) to transition the statutory authority of the boards, the consultant/actuarial resources ($800,000 Other Funds) to guide and execute on board strategy, and two Operations and Policy Analyst 3 positions ($470,709 Other Funds). Staff would be hired in October 2021. DOJ and consultant work would begin in September 2021. The positions would act as an Insurance Producer and a Policy Analyst liaison to expand PEBB/OEBB's footprint with other public purchasers and orient them to the coordinated care model.

Consultants working with staff, would establish an aligned core set of metrics measuring access and quality, and aligned payment methodologies across all markets that move providers to shared savings/shared risk arrangements and population-based payments like "total cost-of-care" initiatives on a per employee basis.

Plans would be encouraged to negotiate the best rates with providers. PEBB and OEBB could act as an "public exchange" function for other public employers that allows these employers to provide varying plan offerings, benefits and cost-sharing, without impact to collective bargaining agreements.

3. How does this policy package further OHA's mission and align with its strategic plan?

The desired outcome for this policy package is that consumers and taxpayers have access to an equitable, more sustainable health care system for the entire state, in line with the Triple Aim of lower cost, higher quality benefits that offer better care. This aligns with the Governor's policy priorities, OHA's strategic plan and the guiding principles of the PEBB and OEBB boards.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

Success will be measured in 3 ways 1) statewide enrollment migration from fee-for-service plans to coordinated care model plans, 2) volume of enrollment increases in PEBB and OEBB by local governments, special districts and other public payers, and 3) flexibility in procurement enabling the boards to meet the 3.4% annual increase test every year.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

Key Performance Measure: Customer Service. This policy package delivers a level of customer service to school districts that they lost when OEBB was formed by adding an insurance broker service that can assist them in their contribution strategies and plan offering selections. This would also be desired by local governments outside of PEBB and OEBB.

7. What are the long-term desired outcomes?

What does this mean for consumers and taxpayers?

- Contributes to an affordable, stable, predictable health system: with a global budget health care costs no longer outpace family and household incomes, freeing up funding for wage growth and other important state services.

- Improved quality and population health: The health care system is working together to keep patients healthy and improve the quality of care they receive.
- Improved patient experience: All patients have timely access to high quality care. They receive the right care at the right time in a coordinated system that puts patients in the center.
- Local flexibility: Employers have access to sustainable, high-value health care with flexibility to provide unique benefit offerings.

What does this mean for providers?

- Stable, predictable revenue: By moving from a system that pays for volume of care to one that pays for value, providers will have more stable, predictable revenue that grows within a sustainable rate of growth.
- Administrative streamlining and efficiency: By aligning payment models and metrics, providers can spend more time helping their patients and less time on paperwork.
- Contracting flexibility: the ability to approach PEBB and OEBB with innovative programs without an RFP.

8. What would be the adverse effects of not funding this policy package?

A continued lack of procurement flexibility and accountability. The boards and the state will set broad ambitious goals but will be hamstrung to innovate to best meet the goals within a sustainable budget.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

The PEBB and OEBB boards have merged administratively but are still separate and distinct boards. A joint policy workgroup was conceived in 2018 called the "PEBB/OEBB Innovation Workgroup" to consider joint

policy initiatives shared by the two boards, opportunities for leveraging their purchasing power and data, and for strategizing how to meet the 3.4 percent annual test.

10. What alternatives were considered and what were the reasons for rejecting them?

The alternative is to remain separate boards that operate independently. This is a less desirable option when there are opportunities to advance the coordinated care model across the state and add additional local governments.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

Yes. Current authority does not allow for direct contracting with vendors. House Bill 2083 would provide new statutory authority for the board's procurement authority.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

Local governments can already participate in PEBB and OEBB. This policy package would help support their information and support needs when they inquire about participating in PEBB or OEBB plans.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

None.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

This policy package would allow PEBB and OEBB to be responsive in contracting with providers in under-served areas in Oregon without being subject to a long RFP process that can stretch over 12 months. It also offers the boards with a tool to enhance accountability with current providers for achieving outcome-related goals under health equity.

Staffing and fiscal impact

Implementation date(s): July 1, 2021

End date (if applicable): Ongoing

15. What assumptions affect the pricing of this policy package?

Legal Department of Justice costs, consultant/actuarial costs and two new position costs have been taken into consideration in development of the policy package over the course of the 2021-23 biennium.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

With the passage of the policy package, both PEBB and OEBB will have new program responsibilities. Two new Operations and Policy Analyst positions will act as an insurance producer and as a policy liaison to expand PEBB and OEBB's enrollment footprint with other public purchasers, and ensure they are on-boarded

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

as efficiently as possible. The positions would develop standards for bringing new entities into the PEBB and OEBB family of benefits and create innovative approaches to sales and service delivery.

17. Will there be new responsibilities for or an impact on Shared Services?

None.

18. Will there be changes to client caseloads or services provided to population groups?

None.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

Two new permanent full-time Operations and Policy Analyst 3 positions to act as an Insurance Producer (without commissions) and a Policy Analyst liaison with other public programs working on plan brokering, cost analysis, outcome metrics and purchasing strategies.

20. What are the start-up and one-time costs?

None.

21. What are the ongoing costs?

Ongoing costs include personnel costs including employee services, supplies, shared services and State Assessments & Enterprise-wide Costs. It also includes professional services and Department of Justice costs.

22. What are the potential savings?

In five years, one model showed that by eliminating waste, redundancy, and purchasing healthcare as one statewide purchaser, results have shown improvements in quality of care, patient satisfaction and health status while saving $2.2 billion.

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

Revenue source is the OEBB and PEBB Administrative Fee attached to premiums. One hundred percent Other Funds. This policy package will be split evenly between PEBB and OEBB.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services		$470,708		$470,708	2	1.76
Services & Supplies		$1,100,000		$1,100,000		
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$1,570,708**	**$0**	**$1,570,708**	**2**	**1.76**

Fiscal impact by program

	PEBB	OEBB			Total
General Fund	$0	$0			**$0**
Other Funds	$785,354	$785,354			**$1,570,708**
Federal Funds	$0	$0			**$0**
Total Funds	$785,354	$785,354			**$1,570,708**
Positions	1	1			**2**
FTE	0.88	0.88			**1.76**

Oregon Health Authority
2021-23 Policy Package

Division:	Health Policy and Analytics
Program:	Public Employees' Benefit Board & Oregon Educators Benefit Board
Policy package title:	Benefits Management System (OEBB-PEBB BMS) Replacement
Policy package number:	426
Related legislation:	None

Summary statement:

The current benefit management systems (BMS) used by the Oregon Educators Benefit Board (OEBB) and Public Employees' Benefit Board (PEBB) no longer support all current business needs since their respective introductions in 2008 and 2003. OEBB and PEBB, along with the OEBB and PEBB boards, are seeking to integrate the administration and support of the two systems, with improved user experience and customer care, into a single platform to meet the legislative direction provided under Senate Bill 1067 (2017). Not prioritizing and supporting a replacement effort for the current system will result in the continued use of end-of-lifecycle technology that is fragmented, non-standard, difficult to support, and is not scalable. Approximately 300,000 covered lives would be at risk for benefits interruption if a replacement system is not identified and procured prior to the expiration of existing vendor support in 2022.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$8,182,928**	**$0**	**$8,182,928**	**0**	**0.00**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

Over the next two years, Health Policy and Analytics (HPA) expects to be responding to the enormous disruption of COVID -19 by adopting targeted policy and program changes that stabilize the health system and coverage and allow us to rebuild a more sustainable and equitable system for the longer term. One of the most important levers we have for spreading change across markets is aligning the state's operational and support processes to provide demonstrably improved services with increased efficiency and sustainable effectiveness, and a fundamental step to activate that lever is alignment across OEBB and PEBB. Replacing the antiquated and independent operating systems for benefit management in the two programs with a single, modernized and efficient system is a necessary step toward integration and alignment of benefits.

The current benefit management systems used by OEBB and PEBB (MyOEBB and pebb.benefits respectively) no longer support all current business needs since their respective introduction in 2008 and 2003. These needs include the ability of OEBB and PEBB subscribers in securely accessing and changing their personal account information; updating family member eligibility with legal documentation which may include personally identifiable information (PII) data; modernized, secured communications between subscribers and OEBB/PEBB support staff, and enhanced remote capabilities for school district/university/state hospital benefits administrators to properly manage accounts for their organizations and employees.

OEBB and PEBB, along with the OEBB and PEBB boards, are seeking to integrate the administrative and support of the two systems, with improved user experience and customer care, into a single platform to meet the legislative direction provided under Senate Bill 1067 (2017). Section 25 of the bill specifies the need for increased efficiency, reduction of duplication and merging of the two separate PEBB and OEBB oversight boards into one function as essential to driving cost reductions and driving operational improvements consistent with applicable law and administrative rule.

Both systems were built on, and still maintained with antiquated legacy technologies utilizing extensive custom code using development languages, tools and infrastructure which are well past the end of their product lifecycle. High turnover of the current support staff further increases the urgency of this project as replacement staff require increasing amounts of time to become familiar with the old architecture before reaching a level of sufficient competency to address issues.

In addition, the continued Operations and Maintenance (O & M) support of an aging, complex and highly customized system (by essentially the same vendor under different names) has led to an increased dependency on this single vendor. The current contract ends June 30, 2022.

Finally, OHA's 2015 Benefit Management System Technical Assessment Report noted that both systems are at the end of their lifecycles and continue to be supported with obsolete technologies. The report recommended implementing system upgrades in the short term and replacing the entire system as quickly as feasible to allow OEBB and PEBB to meet their statutory responsibilities.

2. What would this policy package buy and how and when would it be implemented?

This policy package is for the replacement of the antiquated MyOEBB and pebb.benefits (PDB) systems that currently require significant business resources to maintain. Processing of invoices, importing and exporting large amounts of data to/from external partners, mailing list generation, financial and accounting report generation, retroactive adjustments (to name a few), all of which would benefit greatly from automation.

At this time a full market analysis, including both state contracted technical vendors and external market providers specializing in the benefits management industry, is being completed with the results to be forwarded to the OEBB-PEBB executive steering leadership for consideration and selection of the best implementation strategy. The following solutions are being considered:

- Upgrade/enhance current OEBB/PEBB systems (including consolidation of core processes and reporting methods) by current support vendor.
- Incorporation of BMS reporting and management into the current WorkDay Human Resource Management platform.
- Outsourcing of operations and support to a third-party entity (e.g., Infrastructure as a Service (IaaS), Software as a Service (SaaS), Business Processes as a Service (BPaaS), External Service Provider / Integrator (ESP, ESI).
- Internal custom development and support of a state-funded, self-maintained software package and hardware platform (an "in-house" product).
- Development and release of a Request for Proposal (RFP) for competitive bidding by third-party entities able to fulfill business, technical and sustainability requirements of the State.
- Transfer/leverage solution already in use by another public sector organization in Oregon or another state.

The cost basis estimate for this proposal includes external service providers (including BMS integration, Operations & Maintenance services, Quality Control and Assurance oversight), and BMS product licensing. Gartner and InfoSys market analysis reports were also used to determine a median cost of BMS providers servicing states and large corporations in line with the size and demographics of our serviced population.

3. How does this policy package further OHA's mission and align with its strategic plan?

PEBB and OEBB goals are the same – provide a modernized, centralized, standardized, supportable, and scalable solution to replace both OEBB's and PEBB's benefit management systems for public employees, with the ability to accommodate the administrative and organizational changes subsequent to Senate Bill 1067 (2017), while implementing and maintaining more rigorous security best practices.

Alignment with the DHS / OHA Strategic Technology Plan (STP) Initiatives includes:

Business Automation

While the current Benefit Management System (BMS) solutions have provided significant efficiency gains, the multitude of options now available provide greater functionality and capability to further automate and streamline essential business processes, including support of dependent eligibility verification.

Dynamic Needs Supported by Seamless Technology Services

OEBB and PEBB's existing systems have been continuously enhanced to meet the needs of the member populations served, and the program staff responsible for overseeing benefits administration; replacement solutions provide for additional capabilities including modularity, agility, reusability, and incorporation of best practices in benefit administration.

Enables Connectivity Anytime, Anywhere, in Multiple Ways

The current solutions provide connection capability via multiple interfaces, but alternative solutions offer expanded capabilities to better meet member, staff, and partner needs through inclusion of mobile devices.

Trusted Source for Health & Human Service Data

The member information collected in the existing systems is organized in such a way as to allow searching and reporting capabilities, but lacks the ability to provide predictive analytics, which may be available with more modern solutions. The proper use of predictive analytics would allow for a strong improvement of customer service and support, reduce unnecessary insurance risks based on more reliable interpretation of provider data, assist in detecting possible fraud, enable better marketing and facilitation of currently available options as well as new, innovative wellness and healthcare options, all while helping strengthen accessibility to improved healthcare and meet the insurance expectations of a highly diverse population of clients and their families.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

OHA's 2015 Benefit Management System Technical Assessment Report noted that both systems are at the end of their lifecycles and continue to be supported with obsolete technologies. Vulnerabilities in security, operational support and sustainability were also highlighted in this report with a recommendation to modernize these systems as quickly as is possible.

Quantifying results

5. How will OHA measure the success of this policy package?

Success of this policy package will be validated by the following outcomes being met:

- Business process improvements and cost containment/recovery upon system implementation shall be quantitatively and measurably improved relative to their respective initial baseline measurement.
- System performance and reliability shall be measurably improved relative to their initial baseline measurement.
- Data integrity and security shall fully meet all state and federal Health Insurance Portability and Accountability Act (HIPPA), Producer Price Index (PPI) and Personally Identifiable Information (PII) security standards.
- Reports and notifications to both internal and external partners and customers shall be complete, correct, and verifiable against currently held account and personal information to ensure correctness and timeliness of distribution.
- Security access shall be verifiably controlled (by role access) and limited to the appropriate agency representatives.
- Disaster recover stand-up and on-line accessibility shall meet or exceed their currently observed level with 99.5 percent reliability and database management redundancy.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

This policy package 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. The goal is to 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.

This policy package is also tied directly to one of the objectives outlined in Senate Bill 1067 (2017). Section 26 directs the executive director to combine administrative functions and operations of the Public Employees' Benefit Board and the Oregon Educators Benefit Board to the greatest extent practicable to avoid duplication of effort and to promote efficiency, to the extent the combination of functions and operations is consistent with applicable law and administrative rule.

7. What are the long-term desired outcomes?

A new combined Benefit Management System (BMS) would allow OEBB and PEBB to modernize its members' and administrators' user experience. Among the top modernization goals:

- 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.

In replacing the existing systems with a modernized, centralized, sustainable, and scalable benefits management solution it is anticipated the new system will provide features including, 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 administrators
  - 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, communications tracking, 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 the history of changes to qualifying events, etc.)
- Expanded automated error checking / 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).

8. What would be the adverse effects of not funding this policy package?

OEBB and PEBB's BMS are not meeting all current business needs, which have grown since their original implementations in 2008 and 2003 respectively. Not prioritizing and supporting a replacement effort for the current OEBB-PEBB BMS system will result in the continued use of end-of-lifecycle technology that is fragmented, non-standard, difficult to support, and is not scalable. Approximately 300,000 covered lives would be at risk for benefits interruption if a replacement system is not identified and procured prior to the expiration of existing vendor support in 2022.

Additionally, the anticipated increase of personal customer information (including PPI and potentially protected health information (PHI)) being added to the two systems poses a risk to the state in the event of a data security breach. While the current systems have been fortified against data intruders as a result of the 2015 security review, penetration tools used by system intruders have become more and more sophisticated and may outstrip the security protocols supportable by the use of antiquated technologies.

9. What actions have occurred to resolve the issue prior to requesting a policy package?

PEBB and OEBB have sought advice from technical experts within the Oregon Office of Information Services (OIS) and Oregon Office of the State Chief Information Officer /Enterprise Information Services OSCIO/EIS. OEBB and PEBB have continued to contract, with little negotiating leverage due to the antiquated technologies involved, for maintenance and operations support to maintain basic system functions. OEBB and PEBB staff must either rule out or be very selective about enhancements to the systems as new functionality adds to the custom-made complexity of each system and could introduce new security risks.

In 2015, PEBB and OEBB contracted to have an in-depth security penetration test conducted to identify and help in addressing any discovered risks and issues. Recommendations proposed by the 2015 Benefit Management System Technical Assessment Report were followed, including implementing hardware and software system upgrades to remedy issues identified in the report, and to allow OEBB and PEBB to continue meeting their statutory responsibilities until the replacement solution could be implemented.

10. 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. OEBB-PEBB recently had an independent security assessment conducted. Future security assessments and remediation would be conducted biannually but the risk of a browser-based penetration attack is increased with the older technology.

Because of the custom nature of the systems, transition time related to contractor staff turnover puts programs more at risk as it takes new staff a much longer period of time to understand the systems well enough to address identified issues. The continued contractual relationship with the same vendor from the initial build to current maintenance and operations has resulted in an increased dependency on a handful of key knowledgeable individuals employed by the contractor due to the age, customization and complexity of the

systems. Transitioning to a new vendor could be both cumbersome and costly in terms of maintenance and operations. In addition, the architecture of the systems, implemented over a decade ago, relies on server side, data base driven procedures and modernization of current systems to accommodate newer technology and program goals would be costly.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

All the benefit and payroll processes of state agencies, universities, school districts, education service districts and community colleges would be impacted: either by benefiting from a new benefit management system or adversely impacted if the benefit systems were not maintained, maintenance costs increased substantially due to the reliance on a single vendor, or if the systems became no longer viable.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

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.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

This policy package assumes equity of benefit enrollment and management services across geographic areas and demographically diverse populations (including First Nation and Native Peoples, People of Color (POC) LGBTQAI+, Aged and Infirmed, Developmentally Challenged and others) and ensuring those services are provided equitably to all (including considerations of vision/hearing impairment, language differences and alternative presentation formats) to enable and provide accessibility, support and delivery of benefits services to all subscribed customers and their families.

Additionally, Race, Ethnicity, Language and Disability (REAL D) Standards demographic data will be 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 undertaken by both boards and their representatives will better allow OEBB and PEBB to include all stakeholders in the planning for the replacement, including the Equity and Inclusion Division.

Staffing and fiscal impact

Implementation date(s): July 1, 2021

End date (if applicable): _____

15. What assumptions affect the pricing of this policy package?

The cost basis estimate for this proposal includes external service providers (including BMS integration, O&M services, Quality Control and Assurance oversight), and BMS product licensing. Gartner and InfoSys market

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

analysis reports were also used to determine a median cost of BMS providers servicing states and large corporations in line with the size and demographics of our serviced population.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

No new responsibilities are assumed at this time, however it is possible there will be new responsibilities in the future depending on the final solution chosen.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

No new responsibilities or impact on Shared Services is anticipated unless the option to internally develop and maintain a new system is chosen. This is not likely due to the current, and anticipated, lack of technical resources which can be recruited and assigned in a timely manner to the OEBB and PEBB organization.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No changes anticipated to caseload, both services are expected to be enhanced with better communications, mobile access, security management and customer support capabilities.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

This project will be implemented with current staff. The staffing level will fluctuate between 4-12 (OEBB-PEBB) and from 2-4 (OIS) depending on the phase the project is in during development and delivery.

20. What are the start-up and one-time costs?

Initial development costs including license purchases, software/hardware/security management, a contracted strategic advisor and documentation tools are estimated to be $8.2 million.

21. What are the ongoing costs?

The ongoing costs of this policy package is for increased Operations and Maintenance (O & M) of the new system. The increased O & M are estimated to be $3.2 million per year. Costs will be based on industry standards. Costs and the timing of the transition from implementation to O & M will be dependent on the alternative chosen and subsequent contract negotiations. This policy package includes one year of O & M because it is assumed a portion of the population will "go live" with the new system in July 2022.

22. What are the potential savings?

Potential savings will be better known and realized after a new solution has been selected by the steering committee. It is anticipated, at a minimum, ongoing O & M costs will be lower due to retirement of technical debt, more agile response to business requests, reduced development and testing time plus consolidation and redesign of supporting business and technical processes. Potential savings likely will not be realized until several years after implementation.

If the current O & M contractor lost key staff due to turnover or if a security vulnerability was exposed in our outdated systems, the recovery costs would be very high. Avoidance of these potential costs through system replacement could yield significant potential savings.

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

Funding sources are Other Funds revenue from Administrative Fees assessed on PEBB and OEBB Core Benefits. The Administrative Fee is paid by members and state agencies through an assessment added to medical and insurance premiums and premium equivalents. A greater percentage is allocated to PEBB as it is assumed the BMS will be implemented and transition to O & M for PEBB before OEBB.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services						
Services & Supplies		$8,182,928		$8,182,928		
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$8,182,928**	**$0**	**$8,182,928**	**0**	**0.00**

Fiscal impact by program

	PEBB	OEBB			Total
General Fund	$0	$0			**$0**
Other Funds	$4,173,293	$4,009,635			**$8,182,928**
Federal Funds	$0	$0			**$0**
Total Funds	$4,173,293	$4,009,635			**$8,182,928**
Positions	0	0			**0**
FTE	0.00	0.00			**0.00**

Oregon Health Authority
2021-23 Policy Package

Division:	Health Policy & Analytics
Program:	Office of Health Policy
Policy package title:	Oregon State Option & Coverage Stabilization
Policy package number:	427
Related legislation:	None

Summary statement:

This policy package would enable the Oregon Health Authority (OHA) to refine the details of health insurance reforms that would be intended to increase access to health insurance while reducing premiums paid by consumers, potentially through a public option or a "Medicaid buy-in" plan as envisioned by Senate Bill 770 (2019).

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$200,000**	**$0**	**$0**	**$200,000**	**0**	**0.00**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

Over the next two years, Health Policy and Analytics (HPA) expects to be responding to the enormous disruption of COVID -19 by adopting targeted policy and program changes that stabilize coverage and the health system overall and allow us to rebuild a more sustainable, equitable system for the longer term. While Oregon's uninsured rate had declined considerably as a result of the implementation of the Affordable Care Act, progress largely stalled in the years leading up to the pandemic, leaving approximately 6 percent of the state without health coverage pre-COVID-19.

COVID-19 and its aftereffects are likely to impact coverage, cost and availability in ways yet to be determined. It will be important for OHA to provide ongoing updates to the changes to coverage and reassess the options for addressing barriers to access, particularly for communities hard hit by structural and historical racism who are now bearing a disproportionate rate of infection with COVID-19. This policy package details the resources that would be needed to produce a report similar in scope to that produced for the public option report issued to comply with Senate Bill 770 (2019).

2. What would this policy package buy and how and when would it be implemented?

This policy package would enable OHA to refine the details of health insurance reforms that would be intended to increase access to health insurance while reducing premiums paid by consumers, potentially through a public option or a "Medicaid buy-in" plan as envisioned by Senate Bill 770 (2019). The term "public option" broadly refers to a health insurance plan set up or backed by a public entity (such as the state) while "Medicaid buy-in" refers more specifically to a publicly available plan that uses the Medicaid infrastructure, such as the coordinated care organizations (CCOs).

3. How does this policy package further OHA's mission and align with its strategic plan?

This policy package would further OHA's mission as is relates to expanding health insurance coverage and access to health care services for Oregonians who are currently uninsured and help address affordability issues for those who currently have coverage. Additional policy development work enabled by this policy package would also allow OHA to focus efforts to design a public option program explicitly reduce health disparities and to invest in efforts to improve health equity. Additional policy development would enable OHA to more explicitly consider the equity challenges highlighted by COVID-19 pandemic and to refine initial proposals to prioritize health equity goals and reducing health disparities.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

OHA seeks to develop health coverage policy that increases health insurance coverage rates in Oregon while also increasing affordability for Oregon residents. Without further policy development in the wake of COVID-19, Oregon residents may lose health insurance coverage or face increased insurance premiums and deductibles.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

Yes, increases in coverage would impact all KPMs associated with diagnosis and treatment of illnesses and conditions, KPMs related to preventive care, and eventually those related to health status.

OHA performance measures would also be impacted, specifically outcome measures related to Outcome 1AOM7 - Improve Population Health, including quality of life, premature death, mortality from drug overdose, tobacco use and obesity.

7. What are the long-term desired outcomes?

The long-term desired outcome is to increase the percentage of Oregonians who have health insurance broadly but also to increase the ability of Oregon residents to use their insurance to obtain health care services when they are needed.

8. What would be the adverse effects of not funding this policy package?

Without adequate resources, OHA will not be able to invest dedicated staff time to develop forward-thinking health coverage policy that moves Oregon closer to achieving universal health insurance coverage and access to health care services.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

Prior to the COVID-19 crisis, OHA had been developing a report on the potential for a public option or Medicaid buy-in to increase health insurance coverage in Oregon along with access to health insurance services. In the wake of COVID-19, additional policy development will be needed to address the forthcoming challenges that may not be readily apparent in the middle of the crisis.

10. What alternatives were considered and what were the reasons for rejecting them?

The COVID-19 emergency has caused OHA to re-examine policy proposals and to develop more timely policy ideas to address underlying health coverage challenges in a new, more uncertain environment.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

The goal of this policy package is to enable further analysis and development of health coverage policy that increases coverage and access to care. If this policy development is successful, local and tribal governments would benefit from having more residents with health coverage and access to health care services when they are needed.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

Staff and leadership from the Department of Consumer and Business Services (DCBS) has been working with OHA on the development of the report on a public option or Medicaid buy-in requested by Senate Bill 770. Agency staff from DCBS would continue to participate in further policy development based on their role regulating health benefit plans and overseeing Oregon's health insurance marketplace.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

Increasing health insurance coverage and the affordability of health insurance and health care services would be of substantial benefit to Oregon residents who do not currently have health insurance coverage. Ongoing policy development work is underway to develop a public option or Medicaid buy-in in a way that advances

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

health equity and increases affordability to communities currently unable to afford necessary health care services.

Staffing and fiscal impact

Implementation date(s): To be determined

End date (if applicable): To be determined

15. What assumptions affect the pricing of this policy package?

There is significant uncertainty related to the impact of COVID-19 on health insurance carriers, health care providers, and consumers.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

Policy development in the Office of Health Policy would be necessary to evaluate the needs of the health care system and Oregonians in the wake of the COVID crisis.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

No.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

To be determined based on policy choices.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

Policy development could be carried out by existing staff in conjunction with outside consultants or by new full-time staff, depending on whether specialized skillsets or expertise is necessary.

20. What are the start-up and one-time costs?

This policy package includes funds for dedicated staff support or consulting work to build on policy development work associated with Senate Bill 770 to develop plans for a public option or "Medicaid buy-in" program.

21. What are the ongoing costs?

None are included in this policy package; however future policy decisions could necessitate ongoing resources.

22. What are the potential savings?

To be determined based on policy decisions.

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

General Fund only. There is a possibility some or all this work could receive federal Medicaid matching funds at the administrative rate of 50 percent state funds and 50 percent Federal Funds.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services						
Services & Supplies	$200,000			$200,000		
Capital Outlay						
Special Payments						
Other						
Total	**$200,000**	**$0**	**$0**	**$200,000**	**0**	**0.00**

Fiscal impact by program

	HPA Health Policy				**Total**
General Fund	$200,000				**$200,000**
Other Funds	$0				**$0**
Federal Funds	$0				**$0**
Total Funds	$200,000				**$200,000**
Positions	0				**0**
FTE	0.00				**0.00**

Oregon Health Authority
2021-23 Policy Package

Division:	Health Policy & Analytics
Program:	Transformation Center
Policy package title:	Statewide Value-based Payment Adoption, Alignment, and Infrastructure
Policy package number:	429
Related legislation:	House Bill 2082

Summary statement:

To leverage the Oregon Health Authority's (OHA) leadership role in establishing a statewide value-based payment (VBP) roadmap and requisite technical assistance infrastructure to support increased adoption and alignment of VBP across Oregon.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$946,781**	**$0**	**$605,319**	**$1,552,100**	**1**	**0.88**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

The move from a predominantly fee-for-service (FFS) payment system to one based on value using value-based payment (VBP)—which supports more holistic, patient-centered care—is a priority across Oregon's health systems, including within Medicaid, the Oregon Educators' Benefits Board (OEBB), Public Employees Benefits Board (PEBB), and commercial payers. In fact, the importance of VBP has become increasingly evident during the COVID-19 crisis, as clinics that rely on FFS struggle with financial viability due to decreased visit volume. In the coming years, OHA will be focused on rebuilding the health system, post COVID-19, while simultaneously working toward our long-term health system reform goals, including VBP.

While there existed a need for a statewide leadership on VBP prior to the COVID-19 pandemic, the crisis has amplified the need for VBP leadership. Further, the Health Care Cost Growth Target Implementation Committee identified VBP as a strategy to meet the state's cost growth benchmark goal. Much of the state's VBP work is fragmented and uncoordinated. Oregon lacks a cohesive statewide VBP vision, set of strategies, and supportive infrastructure, thereby creating risk for provider burnout, clinic unsustainability, and ineffective approaches that fail to contribute to OHA's health system goals.

2. What would this policy package buy and how and when would it be implemented?

The solution is for OHA to play a leadership role in in ensuring successful VBP adoption and alignment across all markets by convening a statewide, multi-stakeholder VBP Advisory Committee that would develop an Oregon VBP Roadmap, which would include (1) statewide VBP targets and expectations for VBP alignment across all payers and providers; (2) supporting statewide VBP infrastructure, including statewide, data-driven technical assistance (TA) for payers and providers, identification of VBP models for possible statewide

adoption, and evaluation of VBP model effectiveness; and (3) recommendations for resourcing the infrastructure over the longer term.

Resources would be needed to develop a VBP infrastructure during the initial rollout of the VBP Roadmap (before long-term resourcing has been secured) via contracts in the following areas:

- TA: Contractor(s) would develop and provide a robust system of TA to payers, health systems, and providers, ranging from VBP contracting to practice transformation associated with VBP adoption.
- Research and analysis: Contractor(s) would oversee VBP model evaluation and identify VBP models for statewide adoption.

In addition, one new OPA 4 position will be needed to:

- Staff the VBP Advisory Committee.
- Oversee and closely monitor the multiple contracts identified above.

3. How does this policy package further OHA's mission and align with its strategic plan?

This policy package would support development and implementation of an Oregon VBP Roadmap, which would ensure increased adoption and alignment of VBP across Oregon's health delivery system, leading to a more sustainable delivery system. This would, in turn, help further OHA's mission of "a healthy Oregon" through supporting the triple aim—improved health, better care, and lower costs for Oregonians—by promoting higher quality care as a result of (a) tracking of metrics tied to care delivery, and (b) giving providers increased flexibility to provide holistic, patient-centered care. In addition, VBP models can be designed to promote health equity by affording practices the flexibility to deliver holistic, patient-centered care that can meet the needs of populations at risk for health inequities. Consequently, this policy package can support achievement of OHA's 10-year goal of eliminating health inequities.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

Success of this policy package would be measured as follows:

- Development of a statewide VBP Roadmap by January 1, 2022 that is ultimately adopted by all payers across the state and includes VBP targets, expectations for VBP model implementation alignment, and a timeline for adoption.
- Creation of an infrastructure to support VBP adoption and alignment, including statewide, data-driven TA for payers and providers, VBP models for potential statewide adoption, and an evaluation of VBP model effectiveness.
- Recommendations for, and endorsement by, all VBP Advisory Committee members, as codified within the VBP Roadmap, for resourcing the VBP infrastructure beyond the biennium.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

This policy package is linked to the following areas in OHA's performance system:

- Key goals of "better health," "lower care," and "lower costs"
- Outcome Measure 8, "improve quality care"
- Outcome Measure 6, "reduce health disparity"
- Core Process (OP 4), "purchasing for health care value"

7. What are the long-term desired outcomes?

Increasing adoption of VBP, and incorporating models that have been proven effective, would lead to the following long-term outcomes:

- Financial sustainability of health system providers as a result of consistent payment which is divorced from patient visits and services volume.
- Improved patient care and patient outcomes, due to the increased flexibility in care provision associated with VBP.
- Decreased provider burnout due to alignment of VBP payment models and metrics.

8. What would be the adverse effects of not funding this policy package?

- Adoption of VBP will be slowed, continuing the inefficient use of FFS and preventing the sustainable funding approach so needed for health system recovery and sustainability, post-COVID.
- There will be minimal alignment of VBP requirements, including metrics and models, which creates further system inefficiencies and puts additional stress on providers.
- Patients will not benefit from the holistic, patient-centered care supported via the flexibility afforded by VBP.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

The activity to increase adoption and alignment of VBP across Oregon have thus far been piecemeal. For example, the Primary Care Payment Reform Collaborative, established through Senate Bill 231 (2015) and Senate Bill 934 (2017), was established to increase VBP adoption and alignment, but is only focused on primary care. In addition, VBP targets established through CCO 2.0 only focus on Medicaid. Finally, the

Health Care Cost Growth Target Implementation Committee, which identified VBP as a strategy to meet the state's cost growth benchmark, developed VBP principles that were incorporated in a VBP Compact; however, it is unclear whether there will be sufficient payer and provider commitment to these principles by signing on to the Compact. In order to realize statewide impacts of VBP, stakeholders representing all facets of the health system, including all payers, hospitals, specialists, behavioral health, and primary care must collaboratively develop expectations through a VBP roadmap.

10. What alternatives were considered and what were the reasons for rejecting them?

The alternative would be to support statewide VBP adoption and alignment with current staff; however, given other demands on OHA's VBP work related to CCO 2.0, this is not possible. Further, resources for funding statewide VBP infrastructure are not available.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

Section 2, Chapter 575, Oregon Laws 2015 may need to be modified to adjust and expand the requirements for the Primary Care Payment Reform Collaborative, making it applicable to all payers and for all service areas.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

VBPs can result in higher-quality care, leading to a healthier population that requires fewer health and social service resources over the long term. Thus, the decrease in costs that can result from greater use of VBP can lead to lower state health and tribal program budgets, meaning additional resources may be available for other governmental programs as well as tribal agencies throughout Oregon.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

This policy package would require collaboration with the various VBP adoption efforts currently occurring across the state, including those within PEBB, OEBB, the Department of Consumer and Business Services, and the Oregon Health Leadership Council.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

VBPs can cause unintended consequences on equity by incentivizing providers to limit care provision to patients who have relatively challenging health needs, since some VBP models hold providers to a fixed budget. Conversely, VBPs can support equitable health outcomes due to the flexibility associated with some VBP models which allows for providers such as traditional health workers (i.e., doulas or community health workers), which have been associated with addressing health disparities, to be more easily incorporated into standard care delivery approaches.

Staffing and fiscal impact

Implementation date(s): July 1, 2021

End date (if applicable): Not applicable.

15. What assumptions affect the pricing of this policy package?

The full-time Operations and Policy Analyst 4 position is needed for the first biennium to launch the VBP Advisory Committee and manage the various VBP infrastructure contracts identified above. After that, the contracts should be funded through other sources, but the OPA 4 would be needed to manage the contracts as well as the VBP Advisory Committee.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

Standing up and staffing a statewide VBP Advisory Committee and overseeing contracts required for a statewide VBP infrastructure would be a new responsibility for OHA.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

No.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

One permanent, full-time position would be needed to implement this policy package.

20. What are the start-up and one-time costs?

The statewide VBP infrastructure (i.e., TA and research and/or analysis contracts) would be start-up costs over one biennium; the VBP Advisory Committee would develop recommendations for long-term resourcing of the VBP infrastructure.

21. What are the ongoing costs?

The Operations and Policy Analyst 4 position would be an ongoing cost.

22. What are the potential savings?

Increased use of VBP can result in decreased costs for both OHA (in the Oregon Health Plan, OEBB, and PEBB) and commercial health systems across the state. For example, Tennessee Medicaid's episode-based payment strategy reduced perinatal costs by 3.4 percent, or almost $5 million, over the first year of implementation.

OHA may realize long-term savings in OHP expenditures due to more cost-effective, high-quality care being delivered to OHP members. To the extent savings occur, they will be reflected in subsequent years' CCO rates, which are based on past expenditures, and incorporated into OHA's budget as part of the capitation rates for CCO-enrolled OHP members.

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

This package includes 61 percent General Fund and 39 percent Federal Funds from Medicaid match.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$130,481	$0	$83,424	$213,905	1	0.88
Services & Supplies	$816,300		$521,895	$1,338,195		
Capital Outlay						
Special Payments						
Other						
Total	**$946,781**	**$0**	**$605,319**	**$1,552,100**	**1**	**0.88**

Fiscal impact by program

	Health Policy & Analytics			Total
General Fund	$946,781			**$946,781**
Other Funds	$0			**$0**
Federal Funds	$605,319			**$605,319**
Total Funds	$1,552,100			**$1,552,100**
Positions	1			**1**
FTE	0.88			**0.88**

Oregon Health Authority
2021-23 Policy Package

Division:	Health Systems Division
Program:	Behavioral Health
Policy package title:	Substance Use Disorder 1115 Waiver State Plan Amendment
Policy package number:	431
Related legislation:	None

Summary statement:

Oregon has submitted a substance use disorder (SUD) 1115 Waiver and will shortly submit a state plan amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) to support an enhanced full continuum of care delivery system for individuals with SUD. If the waiver and corresponding SPA are approved, the Oregon Health Authority (OHA) would be able to utilize additional Medicaid dollars to pay for residential treatment for more Oregonians with SUD. If approved, this would provide the supports needed to prevent and treat SUD and sustain long-term recovery, including crisis intervention, outreach and education to help individuals in recovery find and keep housing. This policy package would staff the SUD waiver implementation and would provide funds to contract for an evaluation to measure the effectiveness of the implementation process and waiver at creating desired outcomes.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$11,511,910**	**$0**	**$106,509,066**	**$118,020,976**	**1**	**1.00**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

Substance use disorder (SUD) is a chronic health condition that requires long-term comprehensive care and support. Oregon's current Medicaid SUD treatment system faces significant barriers to providing the services Oregonians need due to limitations put in place through federal regulations:

- Medicaid funds cannot be used to pay for residential treatment provided in facilities with more than 16 beds. A majority of Oregon's residential treatment facilities have more than 16 beds. Oregon pays for services in these residential treatment facilities with General Fund dollars.
- Medicaid only allows for treatment; however, an effective and comprehensive SUD system requires prevention, outreach, treatment and ongoing maintenance and support.

These limitations are restricting the number of Oregonians who can access the help they need, when they need it. The lack of comprehensive supports is creating unnecessary suffering, increasing emergency department use and hospitalizations, which further burdens the treatment system. Emergency department and hospitalizations related to SUD cost Oregon nearly $13 million in 2017 and 2018.

Often the burden of implementing equity, diversity and inclusion strategies in health systems falls on the shoulders of those who belong to historically marginalized communities. Oregon is committed to ensuring that advancing racial and health equity in the system becomes a collaboration of all regions and sectors in the state, including tribal governments. This waiver provides a unique opportunity to support health equity by increasing recovery supports and other critical services such as crisis intervention to individuals disproportionately affected by substance use within historically marginalized communities. Expanding the spectrum of covered substance use disorder services is an important part of treating the "whole person", a treatment paradigm that is compatible with culturally specific services.

COVID-19 has brought an increased strain on Oregonian's behavioral health. Underlying health conditions, homelessness, and inconsistent access to the health system leave many with behavioral health issues particularly vulnerable to the economic, health and health system impacts of COVID-19. Social isolation and financial instability could trigger worsening symptoms or crises. The needs for those using substances are anticipated to become even greater as we move through the pandemic. This waiver will ease the pressure placed on the substance use system by providing critical services to address gaps and provide long term support to those in recovery. By expanding the availability of these critical services and recovery supports, we anticipate individuals will have access to appropriate levels of care; reducing need for repeat visits to higher levels of care and increasing the support available to assist with housing security and maintain recovery.

Oregon has submitted a SUD 1115 Waiver and will shortly submit a state plan amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) to support an enhanced full continuum of care delivery system for individuals with SUD. If the waiver and corresponding SPA are approved, the Oregon Health Authority (OHA) would be able to utilize additional Medicaid dollars to pay for residential treatment for more Oregonians with SUD. If approved, this would provide the supports needed to prevent SUD and sustain long-term recovery, including crisis intervention, outreach and education to help individuals in recovery find and keep housing.

2. What would this policy package buy and how and when would it be implemented?

This policy package would purchase one full time staff member for the Health Systems Division to lead the implementation of the SUD waiver. The SUD 1115 Waiver Application process is currently being managed by staff borrowed from other positions. This means the work normally assigned to these staff has been temporarily put on hold and must be resumed. Demand on Medicaid and Behavioral Health staff has increased as OHA responds to the COVID-19 pandemic; staff working on the waiver do not have capacity to implement the waiver demonstration once the application is approved. Implementation of the waiver demonstration will

require one full-time position to manage the varying components to the implementation, including working across the agency internally and with external partners including coordinated care organizations (CCO), SUD treatment providers, recovery service providers and advocates, and Peer Run Organizations. If we do not receive authority for this position, we risk not fulfilling the waiver demonstration requirements, repayment of funds, and the inability to receive federal match and/or increased federal match for services provided at an institution for mental disease (IMD). This could negatively impact Oregon's ability to provide adequate services to those in need as well as continue costs associated with inability to secure Medicaid match for people treated in IMDs.

This implementation would require Medicaid rule change and updates. This includes 90 days for tribal consultation, time frames for rules advisory committee, and a 30-day public comment period.

This policy package requests funding for:

- Contracting with an external partner to provide CMS-required evaluation design and reporting requirements for the Waiver demonstration project.
- One permanent, full-time SUD 1115 Waiver Coordinator (Operations and Policy Analyst 3) within the Health Systems Division (HSD) to support the implementation and oversight of these activities. This position would serve as the program lead and would be responsible for overseeing the implementation of the SUD 1115 Waiver Demonstration SPA and implementation plan ensuring compliance with all requirements including reporting internally and externally.
- Beginning July 1, 2021 FFS and CCOs would begin rate increases on select services such as residential and methadone administration services in addition to the increase in new services to create a full continuum of care of care to those with substance use disorder. This is in alignment with the Mental Health Parity and Addiction Equity Act of 2008, which requires insurers and group plans to provide the same level of benefits for mental and substance use disorder treatment and services that they for

medical/surgical care. This package would expand services and treatments in behavioral health to reflect the needs of the community. Parity of services is a priority; through this policy package services such as case management, skill restoration and crisis intervention currently only available for mental health would be available for those with substance use.

3. How does this policy package further OHA's mission and align with its strategic plan?

This policy package aligns with the Governor's policy priorities and executive order declaring addiction and substance use a public health crisis in the state of Oregon. The declaration aims at raising public awareness about the challenges the state faces in dealing with SUD, along with prevention, treatment, and recovery to turn the tide on the opioid epidemic.

This policy package aligns with OHA's strategic plan though the creation of healthier environments for Medicaid members with SUDs. Building a full continuum of care promotes health equity, reduces comorbidity in health and psychopathology, and aligns with state and federal policies for public health modernization and would support the long-term recovery of Oregonians.

This policy package is supportive of OHA's commitment to eliminate health disparities in Oregon by 2030, as people of color and other minority populations are disproportionately impacted by the effects of substance misuse.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

Success would be measured by the increase in services and decrease in cost demonstrating quality improvement across the full continuum of care for those with substance use and ensuring the system has an increase in capacity for services. It would also assist with cross education, knowledge level increase and partnerships with behavioral health and Medicaid/physical health professionals related to substance use awareness and identification and referral leading to better integration of services within the behavioral health system and guaranteeing we are treating the "whole" individual with no wrong door entry into services whether through prevention, treatment or recovery supports.

Oregon has developed a draft evaluation plan to be submitted and approved by CMS. Upon approval of the demonstration and evaluation plan, an independent party would be contracted to conduct an evaluation of the demonstration to ensure the collection and analysis of the demonstration. This evaluation would be done independently and in alignment with the CMS-approved, draft evaluation design. Every effort would be made to follow the design when conducting analyses, evaluations and reporting. Some of the metrics to be measured will be: shorter duration between screening and treatment, reduced SUD readmissions to hospital at same or higher level of care and coordinated care transitions between levels of care. Intended outcomes are: Improved member quality ratings, increased treatment engagement, and decreased fatal and non-fatal overdoses.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

This policy package aligns with the legislative Key Performance Measures (KPM), Initiation of Alcohol and Other Drug Dependence Treatment- which is measuring the percentage of members with a new episode of alcohol or other drug dependence who received initiation of AOD treatment within 14 days of diagnosis. With

the expansion of services serving those with substance disorder, , it is anticipated individuals would be able to use, engage and receive services earlier supporting long-term recovery and reducing the number of new episodes of alcohol or other drug dependence.

7. What are the long-term desired outcomes?

The development of the full continuum of care for those with substance use disorder would increase access and expand needed services before, during and post treatment. Increased access enhances the current SUD benefit packages covered by CCOs. As a result of activities described in the 1115 SUD waiver and SPA, OHA anticipates:

- Reductions in the number of individuals with mental disorders and shorter life expectancies resulting from lack of SUD treatment.
- Establishment of an optional statewide SUD-specific Performance Improvement Project.
- Increased access to supports for housing and skills needed to sustain sobriety.
- Reductions in overdose and overdose deaths due to opioids.
- Reduced utilization of emergency room departments and inpatient hospital settings for SUD treatment.
- Improved access to care for outreach, initiation, treatment and recovery.
- Expanded access for those in need of long-term recovery supports.

The SUD 1115 Waiver and SPA presents a unique ability for health reform. It creates a full continuum of care where health disparities may be addressed for individuals with SUDs through enhanced services such as early intervention and recovery support services. SUD services would be delivered in a seamless and integrated manner, while meeting the Triple Aim objectives of better health, better care, and lower costs.

8. What would be the adverse effects of not funding this policy package?

Without funding for this policy package, OHA risks not fulfilling the demonstration requirements. This could affect Oregon's ability to provide adequate services to those who need them. If Oregon is unable to fulfill demonstration requirements OHA could be required to repay federal funds and/or not be able to receive federal matching funds or increased federal match for services currently funded with General Fund.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

Over the last several years, OHA has been exploring opportunities to enhance and improve the state's provider delivery system for SUD treatment. The goal is to address the ongoing opioid crisis and provide a robust person-centered approach that supports long-term recovery with a full continuum of care for individuals with SUD. Oregon is transforming its SUD delivery system by creating a full continuum of care, improving access and utilization of high-quality treatment, increasing rates of identification and engagement in treatment, reducing recurrent visits to equal or higher levels of care including ED and inpatient admissions related to substance use, and improving the quality of care and population outcomes for individuals with SUD. Recent efforts include:

- Coverage of peer-delivered services as part of the OHP benefits package.
- Working with the nine federally recognized tribes of Oregon and the Urban Indian Health Program to identify mechanisms to help ensure tribal health care objectives are achieved while respectfully honoring Tribal Based Practices, which may be reimbursed by the Oregon Health Plan.
- Implementation of block grant funds and SAMHSA Medication Assisted Treatment-Prescription Drug and Opioid Addiction (MAT-PDOA); State Targeted Response (STR) and the State Opioid Response (SOR) grants to provide support and funding for prevention, treatment and recovery.

- Amending Oregon administrative rules and Medicaid rules to require licensed and certified providers to offer MAT services.

10. What alternatives were considered and what were the reasons for rejecting them?

The alternative is to continue to pay General Fund for these services. Currently residential services provided in an IMD for SUD are paid with state General Fund, because Oregon recognizes the necessity of these services for those with substance use disorder.

The Medicaid IMD exclusion prohibits the use of federal Medicaid financing for care provided to most patients in mental health and substance use disorder residential treatment facilities larger than 16 beds. The exclusion is one of the very few areas where Medicaid law prohibits the use of federal financial participation (FFP) for medically necessary care furnished by licensed medical professionals to enrollees based on the health care setting providing the services. The exclusion applies to all OHP beneficiaries under age 65 who are patients in an IMD, except for payments for inpatient psychiatric services provided to beneficiaries under age 21 and has long been a barrier to efforts to use Medicaid to provide nonhospital inpatient behavioral health services.

The only option available to receive FFP for services provided within an IMD is to apply for an 1115 Waiver. Receiving this waiver and the FFP would provide an opportunity to expand access to critical services that are currently limited due to the sole use of General Fund dollars to provide this service. It is required to meet certain milestones to apply for the waiver, these milestones are included within the full continuum of care.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

This policy package would improve access to substance use services for the nine-federally recognized tribes and the Urban Indian Program, OHP members and provide local community mental health programs (CMHPs) and the coordinated care organizations the resources to provide the full continuum of care to OHP members.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

Collaboration on this policy package includes but is not limited to the nine-federally recognized tribes and Urban Indian Program, consumers and those utilizing services, Medicaid providers, CCOs, peer-delivered services community, local community mental health programs (CMHPs), Oregon Council Behavioral Health (OCBH), Oregon Recovers, OHP members, Medicaid Advisory Committee (MAC), Quality and Health Outcomes Committee (QHOC), Oregon Consumer Advisory Council (OCAC), Health Policy Board, Alcohol Drug Policy Commission (ADPC), Addictions and Mental Health Planning and Advisory Council (AMPHAC)

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

Oregon is committed to ensuring advancing racial and health equity in the system becomes a collaboration of all regions and sectors in the state, including tribal governments. This waiver provides a unique opportunity to support health equity by increasing recovery supports and other critical services such as crisis intervention to individual's disproportionately affected by substance use within historically marginalized communities. These services would provide opportunities to fill needed gaps in services and provide access to services outside of the traditional treatment model, such as housing supports for those with substance use disorder transitioning

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

out of residential treatment or are chronically houseless, supporting especially communities of color and other historically marginalized communities.

Staffing and fiscal impact

Implementation date(s): July 1, 2021

End date (if applicable): Not applicable

15. What assumptions affect the pricing of this policy package?

- Fee-for-service utilization would increase 8 percent as a result of adopting the waiver. This assumption underlies the estimated cost for the fee-for-service rate increases seen in the first year of implementation.
- Necessary work can be completed by one Operations and Policy Analyst 3 position.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

HSD would be responsible for overseeing the implementation of the SUD 1115 Waiver Demonstration, which includes facilitating the steering and advisory committees, coordination across the agency and public, coordinating with the Consumer Activities in creating the Peers Delivered Services State Plan to certify peer run organizations, working on the technical assistance for CCOs, and management of statewide SUD community integration services.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

No.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

There would be an initial FFS 8 percent client caseload increase across the board to the population groups served by this policy package. After the initial caseload increase as a result of the waiver, new caseload increases are not expected. There would be some new services offered to OHP members to fulfill the full continuum of care for substance use services.

SUD Waiver Activities

Community Integration Services: providing housing support services for those who are in transition and/or chronically homeless in need of support.

IMD Match: increase access to substance use residential services by receiving federal match for IMD services.

SPA Activities

Crisis Intervention is an intensive, short-term, brief service to stabilize an individual so they can cope with and overcome crisis.

Community Integration; Skills Restoration is a range of integrated and varied life skills restoration (e.g., housing assistance, employment, health, hygiene, nutritional issues, money management) provided in a wide array of settings, including residential, community, and outpatient, for Medicaid and CHIP enrollees intended to promote improved functioning and treatment retention, to minimize the risk of relapse and to increase the community tenure for the individual.

Early Intervention Services activities are sub-clinical or pre-treatment and designed to explore and address problems or risk factors that appear to be related to substance use, and/or to assist individuals in recognizing the harmful consequences of unhealthy substance use.

Prevention Services activities are related to screening, education, psychoeducation, and outreach designed to assist individuals in discovering and addressing problems or risk factors that are related to substance use, to assist in their recognizing harmful consequences or unhealthy substance use prior to use.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

This policy package requests one new permanent, full-time Operation and Policy Analyst 3 position (SUD 1115 Waiver Coordinator) within HSD to support the success of the waiver activities. This position would serve as the program lead and manager and would be responsible for overseeing the implementation of the SUD 1115 Waiver Demonstration SPA and Implementation plan and ensuring compliance with all requirements including reporting internally and externally.

20. What are the start-up and one-time costs?

A contract with OHSU to provide program evaluation ($775,000) and initial recruitment and onboarding costs of for one new position.

21. What are the ongoing costs?

Ongoing costs include the position, new SUD services in fee-for-service, increased CCO capitation rates to cover the new SUD services, rate increases for current SUD services in both FFS and CCO rates, and new community and recovery supports.

2021-23 ongoing costs in millions	General Fund	Federal Funds	Total Funds
Fee-for-service rate increases/related codes	$5.5	$16.5	$22.0
CCO rate increases/related codes	$6.5	$19.5	$26.0
Fee-for-service community & recovery supports	$3.0	$13.0	$16.0
CCO community & recovery supports	$10.0	$43.0	$53.0
Operations and Policy Analyst 3 position	$0.1	$0.1	$0.3
Total	**$25.1**	**$92.1**	**117.3**

22. What are the potential savings?

This policy package incorporates a savings of $14.0 million General Fund as a result of gaining approval for federal matching funds for services provided in IMDs, which are currently supported entirely by General Fund.

The SUD 1115 Waiver may reduce recidivism into more expensive, higher levels of care over the course of the five-year demonstration due to improved access to less costly, lower levels of treatment as well as post-treatment services and supports that promote long-term recovery. Any potential savings from shifting services from higher to lower levels of care, however, could be all or partially offset by increased access to and use of residential treatment beds.

OHA anticipates potential long-term reductions in OHP expenditures due to from declines in SUD-related emergency department admissions and hospitalizations; however, to the extent savings occur, they will be reflected in subsequent years' CCO rates, which are based on past expenditures, and incorporated into OHA's budget as part of the capitation rates for CCO-enrolled OHP members.

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

The sources of funding are General Fund and Medicaid matching funds. The funding split for the services provided by the new and increased codes would be 75 percent Federal Funds and 25 percent General Fund. The funding split for the requested position and the Oregon Health & Sciences University (OHSU) Evaluator Agency would be 50 percent Federal Funds and 50 percent General Fund.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$104,908		$ 104,908	$ 209,816	1	1.00
Services & Supplies	$ 20,919		$ 20,910	$ 41,829		
Capital Outlay						
Special Payments	$ 11,386,083		$ 106,383,248	$ 117,769,331		
Other						
Total	**$11,511,910**	**$0**	**$106,509,066**	**$118,020,976**	**1**	**1.00**

Fiscal impact by program

	HSD Medicaid	HSD Program Support & Administration	**Total**
General Fund	$11,386,083	$125,827	**$11,511,910**
Other Funds			
Federal Funds	$106,383,248	$125,818	**$106,509,066**
Total Funds	$117,769,331	$251,645	**$118,020,976**
Positions	0	1	**1**
FTE	0.00	1.00	**1.00**

Oregon Health Authority
2021-23 Policy Package

Division:	Oregon State Hospital
Program:	Finance and Operations
Policy package title:	Technology Modernization
Policy package number:	433
Related legislation:	None

Summary statement: This technology modernization package replaces videoconferencing equipment at the Oregon State Hospital, primarily related to hearing rooms.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$10,180**	**$60,401**	**$0**	**$70,581**	**0**	**0.00**

Oregon Health Authority: 2021-23 Policy Package

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

Oregon State Hospital's (OSH) technology infrastructure, software, and staffing levels are insufficient to support the demands of enhancements in patient care and treatment.

Healthcare, like most other fields of work, is becoming more reliant on mobile devices, increasingly sophisticated software, and data-driven processes. OSH's response to the COVID-19 emergency has included telework by non-patient-care staff, and telehealth services by outside providers and OSH physicians—highlighting the benefits of tech-intensive processes. Adapting to current technologic standards will require OSH to accelerate adoption of evolving technologies.

This package increases the rigor and accountability of technology administration at the hospital, providing a more robust treatment environment and ease of use for OSH patient care.

2. What would this policy package buy and how and when would it be implemented?

It would fund some equipment upgrades and enhancements in the form of completing the rollout of hospital message boards and replace the "VCON" systems at the hospital with more economical systems compatible with Skype and Microsoft Teams. Estimated cost of $58,000.

3. How does this policy package further OHA's mission and align with its strategic plan?

This package aligns with the Governor's priority on Healthy and Safe Communities by contributing to the treatment of one of Oregon's vulnerable populations. It also aligns well with the OHA Core Values of Health Equity, Service Excellence, Partnership and Innovation.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

All OSH hearing rooms would have videoconference equipment compatible with Microsoft Teams and/or Skype for Business by July 1, 2022.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

This package is not tied directly to an OHA KPM but aligns well with the OHA core values of Health Equity, Service Excellence and Innovation. In addition, it aligns with the following OHA performance measures:

SP3 Developing & Supporting the Workforce: Technical Writer, message boards, API mobile app, software upgrades and optimization, and videoconferencing upgrades.

7. What are the long-term desired outcomes?

OSH technology is maintained at modernization levels comparable to other mid-sized inpatient hospitals in both public and private sectors, to facilitate service delivery to patients, optimize patient outcomes, and support timely community reintegration.

8. What would be the adverse effects of not funding this policy package?

Aging OSH infrastructure and technology would continue to decline, impeding service delivery to patients, requiring manual workarounds, compromising patient outcomes, and complicating timely community reintegration.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

Obsoletion of older video technologies requires new equipment. No permanent alternative available.

10. What alternatives were considered and what were the reasons for rejecting them?

OSH has maintained functionality of exiting equipment for as long as feasibly possible. The current systems will not support requirements for advancing technologies supporting the care of OSH patients.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

No.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

Office of Information Systems involvement necessary.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

Oregon State Hospital's vision statement is, "We are a psychiatric hospital the inspires hope, promotes safety, and supports recovery for all." Often the people receiving OSH's services are some of the most marginalized members of our society. Enhancing technology supports quality care for all patients, allowing additional focus on the patient and their individual needs rather than cumbersome administrative systems.

Staffing and fiscal impact

Implementation date(s): October 1, 2021

End date (if applicable):

15. What assumptions affect the pricing of this policy package?

- All vendor prices are derived from 2020 estimates by vendors and/or contractual agreements with vendors.
- The videoconferencing components of this package are eligible for bond financing as capital outlay and are priced at par amount (the cost of the bond with the cost of the bond issuance), with the associated 2021-23 debt service interest amount.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

No new responsibilities.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

Additional responsibility for expanded technology infrastructure may occur within both EIS and OIS, up to and including Wireless Access Point, servers, firewall, software support, etc.

This package would reduce the utilization of some State Data Center servers by OSH.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

No staff are included in this policy package.

20. What are the start-up and one-time costs?

Hearing Room and Conference Room videoconferencing upgrades, $58,000.

21. What are the ongoing costs?

None, outside of periodic maintenance.

22. What are the potential savings?

None.

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

Approximately $58,000 has been requested for bond financing.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services						
Services & Supplies		$2,358		$2,358		
Capital Outlay		$58,043		$58,043		
Special Payments						
Debt Service	$10,180			$10,180		
Total	**$10,180**	**$60,401**	**$0**	**$70,581**	**0**	**0.00**

Fiscal impact by program

	Capital Construction	State Assessments & Enterprise-wide Costs	Debt Service	**Total**
General Fund	$0	$0	$10,180	**$10,180**
Other Funds	$58,043	$2,358	$0	**$60,401**
Federal Funds	$0	$0	$0	**$0**
Total Funds	$58,043	$12,538	$10,180	**$70,581**
Positions	0	0	0	**0**
FTE	0.00	0.00	0.00	**0.00**

Oregon Health Authority
2021-23 Policy Package

Division:	Health Policy and Analytics (HPA)
Program:	Oregon Prescription Drug Program
Policy package title:	Pharmacy Omnibus
Policy package number:	436
Related legislation:	House Bill 2080 (2021)

Summary statement:

This policy package equips the Oregon Health Authority (OHA) with staffing and clarified statutory authority to support and manage pharmacy purchasing in a collaborative and innovative manner. Without this policy package, OHA will be limited in its ability to effectively innovate and keep pace with the dynamic and quickly evolving pharmacy marketplace and supply chain.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$939,262**	**$(75,215)**	**$(23,138)**	**$840,864**	**4**	**3.52**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

This policy package and associated proposed legislation addresses three critical problems:

1. PDL Enforcement Authority. OHA's explicit authority to enforce a medical assistance Preferred Drug List (PDL) through prior authorization "sunset" January 2018. This change caused confusion and undermined OHA's efforts to enforce its PDL. PDL enforcement is essential to meeting the legislative directive to minimize the net cost of our pharmacy benefit program while ensuring Oregon Health Plan members have access to needed pharmaceuticals.

2. Pharmacy Cost and Risk Management in Medicaid. Since 2001 legislation directed OHA to create a PDL, the legislation has been interpreted and operationalized to only apply to the state's fee-for-service (Federal Funds) program. As such, coordinated care organizations (CCOs) currently manage their own PDLs. However, in September 2015, a negative rule determination concluded that OHA is prohibited from allowing CCOs to administer their own PDLs. In 2018, the Oregon Health Policy Board (OHPB) recommended increasing the alignment between Federal Funds and CCO PDLs but did not recommend a single PDL for all. Recent work with the National Governor's Association and independent consultant further examined possible pharmacy policy options and underscored the importance of undertaking a collaborative approach with Oregon stakeholders.

3. Office of Pharmacy Purchasing. The COVID-19 emergency is creating an enormous disruption to health systems and coverage and is exacerbating preexisting health disparities. This disruption impacts pharmacy programs in many ways, including supply shortages of critical medications and medical supplies. Oregon agencies do not currently have a central office with pharmaceutical supply chain experts who can consult and

help coordinate. Such expertise will be especially critical as new COVID-19 treatments become available. Apart from the current public health emergency, prescription drugs continue to be one of the most significant cost drivers in health care spending. Oregon currently has little collaboration in multiagency pharmacy purchasing. This results in missed savings opportunities and administrative inefficiency. However, Oregon has a proven 13-year interstate agreement and collaboration with Washington State's Prescription Drug Program that is on the verge of adding new states to the Northwest Prescription Drug Consortium. Managing the Consortium's growth positions Oregon to mutually benefit from the purchasing leverage derived from the Consortium's growth but doing so requires additional capacity. Finally, improved collaboration with OHA's Program Integrity Audit Unit on pharmacy fraud, waste and abuse strategies can potentiate integrity of Oregon's programs that deliver pharmacy benefits to Oregonians.

2. What would this policy package buy and how and when would it be implemented?

1. PDL Enforcement Authority. All stakeholders would immediately have clarity that OHA is authorized to manage drug costs by requiring prior authorization before covering a higher cost alternative. OHA would continue to minimize the net cost of our pharmacy benefit program while ensuring members have access to needed pharmaceuticals.

2. Pharmacy Cost and Risk Management. New OHA staffing would support the ongoing monitoring of this dynamic field, review all policy options, support operational elements of OHP's pharmacy benefit and assist leadership in engaging with our stakeholders. Further duties would include monitoring Medicaid pharmacy fraud & waste and contribute to a collaborative process to identify a firm policy for Oregon Health Plan's pharmacy benefit that balances multiple interests while ensuring members have a portable pharmacy benefit with positive health outcomes. The anticipated result would be simplified prescribing and lower net cost.

3. Office of Pharmacy Purchasing. Funding would allow OHA to establish and staff a new "Office of Pharmacy Purchasing." The new office would support cross-agency and multi-state collaborative pharmacy purchasing innovations and drive down costs. It would also provide all Oregon agencies ready access to pharmacy operations and supply chain experts with active wholesaler relationships, thereby providing access to subject matter experts that will enhance collaborative relationships with OHA's Program Integrity and Audit unit on pharmacy strategies. OPDP would gain increased capacity to support expansion of the program and generate more savings for participating public and private entities. Expansion would also include modernization of the discount card component of OPDP to improve access to a resource that lower the cost of prescription drugs for under-insured and uninsured Oregonians. The Northwest Prescription Drug Consortium, a multi-state collaborative overseen by the Office of Pharmacy Purchasing, is poised to expand to new states and sufficient staffing is crucial to coordinating and supporting the Consortium's growth.

3. How does this policy package further OHA's mission and align with its strategic plan?

This policy package is in alignment with OHA's mission to help people achieve optimum physical, mental, and social well-being through partnership, prevention and access to quality, affordable health care. Clarifying statutory authority for PDL enforcement would strengthen the established legislative purpose and creating a pharmacy policy formed in collaboration with OHA and all stakeholders.

This policy package contributes to OHA's strategic plan of eliminating health inequities by implementing strategies and policy changes that could stretch the pharmacy budgets for Medicaid as well as other agencies, which would support access to medications for Medicaid populations and target other populations who have historically suffered health disparities and inequities.

This policy package would improve capacity for OHA to fully support the Governor's call for leading the Multi-Agency Pharmacy Purchasing Collaborative and support alignment efforts across OHA and other agencies and entities able to participate.

Finally, the policy package would enhance OHA's ability to respond to future statewide emergencies, like COVID-19. Establishing a centralized Office of Pharmacy Purchasing would more readily mobilize supply chain experts to the forefront to support solutions to public and private medication and supply shortages.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

1. PDL Enforcement Authority. There would be consistent, widespread understanding of OHA's authority to enforce the PDL through prior authorization.

2. Pharmacy Cost/Risk Management. OHA will arrive at a pharmacy policy that results in the delivery of a pharmacy benefit that is portable for members, administratively less burdensome for providers and delivers a lower net cost.

3. Office of Pharmacy Purchasing. Specific metrics to document success could include number of lives served under coordinated purchasing and amount saved by entities choosing collaborative approaches led by the

Office of Pharmacy Purchasing. Continued tracking and monitoring of costs paid by all OPDP participating entities would allow for analysis of cost trends. Consortium growth would also be a key marker of success in generating improved purchasing power and leverage.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

No.

7. What are the long-term desired outcomes?

1. PDL Enforcement Authority. OHA would have clear, explicit authority to enforce the PDL and fulfill legislative directives. This would avoid confusion by interested parties and obviate the need for OHA to explain the authority.

2. Pharmacy Cost and Risk Management. OHA would slow the trend in increased net cost of Oregon's medical assistance pharmacy program. Prescribers would have an acceptable level of administrative burden in navigating the Oregon Health Plan's pharmacy benefit, which would lead to better health and a better experience of care for members.

3. Office of Pharmacy Purchasing. OHA would be equipped to adapt to the dynamic and rapidly changing pharmacy supply chain and Oregon would be positioned as a leader in the area of collaborative and efficient pharmacy purchasing.

8. What would be the adverse effects of not funding this policy package?

1. PDL Enforcement Authority. This item doesn't require funding; however, without clear enforcement authority in statute, OHA could be subject to legal challenges and questions.

2. Pharmacy Cost and Risk Management. The negative rule determination would remain unresolved and OHA would be obligated to work toward a single, statewide PDL for Federal Funds and CCOs. This would conflict with Oregon Health Policy Board recommendations, which were informed by the Myers and Stauffer report. That report remains the best guidance we currently have. CCOs would be required to make major changes to their individual PDLs to comply. This would mean more treatment disruption and greater administrative burden, but it would not generate significant additional savings.

3. Office of Pharmacy Purchasing. Without an Office of Pharmacy Purchasing, OHA lacks the resources to effectively support multi-agency and multi-state innovations that could leverage purchasing power and drive savings. Additionally, OHA would continue to struggle to respond to future emergencies and disasters that impact the pharmacy supply chain. Current OPDP staffing levels are insufficient to support the Office of Pharmacy Purchasing described in this policy package.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

1. PDL Enforcement Authority. OHA responded to questions to explain the agency's continued authority to enforce the PDL.

2. Pharmacy Cost/Risk Management. OHA engaged CCOs and consulted with Myers & Stauffer on the costs and benefits of a partially aligned PDL. OHA presented the results of this work to the Oregon Health Policy

Board, including their recommendation to include a partially aligned PDL in the initial CCO 2.0 plan. Full implementation required legislative change through House Bill 2678 (2019), but the bill did not pass. OHA has worked with the National Governor's Association and Mercer to explore additional pharmacy policy options and Mercer has provided recommendations for Oregon to consider.

3. Office of Pharmacy Purchasing. OHA directed the OPDP Director to oversee Medicaid Pharmacy programs to allow his position to be federally matched at a 50 percent rate. This is problematic long-term if the OPDP Director is to lead non-Medicaid work as well, including statewide pharmacy responses to emergencies such as COVID-19. The OPDP Operations Manager position has been offset partially by OPDP discount funds, but only for a couple of months each calendar year. The OPDP Director is currently taking actions to leverage statutory authority to better establish a funding stream for OPDP staffing. However, this revenue stream will not be established until January 2022. The OPDP has had to rely on a third-party administrator to manage wholesaler and pharmacy benefit manager relationships, which has minimized the OHA's influence and ability to directly represent OHA interests.

10. What alternatives were considered and what were the reasons for rejecting them?

1. PDL Enforcement Authority. OHA is faced with the reality that some statutes have sunset. However, OHA's efforts will position the agency to leverage the statues that remain to contain pharmacy costs.

2. Pharmacy Cost/Risk Management. OHA considered each of the options below:

- Request legislative authority for a partially aligned PDL that requires CCOs to align their PDLs across certain drug classes. OHA rejected this option based on past objections from CCOs and the need to verify savings and ensure disruption of therapy would not adversely impact health outcomes for members.

- Carve out all pharmacy benefits from CCO global budgets and cover those benefits directly on a Federal Funds-basis. OHA rejected this because we do not yet know the potential savings, client and provider impacts, CCO impacts, resource demands, or other advantages or disadvantages of this approach.

3. Office of Pharmacy Purchasing. Contracting for this body of work would introduce potential conflict of interest as most firms possess a bias that favors one or more element of the supply chain.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

Yes. Changes are described in the associated Pharmacy Omnibus proposed legislation, and include amendments to ORS 414.325, 414.334 and 414.337.

For the new Office Pharmacy Purchasing and OPDP to forge wholesaler relationships, ORS 414.312 (7)(b) would need to be amended. Similarly, ORS 414.312 (7) (a) should be amended to allow OHA to directly contract with PBMs to reduce administrative costs.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

The Office of Pharmacy Purchasing and OPDP could assist other agencies choosing to engage in multi-agency innovations around purchasing. Additionally, multi-state innovations could provide mutual benefit to interstate agreements and the consortium established by OPDP with Washington Prescription Drug Program.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

No other agencies, programs or stakeholders are collaborating on this policy.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

The Office of Pharmacy Purchasing would help establish programs that support all vulnerable and marginalized populations who suffer from health inequities. The Office of Pharmacy Purchasing would work with OPDP, which already works with Oregon's medical assistance program and serves some of Oregon's most vulnerable citizens.

Staffing and fiscal impact

Implementation date(s):	The new pharmacy policy elements would be incorporated into CCO contracts starting January 1, 2022. The Office of Pharmacy purchasing could be stood up within six months.
End date (if applicable):	Ongoing

15. What assumptions affect the pricing of this policy package?

New OPDP contract commences January 1, 2022 through end of 2026 (eligible for up to five additional years), which could include an improved revenue stream to generate Other Funds.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

OHA would collaborate with CCOs and other stakeholders in the development of a pharmacy benefit that is portable for members, administratively less burdensome for providers and results in a lower net cost.. OHA would incorporate necessary CCO capitation and contract changes.

The Office of Pharmacy Purchasing would be established with specific responsibilities as outlined in this policy package. There would be additional responsibilities for the Medicaid program and P&T Committee to establish a PDL and changes to pharmacy program administration.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

None.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No caseload or service changes are anticipated as a result of this policy package.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

All requested new positions are permanent, full-time and priced for 23 months of the 2021-23 biennium.

1. PDL Enforcement Authority: None.

2. Pharmacy Cost/Risk Management: Establish one Administrative Specialist 2 position to support pharmacy benefit administration and policy development.

3. Office of Pharmacy Purchasing:

Existing Staff:

- Shift funding for the OPDP Director (Principle Executive Manager G) from 50 percent General Fund and 50 percent Federal Funds to 75 percent General Fund and 25 percent Federal Funds. This shift would allow the OPDP Director to expand beyond Medicaid pharmacy work and allow the director to lead on Non-Medicaid pharmacy work and lead statewide pharmacy responses to emergencies.
- Reclassify the OPDP Operations Manager from an Operations and Policy Analyst 3 to an Operations and Policy Analyst 4 classification and shift funding from 100 percent Other Funds to 25 percent General Fund and 75 percent Other Funds because current Other Funds revenue cannot support the additional costs associated with the reclassification.

New staff:

- Establish one Operations and Policy Analyst 4 position to support multi-agency and multi-state policy and programs.
- Establish one Operations and Policy Analyst 3 position to support contract administration of multiple intra-agency, intergovernmental agreements. Assist with policy and program operations and oversight of contractors.
- Establish one Operations and Policy Analyst 2 to support the day-to-day operations of the various programs and stakeholder inquiries coming into the Office Pharmacy Purchasing.

Due to the uncertainty regarding the ongoing demands on staff related to the COVID-19 emergency and the potential to onboard other states into the Consortium, which would put further demand on staff time and program resources, further staffing or contracting resources could be required.

20. What are the start-up and one-time costs?

There are no known start-up or one-time costs.

21. What are the ongoing costs?

Staffing costs for three new positions, as identified above, would be ongoing.

22. What are the potential savings?

1. PDL Enforcement Authority. None.

2. Pharmacy Cost/Risk Management. Expected savings, but indeterminate. Without further study to determine how many clients utilize the drugs on the PDL, the impact the increased costs would have on CCO rates, the additional administrative costs, and the amount of drug rebates cannot be calculated to determine the potential savings. To the extent savings occur, they will be reflected in subsequent years' CCO rates, which are based on past expenditures, and incorporated into OHA's budget as part of the capitation rates for CCO-enrolled OHP members.

3. Office of Pharmacy Purchasing. While multi-agency and multi-state collaboration around purchasing could decrease net costs to the state, quantifying this amount is difficult. However, through its 13-year history, the NW Prescription Drug Consortium has demonstrated that, in working together, Washington and Oregon have provided services at a fixed and predictable administrative cost, and designed a pharmacy benefit management

product that delivers 100 percent passthrough of rebates collected, and passes through all overperformance on pricing guarantees to participating entities, resulting in substantial savings.

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

1. PDL Enforcement Authority. No costs are associated with this policy clarification.

2. Pharmacy Cost and Risk Management. Position would be eligible for 50 percent federal Medicaid match.

3. Office of Pharmacy Purchasing. Federal matching funds would be from Medicaid and Other Funds would be from OPDP fees.
   - OPDP Director (PEM G) would be funded with 75 percent General Fund and 25 percent Federal Funds.
   - OPDP Operations Manager (OPA 4) would be funded with 25 percent General Fund and 75 percent Other Funds.
   - The three new positions would be funded with 100 percent General Fund.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$806,168	$(75,215)	$(42,070)	$688,883	4	3.52
Services & Supplies	$133,094		$18,887	$151,981		
Capital Outlay						
Special Payments						
Other						
Total	**$939,262**	**$(75,215)**	**$(23,138)**	**$840,864**	**4**	**3.52**

Fiscal impact by program

	HPA Health Policy				**Total**
General Fund	$939,262				**$939,262**
Other Funds	$(75,215)				**$(75,215)**
Federal Funds	$(23,138)				**$(23,138)**
Total Funds	$840,864				**$840,864**
Positions	4				**4**
FTE	3.52				**3.52**

Oregon Health Authority
2021-23 Policy Package

Division:	Health Policy & Analytics
Program:	Health Policy
Policy package title:	Strengthen Purchasing Power of the Marketplace
Policy package number:	437
Related legislation:	Senate Bill 65 (2021)

Summary statement:

This policy package would move the health insurance Marketplace from the Department of Consumer and Business Services (DCBS) to the Oregon Health Authority (OHA), creating greater opportunities for aligned policy, which would utilize all state levers to maximize opportunities for greater alignment in pursuit of the triple-aim.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$2,616,499**	**$16,276,637**	**$0**	**$18,893,136**	**0**	**0.00**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

Over the next two years, Health Policy and Analytics (HPA) expects to be responding to the enormous disruption of COVID -19 by adopting targeted policy and program changes that stabilize the health system and health insurance coverage and allow us to rebuild a more sustainable and equitable system for the long term. One of the most important levers for spreading change across markets is aligning the state's purchasing power across public purchasers.

Oregon needs to better leverage the state's health care purchasing power in order to contain costs.

- Health care coverage remains insufficient and unaffordable for many. In 2017, 8 percent of families had problems paying medical bills.
- With health insurance coverage at record highs and uncompensated care for providers at record lows, there's an opportunity for Oregon to leverage its purchasing power to contain costs for more Oregonians.
- The state has not maximized opportunities to fully align benefits and purchasing across all public programs and looks to expand the purchasing power available to the Oregon Health Insurance Marketplace (Marketplace). The Oregon Health Authority (OHA) is unable to "move the market" by utilizing all public payer levers available to support health care policy reforms because the Marketplace is apart from OHA, in the Department of Consumer and Business Services (DCBS).
- Reducing health care costs allows resources to go to wages and other critical investments.

This policy package would move the Marketplace to OHA to create greater opportunities for aligned policy that utilizes all state levers to maximize opportunities for alignment in pursuit of the Triple Aim of better health, better care, and lower costs.

2. What would this policy package buy and how and when would it be implemented?

The policy package would transfer all functions and responsibilities for administering the Oregon Health Insurance Marketplace from the Department of Consumer Services (DCBS) to the Oregon Health Authority (OHA). Responsibilities include providing the following services:

- Ensuring Oregonians can access qualified health plans through the Oregon health insurance exchange.
- Reviewing health plans to determine whether they meet certification/recertification standards required for and sale through the exchange as qualified health plans.
- Determining whether a health benefit plan offered by an employer meets minimum essential coverage criteria.
- Assisting individuals to enroll in qualified health plans.
- Facilitating community-based assistance with enrollment by awarding grants to entities certified as navigators or in-person assisters and application counselors.
- Facilitating enrollment via operating a call center.
- Administering the Compact of Free Association (COFA) Premium Assistance Program.

The following permanent, full-time positions would be transferred to OHA to administer the Marketplace functions and services:

- One Principal Executive Manager G position
- One Principal Executive Manager E position
- Eight Operations & Policy Analyst 4 positions
- One Operations & Policy Analyst 3 position
- One Operations & Policy Analyst 1 position
- One Program Analyst 3 position
- Five Program Analyst 2 positions

The transfer of functions, services and staff will begin on July 1, 2021 and be ongoing.

3. How does this policy package further OHA's mission and align with its strategic plan?

Transitioning the Marketplace to OHA would better align policy making and purchasing power for the state by increasing OHA's ability to spread improved models of care and payment reforms from public programs and PEBB/OEBB products into Marketplace plans. Improving care and reforming payment across markets is essential to managing health care costs and ensuring that all Oregonians have access to affordable, quality healthcare. The policy package also aligns with the Governor's health care priority of sustaining the Oregon Model of Health Care Coverage, Quality, and Cost Management by increasing OHA's ability to "move the market" through added leverage over healthcare payers in the Marketplace. The added leverage that the transition provides also assists OHA in assessing and managing cost drivers to reduce the rate of growth in health care spending. Reducing cost growth in health care services is essential in order to make the investments in communities and services to address social determinants of health that are critical to advancing the agency's goal of eliminating health inequity by 2030.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

Success is expected to yield no gaps in services for Marketplace stakeholders. Services include:

- Ensuring Oregonians can access qualified health plans through the Oregon health insurance exchange.
- Reviewing health plans to determine whether they meet certification/recertification standards required for and sale through the exchange as qualified health plans.
- Determining whether a health benefit plan offered by an employer provides affordable minimum essential

coverage.
- Assisting individuals to enroll in qualified health plans.
- Facilitating community-based assistance with enrollment by awarding grants to entities certified as navigators or in-person assisters and application counselors.
- Facilitating enrollment via operating a call center.
- Administering the COFA Premium Assistance Program.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

Yes. The policy package is tied to all KPMs associated with health care coverage and affordable, sustainable cost of care by assisting OHA and the state in meeting the KPMs through greater leverage over the entire health care marketplace. This leverage will assist OHA in meeting any KPMs associated with transitioning quality of care.

OHA performance measures would also be impacted, especially lowering cost of care and improving quality of care. Greater leverage over the health care marketplace will assist OHA in implementing policies to improve quality of care and a sustainable cost of care across public, healthcare providers.

7. What are the long-term desired outcomes?

For Oregonians:

- An affordable, stable, predictable health system: Health care costs no longer outpace family and household incomes, freeing up resources for wage growth and important state services.
- Improved quality and population health: The health care system is working together to keep patients healthy and improve the quality of care they receive.

- Improved patient experience: All patients have timely access to high quality care. They receive the right care at the right time in a coordinated system that puts patients in the center.
- Local flexibility: Employers have access to sustainable, high-value health care with flexibility to provide unique benefit offerings.

For providers:

- Stable, predictable revenue: By moving from a system that pays for volume of care to one that pays for value, providers will have more stable, predictable revenue that grows within a sustainable rate of growth.
- Administrative streamlining and efficiency: By aligning payment models and metrics, providers can spend more time helping their patients and less time on paperwork.
- Local flexibility and accountability: The State will set broad expectations but allow local communities to innovate to best meet the goals within a sustainable budget.

8. What would be the adverse effects of not funding this policy package?

Health care policymaking is fragmented given the Marketplace's housing within DCBS. This inhibits OHA's ability to "move the market" by utilizing all public payer levers available to support health care policy reforms. The result is fractured public-payer policy implementation.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

OHA and DCBS have worked together to deliver the State's health care policy goals, including expanded coverage, aligned quality measures and payment reforms designed to improve quality and reduce costs.

However, these efforts have had limited effectiveness in "moving the market" due to the divided leverage over public payers between DCBS and OHA.

10. What alternatives were considered and what were the reasons for rejecting them?

Maintaining the current system of fragmented leverage over health care markets would limit the state's ability to "move the market" on health care policy goals and policies.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

Yes. This policy package supports proposed legislation (Senate Bill 65) that transfers the Marketplace from DCBS to OHA. The legislation would amend the following statutes: ORS 413.011, 735.601, 735.608, 735.611, 735.617, 741.002, 741.003, 741.004, 741.101, 741.102, 741.105, 741.108, 741.220, 741.222, 741.310, 741.390, 741.400, 741.500, 741.510, 741.520, 741.540, 741.802, and 741.900. It would repeal ORS 735.611.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

The added leverage over health care markets through the transfer could potentially benefit state agencies and tribal and local governments through more sustainable cost and improved quality of care in the healthcare market. State agencies, tribes and local governments could see a reduction in the growth of health care costs.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

Department of Consumer and Business Services

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

Transitioning the Marketplace to OHA would better align policy making and purchasing power for the state's public-payers, leading to a more stable health care solution and potentially lower, more stable Marketplace premiums.

Staffing and fiscal impact

Implementation date(s): July 1, 2021

End date (if applicable): Ongoing

15. What assumptions affect the pricing of this policy package?

Assumes the transfer to OHA of all the moneys in the funds established under ORS 735.617 and 741.102 and any unexpended balances of amounts authorized to be expended by the Department of Consumer and Business Services, from revenues dedicated, continuously appropriated, appropriated or otherwise made available for the purpose of administering and enforcing the duties and functions are transferred to the Authority exclusively for the purpose of administering and enforcing the duties and functions of the Marketplace including the COFA Premium Assistance Program.

Assumes moneys appropriated to the COFA Premium Assistance Fund and Marketplace Fund for the 2019-21 biennium are not decreased by the legislature for the 2021-23 biennium.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

Assumes all employees of the Department of Consumer and Business Services Marketplace, including the COFA Premium Assistance Program, become employees of the Oregon Health Authority Marketplace in their same capacities, positions, classifications and steps.

The Governor's Budget increased this package by $1.1 million General Fund to assist in implementing the COFA Dental Coverage in LC 313 through the Oregon Health Authority.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

OHA would assume ownership and responsibility from DCBS for implementing and maintaining all the duties and functions associated with operating the Marketplace. All DCBS staff working on the Marketplace would be transferred to OHA to perform the current duties associated with the Marketplace.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

Assumes no new responsibilities beyond the standard impact of new positions.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Client caseload associated with the Marketplace is assumed to be at the same level as currently served by DCBS.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

The following Marketplace permanent, full-time positions would be transitioned to OHA:

- One Principal Executive Manager G position
- One Principal Executive Manager E position
- Eight Operations & Policy Analyst 4 positions
- One Operations & Policy Analyst 3 position
- One Operations & Policy Analyst 2 position
- One Program Analyst 3 position
- Five Program Analyst 2 positions

20. What are the start-up and one-time costs?

None identified at this time.

21. What are the ongoing costs?

All positions and program costs.

22. What are the potential savings?

Any potential savings resulting from the transfer is unknown at this time.

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

The Oregon Health Marketplace is funded by assessments paid by insurance companies on plans purchased by Oregonians through the marketplace on HeathCare.gov, 100 percent Other Funds.

In addition to General Fund appropriated to the COFA Premium Assistance Program Fund, 100 percent Other Funds that would also be transferred from DCBS to OHA.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.[2]	FTE[2]
Personal Services		$5,104,723		$5,104,723	0	0.00
Services & Supplies		$9,899,223		$9,899,223		
Capital Outlay						
Special Payments	$ 2,616,499	$16,276,637		$1,272,691		
Other						
Total	**$2,616,499**	**$16,276,637**	**$0**	**$18,893,136**	**0**	**0.00**

Fiscal impact by program

	Health Policy & Analytics				Total
General Fund	$2,616,499				**$2,616,499**
Other Funds	$16,276,637				**$16,276,637**
Federal Funds	$0				**$0**
Total Funds	$18,893,136				**$18,893,136**
Positions	0				**0**
FTE	0.00				**0.00**

[2] Due to a data entry error, position authority and FTE for nineteen full-time positions for this policy package were inadvertently excluded from the 2021-23 Governor's Budget.

Oregon Department of Human Services and Oregon Health Authority
2021-23 Policy Package

Division:	ODHS & OHA
Program:	Integrated Eligibility (IE) / integrated ONE
Policy package title:	IE Maintenance and Operations Post-Implementation
Policy package number:	206
Related legislation:	None

Summary statement:

This policy package includes permanent resources for ODHS and OHA/OIS to support the transition from the IE project to the integrated ONE program through the 2021-23 biennium and into the future biennia. These resources and funding will provide stability and continued support for the Integrated Eligibility (IE) program. The Integrated Eligibility initiative is a multi-biennium effort to develop a comprehensive unified system called integrated ONE that integrates eligibility determination for MAGI and Non-MAGI Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) and Employment Related Day Care (ERDC) benefits. The IE program represents an essential lifeline to vulnerable Oregonians in need.

It should be noted that the integrated ONE system will be implemented statewide before July of 2021. Following implementation there will be a substantial stabilization period to resolve defects and to help staff adjust to the new system. As the project transitions to Maintenance and Operations (M&O), the resource gaps must be addressed to sustain this substantial investment.

This policy package is meant to address three critical areas:

Resource Gaps and Staffing Challenges
To sustain this substantial investment, this policy package is addressing the resource gaps not recognized in the 2019-21 biennium for M&O.

Stabilization and Post-Implementation Support
This policy package includes permanent resources for ODHS and OHA/OIS to support the transition from the IE project to the integrated ONE program through the 2021-23 biennium and into future biennia.

Funding to Support M&O
M&O is key to making sure that the system support Oregonians and that ODHS/OHA can continue to receive funds under the maintenance and operational federal match.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
ODHS	$54,114,124	$0	$79,310,358	$133,424,482	24	24.00
OHA	$518,347	$11,072,142	$726,694	$12,317,183	39	39.00
Total Policy Package:	**$54,632,471**	**$11,072,142**	**$80,037,052**	**$145,741,665**	**63**	**63.00**

Purpose

1. Why does ODHS/OHA propose this policy package and what issue is ODHS/OHA trying to fix or solve?

This policy package includes permanent resources to fill resource gaps and funding for ODHS and OHA/OIS to support the transition from the IE project to the integrated ONE program through the 2021-23 biennium and into the future biennia. These resources and funding will provide stability and continued support for the Integrated Eligibility (IE) program. The Integrated Eligibility initiative is a multi-biennium effort to develop a comprehensive unified system called integrated ONE that integrates eligibility determination for Non-MAGI Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) and Employment Related Day Care (ERDC) benefits. The IE program is an umbrella under which multiple complex inter-dependent, yet disparate, bodies of work fall, and it represents an essential lifeline to vulnerable Oregonians in need.

Funding and position authority were received in the 2019-2021 session for some M&O activities; however, after two years and the system close to go-live, more is known as to what the required ongoing support needs are. It is important to note that M&O activities that are currently being filled by limited duration resources, rotational staff or contracted staff need to be filled by permanent staff to reduce expenses, high turnover and lost productivity.

The integrated ONE system will be implemented statewide before July of 2021. Following implementation there will be a substantial stabilization period. As a result, the following permanent resources and funding will be needed to support the IE program:

- Subject matter experts, testers, analysts, test case writers, site support, coordinators and leadership will need to continue to provide support services into the 2021-23 biennium

- Defect resolution experts and coordinators to manage the code releases in multiple environments
- Site support resources to help staff adjust to the new system
- Ongoing support of the Legacy systems relied upon by IE, such as:
- Changes made to the IE core system typically require changes to the legacy systems, which ultimately pays out benefits for Oregonians
- Test environments created to support user acceptance testing (UAT) and ongoing support and maintenance for the existing automated test suite were not included in previous funding requests
- Additional resources will be needed to ensure the environment and tools can support system changes, system enhancements and testing
- Disaster Recovery functionality for the IE core needs to remain intact and tested annually
- Duties that have been transitioned to OHA/OIS from ODHS that the IE program is dependent upon:
- Ongoing support of the ONE VEC call center, which is relied upon by the IE Program
- PMO administrative services, such as, calendar management, receiving and sending correspondence, and providing reports
- Program Office resources to manage and support a program office versus a project office. The program will need resources to manage cost, scope, schedules, risks and issues, system change requests, deliverable management, testing, site support, reporting needs, governance, administrative support, quality control, and complex communications across several domains.
- On-going M&O support will be provided by Deloitte for the core system. Funding is included in this policy package for those M&O expenses.

The IE program must meet the needs of the Oregonians in which it serves and as the project transitions to Maintenance and Operations (M&O), the resource gaps must be addressed to sustain this substantial investment.

In summary, this policy package is meant to address three critical areas:

Resource Gaps and Staffing Challenges
To sustain this substantial investment, this policy package is addressing the resource gaps not recognized in the 2019-21 biennium for M&O.

Stabilization and Post-Implementation Support
This policy package includes permanent resources for ODHS and OHA/OIS to support the transition from the IE project to the integrated ONE program through the 2021-23 biennium and into future biennia.

Funding to Support the M&O Contract
M&O is key to making sure that the system support Oregonians and that ODHS/OHA can continue to receive funds under the maintenance and operational federal match.

2. What would this policy package buy and how and when would it be implemented?

This policy package includes a total of 63 permanent FTE (ODHS-24, OIS-39) and funding for M&O for the IE program.

Permanent Positions to support the Program by filling resource gaps and to provide post-implementation support
The 2019-21 policy package provided limited duration positions and contractors to fill key positions during the design, development and implementation phase. Using limited duration and contractors for a large multi-year project, created significant staffing challenges. In general contractors are three times more expensive than permanent employees and some staffing contracts only allowed contractors to work 1,040 hours per year. Staff in limited-duration positions continue to look for permanent employment creating instability in the workforce

supporting this program. These challenges impact the business in the following ways: 1) High turnover rate 2) Loss of unique knowledge that is specific to ODHS / OHA 3) Project team members had to train new contractor's continuously 4) Additional workload is assigned to already over-loaded staff.

Investing in permanent staff for the IE Program will help the organization achieve its strategic goals by providing resources that will be invested in stabilizing a critical system that delivers critical services to Oregonians, which are required by our Federal Partners (e.g., Centers for Medicaid and Medicare, Food and Nutrition Services, etc.).

High-Level Implementation Plan:

- Prioritize needed positions and begin hiring permanent staff immediately upon approval
- Establish the IE Program Management Office and transition from a project office to a program office, based on the M&O transition plan
- Execute the M&O program support and transition plan
- Issue the approved funding to the M&O contractor that supports the core system
- Stabilize the ONE system and provide post-implementation support

3. How does this policy package further ODHS's and/or OHA's mission and align with its strategic plan?

The Integrated ONE solution will assist Oregonians achieve well-being and independence by providing timely and efficient eligibility determinations. It will 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 ODHS field offices to complete the application process. The system will generate notices in seven languages and five alternate formats, helping to reduce barriers for traditionally underserved populations. Integrate ONE solution improves access to program eligibilities and program benefits to some of Oregon's

most vulnerable populations. Reducing any wrong doors and consolidating access to services, providing individuals and households with greater opportunity to access benefits and services though the venue of their choice, online, by phone or within a single office space. Integrated ONE 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.

Operations of the Integrated ONE solution will require complex coordination systems, data and processes at an Enterprise level across multiple key program areas and agencies. Permanent resources will assist Oregonians from start to finish in providing timely and efficient eligibility determinations for the IE Program from a field office or a virtual eligibility center. Staff resources are required to support the technology enhancements, maintain the existing 150 system interfaces and support the system. The Applicant Portal is self-service for end-users, but backend work is required to ensure availability.

Performing this level of coordination improves access to care, safety, security and stability to Oregonians and moves us closer to sustaining a no-wrong-door approach.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will ODHS/OHA measure the success of this policy package?

Success will be measured by using the following*:

- Customer Satisfaction: Through the use of surveys, the majority of Oregon citizens using the integrated ONE system will respond with a positive reply of good or excellent.
- Employee Engagement: Through the use of surveys, the majority of staff report medium or high levels of positive engagement with customers
- Accuracy: The integrated ONE programs, Non-MAGI Medicaid, SNAP, TANF, and ERDC show a 95 percent or better-quality control review rating
- Availability: The integrated ONE system has an uptime of 99.99 percent or better and any potential issues can be forecasted and addressed before they impact Oregon citizens
- Reporting: Through the use of several reporting methods that include ad hoc and federally required reporting.

* This policy package lays the foundation of the people and tools to be able to collect and analyze the data used for measuring success.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an ODHS and/or OHA performance measure? If yes, identify the performance measure(s).

This policy package aligns with and directly supports three areas of the Governor's policy:

1. "Modernize and standardize critical statewide systems"
2. "Optimize service delivery to the public and internally by modernizing agency-specific and cross-agency systems" by providing a modern, accessible system enabling clients broader access to services and quantifiable measurements around outreach and quality of services.
3. Create better health through good jobs

7. What are the long-term desired outcomes?

Continue to enhance the integrated ONE system that enables Oregonians to self-serve by accessing their benefits through a web portal. Oregonians will continue to be able to access their benefits by phone, by mail, by fax, or in person.

The new system will provide self-service to Oregonians by enabling applications through the applicant portal at times that are convenient to them. It provides a more dignified and private option to apply and minimizes wait times in ODHS field offices to complete the process. Currently, in person engagement requires staff to use three different agencies using seven different systems to determine eligibility for Oregonians.

The Integrated ONE system will improve efficiency and access to eligibility-based services for Oregonians who will no longer have to visit multiple locations and for staff who will not have to enter information into multiple systems for multiple programs. This solution will increase 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. The system also generates notices in multiple languages and formats, helping reduce barriers for traditionally underserved populations. It also gathers and stores applicants preferred race and ethnicity values allowing for culturally competent care.

8. What would be the adverse effects of not funding this policy package?

If this policy package is not funded, support for one of Oregon's largest IT investments will not be at a level required to make sure that Oregonians relying on the IE program for critical services can be met, which might directly affect eligibility and/or benefit accuracy and customer satisfaction. In addition, lack of support increases the likelihood of staff overloads, longer than expected delays in responding to issues, inability to provide federally mandated reports, lack of predictive mitigation of issues as staff will be too busy just keeping

the system running versus being able to address potential issues before they become a reality and impact Oregonians.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

Funding and position authority were received in the 2019-2021 session for some M&O, ongoing project management and support activities. This is a new environment and one of the largest, most complex IT systems Oregon has ever implemented. Now, with the system close to go-live, more is known as to what the ongoing support needs will be. This policy package is the result of what has been learned and what is needed to support what will be Oregon's largest IT system going forward.

10. What alternatives were considered and what were the reasons for rejecting them?

Alternatives include:

1. Do nothing.
   This is not a viable option. With what is known today, the previous M&O support estimate will only keep the IE program at minimal levels at best, at worst, it will negatively impact both Oregonians and staff. Oregonians may suffer through delays and availability, while staff deal with negative experiences with customers and work overloads.

2. Hire Contracted or Limited Duration Resources and Continue to With Current Staff.
   This is not a viable option. Over the last five years, the two agencies have used contracted staff and limited duration resources to fill its resource gaps. This strategy is not the most effective or efficient method for IT services. Hiring contractors using the IT Professional Services contract can be up to three times more expensive than permanent employees and some staffing contracts limit contractors to 1,040 hours per year.

Staff in limited-duration positions continue to look for permanent employment creating instability in the workforce supporting the IE program. These challenges result in the following impacts:

- Contracted staff can cost up to three times more; thus, impacting Oregonians bottom line
- High turnover rate
- Additional workload is assigned to already over-loaded staff
- Permanent staff must continuously train new hires
- Loss of unique knowledge that is specific to the IE program and/or OIS
- Reduced productivity.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

OHA and ODHS are the primary stakeholders and beneficiaries outlined in this policy package. In addition to OHA and ODHS, the following agencies are affected:

- DAS - Equipment and services at ETS are required to support this policy package
- DOJ - The IE program will need to interface with the Child Support system
- OED - The IE program will have interfaces with the Employment Department
- ODE - The IE program will interface with systems that make payments to Early Learning Division Child Care Providers.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

This is a collaborative effort between ODHS and OHA.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

This policy package, if approved, will ensure that Oregonians can continue to achieve wellbeing and independence by providing timely and efficient eligibility determinations for the IE programs that are relied upon. In addition, it continues support for the following:

- Allow Oregonians to self-service by applying through the applicant portal at times that are convenient for them, minimizing time needed in field offices to complete the process
- Generate notices in seven languages and in five alternate formats, helping to reduce barriers for traditionally underserved populations
- Gather, and store applicants preferred race and ethnicity values allowing for culturally competent care.

Staffing and fiscal impact

Implementation date(s): July 1, 2021

End date (if applicable): Ongoing effort anticipated for each biennium to ensure that both ODHS and OHA have the resources to support the IE program and Oregonians.

15. What assumptions affect the pricing of this policy package?

- Cost of professional services is assumed to be in alignment with other comparable efforts

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

- Cost of staffing is assumed to be relatively constant
- Federal funding will be available and leveraged for all ODHS & OHA efforts where available
- Resources with the necessary skills will be available

16. Will there be new responsibilities for ODHS/OHA? Specify which programs and describe their new responsibilities.

No.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

The following duties have been transitioned to OHA/OIS from ODHS that the IE program is dependent upon:
- Ongoing support of the ONE VEC call center, which is relied upon by the IE Program
- Administrative services, such as, calendar management, administrative support, receiving and sending correspondence, and/or providing reports

Additional scope was added over the last two years:
- Maintenance of Legacy test environments
- Disaster Recovery support

Additional permanent resources are needed to support the above work efforts for OHA/OIS.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

This policy package funds 63 permanent positions. The positions are new and will work collaboratively within ODHS and OIS to support M&O for the IE program.

ODHS - Funding for 24 permanent positions to provide support in various key roles:

- SSP Program Support: Funding and permanent position authority for 4 FTE (4-OPA4) to support Virtual Eligibility Center operations
- OBIS Support: This package reclasses 1-PEMD to PEME (1018540), and provides funding and permanent position authority for 19 FTE (2-OPA4 MMN, 1-OPA3, 8-OPA2, 8-OPA1) for resources to support testers and test case writers, to ensure system functionality remains synchronized and in-tact, IE program infrastructure including data dictionary management, report writing, release management, and the ONE Helpdesk
- Administrative staff: Funding and permanent position authority for 1 FTE (1-AS2)

OIS Technical - Funding for 26 permanent positions to address technical expertise gaps not requested previously. These include:

- Business Intelligence Developer: Funding and permanent position authority for 1 FTE (1-ISS8) to develop, deploy, and maintain BI interfaces for data visualization, interactive dashboards, ad hoc reporting, and data modeling
- AD / Express Route System Architect: Funding and permanent position authority for 1 FTE (1-ISS8) to support complex infrastructure that crosses multiple domains
- Database Administrator: Funding and permanent position authority for 1 FTE (1-ISS8) to provide expertise in-house for a complex and large database that consists of 1,700 tables

- Senior Privacy / Risk Coordinator: Funding and permanent position authority for 1 FTE (1-ISS8) to coordinate between the vendor and EIS CSS on applications for privacy, risk and compliance
- Test Environments / Batch scheduler support: Funding and permanent position authority for 2 FTE (1-ISS7, 1-ISS6) to provide ongoing support and maintenance of the new infrastructure created during the project to support testing and training
- JV Support: Funding and permanent position authority for 1 FTE (1-ISS7) to join the JV financial system support team
- Operations Support: Funding and permanent position authority for 3 FTE (3-ISS7) to coordinate change requests and triage activities for legacy system changes
- Legacy Mainframe Team: Funding and permanent position authority for 3 FTE (PEME, 1-ISS8 mainframe architect, 1-ISS8 Interface Architect) to support ongoing IE M&O to the legacy systems
- Compliance Specialist: Funding and permanent position authority for 1 FTE (ISS8) to manage compliance and audit activities with SOS, federal partners and oversight analysts
- Increased coverage for test environment: Funding and permanent position authority for 3 FTE (1-ISS7, 2-ISS6) to increase support of the test environment to 6pm-10pm plus 8am-8pm Saturday / Sunday
- Legacy Integrated Test Environment Manager: Funding and permanent position authority for 1 FTE (1-PEMD) to manage complex environments that crosses multiple domains
- Call Center Support: Funding and permanent position authority for 8 FTE (8-ISS4) to support the integrated call center

<u>OIS Program Office - Funding for 13 permanent positions to transition from a project office to a program office, while also supporting an ongoing administrative function and backfilling modernization positions, limited duration positions and contractors</u>:

- Program Management support is needed to backfill two positions that are on rotation: Program Management Office (PMO) Director (1-PEMF) and PMO Manager (1-PEMD)

- Senior Project Manager (1-PM3) and Project Coordinators (2-PM2) are needed to backfill staff who are on rotation or who are in Limited Duration positions that manage cost, scope, schedules, risks and issues, system change requests, deliverable management, testing, site support, reporting needs, governance, quality control, IE TEAMS site, IE SharePoint and help manage complex domains across several domains.
- Business System Analysts (3-ISS7) provide a critical function and are needed to fill a resource gap by helping gather technical requirements, deliver technical documentation and implement technical reports
- PMO Administration (4-PM1) and an Executive Assistant (1-ESS2) are needed to provide program management support that includes: administrative support, calendar management and complex communications across several domains.

20. What are the start-up and one-time costs?

N/A.

21. What are the ongoing costs?

IT Professional Services: $63.6 million
Software: $8 million
Hosting: $18 million
Hardware: $4 million
ESS Costs: $9 million (28,000 hours)

22. What are the potential savings?

N/A.

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

General Funds with Medicaid Match federal funds.

ODHS Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$2,496,240	$0	$2,165,899	$4,662,139	24	24.00
Services & Supplies	$51,617,884	$0	$77,144,459	$128,762,343		
Total	**$54,114,124**	**$0**	**$79,310,358**	**$133,424,482**	**24**	**24.00**

Fiscal impact by program

	ODHS IE ME Project Office	ODHS SSP	OHA HSD	OIS +ODHS & OHA SAEC (Infrastructure)	**Total**
General Fund	$44,523,376	$458,832	$165,738	$9,484,525	**$54,632,471**
Other Funds	$0	$0	$0	$11,072,142	**$11,072,142**
Federal Funds	$66,585,468	$688,252	$497,214	$12,266,118	**$80,037,052**
Total Funds	$111,108,844	$1,147,084	$662,952	$32,822,785	**$145,741,665**
Positions	20	4	0	39	**63**
FTE	20.00	4.00	0.00	39.00	**63.00**

Oregon Health Authority and Oregon Department of Human Services
2021-23 Policy Package

Division: Oregon Department of Human Services and Oregon Health Authority

Program: ODHS Aging & People with Disabilities

Policy package title: Maintenance & Operations of Provider Time Capture

Policy package #: 207

Related legislation: None

Summary statement:

The Oregon Department of Human Services and Oregon Health Authority in-home care programs need a system that will increase program integrity and comply with the federal 21st Century CURES Act for Electronic Visit Verification System and the U.S. Department of Labor Fair Labor Standards Act. This would be done with a time, attendance and payment system for the program's Home Care Workers and Personal Support Workers. The drivers for this work include a need for:

1. Improved timeliness and accuracy of data
2. Improved compliance with federal, state, and bargaining requirements
3. Increased efficiency and internal controls
4. Decreased duplication of efforts across agencies
5. HCW/PSW to accurately and timely report services provided across programs
6. Decrease dependency on outdated legacy systems

This policy package would implement ongoing maintenance and enhancements that build upon a base system implemented in the 2021-23 biennium that would result in an integrated solution that meets the 21st Century Cures Act criteria and helps protect vulnerable Oregonians.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
ODHS	**$1,814,048**	**$0**	**$1,000,000**	**$2,814,048**	**0**	**0.00**
OHA	**$58,615**	**$824,214**	**$18,246**	**$901,075**	**3**	**3.00**
Total policy package:	**$1,872,663**	**$824,214**	**$1,018,246**	**$3,715,123**	**3**	**3.00**

Purpose

1. Why does ODHS/OHA propose this policy package and what issue is ODHS/OHA trying to fix or solve?

The Department of Human Services (ODHS) and Oregon Health Authority (OHA) programs utilize Home Care Workers (HCWs) and Personal Support Workers (PSWs) to provide in-home care for patients across Oregon and must keep certain records for each HCW or PSW. The requirements apply to HCWs and PSWs who provide personal and home care assistance to older adults and people with disabilities. The Fair Labor Standards Act (FLSA) requires the records include certain identifying information about the HCW or PSW and data on hours worked. The law requires this information be accurate and attested to by both service recipients and providers.

Currently, these records are being captured through manual processes. Paper timesheets are completed by HCWs and PSWs and data is entered manually into state systems by employees at state field offices. These processes are time-intensive, have many manual steps and do not meet federal guidelines for Electronic Visit Verification (EVV) tracking.

2. What would this policy package buy and how and when would it be implemented?

This policy package would fund operations and maintenance costs for the PTC system including staffing related to shared services (OIS) as well as software, platform, and hosting licensing costs for the 2021-23 biennium.

The Legislature previously approved a limited portion of the ODHS request to support the system implementation and maintenance, but the OIS positions remain critical to the success of the project given current capacity and priority constraints.

3. How does this policy package further ODHS's and/or OHA's mission and align with its strategic plan?

ODHS and OHA programs utilize HCWs and PSWs to provide in-home care for patients across Oregon. ODHS and OHA must keep certain records for each HCW/PSW. The requirements apply to HCW/PSW's who provide personal and home care assistance to older adults and people with disabilities. The FLSA requires that the records include certain identifying information about the HCW/PSW and data about the hours worked. The law requires this information to be accurate and attested to by both service recipients and providers. Currently, these records are being captured through manual processes. Paper timesheets are completed by HCW/PSW, and data is entered manually into State systems through employees at state field offices. These processes are time-intensive, have many manual steps, and do not meet Federal guidelines for EVV tracking.

The full implementation of such a system would directly contribute to the ODHS 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 problems with the Consumer Employed Provider program.

The PTC solution would also align with the framework and maturity assessment from Medicaid Information Technology Architecture (MITA), which will assist project decision makers in considering an appropriate path and metrics for success for this IT investment. The PTC project would focus on the maturity of the MITA process: Manage Invoice Payment. The capability maturity measure will move Oregon toward the "To Be" assessment level. The State is currently at Level 1 which is "The process is primarily manual". PTC will strive to move the State to level 2 which specifies "The State uses a mix of manual and automated processes to accomplish tasks".

By implementing a service across both APD and HSD, this solution will create a common time reporting process across State agencies. Implementing a single time capture and payment process among agencies will align these agencies for potential future enhancements.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

This is part of the response to the Oregon Secretary of State audit in 2019. This report was titled, "Consumer-Employer Provider Program Needs Immediate Action to Ensure In-Home Care Consumers Receive Required Care and Services" completed in February 2019 and numbered Report 2019-05.

Quantifying results

5. How will ODHS/OHA measure the success of this policy package?

ODHS has identified a series of goals and objectives we will perform initial baselines and final metrics collection and analysis to confirm our expected outcomes.

Goal #1: Comply with Federal requirements, including 21st Century Cures Act.	1.1 **Objective:** Establish use of Electronic Visit Verification (EVV) compliant recording mechanism(s).
	1.2 **Objective:** Establish electronic approval of time entries by individuals.
	1.3 **Objective:** Capture the six required data elements for Electronic Visit Verification (EVV).
Goal #2: Improve program integrity.	2.1 **Objective:** Decrease number of time entry/reporting errors.

	2.2 **Objective:** Decrease number of over/under payments.
	2.3 **Objective:** Decrease number of incidents of potential fraud.
	2.4 **Objective:** Decrease number of errors in reporting travel time.
	2.5 **Objective**: Improve reports and tracking of issues with time capture processes available for staff to leverage as part of program integrity operations/processes.
Goal #3: Decrease workload on identified impacted groups.	3.1 **Objective:** Decrease workload for Voucher Clerks (Field Offices) and Provider Relations Unit (PRU) (Central Office) in voucher issuance and reprint processes.
	3.2 **Objective:** Decrease workload for Travel Time Clerks (Central Office) and PRU staff in processing travel time.
	3.3 **Objective:** Decrease workload for field staff in time entry and correction processes (time entry corrections and over/under adjustments).
	3.4 **Objective:** Decrease workload for staff in the payment correction processes (adjustments, exceptions, and corrections). (PRU and BOTS)
	3.5 **Objective:** Decrease workload for providers in submitting time worked.

	3.6 **Objective:** Decrease workload for individuals in approving time entries.
	*3.7 **Objective:** Decrease workload for staff in collecting, updating, and issuing payroll related documentation (W-2, W-4, DD, etc.).
	*3.8 **Objective:** Decrease workload for staff in garnishment and recoupment processes.
Goal #4: Decrease processes within legacy systems functions and/or data.	4.1 **Objective:** Decrease number of functions performed by the existing state systems in the time entry, calculation, and payment processes.
	4.2 **Objective:** Decrease number of validations performed by the existing state systems in the time entry, calculation, and payment processes.
	4.3 **Objective:** Decrease number of business processes that require legacy systems.
Goal #5: Reduce costs associated with manual processes.	5.1 **Objective:** Decrease paper voucher storage costs and physical location needs.
	5.2 **Objective:** Decrease number of time entry claims that are paid solely out of the General Fund.
	5.3 **Objective:** Decrease printing and mailing costs for printed paper vouchers.
	5.4 **Objective:** Decrease Mainframe processing and storage costs.
Goal #6:	6.1 **Objective:** Decrease stakeholder barriers to adoption.

Maximize user adoption through identified, organized, and prioritized change management, communications, and trainings.	6.2 **Objective:** Increased accessibility for successful time entry and approval.
	6.3 **Objective:** Increase user satisfaction for all impacted groups.
Goal #7: Ensure system and processes are clear and understandable for identified impact groups (Individuals, Providers, and Staff)	7.1 **Objective:** Increase number of readily accessible training materials and online documentation.
	7.2 **Objective:** Decrease time for staff in describing/explaining the time entry and approval processes.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an ODHS or OHA performance measure? If yes, identify the performance measure(s).

Yes, this aligns with the 2015-17 approved Key Performance Measure below:

11 – LTC Recipients Living Outside Nursing Facilities
13 – People with Disabilities Living at Home
14 – Supported Employment

7. What are the long-term desired outcomes?

By removing workload from field administrative support of the Consumer Employed Provider program it will allow APD and HSD to shift other work to this body of workers freeing up Case Managers to spend more time on case management and more critical issues for vulnerable Oregonians.

8. What would be the adverse effects of not funding this policy package?

The Committee approved a portion of the agency's January 2020 position request to support the Provider Time Capture (PTC) project, which is an information technology project redesigned after it was initially started to meet federal requirements around electronic visit verification for Medicaid personal care and in-home services provided by home care workers. In order to support the implementation of automated interfaces in Phase 2 of the project, which was decoupled to avoid conflicts with IE, positions are being requested to assist in the implementation and maintenance of the data feeds and work involved with PTC for our Shared Services.

The PTC project has a mandatory January 1, 2021 start date and ODHS requested extra resources to ensure the program is implemented on time and to avoid a potential loss of federal funding due to non-compliance. Failure to support and successfully implement PTC will have two main areas of impact. The current Collective Bargaining Agreement (CBA) with SEIU that covers the HCWs and PSWs requires implementation by the end of calendar year 2020 for Phase 1 and the end of 2021 for Phase 2.

Additionally, Compliance with the standards required by the 21st Century CURES Act would allow the state to continue to receive federal funding match. Failure to comply will result in a reduction of this funding, along with potential penalties. The percentage of an individual reduction on FMAP for Consumer-based Care and In-Home Care expenditures begins with 0.50 percent on January 1, 2021. Subsequent six-month percentage reductions increase to 0.75 percent by 2022, 1.00 percent by 2023 and beyond.

EVV Penalty pricing In Home Supports

	In Home Projected Expenditures at 21-23 CSL (TF)	% FMAP Reduction Per schedule	Federal Fund Penalty Reduction Estimate (GF Cost)	
1/1/21-6/30/21	$ 275,898,626	0.50%	$1,379,493	19-21
7/1/21-12/31/21	$294,195,880	0.50%	$1,470,979	21-23
1/1/22-6/30/22	$295,127,270	0.75%	$2,213,455	21-23
7/1/22-12/31/22	$297,532,442	0.75%	$2,231,493	21-23
1/1/23-6/30/23	$298,207,326	1.00%	$2,982,073	21-23
21-23 General Fund Cost			$8,898,000	21-23

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

Options were considered for inclusion in current process or expansion of the Legacy systems to capture this information, but it is not considered sustainable nor would it be supported by current staffing levels. Staffing for the project have been sourced from numerous sources including pulling in employees from the Field on limited duration double fill positions. Given the nature of staffing in the field this creates additional strain and does not account for the long-term operations and maintenance required.

10. What alternatives were considered and what were the reasons for rejecting them?

All the PTC alternative approaches were evaluated to determine if they have the ability to solve the business problem defined by the product requirements. The updated business case completed in July of 2019 analyzed 10 options which included a variety of in-house options, custom build, use of existing contracts or Statewide agreements, no action, or a new procurement. Ultimately, a recommendation of a Software as a Service procurement was adopted by Agency leadership based on the reasons identified below.

1. Implement a Software as a Service (SaaS) solution.
   - This option has the benefit of requiring the burden of the development and design activities and long-term operations and maintenance of code on the vendor compared to an in-house or other commercial solution. Additionally, selecting a vendor who has performed this work in other states increases Oregon's chances of capitalizing on lessons learned and efficiencies of scale based on the work already put into the system.

The recommended approach for the PTC Project is to utilize a SaaS solution for the following reasons:

- Ability for advanced configuration, integration with other applications, and possible customization
- Aligns with the direction the software industry is going

- Possibility to expand to other solutions in the future for FMAS, Case Management, Provider Management, etc.
- Fewer technical resources would be required from the State and there would be no dependency on the State Data center
- Possibility of faster implementation
- Workload reduction in the State field offices and Type A and Type B AAA offices
- Moves the Agency away from having sole responsibility for supporting an increasing number of systems
- Ability to access data for reporting
- Several vendors are now offering EVV solutions that are incorporated into their system

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

It does not require statutory changes.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

Other agencies affected by this policy package include APD and HSD's Program Partners and those with a business need for payroll or service time worked data, such as:

- Area Agencies on Aging (AAAs)
- County Mental Health Programs
- The Oregon Health Authority / Health Systems Division

These agencies would experience a change in how they receive data and reports from APD/HSD. Access to data would be based on business need and enforced using a role-based security protocol.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

Oregon Home Care Commission, OHA – Office of Information Services, & Health Systems Division.

14. How does this policy package help, or potentially hinder, populations impacted by inequities or disproportionalities from achieving health, well-being and independence?

Depending on the selected vendor the need for providers or individuals to access the solution via the internet or a personal data enabled device could present barriers to some populations. Additionally, depending on the language capacities of the vendor and solution this could pose inequities for individuals and providers whose first language is not English. The Agency is working to ensure the system, training, and support are available in multiple languages to try and mitigate these concerns.

Staffing and fiscal impact

Implementation date(s): Phase 1 September 12, 2021, Phase 2 TBD, Phase 3 TBD

End date (if applicable): N/A

15. What assumptions affect the pricing of this policy package?

These are based on staffing and vendor onboarding assumptions and compliance with the planned phase deadlines.

16. Will there be new responsibilities for ODHS/OHA? Specify which programs and describe their new responsibilities.

ODHS, APD will be responsible for the creation and delivery of training for the long-term solution. OHA will have additional work to perform to establish the interfaces and make and maintain system changes to legacy

systems in order to allow appropriate service, provider, and consumer information to be exchanged. See #17 below.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

There is expected to be some maintenance, support, and coordination between developers to troubleshoot and make changes to the various interfaces and systems to support long term success. Additionally, to coordinate and manage contract administration across IT initiatives and services we are requesting a position for contract administration to be housed with OIS. We have coordinated with the Office of Information Services (OIS) to request 3.00 FTE of resources for this support.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No changes anticipated.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

There are no staffing supports funded in the ODHS-APD side of this Policy Package.

20. What are the start-up and one-time costs?

The initial project implementation estimates for phase 1 and 2 is approximately $600,000.

21. What are the ongoing costs?

On-going costs outside of staffing are licensing and support costs for the system, which is currently estimated to be $840,000 annually.

22. What are the potential savings?

The use of a mobile app to track time and, potentially, location using location services, would reduce potential fraud in time reporting. While the current amount of fraud in time reporting is difficult to quantify, data provided by the Office of Payment Accuracy and Recovery (OPAR) report a total amount of HCW debt related to potential fraud or client error was $1 million of which $676,000 has yet to be recovered over a five-year period. By using a technology-based product the state could track specific time worked and the geolocation of services provided.

Compliance with the standards required by the 21st Century CURES Act would allow the state to continue to receive federal funding match. Failure to comply will result in a reduction of this funding, along with potential penalties.

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

ODHS: The Federal Funds are Medicaid with CMS providing 90/10 split for the project phase of this work and ODHS is seeking 50/50 match during Operations and Maintenance. The remainder is paid via General Funds.

OHA: Other Funds via direct charge to ODHS.

ODHS Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$0	$0	$0	$0	0	0.00
Services & Supplies	$1,814,048	$0	$1,000,000	$ 2,814,048		
Total	**$1,814,048**	**$0**	**$1,000,000**	**$2,814,048**	**0**	**0.00**

Fiscal impact by program

	APD	OHA Shared	OHA SAEC		**Total**
General Fund	$1,814,048	$0	$58,615		**$1,872,663**
Other Funds	$0	$814,044	$10,170		**$824,214**
Federal Funds	$1,000,000	$0	$18,246		**$1,018,246**
Total Funds	$2,814,048	$814,044	$87,031		**$3,715,123**
Positions	0	3	0		**3**
FTE	0.00	3.00	0.00		**3.00**

Oregon Health Authority
2021-23 Policy Package

Division:	Public Health Division
Program:	Health Licensing Office (HLO)
Policy package title:	Board of Cosmetology Licensing Fees
Policy package number:	447
Related legislation:	None

Summary statement:

The Board of Cosmetology licensing fees must be increased to cover the cost of licensing and regulating the board's professionals and protecting the public.

The board's current fees cannot sustain the program. Revenue and expense forecasts predict the board to slip into a budget deficit in 2020 that will continue in 2021-23. Without an increase in fees, the Health Licensing Office (HLO) will not be able to issue licenses to applicants in a timely manner and protect the public from potential health and safety violations. This would have an extremely negative impact on this board and HLO. In addition, the Legislature's mandate to protect the public would be compromised.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$1,562,547**	**$0**	**$1,562,547**	**0**	**0.00**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

The Board of Cosmetology licensing fees must be increased to cover the cost of regulating the board's professionals and protecting the public.

The Health Licensing Office (HLO) has been tasked by the Legislature with administering 16 boards and programs, regulating tens of thousands of licensees, and dozens of professions. The Board of Cosmetology is by far the largest program, with more than 66,000 licenses in hair, nails, barbering, natural hair care, and esthetics, as well as licenses that cover facilities and independent contractors.

House Bill 2074 (2013) moved the independent Oregon Health Licensing Agency under the Oregon Health Authority, creating the Health Licensing Office (HLO). This changed the indirect costs from funding in an independent small agency to being part of the Oregon Health Authority (OHA). HLO now contributes to OHA's and Public Health's cost allocation, which distributes shared costs among divisions. This increased the expenses to the board without an increase in fees to offset the additional costs. Each board pays these shared costs based on the number licenses provided by HLO and the services provided to licensees. The Board of Cosmetology carries more than 90 percent of the total cost allocation due to the number of licenses HLO administers. The current fees are no longer adequate to cover the costs.

The fees charged by the board have not changed since June 1, 2011.

The board's current fees cannot sustain the program. Revenue and expense forecasts predict the board to slip into a budget deficit in 2020 that will continue in 2021-23. Without an increase in fees, HLO will not be able to issue licenses to applicants in a timely manner and protect the public from potential health and safety violations.

This would have an extremely negative impact on this board and HLO. In addition, the Legislature's mandate to protect the public would be compromised.

2. What would this policy package buy and how and when would it be implemented?

HLO and the board designed the fees to be less for individuals entering the profession and more for individuals who were established along with businesses. The fees for individuals who are entering the profession out of school increased on an average of $10 and the fees for individuals renewing or coming from another state increased an average of $20. Applications for business licenses (facility, independent contractors, freelance, etc.) increased an average of $34 and business license renewals increased an average of $43. These fee increases would go into effect January 1, 2022.

3. How does this policy package further OHA's mission and align with its strategic plan?

OHA's mission is to ensure all people and communities can achieve optimum physical, mental and social well-being through partnerships, prevention, and access to quality, affordable health care. The focus of the Health Licensing Office is on helping its applicants have healthy and safe communities and a thriving statewide economy.

Raising the Board of Cosmetology's fees would support the administration of the board, which is tasked with protecting the public from unqualified practitioners and practitioners violating health and safety requirements. The fee increase has a direct impact on the agency's ability to ensure public health and safety for people who receive services by cosmetology licensees.

The board also oversees tens of thousands of licensees who depend on the license to make a living and contribute to the economy of Oregon.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

OHA will measure the success of the policy package through metrics associated with OHA performance measures. Specifically, with the foundational capabilities related to OP6, "Regulating & Ensuring Compliance" core processes and meeting timely Regulatory Compliant Investigations (2KOP6F) and completion of Inspections and Surveys (2KOP6G) performance metrics.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

This policy package allows achievement of OHA foundational capabilities related to OP6, "Regulating & Ensuring Compliance" core processes. Specifically, meeting timely Regulatory Complaint Investigations (2KOP6F) and completion of Inspections and Surveys (2KOP6G) performance metrics, including Regulatory Complaint Investigations, Inspections & Surveys.

7. What are the long-term desired outcomes?

The Board of Cosmetology's revenue will stabilize. The board and HLO will continue its mission to protect Oregonians who receive services from these professionals. Once revenues are stabilized the board will be able to cover expenses without affecting the other boards within HLO. The revenue collected will cover the cost of licensing practitioners, inspecting facilities, administering qualifying examinations in several languages, investigating complaints and protecting the public.

8. What would be the adverse effects of not funding this policy package?

The board will not have enough revenue to continue to operate efficiently. Without the needed revenue, HLO would have insufficient staff to process applications timely and license practitioners so they can begin working. HLO would also have insufficient staff to inspect facilities throughout Oregon to make sure facilities are abiding by the safety and sanitation rules adopted by the board.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

HLO is a cost-conscious organization, constantly streamlining and trying to reduce administrate costs. With the Board of Cosmetology, HLO had offered a fee discount in July 2015 for renewing licenses online, as it takes less staff time to process online renewals but stopped offering the discount in December 2019 to address the revenue shortfall. The number of licenses issued under this board remains steady with little growth over the years, so revenues are not increasing enough to cover administrative costs.

10. What alternatives were considered and what were the reasons for rejecting them?

HLO worked to reduce cost by streamlining administrative processes however, that did not reduce expenditures enough to allow the Board of Cosmetology to cover expenses.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

None.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

None.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

Increased revenue will continue to allow HLO to serve diverse populations such as administering the qualification examinations in several different languages, having forms translated and hiring bilingual staff.

Staffing and fiscal impact

Implementation date(s): January 1, 2022

End date (if applicable): Ongoing

15. What assumptions affect the pricing of this policy package?

Analyzing revenue and expenditure trends since the HLO moved under the administration of OHA. This proposal amounts to a fee increase of approximately 39 percent across 60 distinct fees. The increase will be collected in two renewal cycles in the 2021-23 biennium and will offset a projected cash shortfall.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

No.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

No.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

No new positions would be needed, nor would the existing positions need to be modified. This policy package would maintain the current staffing levels.

20. What are the start-up and one-time costs?

None.

21. What are the ongoing costs?

Cost of administering the program.

22. What are the potential savings?

None.

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

Other Funds from fees paid by Board of Cosmetology licensees.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services						
Services & Supplies		$1,562,547		$1,562,547		
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$1,562,547**	**$0**	**$1,562,547**	**0**	**0.00**

Fiscal impact by program

	Center for Health Protection				Total
General Fund	$0				**$0**
Other Funds	$1,562,547				**$1,562,547**
Federal Funds	$0				**$0**
Total Funds	$1,562,547				**$1,562,547**
Positions	0				**0**
FTE	0.00				**0.00**

Oregon Health Authority
2021-23 Policy Package

Division:	Public Health Division
Program:	Radiation Protection Services (RPS)
Policy package title:	Radiation Protection Services Fee Increase
Policy package number:	448
Related legislation:	House Bill 2075

Summary statement:

The purpose of this policy package is to ensure that Radiation Protection Services (RPS) can continue providing adequate radiation health and safety of Oregonians by creating 2021-2023 financial stability and adequate biennia funding through user-fee increases.

Without additional revenues, RPS budget solvency will be threatened, leading to significant program staff and service reductions resulting in increased potential for harmful radiation exposure and injury to patients, workers and the public; and breaching of inter-agency agreements.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$1,408,249**	**$0**	**$1,408,249**	**3**	**2.25**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

OHA is proposing this policy package to ensure that Radiation Protection Services (RPS) can continue conducting radiological health and safety regulatory inspections, issue licenses, and meet emergency response requirements by creating critical sustainable biennia funding. RPS needs the means to eliminate unfunded liabilities in order to address the below issues.

Inadequate funding has resulted in a significant service gap. Out of 3,850 X-ray and tanning bed registrant facilities in Oregon, there is an inspection backlog of 676 facilities (652 and 24 respectively) which continues to increase. This means that RPS is unable to achieve OHA foundational capabilities related to OP6, "Regulating & Ensuring Compliance" core processes and comply with Oregon Revised Statutes (ORS 453).

Current service levels allow only six of eight) cross trained RPS Radiation Health Physicist inspectors to conduct on-site facility inspections. In 2019, RPS completed 1,148 total facility inspections including 844 X-ray, 96 tanning, 102 mammography and 106 radioactive material licensing (RML) inspections. Additional inspectors are needed to address the backlog.

A lack of funding has meant that for medical registrants and licensees, RPS is not able to effectively complete timely investigations and mandate corrections of mis-administrations of radiation involving patient cancer treatments or diagnostic procedures. OHA/RPS is not be able to ensure that tanning facilities are being operated properly, including that operators have met training requirements and underaged tanning is not taking place. Furthermore, inadequate funding would mean that RPS has reduced staffing and less capacity to provide the Oregon Department of Energy with an ORS-mandated radiological emergency response team for mitigating radiological incidents.

The Radioactive Material Licensing (RML) program is also in jeopardy of breaching the agreement between the United States Nuclear Regulatory Commission (NRC) and the state of Oregon's Governor's letter of certification to comply with the provisions of Section 651(e) of the Energy Policy Act of 2005. Since 1965, Oregon has been an Agreement State (AS) through the Governor's decree. As such, RPS enforces federal regulations and Oregon's statutes and administrative rules relating to Oregon's radioactive material licensees. RPS is required to satisfy NRC performance indicators which hold the state accountable for staffing levels, regulatory practices, incident response, and investigation performance.

RPS has limited capabilities to conduct consumer complaint follow up; train local and state radiological emergency first responders-receivers; offer radioanalytical laboratory services to test agricultural products or complete environmental surveillance activities.

Originally, RPS was supported by State of Oregon, General Fund. However, several years ago, the funding mechanism changed to a user-fee model. Since 1989, RPS has implemented four Legislatively approved user-fee increases (most recently 25 percent for its X-ray and RML programs, and 50 percent for the tanning program in 2015). Unfortunately, current user-fees have not been able to keep pace with inflation and increasing program/staffing expenses. This has had a direct impact on how our agency tries to ensure radiation health and safety of Oregonians. Over the past 12 years there has been a 30 percent staff reduction (22 to 16 members).

2. What would this policy package buy and how and when would it be implemented?

RPS needs to ensure adequate funding through 2023-2025 to maintain its licensing, inspection and emergency response capabilities. A 2021-2023 policy package will generate additional biennial revenue. This will provide RPS financial stability and ensure adequate radiation health and safety of Oregonians. Studies of comparable RML state and federal funding mechanisms indicate that increased fees and new revenue streams are warranted.

Effective January 1, 2022, RPS is proposing to 1) institute radioactive material licensing (RML) user-fee increases, 2) restructure the agency X-ray registrant user-fee model, 3) implement X-ray vendor licensing fees, and 4) implement tanning registrant user-fee increases.

1) Implement a 30 percent fee increase for Radioactive Material Licensees who pay less than a current $3,000 licensing fee, and a 50 percent fee increase for licensees who pay a current $3,000 or more licensing fee to recover unfunded program costs and properly reapportion the fee structure (based upon past user-fee cap inequities). The fee-change properly reapportions all licensee fees and is projected to generate $559,241 additional biennial revenue.

2) Restructure the 2021-2023 X-ray registrant fee schedule to be "tube based", rather than the existing facility machine control panel fee. This would align Oregon's fee structure with the states of Washington and California tube-based fee models. This would assure that RPS is being appropriately compensated and that Registrants are paying a registration fee based upon RPS staff's inspection time required to ensure safe machine operation and to reflect higher tube energy levels which present potential for increased patient/operator/public harm. The above fee schedule is projected to generate $1,228,198 additional biennial revenue.

3) Initiate a new annual $500 X-ray vendor licensing fee for vendors that are licensed for Sales, Services, and Consultation for Radiation Machines in order to recover unfunded staff costs associated with processing license applications, vetting vendor qualifications, and reviewing/approving training curriculums. The vendor license fee is projected to generate $60,000 additional biennial revenue.

4) Implement a 33 percent tanning registrant annual user-fee cap increase to $200 per device to recover unfunded program costs. This fee cap increase is projected to generate $135,563 additional biennial revenue.

Implementation of the above 2021-2023 RPS program funding strategies is projected to increase revenue by $1,983,002 biennially and avert a significant staff/service reduction, reverse inadequate Section funding, eliminate a deficit, and ensure financial sustainability and staffing through 2025-2027.

With increased funding and position authority during 2021-2023, RPS will establish three new positions, effective January 1, 2022, with RML inspection, licensing, emergency response and administrative functional responsibilities. This will allow RPS to be at 76 percent of Conference of Radiation Control Program Directors, Inc. recommended staffing levels (19 versus 25), which is essential to meet state and federal RML mandates relating to radiation public health and safety.

Implementation of 2021-2023 RPS program funding strategies will avert a significant staff and service reduction, reverse inadequate Section funding, and eliminate a deficit. RPS will also be able to add two Environmental Health Specialist 3s (EHS3) who will act as Radiation Health Physicists cross trained to complete RML, X-ray and tanning facility inspections and an Administrative Specialist 1 (AS1) to administer a new database for a new X-ray tube-based fee schedule. The increased revenue is projected to exceed increased staffing costs, creating a reserve/ending balance of $131,557 for 2021-2023. Because of the increased funding and elimination of an accrued deficit, the revenue versus expense projected reserve/ending balance would improve to $416,893 for the 2023-2025 biennium.

3. How does this policy package further OHA's mission and align with its strategic plan?

This policy package aligns with the Governor's policy priorities, including to "control cost growth in health care spending," and "modernize public health." It also aligns with the OHA strategic plan to 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.

The policy package helps ensure OHA/Radiation Protection Services (RPS) can offer adequate, essential staffing/services that promote the health and safety of all Oregonians. It directly impacts the triple aim of better health, better care, and lower cost for all Oregonians.

Through RML safety regulation of service providers, patients achieve better health and care. A stable RPS/ RML program also allows for public health modernization efforts. Radiation emerging technologies are evaluated and approved for use in Oregon by RML staff, and new radiation operators (practitioners) are approved to use new radiation modalities which improve patient healthcare.

As a result, progress toward achieving triple aim goals and health equity is made because financially challenged patients are afforded more opportunities to receive high-quality, high-tech health care. Health equity is also improved for rural communities in that high-quality, lower cost patient care is more readily accessible.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

OHA will measure the success of the policy package through metrics associated with the OHA performance measures and the foundational capabilities related to OP6, "Regulating & Ensuring Compliance" core processes. Specifically meeting timely Regulatory Compliant Investigations (2KOP6F) and completion of Inspections and Surveys (2KOP6G) performance metrics, including meeting Timely & Accurate Report submissions, Monitoring Contracts & Grants, Remediating Audit Findings, Licensure & Certifications, Regulatory Complaint Investigations, Inspections & Surveys, and Rule Reviews.

In addition, success regarding the RPS radioactive material licensing program will be measured by NRC, "Integrated Material Performance Evaluation Program" (IMPEP) formal audit results which include performance indicators for staffing levels, regulatory practices, incident response, and investigation performance.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

This policy package allows achievement of OHA foundational capabilities related to OP6 "Regulating & Ensuring Compliance" core processes. Specifically, meeting timely Regulatory Complaint Investigations (2KOP6F) and completion of Inspections and Surveys (2KOP6G) performance metrics, including meeting Timely & Accurate Report submissions, Monitoring Contracts & Grants, Remediating Audit Findings, Licensure & Certifications, Regulatory Complaint Investigations, Inspections & Surveys, and Rule Reviews.

Additionally, this policy package is related to RPS' role with the, *"Oregon Emergency Comprehensive Plan, Emergency Support Function (ESF) #8, Public Health and Medical Services"* for radiation incidents.

7. What are the long-term desired outcomes?

The overall expected result is that OHA/RPS will have adequate revenue to support protecting Oregonians from unnecessary and harmful radiation and, at the same time, improve the health of its citizens through regulating safe and appropriate use of radioactive sources.

Additional funding gives RPS the capability to conduct timely radiation incident mitigation and consumer complaint follow up; training of local and state radiological emergency first responders/receivers; testing of agricultural products through radioanalytical laboratory services and completing environmental monitoring activities.

With adequate funding, the Radioactive Material Licensing (RML) program can maintain its good standing as a Nuclear Regulatory Commission (NRC) Agreement State (AS) member and properly enforce NRC safety regulations for Oregon radioactive material licensees. RPS will be able to satisfy NRC performance indicators which address minimal inspection and license reviewer staffing levels, standards for inspections and licensing actions, and emergency response/incident investigation minimum requirements. Even with a fee increase, there are health care system cost-savings because as an AS member, OHA/RPS licensing fees will still be significantly lower than if licensees were regulated directly by the NRC.

ORS 469.533 requires OHA/RPS to provide the Oregon Department of Energy with a 24/7 radiological emergency response team trained/equipped to mitigate radiological transportation events and provide environmental sampling assistance for potential Columbia Generating Station/Hanford Reservation radiological release events which cross into Oregon. Increased funding will more fully support operational staffing and equipment expenses to meet mandated emergency response team requirements.

The health and safety of every Oregonian is impacted by appropriate uses of radiation. Examples include Gamma Knives and other radiation therapies used to treat cancers, gauges containing radioactive materials for food manufacturing and road construction, and industrial radiography cameras to ensure building steel girder integrity.

Increased financial stability means that OHA/RPS will be able to provide timely, effective regulation and safety inspections and licensing of 400 Radioactive Material Licensing (RML) facilities that use approximately 1,500 radioactive sources, and more than 3,600 X-ray facilities that use over 12,000 machines for medical, academic, industrial, and research applications; and 316 tanning facilities that use approximately 1,299 devices. Virtually, all Oregonians benefit from radiation sources and devices and OHA/RPS programs.

8. What would be the adverse effects of not funding this policy package?

Overall, without additional funding, RPS will have to significantly reduce staff and services which will increase the potential for harmful radiation exposure and injury to patients, workers and the public. RPS will not be able to complete facility inspections of all registrants to ensure radiation devices/sources are being used safely and within manufacturer specifications, or conduct timely licensing activities, radiological environmental surveillance and emergency response services.

Current staffing will most likely reduce from 16 full-time equivalent (FTE) to 8 FTE, deteriorating to a level of nominal services (i.e., device registry only programs and no regulatory work to protect health and safety). As such, RPS and the RML program will also be in jeopardy of breaching interagency responsibilities including 1) an agreement between the United States Nuclear Regulatory Commission and the state of Oregon's Governor's letter of certification to comply with the provisions of Section 651(e) of the Energy Policy Act of 2005, 2) an ORS 469.533 mandate to have radiological emergency preparedness/response capabilities, and 3) a long-

standing FDA services contract to inspect all mammography facilities in Oregon. RPS, as the only State of Oregon radiation control agency, would be rendered ineffective to provide adequate radiation use and safety.

Based upon 2023-25 biennium revenue/expenditure projections, RPS will be in a significant deficit position ($2.2 million), unless revenues are increased. The existing legislatively approved RPS registration and licensing fee schedules place RPS in a fragile position because of its sole reliance upon user fees to meet budgetary responsibilities.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

To compensate for inadequate funding, RPS has reduced its staff. Over the past 12 years there has been a 30 percent staff reduction (22 to 16 members). RPS has also utilized LEAN principles to fully maximize its productivity and efficiency through staff reconfigurations, on-site facility inspection frequency changes, and use of new IT equipment. Via cross-training, other tanning/X-ray facility inspection staff have taken on added RML functions including performing inspections, emergency response, and environmental surveillance/radioanalytical lab responsibilities.

Based upon risk evaluation, selected facility inspection frequencies have been decreased. RPS instituted electronic field reporting for inspections, created new databases for monitoring regulatory functions and generating new radioactive material licenses, and smart phone technology has been utilized, combined with new radiation detection software, to enhance emergency response/environmental surveillance.

All options have been exhausted to maximize existing funding.

10. What alternatives were considered and what were the reasons for rejecting them?

Initially, RPS considered a policy package allowing establishment of additional service fees for hazardous material response; however, it was determined that further legal review was required to determine if RPS possesses the appropriate statutory authority. This alternative was not rejected, but the time constraints of research would threaten implementation in the next biennium.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

Yes. Proposed legislation (House Bill 2075) "RPS Fee Increases" does the following:

1) Amends ORS 453.757(1) to establish a new X-ray tube-based registration program.
2) Amends ORS 453.729(2) to increase the tanning registration cap fee.
3) Creates a new ORS for X-ray vendor licensing fee.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

Other agencies could be affected negatively if the policy package is *not* implemented as part of the proposed legislation (House Bill 2075). RPS would be in jeopardy of breaching interagency responsibilities including 1) an agreement between the US Nuclear Regulatory Commission (NRC) and the State of Oregon, Governor's letter of certification to comply with the provisions of Section 651(e) of the Energy Policy Act of 2005, 2) the Oregon Department of Energy (ODOE), via an ORS 469.533 mandate to have radiological emergency preparedness/response capabilities, and 3) a long-standing Food and Drug Administration (FDA) RPS services contract to inspect all mammography facilities in Oregon.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

The State Radiation Advisory Committee (RAC) is a primary stakeholder group representing all Registrants and Licensees and provides guidance to RPS regarding Oregon Administrative Rule revisions and budgetary issues. It has been very supportive of past fee changes. The RAC would be an influencer of any proposed fee structure change. They are unanimous in supporting the need for more revenue.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

The policy package will have a significant impact in sustaining RPS functions and capabilities for the benefit of all populations in the state, specifically to address health equity issues, including advancement of triple aim objectives. RPS efforts serve economically challenged patients, improve rural health accessibility to medical services, and facilitate physician extender opportunities.

Examples include:

- Working with manufacturers to approve the sale of hand-held dental X-ray devices used for dental care of indigent people and improving rural service accessibility through communities offering mobile urgent/dental care clinics.
- Ensuring that emerging technologies, like superficial radiation therapy devices, are evaluated/approved for safe use by new groups of medical practitioners (e.g., dermatologists), to increase general and rural community accessibility to skin cancer treatments.
- Facilitating an inter-agency process to evaluate/approve fluoroscopy training requirements for Advanced Practice Registered Nurses to serve as physician extenders offering pain management treatments to general and rural populations that do not have ready access to physicians.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

RPS is challenged to provide timely facility inspections to rural community registrant /licensees. A significant number of the back-logged X-ray facility inspections are in rural and hard-to-reach communities. Due to the added travel time and a lack of RPS staff to complete rural facility on-site inspections, including radiation use and safety education, many medical service providers do not have an opportunity to learn diagnostic and therapeutic imaging techniques which can decrease radiation exposure for their patients.

RPS also serves a select Oregon population, namely, incarcerated citizens and the correction officers who provide security by ensuring the safe use of body scanners in Oregon's correctional facilities. X-ray body scanners improve overall safety and security through detection of contraband and other destructive and dangerous devices.

Finally, this policy package addresses health equity issues in that RPS gives medical practitioners opportunities to treat economically challenged and rural community patients with new diagnostic and therapeutic radiation modalities. This is accomplished through RPS facilitating inter-organizational efforts to evaluate formal radiation education curriculums and their approval as new operator training programs.

Staffing and fiscal impact

Implementation date(s): July 1, 2021 for proposed legislation (HB 2075) and January 1, 2022 for staffing

End date (if applicable): Ongoing

15. What assumptions affect the pricing of this policy package?

The pricing assumes the number of licensees will remain approximately the same.

16. Will there be new responsibilities for OHA?

No.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

Development of a new X-ray tube-fee schedule database. This work will be completed with existing resources, so no additional funding necessary.

18. Will there be changes to client caseloads or services provided to population groups?

No.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

Three new permanent full-time positions, effective January 1, 2022, including two Environmental Health Specialist 3s (EHS3) who will act as Radiation Health Physicists cross trained to complete RML, X-ray and tanning facility inspections and an Administrative Specialist 1 (AS1) to administer a new database for a new X-ray tube-based fee schedule.

20. What are the start-up and one-time costs?

No.

21. What are the ongoing costs?

The personal services and service and supplies expenditures for the three permanent positions.

22. What are the potential savings?

N/A

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

Other Funds limitation requested to support increased revenue from fees paid by Radiation Protection Service licensees.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services		$390,950		$390,950	3	2.25
Services & Supplies		$1,017,299		$1,017,299		
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$1,408,249**	**$0**	**$1,408,249**	**3**	**2.25**

Fiscal impact by program

	Center for Protection				Total
General Fund	$0				**$0**
Other Funds	$1,408,249				**$1,408,249**
Federal Funds	$0				**$0**
Total Funds	$1,408,249				**$1,408,249**
Positions	3				**3**
FTE	2.25				**2.25**

Oregon Health Authority
2021-23 Policy Package

Division:	Public Health Division
Program:	Oregon State Public Health Lab, Oregon Environmental Laboratory Accreditation Program (ORELAP)
Policy package title:	Oregon Environmental Laboratory Accreditation Program (ORELAP)
Policy package number:	449
Related legislation:	None

Summary statement:

The Oregon Environmental Laboratory Accreditation Program (ORELAP) was established in 1999 and is statutorily mandated. ORELAP accredits Oregon drinking water, environmental and cannabis laboratories based on national standards to ensure laboratories are following federal and state regulations. ORELAP is a fee-based program and is experiencing a budgetary shortfall. This policy package will support a fee increase and an update to the ORELAP fee structure for simplification and to ensure fees are appropriate for the work required to perform laboratory accreditations of differing complexity. A fee increase is needed to ensure ORELAP can provide timely and quality accreditations that meet established standards and regulatory requirements to best serve ORELAP's clients and protect the health of all Oregonians.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$896,094**	**$0**	**$896,094**	**0**	**0.00**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

Environmental laboratories conduct analysis of air, drinking water, wastewater, solid and chemical waste, biological tissue and, in Oregon, cannabis. Analyses performed by these laboratories are used to determine compliance with federal, state and local regulations and may have a direct effect upon human health and the environment.

The Oregon Environmental Laboratory Accreditation Program (ORELAP) was established in 1999 and operates under ORS 438.605 to 438.620 and ORS 475B.565. ORELAP accredits laboratories based upon standards established by the National Environmental Laboratory Accreditation Program (NELAP) and under the guidance of the Clean Air Act, Clean Water Act, Safe Drinking Water Act, the Resource, Conservation and Recovery Act and Oregon statute related to cannabis.

ORELAP accredits Oregon drinking water, environmental and cannabis laboratories as well as provides primary and secondary accreditation to laboratories outside of Oregon. ORELAP provides an on-site assessment for accredited laboratories every two years and for new laboratories seeking accreditation to ensure they are complying with accreditation standards.

ORELAP is a fee-based program within the Oregon State Public Health Laboratory that supports a team of six. Funding of ORELAP is accomplished using fees to reimburse the program for cost of performing all accreditation activities performed by ORELAP staff to ensure compliance to all TNI (The NELAC Institute) standards, federal regulations and state rules and statutes. The program also receives a small amount of federal funding for its drinking water work.

ORELAP is projected to have a budget shortfall in the next biennium. ORELAP's current fees are some of the lowest in the country and have not increased for in-state laboratories since the inception of the program in 1999. A fee revision is needed to ensure that ORELAP can provide timely and quality accreditations that meet established standards and regulatory requirements to best serve ORELAP's clients and protect the health of Oregonians. In addition, there are proposed changes to the ORELAP fee structure for simplification and to ensure fees are appropriate for the work required to perform laboratory accreditations of differing complexity. Importantly, the policy package will help ORELAP accredit laboratories that respond to critical emerging needs, such as cyanotoxin exposures from algal blooms and Per- and polyfluoroalkyl substances (PFAS) chemicals in drinking water.

2. What would this policy package buy and how and when would it be implemented?

The policy package is proposing changes to the ORELAP fee structure and increases to its fees. ORELAP's fees use a complex tiered structure that scales up based on each laboratory's accreditation needs. The proposed fee increases are wide-ranging and impact all of ORELAP's clients. The proposed fees include a switch to a five- to three-tier system to better address the disparity in program time required to assess small laboratories as compared to very large laboratories. In-state annual application fees would increase by $750 to $4,200. Biennial on-site assessment fees would increase by $210 to $500 for the first program in each field of accreditation, while a biennial "Trip Fee" for on-site assessments would be eliminated. Out-of-state application fees would see increases of $1,450 to $7,190. Out-of-state assessment fees would be brought in line with in-state fees through increases of $60 to $440. These proposed changes would ensure the sustainability of ORELAP and support current ORELAP staff to perform timely and quality accreditations of drinking water, environmental and cannabis laboratories to established national and state standards to protect the health of Oregonians.

The proposed fee increase would be implemented November 1, 2021 upon completion of a rule update.

The policy package will support:

- ORELAP staff, including the below activities:
  - Preparing for and conducting on-site assessments for accredited laboratories every two years, when a new laboratory seeks accreditation and when a laboratory adds a new testing method to ensure laboratories are compiling with established testing standards.
  - Writing and responding to assessment corrective actions to ensure deficiencies found during the on-site assessment are addressed.
  - Review of proficiency tests to ensure testing at accredited laboratories are performed accurately.
  - Providing client services to laboratories regarding accreditation, including addressing questions related to obtaining and maintaining accreditation and providing recommendations for improvement. Assessors may assist laboratories with technical questions related to laboratory operations.
  - Training for ORELAP assessors to be certified in advanced testing methods advance testing technologies laboratories request for accreditation. ORELAP assessors are highly skilled in advanced testing technologies needed to support and accredit laboratories to national standards.
  - Billing services to ensure billing is timely and accurate.
  - Investigating and collaborating with other agency partners regarding complaints.
- Information Technology (IT) support for the ORELAP electronic database.
  - The ORELAP Data Input and Edit (ODIE) state database application is the interface between ORELAP and accredited laboratories and support will improve ORELAP operations and ensure ease of usability by clients.
- Travel associated with on-site assessments.
  - ORELAP accredits laboratories throughout Oregon and other states to ensure all Oregonians have access to accredited laboratory services to protect and promote the health of their communities.

3. How does this policy package further OHA's mission and align with its strategic plan?

The goal of OHA's strategic plan is to eliminate health inequities in Oregon with a vision of a healthy Oregon. In addition, OHA's mission is ensuring that all people and communities can achieve optimum physical, mental, and social well-being through partnerships, prevention and access to quality, affordable health care.

ORELAP serves all drinking water, environmental and cannabis laboratories in the state, including laboratories that support rural communities. For example, upon a real estate transaction containing a well, the well water needs to be tested for nitrates, arsenic and total coliform at an ORELAP accredited laboratory to inform the safety and health of communities sourcing water from wells.

ORELAP plays a vital role in protecting and promoting the health of all people and communities by helping ensure the water we drink, the air we breathe and the environment we live in is free of chemicals, toxins and other substances that impact health. Specifically, ORELAP-accredited laboratories have played a critical role in testing for lead in school drinking water and cyanotoxins from harmful algae blooms. In addition, ORELAP helps protect public health by ensuring that laboratories testing cannabis for solvents and pesticides are performing quality and accurate testing.

Importantly, ORELAP helps respond to critical public health events by accrediting laboratories that test for emerging contaminants that impact health, such as cyanotoxin exposures from algal blooms and exposure to PFAS chemicals.

Promoting the sustainability of ORELAP is critical for protecting the health and ensuring the safety of all Oregon communities.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

The Secretary of State Audits Division completed an audit report of the Oregon Health Authority marijuana programs entitled *Oregon's Framework for Regulating Marijuana Should Be Strengthened to Better Mitigate Diversion Risk and Improve Laboratory Testing* (2019-04). Two findings from the report may be assisted by this policy package:

Key Finding #3: *All recreational marijuana in Oregon must be tested for pesticides and solvents, but most medical marijuana is not required to be tested. Also, OHA does not require heavy metal and microbiological testing, in contrast to some other states. These contaminants could pose a risk to consumers.*

The inclusion of heavy metals and microbiological testing will require ORELAP to offer new fields of accreditation for cannabis testing laboratories. This policy package will help sustain ORELAP staff, potentially supporting the addition of these new fields of accreditation for cannabis laboratories.

Key Finding #4: *Without a mechanism for verifying test results, Oregon's marijuana testing program cannot ensure that test results are reliable, and products are safe. Limited authority, inadequate staffing, and inefficient processes reduce OHA's ability to ensure Oregon marijuana labs consistently operate under accreditation standards and industry pressures may affect lab practices and the accuracy of results.*

The update to the fee structure and fees proposed in this policy package will help support ORELAP staff to be able to examine and work to address the findings of the Oregon Secretary of State, particularly the assessment of potential process improvements.

Quantifying results

5. How will OHA measure the success of this policy package?

ORELAP is projected to have a budget shortfall. Current program fees do not support the programmatic work needed to complete timely accreditations and the work needed to investigate complaints regarding ORELAP accredited laboratories. The proposed option package would update the fee structure to reflect fees that are appropriate for the work required to accredit laboratories of different complexities and increase fees to ensure ORELAP is sustainable. OHA will be able to measure the success of the policy package by determining whether the updated fee structure and fees support programmatic expenses to continue providing quality services to accredited laboratories and protect the health of Oregonians.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

ORELAP accredits drinking water, cannabis and environmental laboratories to ensure they are in compliance with established standards and they are meeting regulatory requirements for the protection of the health of Oregonians. In addition, in partnership with other agencies, ORELAP is involved in the investigation of complaints against ORELAP accredited laboratories. This policy package will support ORELAP in the quality, timely execution of these activities.

This policy package strongly aligns to the Operating Process 6 (OP6), “Regulating and ensuring compliance” in the OHA Performance System Fundamentals Map. In OP6, this policy package supports the sub-processes of: Setting, communicating and implementing standards to ensure compliance; Monitoring and managing compliance; Reporting compliance; Providing technical assistance and Developing and implementing process improvements. In particular, it impacts the Process Measures, Percent of external audit findings remediated; Regulatory complaints investigations and inspections and surveys.

Some of the OHA Key Goals are:

- Effective Partnerships
  - ORELAP works closely not only with other state agencies, such as the Oregon Liquor Control Commission (OLCC), the Department of Environmental Quality (DEQ) and the Oregon Department of Agriculture (ODA), but also with ORELAP accredited laboratories. ORELAP has regular meetings with the ORELAP Technical Advisory Committee (OTAC) that is comprised of interested stakeholders to share information and receive feedback regarding accreditation standards and processes. This policy package will help allow ORELAP staff continue these important partnerships.
- Operational Excellence
  - ORELAP is continually pursing process improvements to create efficient and effective operations. This policy package will support ORELAP building increased quality assurance processes into workflows, updating the ORELAP electronic database for efficiencies and ease of use, and ensuring the accreditation process is streamlined for timely services.
- Equity and Inclusion
  - ORELAP accredits all drinking water, cannabis, and environmental laboratories in Oregon to confirm state and federal regulations and established standards are being meet and assists all areas of the state having access to accredited laboratory services needed to protect public health.
- Better Health
  - ORELAP has been critical in the response to critical public issues, such as lead in the drinking water of schools and cyanotoxins from harmful algae blooms. This policy package will help ensure the safety of drinking water, cannabis and our environment as well as help support ORELAP in being able to respond to emerging health issues to protect and promote the health of all Oregonians.

7. What are the long-term desired outcomes?

Environmental laboratories, in part, perform tests on air, drinking water, environmental and cannabis samples to measure microbiology analytes, compounds, chemicals and other substances that could potentially affect the environment and the health of individuals. This testing also helps ensure compliance with federal, state and local regulations. Some of the test compounds include pesticides and solvents in cannabis products, lead in drinking water, cyanotoxins in water, PFAS in environmental samples and asbestos in commercial and residential setting.

ORELAP accredits the laboratories performing these tests to federal and state standards to certify that test results produced are accurate, therefore promoting the safety of drinking water, cannabis products and the environment. The fee increase would ensure fees are appropriate for work performed so ORELAP is sustainable and able to provide quality, timely accreditations to protect the health of Oregonians.

8. What would be the adverse effects of not funding this policy package?

ORELAP is a fee-based program and is projected to have a budget shortfall. Without the support of this package, the sustainability of ORELAP would be in jeopardy; therefore, ORELAP's compliance with its statutory mandates, the accreditation of laboratories to established standards throughout the state, assurance of compliance to established testing standards and state and federal laws, and the safety of public health would also be at risk.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

ORELAP has implemented several process improvements to make operations more efficient and utilize existing resources as best as possible. These include:

- Reorganizing how ORELAP assessors are sent on on-site assessments to reduce the number of ORELAP assessors traveling per on-site assessment.
- ORELAP conducted a six-month touch-time analysis to determine the true time and cost to accredit laboratories and the other work necessary to perform accreditations to established international standards. This analysis helped inform programmatic decisions and the proposed fee changes in this policy package.
- Enhancement of the ORELAP Data Input and Edit (ODIE) state database application (the interface between ORELAP and accredited laboratories) to improve ORELAP operations and ensure ease of usability by clients.
- Reorganization and delegation of ORELAP staff job duties to streamline the accreditation process.
- Notifying international clients, and out-of-state clients involved in radiochemistry testing, that they will need to seek primary accreditation through another accrediting body other than ORELAP to ensure staff resources are utilized most efficiently.

10. What alternatives were considered and what were the reasons for rejecting them?

ORELAP recently completed a touch-time analysis where time spent on all activities was recorded for 6 months. The purpose of this project was to better understand the time and associated costs required for different accreditation processes and complexity of laboratories to inform program strategic and business plans. This also included researching other state's fee structures and fees. The data from this analysis helped inform the discussions and decisions that formed the proposed updates to the ORELAP fee structure and fees.

Some of the different fee structures and program changes that were considered were a fee-for-service fee structure, a fee based on how many different methods a laboratory needs to be accredited and examining ORELAP's client base.

Ultimately, the proposed fee structure was determined to be the most appropriate based on the work required to accredit laboratories of different complexities, the simplest and most familiar for clients for incorporating changes and suitable to ensure ORELAP is sustainable to be able to perform timely, quality accreditations and support accredited laboratories and their clients.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

There is no associated legislative concept with this policy package.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

ORELAP accredits laboratories throughout Oregon to ensure that communities have access to needed accredited laboratory services, including a non-profit environmental laboratory owned and operated by The Klamath Tribes. ORELAP may also accredit environmental laboratories performing work for Tribal entities. In addition, ORELAP accredits municipal laboratories performing analysis of drinking water, wastewater, and solid waste. All accredited laboratories would experience increased fees under the proposed policy package.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

The ORELAP Executive Team consists of the OSPHL Laboratory Director, DEQ Laboratory Director, and ODA Laboratory Manager. This team guides the strategic direction of ORELAP. During the analysis of the ORELAP fee structure and fees the ORELAP Executive Team provided input and helped determine the final decision on the proposed policy package to ensure it reflects the best strategy for ORELAP, stakeholders, clients and the health of Oregonians. These agencies are not requesting funding in relation to this policy package.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

ORELAP serves drinking water, environmental and cannabis laboratories throughout the state, including laboratories that support rural communities and Tribes. Fees would be increased for all laboratories based on the work needed to accredit a laboratory for the number and complexity of the methods being accredited. The policy package would ensure ORELAP is sustainable to accredit all laboratories in Oregon to established standards for the protection of health of all communities.

Staffing and fiscal impact

Implementation date(s): November 1, 2021

End date (if applicable): Ongoing

15. What assumptions affect the pricing of this policy package?

The key assumption of this package is that the ORELAP program will retain the bulk of its current client base after increasing its fees, thereby generating additional revenue. Although fees charged by other NELAP accrediting bodies use a wide variety of structures that are difficult to directly compare to ORELAP's, the program's analysis indicates that the increased rates would remain competitive in the industry. Other assumptions include continued partial funding of the ORELAP program by the EPA Drinking Water Primacy grant, approximately $90,000 per biennium.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

There will be no new responsibilities for OHA associated with the policy package. It would promote the sustainability of ORELAP and support current ORELAP staff to perform timely and quality accreditations to international standards and in accordance to ORELAP's mandate ORS 438 and 475B.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

There are no new anticipated responsibilities for Shared Services. The Office of Information Services (OIS) supports the technology maintenance and enhancements for the ORELAP electronic database that is the interface between ORELAP and clients. This policy package will provide for OIS staff to support the ORELAP electronic database to maintain its operations as well as make enhancements to the system to make ORELAP's workflow more efficient and improve client's usability.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

This policy package will not directly result in a change to the ORELAP client caseload.

Currently ORELAP accredits over 140 laboratories. This policy package will help support the services provided to these laboratories by ensuring timely and accurate accreditations and performance reviews (PTs); highly trained assessors that can accredit to national and state standards; and support services regarding accreditation.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

This policy package does not require new positions or modifications to existing positions. It will support current ORELAP staff and ensure the sustainability of ORELAP to provide quality services to accredited laboratories and protect the health of Oregonians.

20. What are the start-up and one-time costs?

None.

21. What are the ongoing costs?

The ongoing costs are personnel costs including employee services, supplies, travel, shared services, and State Assessments & Enterprise-wide costs.

22. What are the potential savings?

None.

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

The policy package is requesting Other Funds limitation to support a fee increase paid for by laboratories needing accreditation.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services						
Services & Supplies		$896,094		$896,094		
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$896,094**	**$0**	**$896,094**	**0**	**0.00**

Fiscal impact by program

	Center for Public Health Practice	Program 2	Program 3	Program 4	**Total**
General Fund	$0				**$0**
Other Funds	$896,094				**$896,094**
Federal Funds	$0				**$0**
Total Funds	$896,094				**$896,094**
Positions	0				**0**
FTE	0.00				**0.00**

Oregon Health Authority
2021-23 Policy Package

Division:	Public Health Division
Program:	Health Care Regulation and Quality Improvement (HCRQI)
Policy package title:	Ambulance Licensing Fees
Policy package number:	450
Related legislation:	House Bill 2076 (2021)

Summary statement:

The Health Care Regulation and Quality Improvement section regulates both ambulance service agencies and ambulance vehicles to ensure the quality and safety of services provided to Oregonians. Revenues generated from current fees no longer support the cost of associated regulatory work. Pursuant to ORS 682.085, the program conducts on-site licensing surveys of ambulance agencies and ambulance vehicles, and complaint investigations to ensure that ambulance agencies and ambulance vehicles provide high-quality and safe services and comply with associated state licensing regulations. Failure to increase fees would jeopardize the program's ability to meet its licensing and investigatory requirements which may jeopardize the quality of available emergency and nonemergency care and place patients and Emergency Medical Services (EMS) providers at risk. It would also threaten the ability to maintain a fiscally sustainable budget, which is necessary to meet the agency's overall fiscal and operational goals.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$106,237**	**$0**	**$106,237**	**0**	**0.00**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

The Health Care Regulation and Quality Improvement, Emergency Medical Services (EMS) and Trauma System (TS) program regulates both ambulance service agencies and ambulance vehicles to ensure the quality and safety of services provided to Oregonians. The EMS and TS program uses licensing fees to recover the direct cost of operational and administrative functions related to the regulation of ambulance service agencies and ambulance vehicles. However, revenues generated from current ambulance service and ambulance vehicle fees no longer support the cost of associated regulatory work. Fees have not increased since 1997.

There are currently 136 licensed ambulance service agencies and 740 ambulance vehicles in Oregon. Pursuant to ORS 682.085, the EMS and TS program conducts on-site licensing surveys of each ambulance service and ambulance vehicle, as well as complaint investigation inspections. These inspections and the prompt investigation of complaints ensure that Oregon's licensed ambulance service agencies and the ambulance vehicles operate to provide high-quality and safe services and comply with associated state licensing regulations.

This policy package proposes to raise both initial licensure and renewal fees for ambulance service agencies and ambulance vehicles established in ORS 682.047 (1997).

2. What would this policy package buy and how and when would it be implemented?

Funding will be used to support current service levels, permanent staff and operating costs. Current services include initial and renewal licensing activities, on-site licensing surveys, on-site complaint investigations, enforcement activities and technical support services expected by licensees and other interested parties including patients and members of the public.

The fee increases are as follows:

- Ambulance service having a maximum of four full-time paid positions – license fees for both initial and renewal:
    - Service license: from $75 to $190
    - Vehicle license: from $45 to $115
- Ambulance service having five or more full-time paid positions – license fees for both initial and renewal:
    - Service license: from $250 to $625
    - Vehicle license: from $80 to $200

3. How does this policy package further OHA's mission and align with its strategic plan?

The Oregon Health Authority's Health Care Regulation and Quality Improvement section furthers the agency's mission by providing regulatory oversight of prospective and licensed ambulance service agencies and ambulance vehicles. These activities directly improve the health and safety of all Oregonians by ensuring that ambulance service agencies and ambulance vehicles are safe and comply with current regulatory standards. This proposal would sustain regulatory and oversight functions at current service levels.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

The agency will measure the success of this policy package by the percentage of on-site licensing surveys completed annually that satisfy applicable OHA performance system measures.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

This policy package is not tied to a legislative Key Performance Measure nor one of the 10 Key OHA performance measures. However, it is related to OHA performance process OP6, "Regulating and Ensuring Compliance."

7. What are the long-term desired outcomes?

The fee increase would maintain a fiscally sustainable budget and would sustain regulatory and oversight functions at current service levels ensuring that ambulance service agencies and ambulance vehicles are safe for the public, patients and providers and comply with current regulatory standards.

8. What would be the adverse effects of not funding this policy package?

Failure to increase licensure fees would jeopardize the ability to meet on-site initial and complaint investigation requirements and may jeopardize the quality of available emergency and non-emergency care, as well as place patients and EMS providers at risk. It would also threaten the ability to maintain a fiscally sustainable budget, which is necessary to meet the agency's overall fiscal and operational goals.

9. What actions have occurred to resolve the issue prior to requesting a policy package?

The EMSand& TS program has improved effectiveness through administrative efficiencies, the use of technology (online licensing), and process improvements when doing on-site surveys and complaint investigations**.**

10. What alternatives were considered and what were the reasons for rejecting them?

Alternatives in lieu of the proposed fee increase, include:

- A limit on the type of regulatory requirements reviewed during initial and/or re-licensure surveys.
- Limiting the type of complaint investigations the program would investigate.
- Reducing the frequency of on-site surveys.
- Reducing the scope of complaint investigations.

Each of these alternatives may jeopardize the ability to ensure that ambulance service agencies and ambulance vehicles meet existing regulatory standards and fail to reduce overall operational costs.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

Yes. Amendments will need to be made to ORS 682.047. Proposed legislation (House Bill 2076) proposes to modernize the Emergency Medical Services and Trauma System in Oregon by creating an integrated emergency healthcare system that recognizes problems, determines which services are needed and deliver a patient to those resources (right assessment, right care, right time, and right place.) The coordination of emergency care in Oregon will lead to better healthcare, through the establishment of regionalized systems of care. The legislation also includes a fee increase for the ambulance agency licensing and oversight program.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

Two tribes would be directly impacted by this package requiring payment of increased fees. Several Oregon cities and counties have licensed ambulance services that would be impacted by this package requiring payment of increased fees.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

None.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

The proposed fee increase described in this document would apply to all ambulance service agencies and ambulance vehicles licensed by and operating within the state and foster the state program to regulate care to vulnerable populations. By adequately surveying, licensing, and following up on complaints for all ambulance service agencies and ambulance vehicles helps to ensure that the most vulnerable populations' health and safety is protected and that they receive quality emergency and non-emergency care and transport. It also helps to ensure safe and reliable transport for rural and low-income communities.

Staffing and fiscal impact

Implementation date(s): January 1, 2022

End date (if applicable): Ongoing

15. What assumptions affect the pricing of this policy package?

The pricing of this policy package was established by projecting expenditures vs. revenues needed to support current service levels. This pricing reflects 18 months of additional fee revenue.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

No new responsibilities are being proposed.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

No.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No .

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

No new staff are needed nor will existing positions be modified.

20. What are the start-up and one-time costs?

No start-up costs will be incurred.

21. What are the ongoing costs?

Current personal services and supply costs will continue and are ongoing.

22. What are the potential savings?

No potential savings have been identified.

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

Other Funds limitation requested to support increased revenue from fees paid by ambulance licensees.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services						
Services & Supplies		$106,237		$106,237		
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$106,237**	**$0**	**$106,237**	**0**	**0.00**

Fiscal impact by program

	Center for Health Protection				Total
General Fund	$0				**$0**
Other Funds	$106,237				**$106,237**
Federal Funds	$0				**$0**
Total Funds	$106,237				**$106,237**
Positions	0				**0**
FTE	0.00				**0.00**

Oregon Health Authority
2021-23 Policy Package

Division:	Public Health Division
Program:	Health Care Regulation and Quality Improvement (HCRQI)
Policy package title:	Home Health Agencies Licensing Fees
Policy package number:	451
Related legislation:	House Bill 2072 (2021)

Summary statement:

This policy package increases home health agency licensure fees to support existing regulatory and complaint investigation activities and to ensure the quality of client care provided by home health agencies. This policy package is dependent upon the passage of the proposed legislation (House Bill 2072). Failure to approve the fee increase would jeopardize the program's ability to meet its statutory obligations including on-site initial and relicensure survey and complaint investigation requirements and may place persons at increased risk of unsafe or ineffective care. It would also jeopardize the program's ability to maintain a fiscally sustainable budget, which is necessary for the program to meet the agency's overall fiscal and operational goals.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$51,265**	**$0**	**$51,265**	**0**	**0.00**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

The Oregon Health Authority's Health Care Regulation and Quality Improvement Section is responsible for the licensure, certification and oversight of multiple non-long-term care health care facilities, including those defined in ORS chapters 442 and 443. These regulated facilities include home health agencies which the Authority is responsible for ensuring the quality of client care, complaint investigations and triennial surveys. The Authority uses licensing fees to recover the costs of these regulatory functions. Revenues generated from these licensing fees no longer support the cost of associated regulatory works. Fees have not been increased since 2009.

The Authority has 67 licensed home health agencies that serve patients across Oregon. As the number of licensees increase and the client population increases in size, the amount of work necessary to ensure safe, home-based medical nursing services and therapeutic services increases.

This policy package proposes to raise both initial and renewal licensing fees for home health agencies established in ORS 443.035 as follows:

- Initial licensing fee from $1,600 to $4,000
- Renewal licensing fee from $850 to $2,125
- Change of ownership fee from $500 to $1,250

2. What would this policy package buy and how and when would it be implemented?

Funding will be used to support current service levels, permanent staff and operating costs. Current services include onsite complaint investigations, initial licensure surveys, routine onsite relicensure surveys, and technical support services expected by licensees, clients and other interested parties including the public.

3. How does this policy package further OHA's mission and align with its strategic plan?

The Authority's Health Care Regulation and Quality Improvement Section furthers the agency's mission and strategic plan by providing regulatory oversight of prospective and currently licensed home health agencies. These activities directly improve the health and safety of all clients by ensuring that home health services are safe, equitable and comply with current regulatory standards.

Oregon home health agencies provide services to vulnerable individuals in their home. Home health services are necessary to assist individuals in order to maintain these individuals in their homes and include skilled medical nursing services and other therapeutic services that impact clients' ability to maintain and improve health in a comfortable and familiar setting.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

The agency will measure the success of this policy package by the percentage of surveys completed that satisfy applicable state performance measures.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

No.

7. What are the long-term desired outcomes?

Sustain current service levels, meet statutory and rule-based regulatory requirements, complete onsite survey work and complaint investigations appropriately, and provide accurate and timely technical guidance to licensees and other interested parties.

8. What would be the adverse effects of not funding this policy package?

Failure to increase home health licensure fees would jeopardize the program's ability to meet its statutory obligations including on-site initial and relicensure survey and complaint investigation requirements and may place vulnerable patients at increased risk of unsafe or ineffective care in their homes. It would also jeopardize the program's ability to maintain a fiscally sustainable budget, which is necessary for the program to meet the agency's overall fiscal and operational goals.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

The program has maintained the current service level, but as the number of home health agencies increases, this will be unsustainable.

10. What alternatives were considered and what were the reasons for rejecting them?

The program considered several alternatives in lieu of the proposed fee increase, including:

- Imposing a limit on the type of regulatory requirements reviewed during required relicensure and/or initial licensure surveys.
- Imposing a limit on the type of complaint investigations that the program would agree to investigate.
- Reducing the frequency of required relicensure surveys in violation of statutory requirements.

- Reducing the frequency of complaint investigations.
- Reducing the scope of regulatory activities performed for other types of health care facilities regulated by the program.
- Increasing travel and workload requirements for existing staff.

Each of these solutions was determined to either jeopardize the program's ability to ensure that licensed Home Health Agencies meet existing regulatory standards or failed to reduce the program's overall Home Health Agency operational costs.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

Yes. Amendments will need to be made to ORS 443.035.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

None.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

The stakeholder engagement plan will be developed with government relations team. We will start with these organizations and add additional stakeholders as they arise.

- Oregon Hospice and Palliative Care Association
- Oregon Health Care Association
- Leading Age Oregon
- Oregon Rural Health Association

- OHA – Health Systems Division (for purposes of OHP home health services program)
- DHS – Home Care Commission
- Coordinated care organizations (CCO)
- Licensed HH agencies

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

There are no known racial or ethnic inequities associated with this policy package. The proposed fee increase described in this document would apply equally to all home health agencies licensed by and operating within the state and foster the state program to regulate care to vulnerable populations.

Staffing and fiscal impact

Implementation date(s): January 1, 2022

End date (if applicable): Ongoing

15. What assumptions affect the pricing of this policy package?

The pricing of this policy package was established by projecting expenditures vs. revenues needed to support current service levels.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

No.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

No.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

No new staff are needed nor will existing positions be modified.

20. What are the start-up and one-time costs?

No start-up costs will be incurred.

21. What are the ongoing costs?

Current personal services and supply costs will continue and are ongoing.

22. What are the potential savings?

No potential savings have been identified.

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

Other Funds limitation request to support increased revenue from fees paid by Health Care Regulation and Quality Improvement licensees.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services						
Services & Supplies		$51,265		$51,265		
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$51,265**	**$0**	**$51,265**	**0**	**0.00**

Fiscal impact by program

	Center for Health Protection				Total
General Fund	$0				**$0**
Other Funds	$51,265				**$51,265**
Federal Funds	$0				**$0**
Total Funds	$51,265				**$51,265**
Positions	0				**0**
FTE	0.00				**0.00**

Oregon Health Authority
2021-23 Policy Package

Division:	Public Health Division
Program:	Health Licensing Office (HLO)
Policy package title:	Respiratory Therapist and Polysomnographic Technologist Licensing Board Fees
Policy package number:	452
Related legislation:	None

Summary statement:

The Respiratory Therapist and Polysomnographic Technologist Licensing Board licensing fees must be increased to cover the cost of licensing and regulating the board's professionals and protecting the public.

Without the increased revenue, the Health Licensing Office (HLO) will have insufficient staff to process applications timely and license practitioners to begin working in Oregon. HLO would also have insufficient staff to investigate complaints received relating to practitioners not following the regulating rules and statutes.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$232,342**	**$0**	**$232,342**	**0**	**0.00**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

The Respiratory Therapist and Polysomnographic Technologist Licensing Board licensing fees must be increased to cover the cost of regulating the board's professionals and protecting the public.

The Health Licensing Office (HLO) has been tasked by the Legislature with administering 16 boards and programs and regulating tens of thousands of licensees and dozens of professions. The Respiratory Therapist and Polysomnographic Technologist Licensing Board has over 2,200 licenses in respiratory care and polysomnography (sleep tech). Polysomnography is also referred to as a sleep study, which is a test used to diagnose sleep disorders.

The fees charged by the board have not changed since January 1, 2012. In 2013, House Bill 2074 moved the independent Oregon Health Licensing Agency under the Oregon Health Authority, creating the Health Licensing Office. This changed the indirect costs from funding in independent small agency to being part of Oregon Health Authority (OHA). HLO now contributes to OHA's and Public Health's cost allocation, which distributes shared costs among divisions. This increased the expenses to the board without an increase in fees to offset the additional expenditures. Each board pays these shared costs based on the number licenses provided by HLO and the services provided to licensees.

The board's current fees cannot sustain the program; revenue and expense forecasts predict the board to slip into a deficit in 2020 meaning that the board and HLO could not issue licensees to applicants in a timely manner and protect the public from potential health and safety violations. This would have an extremely negative impact not just on this board, but HLO, and the Legislature's mandate to protect the public would be compromised.

2. What would this policy package buy and how and when would it be implemented?

By increasing fees, the Respiratory Therapist and Polysomnographic Technologist Licensing Board's revenue could cover the cost of administering the program by licensing practitioners, administering qualifying exams, investigating complaints, and protecting the public.

HLO's successful model is for boards and programs license fees to sustain operations without needing general funds. For Respiratory Therapist and Polysomnographic Technologist Licensing Board to work in HLO's model, their fees must increase. The application, license and renewal fees will increase from $50 to $100 beginning January 1, 2022.

3. How does this policy package further OHA's mission and align with its strategic plan?

OHA's mission is to ensure all people and communities can achieve optimum physical, mental and social well-being through partnerships, prevention, and access to quality, affordable health care. The focus of the Health Licensing Office is on helping its applicants have healthy and safe communities and a thriving statewide economy.

Raising the Respiratory Therapist and Polysomnographic Technologist Licensing Board's fees would support the administration of the board, which is tasked with protecting the public from unqualified practitioners and practitioners violating health and safety requirements. The fee increase has a direct impact on the agency's ability to ensure public health and safety for people that receive services by these licensees.

The board also oversees over two thousand licensees who depend on the license to make a living and contribute to the economy of Oregon.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

OHA will measure the success of the policy package through metrics associated with OHA performance measures. Specifically, with the foundational capabilities related to OP6 "Regulating & Ensuring Compliance" core processes and meeting timely Regulatory Compliant Investigations (2KOP6F) and completion of Inspections and Surveys (2KOP6G) performance metrics.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

This policy package allows achievement of OHA foundational capabilities related to OP6, "Regulating & Ensuring Compliance" core processes. Specifically, meeting timely Regulatory Complaint Investigations (2KOP6F) and completion of Inspections and Surveys (2KOP6G) performance metrics, including Regulatory Complaint Investigations, Inspections & Surveys.

7. What are the long-term desired outcomes?

The Respiratory Therapist and Polysomnographic Technologist Licensing Board's revenue will stabilize, the board will support itself, and HLO will continue its mission to protect Oregonians who receive services from these professionals. The revenue will cover the cost of administering the program by licensing practitioners, administering qualifying exams, investigating complaints, and protecting the public.

8. What would be the adverse effects of not funding this policy package?

The board will not have enough revenue to continue to operate efficiently. Without the needed revenue, HLO would have insufficient staff to process applications timely and license practitioners so they can begin working in Oregon. HLO would also have insufficient staff to investigate complaints received relating to practitioners not following the regulating rules and statutes.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

HLO is a cost-conscious organization, constantly streamlining and trying to reduce administrative costs. With the Respiratory Therapist and Polysomnographic Technologist Licensing Board, HLO began offering a fee discount effective January 2012 for renewing licenses online, as it takes less staff time to process online renewals but stopped offering the discount in in December 2019 to address the revenue shortfall. Unfortunately, the board's license volume is not showing enough growth that would boost revenue to cover expenditures.

10. What alternatives were considered and what were the reasons for rejecting them?

HLO has worked on streamlining administrative processes, however that has not reduced expenditures enough to allow the Respiratory Therapist and Polysomnographic Technologist Licensing Board to cover expenses with the current revenue.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

None.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

None.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

The revenue from this policy package will help ensure qualified Respiratory Therapists and Polysomnographic Technicians are able to provide medical services to all Oregonians.

Staffing and fiscal impact

Implementation date(s): January 1, 2022

End date (if applicable): Ongoing

15. What assumptions affect the pricing of this policy package?

Looking at the revenue and expenditure trends since the HLO moved under the authority of OHA and projected expenditures and revenue to cover the board costs. This proposal is a fee increase of approximately 90 percent across 18 distinct fees. The increase will be collected in two renewal cycles in the 2021-23 biennium and will offset a projected cash shortfall.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

16. Will there be new responsibilities for OHA?

No.

17. Will there be new responsibilities for or an impact on Shared Services?

No.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

No new positions would be needed, nor would the existing positions need to be modified. This policy package would maintain the current staffing levels.

20. What are the start-up and one-time costs?

None.

21. What are the ongoing costs?

Cost of administering the program.

22. What are the potential savings?

None.

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

Other Funds limitation requested to support increased revenue from fees paid by Respiratory Therapist and Polysomnographic Technician licensees.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services						
Services & Supplies		$232,342		**$232,342**		
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$232,342**	**$0**	**$232,342**	**0**	**0.00**

Fiscal impact by program

	Center for Protection				Total
General Fund	$0				**$0**
Other Funds	$232,342				**$232,342**
Federal Funds	$0				**$0**
Total Funds	$232,342				**$232,342**
Positions	0				**0**
FTE	0.00				**0.00**

Oregon Health Authority
2021-23 Policy Package

Division:	Public Health Division
Program:	Injury and Violence Prevention, Prescription Drug Monitoring Program
Policy package title:	Prescription Drug Monitoring Licensing Fees
Policy package number:	453
Related legislation:	House Bill 2074 (2021), House Bill 3440 (2017), House Bill 4124 (2016), House Bill 2257 (2019), House Bill 4143 (2018)

Summary statement:

Increase fees paid by each healthcare licensee to fund the Prescription Drug Monitoring Program (PDMP). Funding is necessary in order to maintain sufficient capacity for program operations and database functions. The PDMP fee impacts all licensees regardless of program registration or program use.

If alternate funding is not made available, the quality of the Oregon PDMP will decrease as the number of staff is decreased and emerging evidence-based services are not implemented. This will result in decreased PDMP use by prescribers and pharmacists and less informed prescribing.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$657,936**	**$0**	**$657,936**	**0**	**0.00**

Purpose

1. Why does OHA propose this policy package and what issue is OHA trying to fix or solve?

The Prescription Drug Monitoring Program (PDMP) is mandated by statute and is a crucial health care tool in Oregon that allows prescribers to ensure they are fully informed of the prescription history of their patients when prescribing controlled substances. The PDMP is continually customized and enhanced to align its practices with evidence best suited to addressing the evolving opioid epidemic and improve healthcare of Oregonians. As the program has grown, additional staff have been added to address requirements. These required enhancements and added staff have increased the cost of program operations. The $25 annual fee currently paid by Oregon healthcare licensees is not sufficient to sustain expenditures.

The fees for PDMP have not been raised since establishment of the program in 2009. Without a fee increase, revenue and expense projections for the 2021-23 biennium show expenses will exceed fee revenue.

2. What would this policy package buy and how and when would it be implemented?

This policy package would increase funding to the existing Prescription Drug Monitoring Program (PDMP) and ensure the current level of service and functionality is sustainable. This includes maintaining a fully staffed program to provide technical and user support and advanced analytics; and maintaining the high-quality Information Technology (IT) contract to provide the PDMP's primary functions. The requested fee increase is needed to cover the costs of operating the current program. The $25 fee paid by Oregon licensed prescribers and pharmacists as part of their licensing fees would be increased to $35 effective January 1, 2022.

3. How does this policy package further OHA's mission and align with its strategic plan?

The Oregon Public Health Division works to protect and promote lifelong health for all Oregonians and the communities where they live, work, play and learn. The opioid epidemic continues to impact the health of

Oregonians and the PDMP is a crucial tool in addressing it. As the epidemic continues to evolve, a robust PDMP tool will need to be customized and expanded. This policy package allows us to keep the PDMP in line with legislative mandates and with emerging best practices.

4. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Quantifying results

5. How will OHA measure the success of this policy package?

The policy package will be a success if OHA is able to fulfill the statutory requirement to provide prescribers with continuous access to the PDMP with full functionality and high-quality data.

The PDMP use metrics will be used to measure the success of this policy package by demonstrating the continued reliance and use of the PDMP by Oregon prescribers.

6. Is this policy package tied to a legislative Key Performance Measure (KPM) and/or an OHA performance measure? If yes, identify the performance measure(s).

Yes, it is tied to an OHA Performance Measure: Improve Population Health, OP5. Improving Individual and Population Health, Top prescribers in PDMP.

7. What are the long-term desired outcomes?

The long-term desired outcome is program sustainability and consistent fulfillment of the legislative mandates to maintain the program and have it available to prescribers. The program will continue to pursue grant funding

to supplement the program budget, however, this fee increase can provide a reliable, sustainable and uninterrupted funding source for daily operations that it not limited to time and project specific federal grants.

8. What would be the adverse effects of not funding this policy package?

If alternate funding is not made available, the quality of the Oregon PDMP will decrease as the number of staff is decreased and emerging evidence-based services are not implemented. This will result in decreased PDMP use by prescribers and pharmacists and less informed prescribing.

How achieved

9. What actions have occurred to resolve the issue prior to requesting a policy package?

OHA completed a budget analysis and created PDMP budget revenue and expenditure projections to allow for a streamlined spending plan to be created. OHA has and continues to look for ways to cut costs. However, with the required enhancements to the PDMP costs will continue to grow.

10. What alternatives were considered and what were the reasons for rejecting them?

OHA continues to pursue additional grants to supplement the PDMP budget, however, grant funding is not guaranteed and is not a long-term solution to the program's anticipated budget deficit.

11. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

Yes, 431A.880 Licensing information; fees; rules.

12. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

Not applicable.

13. What other agencies, programs or stakeholders are collaborating on this policy package?

None.

14. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes?

The Prescription Drug Monitoring Program is a healthcare tool and assists providers in identifying those with substance use disorder, this policy will assist in maintaining this program.

Staffing and fiscal impact

Implementation date(s): January 1, 2022

End date (if applicable): Not applicable

15. What assumptions affect the pricing of this policy package?

Program operational costs will continue at current or increased level in the future, including current level of staffing and IT contract costs. All licensees are required to pay the fees as part of their renewal, and this assumes a steady number of licenses renewed yearly.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

16. Will there be new responsibilities for OHA? Specify which programs and describe their new responsibilities.

No.

17. Will there be new responsibilities for or an impact on Shared Services? If so, describe the impacts and indicate whether additional funding is necessary.

No.

18. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

19. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

No new position would be added. This policy would allow for sustainable funding for existing positions.

20. What are the start-up and one-time costs?

There will be no start-up costs in the 2021-23 biennium.

21. What are the ongoing costs?

The ongoing costs are personnel, services and supplies to maintain the program.

22. What are the potential savings?

There will be no direct cost savings for the agency by implementing this policy.

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

Other Funds limitation requested to support increased revenue from fees paid by Oregon healthcare licensees.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services						
Services & Supplies		**$657,936**		**$657,936**		
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$657,936**	**$0**	**$657,936**	**0**	**0.00**

Fiscal impact by program

	Center for Prevention and Health Promotion				**Total**
General Fund	$0				**$0**
Other Funds	$657,936				**$657,936**
Federal Funds	$0				**$0**
Total Funds	$657,936				**$657,936**
Positions	0				**0**
FTE	0.00				**0.00**

Oregon State Hospital Capital Improvement

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2019-21	$0.75	$0.75	$0.00	$1.51	0	0.00
Governor's Budget 2021-23	$0.79	$0.79	$0.00	$1.57	0	0.00
Difference	$0.03	$0.03	$0.00	$0.06	0	0.00
Percent Change	4%	4%	N/A	4%	N/A	N/A

Overview

The Oregon State Hospital proposes two capital improvement projects for the 2021-23 biennium: Equipment Replacement (policy package #422) and Remodel Therapy Tub Rooms (policy package #423). These projects would be financed with Article XI-Q Bonds issued October 2021 and May 2022 respectively.

Project costs and purpose

The costs described below are for the 2021-23 biennium. Following each project's implementation plan, all bond issuance is expected to occur during the 2021-23 biennium, with no additional financing required in future biennia. Debt service would end in the 2027-29 biennium for the Equipment Replacement project and would extend into the 2029-31 biennium for the Remodel Therapy Tub Rooms project. Debt service for both projects would be funded with General Fund.

The Equipment Replacement project, for the 2021-23 biennium, is expected to cost $1.1 million, which includes approximately $899,000 for project costs, $37,000 for bond issuance, and $158,000 for debt service, as estimated by the Department of Administrative Services (DAS). This project would address immediate large expenditure equipment lifecycle replacement in advance of equipment breakdown. Funding for asset lifecycle replacement would ensure maintenance of the facility to the highest standard and avoid more costly future maintenance, comply with regulatory requirements and stewardship of the state's assets, and a safe and secure environment and optimal treatment services.

Oregon State Hospital Capital Improvement

The Remodel Therapy Tub Rooms project, for the 2021-23 biennium, is expected to cost $728,000, which includes approximately $613,000 for both remodeling costs and a portion of a Construction Project Manager position; $37,000 for bond issuance; and $78,000 for debt service, as estimated by DAS. This project would include remodeling 24 existing therapy tub rooms on the hospital units that are no longer used for patients to create additional treatment space for staff to interact with patients. Currently, OSH plans to use the space for Interdisciplinary Teams to be able to meet with and treat patients.

ESTIMATED PROJECT COST

		$	% Project Cost	$/GSF
DIRECT CONSTRUCTION COSTS				
1	Building Cost Estimate	$ 1,385,300		
2	Site Cost Estimate (20 Ft beyond building footprint)			
3	**TOTAL DIRECT CONSTRUCTION COSTS**	$ 1,385,300	100%	$ -
INDIRECT CONSTRUCTION COSTS				
4	Owner Equipment / Furnishings / Special Systems			
5	Construction Related Permits & Fees			
6	Other Indirect Construction Costs Including 1% Art, 1.5% Renewable Energy and other state or unique regulatory requirements not in hard costs			
7	Architectural, Engineering Consultants			
8	Other Design and PM Costs	$ -		
9	**TOTAL INDIRECT COSTS**	$ -	$ -	$ -
10	**OWNER'S PROJECT CONTINGENCY** insert %			
		$	**% Project Cost**	**$/GSF**
	TOTAL PROJECT COST	$ 1,385,300	100%	$ -

Major Construction/Acquisition Project Narrative

Note: *Complete a separate form for each project*

Agency: 443	Oregon Health Authority - Oregon State Hospital	Priority (Agency #):	3	Schedule	
		Cost Estimate	Cost Est.Date	Start Date	Est. Completion
Project Name:	Potable water treatment and storage facility	$ 4,492,750		Nov 2021	Oct 2022
		GSF	# Stories	Land Use/Zoning Satisfied	
Address/Location:	2600 Center St NE, Salem, OR 97301			Y	N

Funding Source(s): Show the distribution of dollars by funding source for the full project cost.	General Fund	Lottery	Other	Federal
	$ -		$ 4,492,750	

Description of Agency Business/Master Plan and Project Purpose/Problem to be Corrected
OSH is an entirely self-contained facility except for backup water. OSH has one single point of connection to city water that is fed through a 1950's era 10" steel underground pipe. This leaves the hospital vulnerable to a complete loss of domestic water and water for sanitation including flushing toilets. In May of 2018 the City of Salem water supply was contaminated with Cyanotoxins from an algae bloom in Detroit lake and issued a water advisory for at risk individuals.OSH took immediate steps to provide bottled water to all patients and staff since many of our patients and staff could be in the vulnerable categories and all of their medical histories are not known and we needed to ensure that there was a safe source of potable water. We also had to provide thousands of gallons of potable water for cooking patient meals. The total cost of the event to the hospital was $81,882.00. The installation of a backup water system would also provide for sanitation in the event of a disruption of city water that could occur due to multiple reasons including contamination, waterline repairs and or replacement and an earthquake event that could leave the hospital without water for an extended period. Loss of water for sanitation in a secure facility with 620 psychiatric patients and corresponding staff 24-7 would be catastrophic. Loss of water could also shut down critical systems such as cooling which would then lead to overheating server rooms that could damage or require shutting down critical computer systems.

Project Scope and Alternatives Considered
OSH commissioned the services of Affiliated Engineers NW, Inc in 2018 to complete a concept study, preliminary engineering and cost estimate and the study recommends a below grade water storage system in the non-historical area to the SE of the main campus supplemented by the existing well (with significant upgrades) at an estimated total construction cost of $4,380,000. A blackwater storage system was also studied but is a more expensive proposition and meets a less-likely need. The estimated construction cost for this system is $6,330,000 and is only recommended if OSH feels strongly that it meets a likely need. OSH is requesting funding for the potable water treatment and storage facility

ESTIMATED PROJECT COST

		$	% Project Cost	$/GSF
DIRECT CONSTRUCTION COSTS				
1	Building Cost Estimate	$ 4,492,750		
2	Site Cost Estimate (20 Ft beyond building footprint)			
3	**TOTAL DIRECT CONSTRUCTION COSTS**	$ 4,492,750	100%	$ -
INDIRECT CONSTRUCTION COSTS				
4	Owner Equipment / Furnishings / Special Systems			
5	Construction Related Permits & Fees			
6	Other Indirect Construction Costs Including 1% Art, 1.5% Renewable Energy and other state or unique regulatory requirements not in hard costs			
7	Architectural, Engineering Consultants			
8	Other Design and PM Costs	$ -		
9	**TOTAL INDIRECT COSTS**	$ -	$ -	$ -
10	**OWNER'S PROJECT CONTINGENCY** insert %			
		$	**% Project Cost**	**$/GSF**
	TOTAL PROJECT COST	$ 4,492,750	100%	$ -

Major Construction/Acquisition Project Narrative

Note: *Complete a separate form for each project*

Agency: 443	OHA - Oregon State Hospital	Priority (Agency #):	4	Schedule	
		Cost Estimate	Cost Est.Date	Start Date	Est. Completion
Project Name:	Renovation to increase office space	$ 1,733,586		Aug 2022	Jul 2023
		GSF	# Stories	Land Use/Zoning Satisfied	
Address/Location:	2600 Center St NE, Salem, OR 97301	2700		Y	N

Funding Source(s): Show the distribution of dollars by funding source for the full project cost.	General Fund	Lottery	Other	Federal
			$ 1,733,586	

Description of Agency Business/Master Plan and Project Purpose/Problem to be Corrected
The hospital has identified an administrative and program staff space shortage and have had to move staff and programs to the cottages on campus and have identified future space needs requiring additional staff space. OSH proposes the conversion of empty, useable overhead space in a storage area to a second floor. This new second floor would be designated for and built as additional office space to meet current and future needs.

Project Scope and Alternatives Considered
OSH Commissioned SRG architects to perform a feasibility study and budget proposal to infill an existing space within the secure perimeter that would add 2700 square feet of office space that would accommodate 32 staff and include a conference room, copy room, and unisex toilet room.

ESTIMATED PROJECT COST

		$	% Project Cost	$/GSF
DIRECT CONSTRUCTION COSTS				
1	Building Cost Estimate	$ 1,733,586	100%	$ 642
2	Site Cost Estimate (20 Ft beyond building footprint)			
3	**TOTAL DIRECT CONSTRUCTION COSTS**	$ 1,733,586	100%	$ 642
INDIRECT CONSTRUCTION COSTS				
4	Owner Equipment / Furnishings / Special Systems			
5	Construction Related Permits & Fees			
6	Other Indirect Construction Costs Including 1% Art, 1.5% Renewable Energy and other state or unique regulatory requirements not in hard costs			
7	Architectural, Engineering Consultants			
8	Other Design and PM Costs			
9	**TOTAL INDIRECT COSTS**	$ -	0%	$ -
10	**OWNER'S PROJECT CONTINGENCY** insert %			
		$	**% Project Cost**	**$/GSF**
	TOTAL PROJECT COST	$ 1,733,586	100%	$ 642

Capital Financing Six-Year Forecast Summary 2021-23

Agency: OHA - Oregon State Hospital

Agency #: 443

Provide amounts of agency financing needs for the 2021-23 biennium, by expected use and repayment source. Include proposed project amounts only (do not include debt service from either previously issued debt or from new debt issuance).

Use of Bond Proceeds	Bond Type: General Obligation Bonds	Bond Type: Revenue Bonds	Totals by Repayment Source	
Major Construction / Acquisition Projects				
General Fund Repayment	$ 11,724,386	$	$ 11,724,386	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Major Construction	$ 11,724,386	$ -	$ 11,724,386	
Equipment/Technology Projects over $500,000				
General Fund Repayment	$ 898,500	$	$ 898,500	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Equipment/Technology	$ 898,500	$ -	$ 898,500	
Debt Issuance for Loans and Grants				
General Fund Repayment	$ 272,114	$	$ 272,114	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Loans and Grants	$ 272,114	$ -	$ 272,114	
Total All Debt Issuance				
General Fund Repayment	$ 12,895,000	$ -	$ 12,895,000	GF
Lottery Funds Repayment	-	-	-	LF
Other Funds Repayment	-	-	-	OF
Federal Funds Repayment	-	-	-	FF
Grand Total 2021-23	$ 12,895,000	$ -	$ 12,895,000	

Capital Financing Six-Year Forecast Summary 2023-25

Agency: OHA - Oregon State Hospital

Agency #: 443

Provide amounts of agency financing needs for the 2023-25 biennium, by expected use and repayment source. Include proposed project amounts only (do not include debt service from either previously issued debt or from new debt issuance).

Use of Bond Proceeds	Bond Type: General Obligation Bonds	Bond Type: Revenue Bonds	Totals by Repayment Source	
Major Construction / Acquisition Projects				
General Fund Repayment	$	$	$ -	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Major Construction	$ -	$ -	$ -	
Equipment/Technology Projects over $500,000				
General Fund Repayment	$	$	$ -	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Equipment/Technology	$ -	$ -	$ -	
Debt Issuance for Loans and Grants				
General Fund Repayment	$	$	$ -	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Loans and Grants	$ -	$ -	$ -	
Total All Debt Issuance				
General Fund Repayment	$ -	$ -	$ -	GF
Lottery Funds Repayment	-	-	-	LF
Other Funds Repayment	-	-	-	OF
Federal Funds Repayment	-	-	-	FF
Grand Total 2023-25	$ -	$ -	$ -	

Capital Financing Six-Year Forecast Summary 2025-27

Agency: OHA - Oregon State Hospital

Agency #: 443

Provide amounts of agency financing needs for the 2025-27 biennium, by expected use and repayment source. Include proposed project amounts only (do not include debt service from either previously issued debt or from new debt issuance).

Use of Bond Proceeds	Bond Type: General Obligation Bonds	Bond Type: Revenue Bonds	Totals by Repayment Source	
Major Construction / Acquisition Projects				
General Fund Repayment	$	$	$ -	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Major Construction	$ -	$ -	$ -	
Equipment/Technology Projects over $500,000				
General Fund Repayment	$	$	$ -	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Equipment/Technology	$ -	$ -	$ -	
Debt Issuance for Loans and Grants				
General Fund Repayment	$	$	$ -	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Loans and Grants	$ -	$ -	$ -	
Total All Debt Issuance				
General Fund Repayment	$ -	$ -	$ -	GF
Lottery Funds Repayment	-	-	-	LF
Other Funds Repayment	-	-	-	OF
Federal Funds Repayment	-	-	-	FF
Grand Total 2025-27	$ -	$ -	$ -	

Major Construction/Acquisition 10-Year Plan, Lease Plans, Disposals

2021-23 Biennium

Agency Name: OHA - Oregon State Hospital

Proposed New Construction or Acquisition - *Complete for 5 Biennia*

Biennium	Priority	Concept/Project Name	Description	GSF	Position Count	General Fund	Other Funds	Lottery Funds	Federal Funds	Estimated Cost/Total Funds
2021-23	1	Deferred Maintenance	**Salem and Pendleton construction or renovation projects to restore infrastructure**	883,816	1928	1,385,300	-	-	-	1,385,300
2021-23	2	Automated Dispensing Cabinets	**Replacement of medication dispensing equipment**	1,081,858	2242	3,500,000	-	-	-	3,500,000
2021-23	3	Water Treatment	**Potable water treatment and storage facility**	861,858	1886	4,492,750	-	-	-	4,492,750
2021-23	4	Office Renovation	**Renovation to increase office space**	861,858	1886	1,733,586	-	-	-	1,733,586
2023-25										-
2025-27										-
2027-29										-
2029-31										-

Proposed Lease Changes over 10,000 RSF - *Complete for 5 Biennia*

Biennium		Location	Description/Use	Term in Years	Total RSF[2] +/- (added or eliminated)	USF[3]	Position Count[1]	Biennial $ Rent/RSF[2]	Biennial $ O&M[4]/RSF[2] not included in base rent payment	Total Cost / Biennium
					A	B	C	D	E	(D+E)*A
2021-23										-
2023-25										-
2025-27										-
2027-29										-
2029-31										-

Planned Disposal of Owned Facility

Biennium		Facility Name	Description
21-23		Pendleton	Demolition of Building #108 ($100,000)

Definitions:

Position Count: **1** Total Legislatively Approved Budget (LAB) Position Count assigned to (home location) each building or lease as applicable.

RSF **2** Rentable SF per BOMA definition. The total usable area plus a pro-rated allocation of the floor and building common areas within a building.

USF **3** Usable Square Feet per BOMA definition for office/administrative uses. Area of a floor occupiable by a tenant where personnel or furniture are normally housed plus building amenity areas that are convertible to occupant area and not required by code or for the operations of a building. If not known, estimate the percentage.

O&M **4** Total Operations and Maintenance Costs for facilities including all maintenance, utilities and janitorial.

Facilities Maintenance

Key drivers of facility needs and measuring demand

Oregon State Hospital is subject to standards set by the Centers for Medicaid and Medicare Services (CMS) and reviewed and accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). In addition to standard repair and maintenance of buildings and equipment, the hospital may be required to meet more stringent facilities requirements as determined by those governing bodies. These will be related to patient and staff safety, such as anti-ligature efforts.

The occupancy of the hospital is primarily determined by the judicial system. Periodic legislative changes impact the types and number of patients to be admitted to OSH. Depending on the changes in law, this can drive an increase or decrease to the facility demand, partially determined by the level of care required for new patient admissions and the associated adaptation of existing hospital space. Space requirements are therefore fluid. The measurement of space is done through monitoring of legislative and regulatory requirements, with associated increases or decreases to staffing dependent on shifting requirements and the needs of the patients.

Challenges over next 10 years

- Construction or renovation to ensure efficient hospital utilization and sustainability.
- Lifecycle replacement of high value equipment and assets.
- Responding to regulatory changes requiring facility improvements.
- Ensuring a 5- and 10-year equipment replacement cycle is maintained.
- Funding to develop life cycle costing, and budget for life cycles in advance of equipment breakdown.
- Ensure upgrades are made to equipment to extend life cycles.
- Above standard wear and tear of a facility partially occupied by persons not invested in long term facility care.

What is needed to meet challenges

- Receive budgetary funding adequate to meet these challenges.
- Ensure related technology resources are adequate and available.
- Update and maintain associated maintenance software.

Facilities Summary Report

2021-23 Biennium

Agency Name: **Oregon Health Authority**

Owned Facilities Over $1 million — **FY 2020 DATA**

Number of Facilities	21			
Current Replacement Value $ (CRV)	$ 501,259,117	Source	Risk	Risk or FCA
Gross Square Feet (GSF)	*927,733*			
Usable Square Feet (USF)	*675,451*	*Estimate/Actual*	*72.8*	% USF/GSF
Occupants Position Count (PC)	2284	**USF/PC**		

Owned Facilities Under $1 million

Number of Facilities	29
CRV	$ 9,995,456
GSF	64,967

Leased Facilities 0

Total Rentable SF			
Biennual Lease Cost			
Additional Costs for Lease Properties (O&M)			
Usable Square Feet (USF)	*Estimate/Actual*		% RSF/GSF
Occupants Position Count (PC)	**USF/PC**		

Definitions

CRV Current Replacement Value Reported to Risk ***or Calculated Replacment Value Reported from Facility Conditions Assessment (FCA)***

RSF Rentable SF per BOMA definition. The total usable area plus a pro-rated allocation of the floor and building common areas within a building.

USF Usable Square Feet per BOMA definition. Area of a floor occupiable by a tenant where personnel or furniture are normally housed plus building amenity areas that are convertible to occupant area and not required by code or for the operations of a building.
If not known, estimate precentage.

PC Legislatively Approved Budget (LAB) Position Count

O&M Total Operations and Maintenance Costs for facilities including all maintenence, utilities and janatorial.

Report

2021-23 Biennium

Agency Name: Oregon Health Authority

Facilities Operations and Maintenance (O&M) Budget

	2017-19 Actual	2019-21 LAB	2021-23 Budgeted	2023-25 Projected
Personal Service (Maintenance)	$11,657,322	$12,534,656	$13,798,776	$15,190,383
Services & Supplies (Maintenance)	$5,465,104	$4,431,279	$4,621,824	$4,820,562
O&M $/GSF (Maintenance)	$17.25	$17.09	$18.56	
Personal Service (Utilties & Janitorial)	$10,374,119	$11,815,663	$13,007,273	$14,319,056
Services & Supplies (Utilties & Janitorial)	$3,697,589	$3,932,636	$4,101,739	$4,278,114
O&M $/GSF (Utilities & Janitorial)	$14.18	$15.86	$17.23	

	General Fund	Lottery Fund	Other Funds	Federal Funds
O&M Estimated Fund Split %	90%		6%	4%

Non-PICS = .00725

Short and Long Term Deferred Maintenance Plan for Facilities Value Over $1M

	Current Value (2019)	Ten Year Projection	2021-23 Budgeted	2023-25 Projected
riorities 1-3 - Currently, Potentially and Not Yet Critical	$17,326,312	$15,355,356	$10,343,356	$10,225,091
priority 4 - Seismic & Natural Hazard				
Priority 5 - Moderization	$8,120,000	$8,120,000	$6,020,000	
Total Priority Need	$ 25,446,312.00	$ 23,475,356.00	$ 16,363,356.00	$ 10,225,091.46
Facility Condition Index (Need/CRV)	3.389%	3.00%	1.37%	1.00%

Assets Over $1M CRV	$501,259,117

Process/Software for routine maintenance (O&M)	
Process/Software for deferred maintenance/renewal	
Process for funding facilities maintenance	

STATE OF OREGON

DEPARTMENT OF ADMINISTRATIVE SERVICES

DATE: August 18, 2020

TO: Karen Jamieson

FROM: Rhonda Nelson, DAS CFO, Capital Finance Analyst

SUBJECT: **2021-23 XI-Q Request for Equipment Replacement**

The following information is intended to assist you in preparing an Agency Request Budget that incorporates funding for the Equipment Replacement project as outlined in your request dated May 15, 2020. In preparing the following estimate, we anticipated an October 2021 XI-Q bond sale (see attached estimated debt service & COI schedule for further details).

If you decide to move forward with this project a policy package will be required. The policy package should include the project costs, issuance costs and any 2021-23 debt service. Consult with your assigned Chief Financial Office (CFO) Analyst to determine the appropriate packages.

Category	Appropriated Fund	ORBITS Compt Srce #	Amount
Project Proceeds			
Revenue	3020 OF Capital Construction	0555 (GF Bonds)	$898,500
Expense - Capital Outlay	3020 OF Capital Construction	5XXX (Capital)	$898,500
Cost of Issuance			
Revenue	3400 OF Limited	0555 (GF Bonds)	$36,500
Expense - S&S	3400 OF Limited	4650 (Other S&S)	$36,500
Debt Service: 2021-23			
Revenue	8030 GF Debt Service	0050 (GF Appropriation)	$157,588
Expense - Principal	8030 GF Debt Service	7100 (Principal-Bonds)	$125,000
Expense - Interest	8030 GF Debt Service	7150 (Interest-Bonds)	$32,588

Over the life of the financing, your agency will be responsible for on-going financing costs such as fiscal agent fees, arbitrage calculation fees and an assessment for Oregon State Treasury (OST) Debt Management Division. The non-OST financial costs are estimated at $3,000/year for each bond sale. OST financial costs can be found in the Price List under OST assessments.

Please email me at Rhonda.nelson@oregon.gov or call me at (503) 378-8927 if you need additional information.

Attachment: Estimated Debt Service & COI Schedule

cc: Patrick Heath

STATE OF OREGON

DEPARTMENT OF ADMINISTRATIVE SERVICES

DATE: August 18, 2020

TO: Karen Jamieson

FROM: Rhonda Nelson, DAS CFO, Capital Finance Analyst

SUBJECT: **2021-23 XI-Q Request for Deferred Maintenance**

The following information is intended to assist you in preparing an Agency Request Budget that incorporates funding for the Deferred Maintenance projects as outlined in your request dated May 15, 2020. In preparing the following estimate, we anticipated an October 2021 XI-Q bond sale (see attached estimated debt service & COI schedule for further details).

If you decide to move forward with this project a policy package will be required. The policy package should include the project costs, issuance costs and any 2021-23 debt service. Consult with your assigned Chief Financial Office (CFO) Analyst to determine the appropriate packages.

Category	Appropriated Fund	ORBITS Compt Srce #	Amount
Project Proceeds			
Revenue	3020 OF Capital Construction	0555 (GF Bonds)	$1,385,300
Expense - Capital Outlay	3020 OF Capital Construction	5XXX (Capital)	$1,385,300
Cost of Issuance			
Revenue	3400 OF Limited	0555 (GF Bonds)	$39,700
Expense - S&S	3400 OF Limited	4650 (Other S&S)	$39,700
Debt Service: 2021-23			
Revenue	8030 GF Debt Service	0050 (GF Appropriation)	$191,943
Expense - Principal	8030 GF Debt Service	7100 (Principal-Bonds)	$130,000
Expense - Interest	8030 GF Debt Service	7150 (Interest-Bonds)	$61,943

Over the life of the financing, your agency will be responsible for on-going financing costs such as fiscal agent fees, arbitrage calculation fees and an assessment for Oregon State Treasury (OST) Debt Management Division. The non-OST financial costs are estimated at $3,000/year for each bond sale. OST financial costs can be found in the Price List under OST assessments.

Please email me at Rhonda.nelson@oregon.gov or call me at (503) 378-8927 if you need additional information.

Attachment: Estimated Debt Service & COI Schedule

cc: Patrick Heath

STATE OF OREGON

DEPARTMENT OF ADMINISTRATIVE SERVICES

DATE: August 18, 2020

TO: Karen Jamieson

FROM: Rhonda Nelson, DAS CFO, Capital Finance Analyst

SUBJECT: **2021-23 XI-Q Request for Automated Dispensing Cabinets**

The following information is intended to assist you in preparing an Agency Request Budget that incorporates funding for the Automated Dispensing Cabinets project as outlined in your request dated May 15, 2020. In preparing the following estimate, we anticipated an October 2021 XI-Q bond sale (see attached estimated debt service & COI schedule for further details).

If you decide to move forward with this project a policy package will be required. The policy package should include the project costs, issuance costs and any 2021-23 debt service. Consult with your assigned Chief Financial Office (CFO) Analyst to determine the appropriate packages.

Category	Appropriated Fund	ORBITS Compt Srce #	Amount
Project Proceeds			
Revenue	3020 OF Capital Construction	0555 (GF Bonds)	$3,500,000
Expense - Capital Outlay	3020 OF Capital Construction	5XXX (Capital)	$3,500,000
Cost of Issuance			
Revenue	3400 OF Limited	0555 (GF Bonds)	$55,000
Expense - S&S	3400 OF Limited	4650 (Other S&S)	$55,000
Debt Service: 2021-23			
Revenue	8030 GF Debt Service	0050 (GF Appropriation)	$474,497
Expense - Principal	8030 GF Debt Service	7100 (Principal-Bonds)	$320,000
Expense - Interest	8030 GF Debt Service	7150 (Interest-Bonds)	$154,497

Over the life of the financing, your agency will be responsible for on-going financing costs such as fiscal agent fees, arbitrage calculation fees and an assessment for Oregon State Treasury (OST) Debt Management Division. The non-OST financial costs are estimated at $3,000/year for each bond sale. OST financial costs can be found in the Price List under OST assessments.

Please email me at Rhonda.nelson@oregon.gov or call me at (503) 378-8927 if you need additional information.

Attachment: Estimated Debt Service & COI Schedule

cc: Patrick Heath

STATE OF OREGON

DEPARTMENT OF ADMINISTRATIVE SERVICES

DATE: August 18, 2020

TO: Karen Jamieson

FROM: Rhonda Nelson, DAS CFO, Capital Finance Analyst

SUBJECT: **2021-23 XI-Q Request for Well Water Treatment Facility**

The following information is intended to assist you in preparing an Agency Request Budget that incorporates funding for the Well Water Treatment Facility project as outlined in your request dated May 15, 2020. In preparing the following estimate, we anticipated an October 2021 XI-Q bond sale (see attached estimated debt service & COI schedule for further details).

If you decide to move forward with this project a policy package will be required. The policy package should include the project costs, issuance costs and any 2021-23 debt service. Consult with your assigned Chief Financial Office (CFO) Analyst to determine the appropriate packages.

Category	Appropriated Fund	ORBITS Compt Srce #	Amount
Project Proceeds			
Revenue	3020 OF Capital Construction	0555 (GF Bonds)	$4,492,750
Expense - Capital Outlay	3020 OF Capital Construction	5XXX (Capital)	$4,492,750
Cost of Issuance			
Revenue	3400 OF Limited	0555 (GF Bonds)	$62,250
Expense - S&S	3400 OF Limited	4650 (Other S&S)	$62,250
Debt Service: 2021-23			
Revenue	8030 GF Debt Service	0050 (GF Appropriation)	$484,129
Expense - Principal	8030 GF Debt Service	7100 (Principal-Bonds)	$250,000
Expense - Interest	8030 GF Debt Service	7150 (Interest-Bonds)	$234,129

Over the life of the financing, your agency will be responsible for on-going financing costs such as fiscal agent fees, arbitrage calculation fees and an assessment for Oregon State Treasury (OST) Debt Management Division. The non-OST financial costs are estimated at $3,000/year for each bond sale. OST financial costs can be found in the Price List under OST assessments.

Please email me at Rhonda.nelson@oregon.gov or call me at (503) 378-8927 if you need additional information.

Attachment: Estimated Debt Service & COI Schedule

cc: Patrick Heath

STATE OF OREGON

DEPARTMENT OF ADMINISTRATIVE SERVICES

DATE: August 18, 2020

TO: Karen Jamieson

FROM: Rhonda Nelson, DAS CFO, Capital Finance Analyst

SUBJECT: **2021-23 XI-Q Request for Additional Office Space**

The following information is intended to assist you in preparing an Agency Request Budget that incorporates funding for the Additional Office Space project as outlined in your request dated May 15, 2020. In preparing the following estimate, we anticipated a May 2022 XI-Q bond sale (see attached estimated debt service & COI schedule for further details).

If you decide to move forward with this project a policy package will be required. The policy package should include the project costs, issuance costs and any 2021-23 debt service. Consult with your assigned Chief Financial Office (CFO) Analyst to determine the appropriate packages.

Category	Appropriated Fund	ORBITS Compt Srce #	Amount
Project Proceeds			
Revenue	3020 OF Capital Construction	0555 (GF Bonds)	$1,733,586
Expense - Capital Outlay	3020 OF Capital Construction	5XXX (Capital)	$1,733,586
Cost of Issuance			
Revenue	3400 OF Limited	0555 (GF Bonds)	$41,414
Expense - S&S	3400 OF Limited	4650 (Other S&S)	$41,414
Debt Service: 2021-23			
Revenue	8030 GF Debt Service	0050 (GF Appropriation)	$157,772
Expense - Principal	8030 GF Debt Service	7100 (Principal-Bonds)	$100,000
Expense - Interest	8030 GF Debt Service	7150 (Interest-Bonds)	$57,772

Over the life of the financing, your agency will be responsible for on-going financing costs such as fiscal agent fees, arbitrage calculation fees and an assessment for Oregon State Treasury (OST) Debt Management Division. The non-OST financial costs are estimated at $3,000/year for each bond sale. OST financial costs can be found in the Price List under OST assessments.

Please email me at Rhonda.nelson@oregon.gov or call me at (503) 378-8927 if you need additional information.

Attachment: Estimated Debt Service & COI Schedule

cc: Patrick Heath

STATE OF OREGON

DEPARTMENT OF ADMINISTRATIVE SERVICES

DATE: August 18, 2020

TO: Karen Jamieson

FROM: Rhonda Nelson, DAS CFO, Capital Finance Analyst

SUBJECT: **2021-23 XI-Q Request for Remodel Therapy Tub Rooms**

The following information is intended to assist you in preparing an Agency Request Budget that incorporates funding for the Remodel Therapy Tub Rooms project as outlined in your request dated May 15, 2020. In preparing the following estimate, we anticipated a May 2022 XI-Q bond sale (see attached estimated debt service & COI schedule for further details).

If you decide to move forward with this project a policy package will be required. The policy package should include the project costs, issuance costs and any 2021-23 debt service. Consult with your assigned Chief Financial Office (CFO) Analyst to determine the appropriate packages.

Category	Appropriated Fund	ORBITS Compt Srce #	Amount
Project Proceeds			
Revenue	3020 OF Capital Construction	0555 (GF Bonds)	$612,750
Expense - Capital Outlay	3020 OF Capital Construction	5XXX (Capital)	$612,750
Cost of Issuance			
Revenue	3400 OF Limited	0555 (GF Bonds)	$37,250
Expense - S&S	3400 OF Limited	4650 (Other S&S)	$37,250
Debt Service: 2021-23			
Revenue	8030 GF Debt Service	0050 (GF Appropriation)	$78,032
Expense - Principal	8030 GF Debt Service	7100 (Principal-Bonds)	$60,000
Expense - Interest	8030 GF Debt Service	7150 (Interest-Bonds)	$18,032

Over the life of the financing, your agency will be responsible for on-going financing costs such as fiscal agent fees, arbitrage calculation fees and an assessment for Oregon State Treasury (OST) Debt Management Division. The non-OST financial costs are estimated at $3,000/year for each bond sale. OST financial costs can be found in the Price List under OST assessments.

Please email me at Rhonda.nelson@oregon.gov or call me at (503) 378-8927 if you need additional information.

Attachment: Estimated Debt Service & COI Schedule

cc: Patrick Heath

Major Construction/Acquisition Project Narrative

Note: *Complete a separate form for each project*

Agency: 443	Oregon Health Authority - Oregon State Hospital	Priority (Agency #):	2	Schedule	
		Cost Estimate	Cost Est.Date	Start Date	Est. Completion
Project Name:	Automated Dispensing Cabinet replacement	$ 3,500,000		Nov 2021	Apr 2023
	2600 Center St NE, Salem, OR 97301	GSF	# Stories	Land Use/Zoning Satisfied	
Address/Location:	29398 Recovery Way, Junction City, OR 97448			Y	N

Funding Source(s): Show the distribution of dollars by funding source for the full project cost.	General Fund	Lottery	Other	Federal
	$ -		$ 3,500,000	

Description of Agency Business/Master Plan and Project Purpose/Problem to be Corrected

The automated dispensing cabinets (ADCs) are the method by which drugs are dispensed at Oregon State Hospital. These devices are integrated with the electronic health record and control access to medications at the individual patient level. These devices promote patient safety by requiring a bar code scan of the medication prior to administration to ensure patients receive the correct medication, in the proper dosage, at the right time.

Oregon State Hospital currently has 41 ADCs deployed throughout patient care areas on the Salem and Junction City campuses. These devices were purchased in 2012 and are nearing the end of their 10-year service life. The ADCs each have a computer that uses the Windows 7 operating system, which is no longer supported by Microsoft or OIS. This lack of support increases risk for security as well as ongoing product support. The ADCs serve a mission critical function at OSH. Without these cabinets, OSH would be passing medication manually, requiring immediate hire of additional pharmacists and pharmacy assistants.

Project Scope and Alternatives Considered

Project scope would include procurement and roll-out of new machinery at the Salem and Junction City campuses. Because of the deemed security risk to state systems, the only viable alternative to this project is manual pharmaceutical dispensing, requiring additional Pharmacists to be available on each unit; which increases cost, time, and the risk of human error in medication distribution.

ESTIMATED PROJECT COST

DIRECT CONSTRUCTION COSTS				
		$	**% Project Cost**	**$/GSF**
1	Building Cost Estimate			
2	Site Cost Estimate (20 Ft beyond building footprint)			
3	**TOTAL DIRECT CONSTRUCTION COSTS**	$ -		$ -
INDIRECT CONSTRUCTION COSTS				
4	Owner Equipment / Furnishings / Special Systems	$ 3,500,000	100%	
5	Construction Related Permits & Fees			
6	Other Indirect Construction Costs Including 1% Art, 1.5% Renewable Energy and other state or unique regulatory requirements not in hard costs			
7	Architectural, Engineering Consultants			
8	Other Design and PM Costs	$ -		
9	**TOTAL INDIRECT COSTS**	$ 3,500,000	$ 1	$ -
10	**OWNER'S PROJECT CONTINGENCY** insert %			
		$	**% Project Cost**	**$/GSF**
	TOTAL PROJECT COST	$ 3,500,000	100%	$ -

Major Construction/Acquisition Project Narrative

Note: *Complete a separate form for each project*

Agency: 443	Oregon Health Authority - Oregon State Hospital	Priority (Agency #):	1	Schedule	
		Cost Estimate	Cost Est.Date	Start Date	Est. Completion
Project Name:	Deferred Maintenance	$ 1,385,300		Jan 2022	Jun 2025
	2600 Center St NE, Salem, OR 97301	GSF	# Stories	Land Use/Zoning Satisfied	
Address/Location:	2585 Westgate, Pendleton, OR 97801			Y	N

Funding Source(s): Show the distribution of dollars by funding source for the full project cost.	General Fund	Lottery	Other	Federal
	$ -		$ 1,385,300	

Description of Agency Business/Master Plan and Project Purpose/Problem to be Corrected

Oregon State Hospital (OSH) campuses in Salem and Pendleton have unfunded deferred maintenance that could result in health and safety issues for staff and patients if not resolved. Good stewardship of the state's resources is at the forefront of the building maintenance program at OSH to proactively maintain the state's assets and ensure compliance with Joint Commission and Centers for Medicare and Medicaid Services (CMS). We have seen the results of years of deferring maintenance resulting in loss of accreditation and deplorable conditions in the old hospital that was eventually demolished.

Maintaining critical operational continuity and providing 24-hour hospital level of care to patients needing intensive psychiatric treatment for severe and persistent mental illness is part of the mission of the Oregon Health Authority and Oregon State Hospital. Deferring critical maintenance is not an option in a hospital facility and can result in higher costs to replace or repair systems under emergency situations, health and safety issues for patients and staff, and loss of accreditation and CMS reimbursement.

Project Scope and Alternatives Considered

Construction or renovation project components and approximate costs:

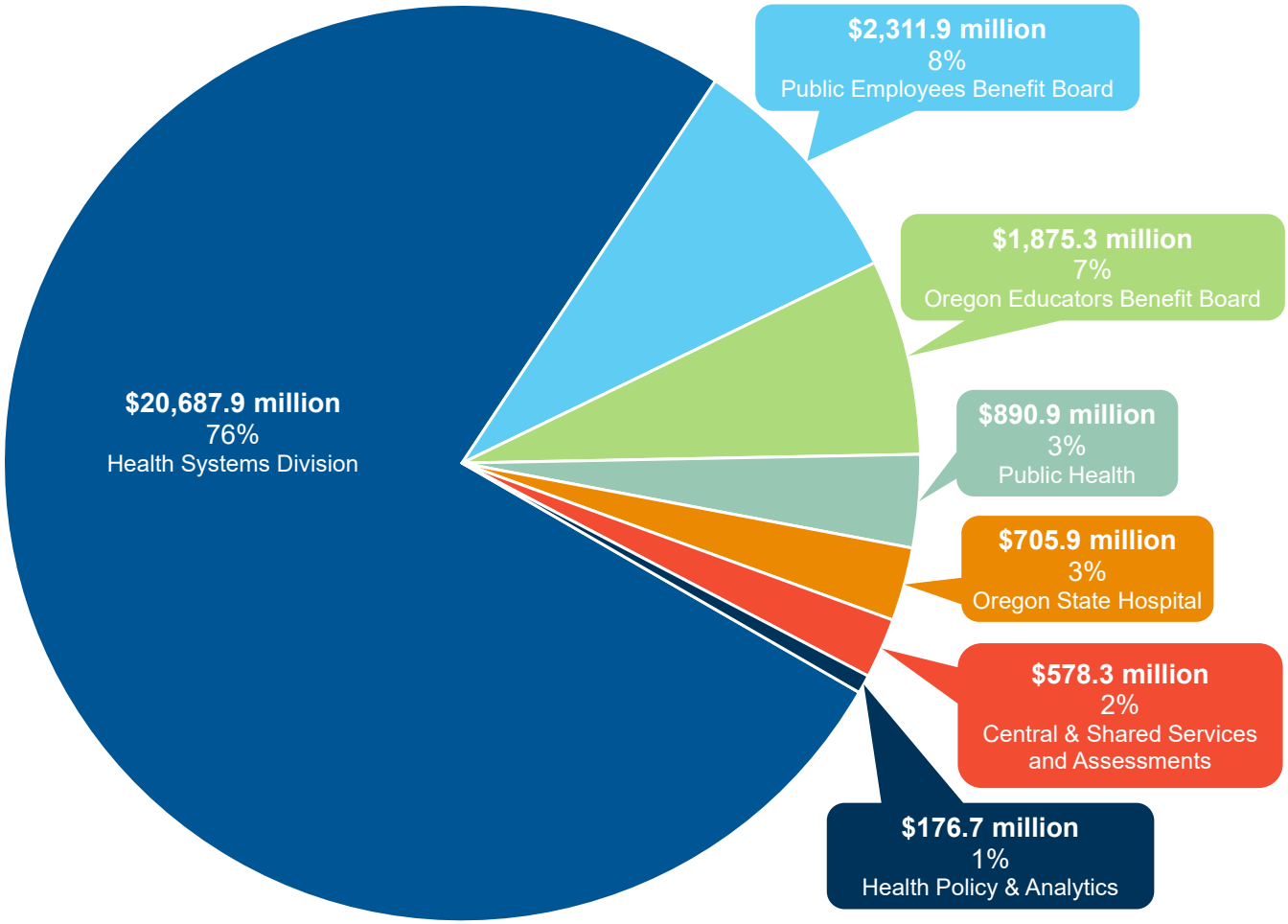
1.Salem backflow preventer system
2.Pendleton asphalt replacement
3.Pendleton concrete sidewalk replacement
4.Pendleton building demolish
5.Pendleton parking lot construction
6.Pendleton water damage repair

Where available, operations have treated scenarios as break/fix to restore to usable state. However, this continued deferral can no longer restore some infrastructure to operationality without greater attention. A specific example being the sidewalks on the Pendleton campus.

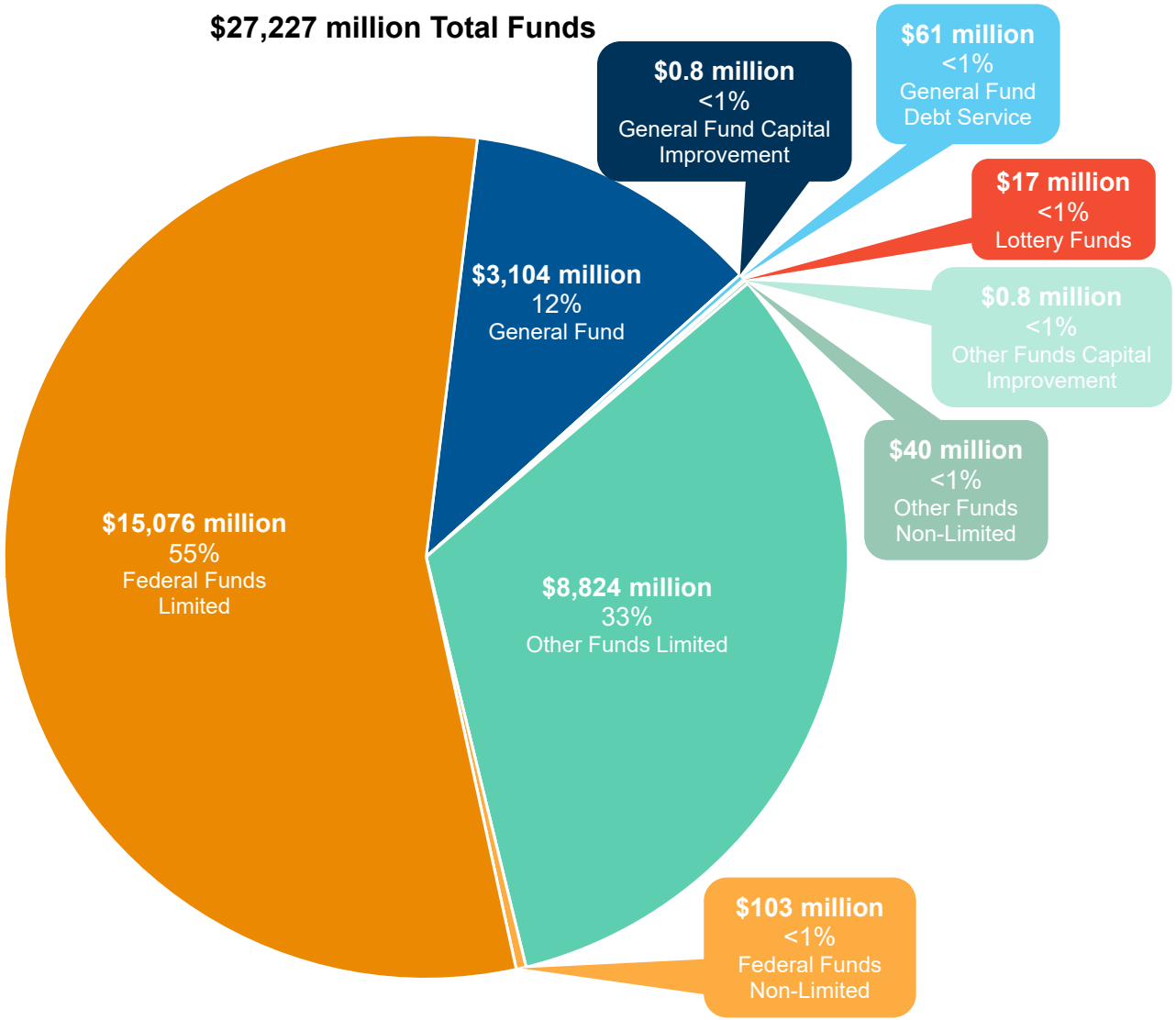
Deferring critical maintenance is not a truly viable option in a hospital facility and results in higher costs to replace or repair systems under emergency situations and could result in health and safety issues for patients and staff. Loss of accreditation and CMS funding is also a risk.

Oregon Health Authority
2021-23 Governor's Budget
By Program

$27,227 million Total Funds

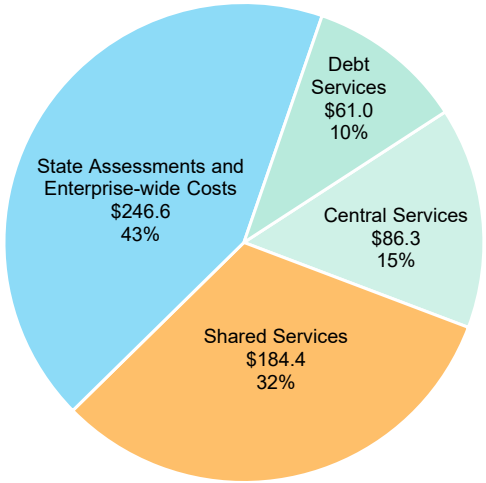


Oregon Health Authority
2021-23 Governor's Budget
By Fund Type

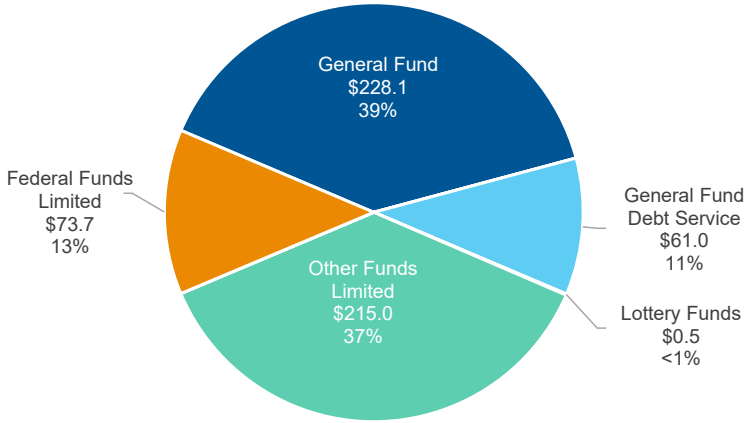


Oregon Health Authority
2021-23 Governor's Budget

Central & Shared Services, State Assessments and Enterprise-Wide Costs by Program
$758.3 million Total Funds

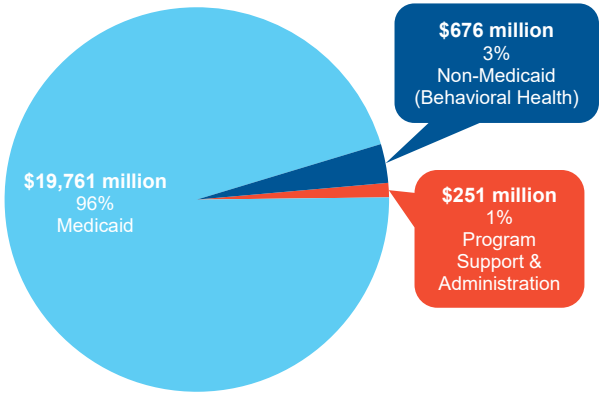


Central & Shared Services, State Assessments and Enterprise-Wide Costs by Program
$758.3 million Total Funds

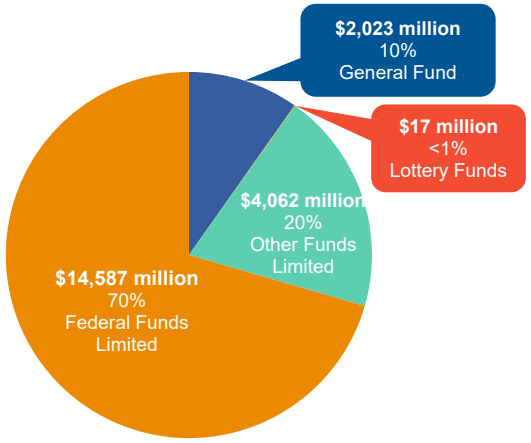


Oregon Health Authority
2021-23 Governor's Budget

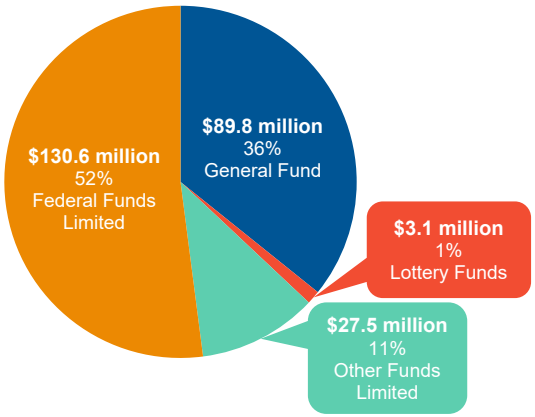
Health Systems Division by Program
$20,688 million Total Funds



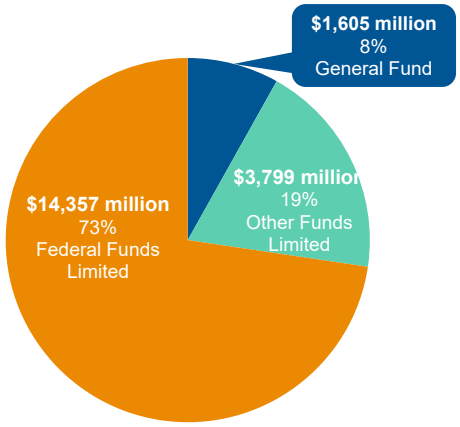
Health Systems Division by Fund Type
$20,688 million Total Funds



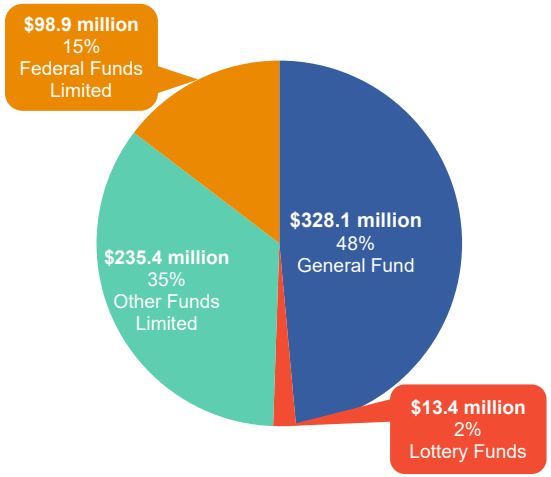
Program Support & Administration by Fund Type
$251.0 million Total Funds



Medicaid by Fund Type
$19,761.2 million Total Funds

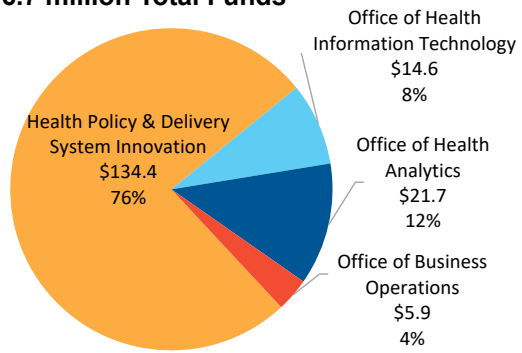


Non-Medicaid (Behavioral Health) by Fund Type
$675.8 million Total Funds

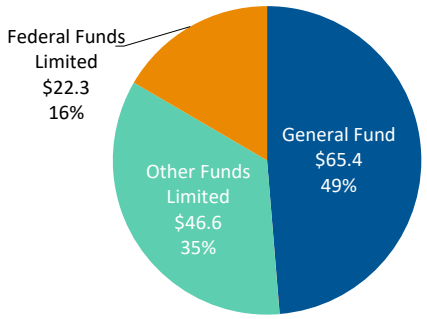


Oregon Health Authority
2021-23 Governor's Budget

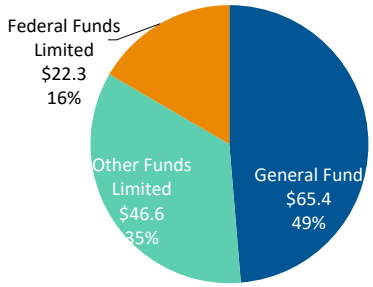
Health Policy & Analytics by Program
$176.7 million Total Funds



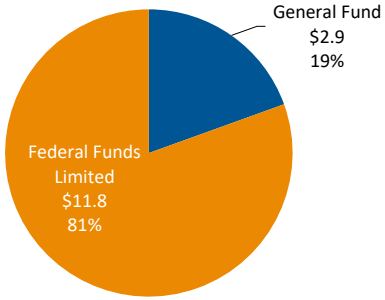
Health Policy & Analytics by Fund Type
$176.7 million Total Funds



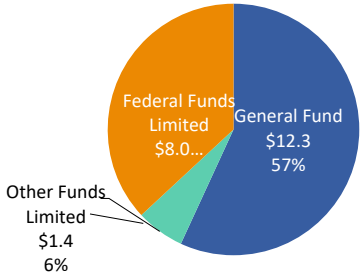
Health Policy & Delivery System Innovation by Fund Type
$134.4 million Total Funds



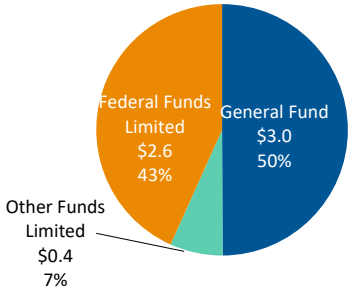
Office of Health Information Technology by Fund Type
$14.6 million Total Funds



Office of Health Analytics by Fund Type
$21.7 million Total Funds

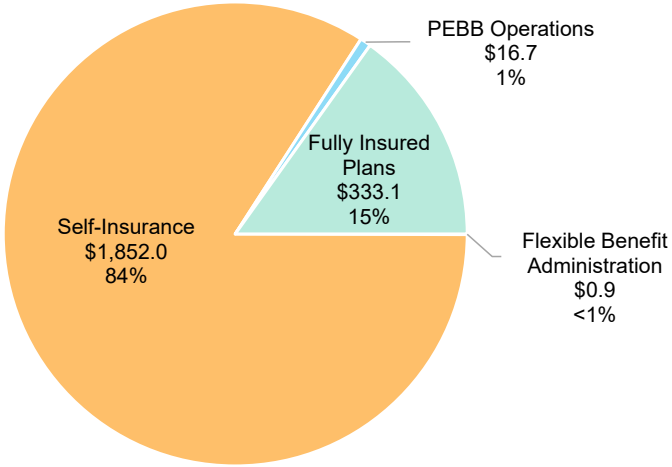


Office of Business Operations by Fund Type
$5.9 million Total Funds



Oregon Health Authority
2021-23 Governor's Budget

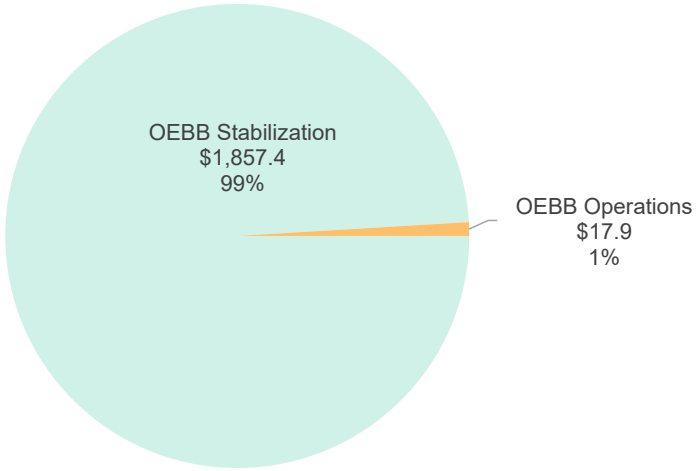
Public Employees' Benefit Board by Program
$2,311.9 million Total Funds



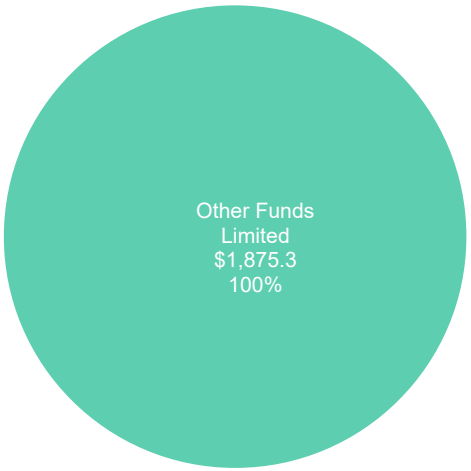
Public Employees' Benefit Board by Program
$2,311.9 million Total Funds

Oregon Health Authority
2021-23 Governor's Budget

Oregon Educators Benefit Board by Program
$1,875.3 million Total Funds

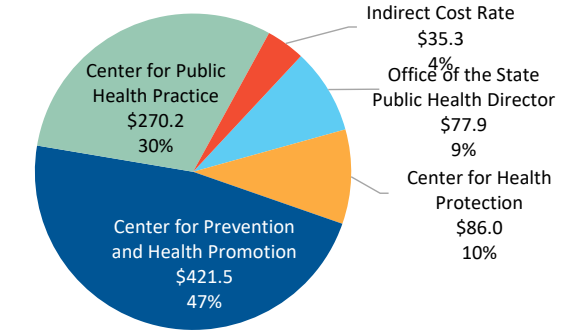


Oregon Educators Benefit Board by Program
$1,875.3 million Total Funds

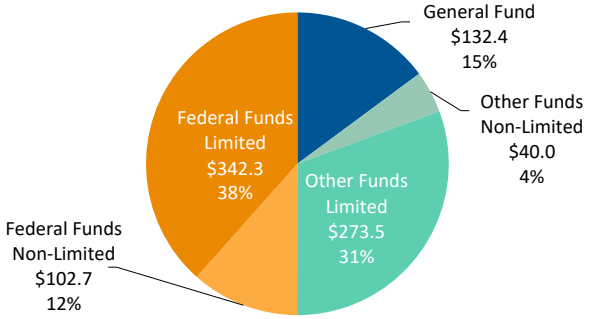


Oregon Health Authority
2021-23 Governor's Budget

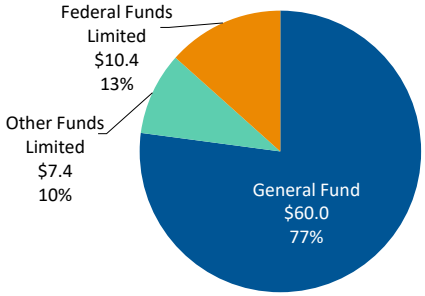
Public Health by Program
$890.9 million Total Funds



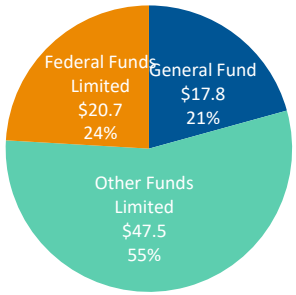
Public Health by Fund Type
$890.9 million Total Funds



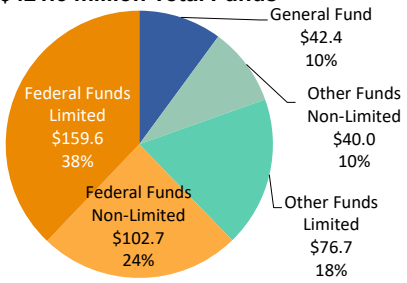
Office of the State Public Health Director by Fund Type
$77.9 million Total Funds



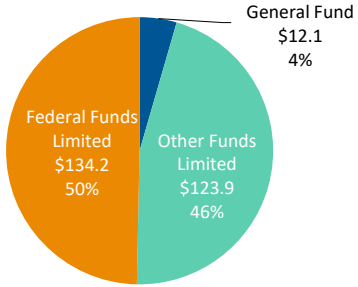
Center for Health Protection by Fund Type
$86.0 million Total Funds



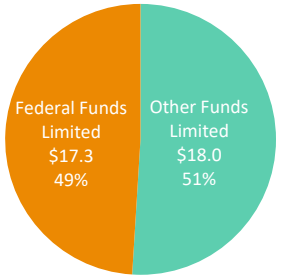
Center for Prevention & Health Promotion by Fund Type
$421.5 million Total Funds



Center for Public Health Practice by Fund Type
$270.2 million Total Funds

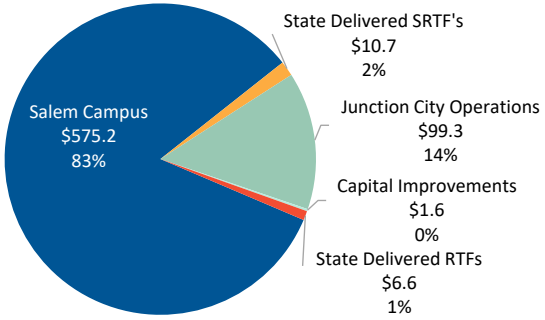


Indirect Cost Rate by Fund Type
$35.3 million Total Funds

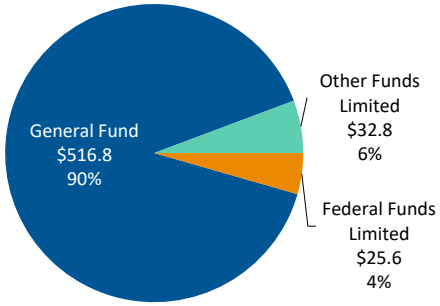


Oregon Health Authority
2021-23 Governor's Budget

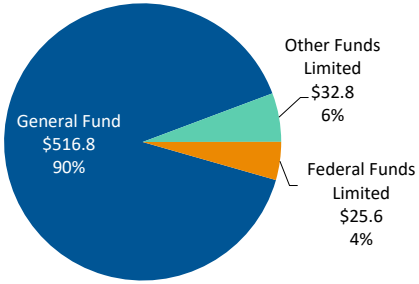
Oregon State Hospital by Program
$705.9 million Total Funds



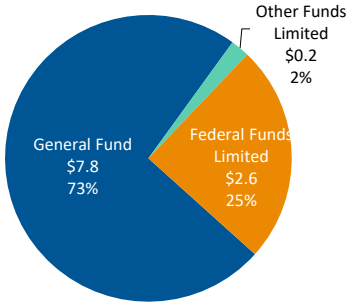
Oregon State Hospital by Fund Type
$705.9 million Total Funds



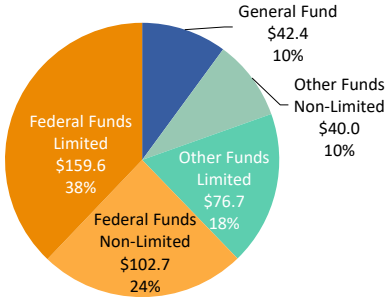
Salem Campus by Fund Type
$549.5 million Total Funds



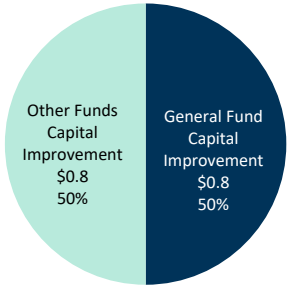
State Delivered SRTFs by Fund Type
$8.0 million Total Funds



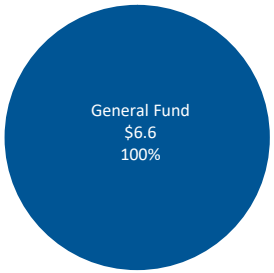
Junction City Operations by Fund Type
$261.9 million Total Funds



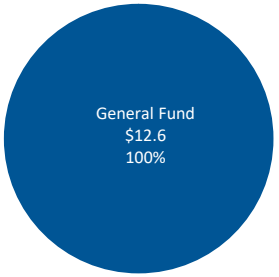
Capital Improvements by Fund Type
$1.6 million Total Funds



State Delivered RTFs by Fund Type
$6.6 million Total Funds



Capital Construction by Fund Type
$12.6 million Total Funds



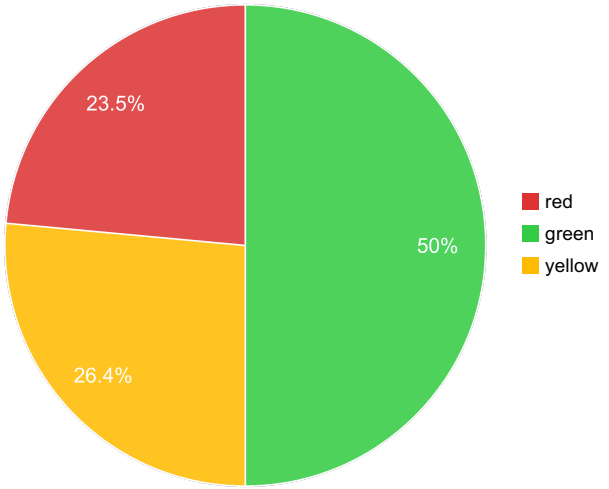
Oregon Health Authority

Annual Performance Progress Report

Reporting Year 2020

Published: 10/12/2020 5:08:00 PM

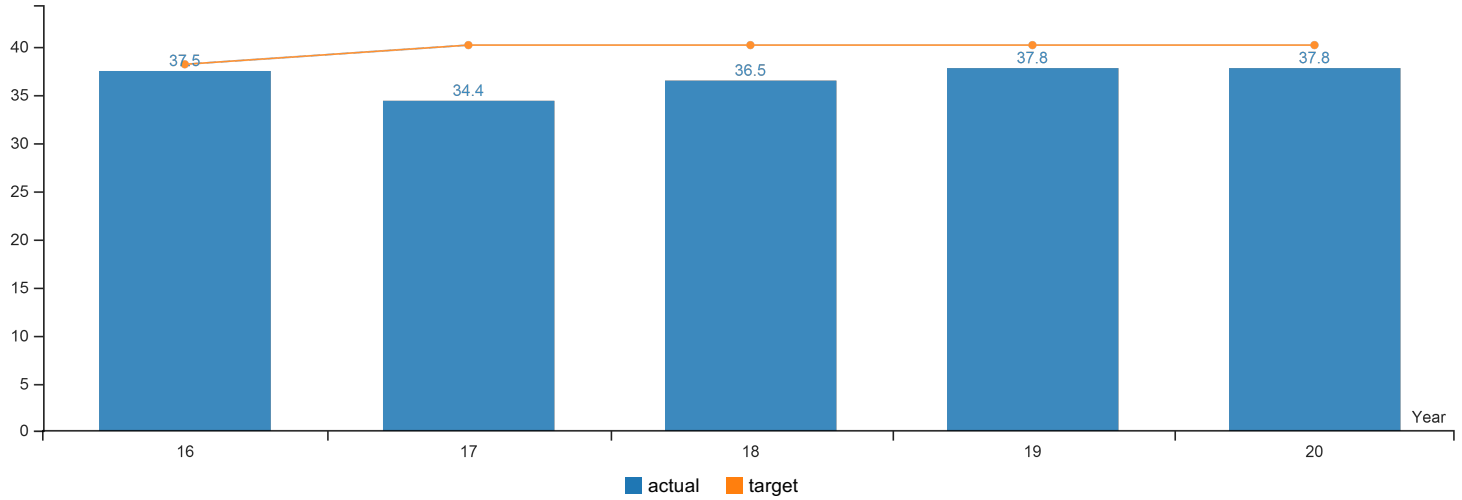
KPM #	Approved Key Performance Measures (KPMs)
1	INITIATION OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received initiation of AOD treatment within 14 days of diagnosis.
2	ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE 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	PQI 15: Asthma in Younger Adults Admission Rate -
20	ACCESS TO CARE - Percentage of members who responded "always" or "usually" too getting care quickly.
21	MEMBER EXPERIENCE OF CARE - Composite measurement: how well doctors communicate; health plan information and customer service (Medicaid population).
22	MEMBER HEALTH STATUS - Percentage of CAHPS survey respondents with a positive self-reported rating of overall health (excellent, very good, or good).
23	RATE OF TOBACCO USE (POPULATION) - Rate of tobacco use among adults.
24	RATE OF TOBACCO USE (MEDICAID) - Percentage of CCO enrollees who currently smoke cigarettes or use tobacco every day or some days.
25	RATE OF OBESITY (POPULATION) - Percentage of adults who are obese among Oregonians.
26	EFFECTIVE CONTRACEPTIVE USE (POPULATION) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
27	EFFECTIVE CONTRACEPTIVE USE (MEDICAID) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
28	FLU SHOTS (POPULATION) - Percentage of adults ages 50-64 who receive a flu vaccine.
29	CHILD IMMUNIZATION RATES (POPULATION) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
30	CHILD IMMUNIZATION RATES (MEDICAID) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
31	PLAN ALL CAUSE READMISSIONS - Percentage of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for members 18 years and older.
32	ELIGIBILITY PROCESSING TIME - Median number of days processing time from date of request to eligibility determination.
33	OHP MEMBERS IN CCOs - Percent of Oregon Health Plan members enrolled in Coordinated Care Organizations.
34	CUSTOMER SERVICE - Percentage of OHA customers rating their satisfaction with the agency's customer service as "good" or "excellent" overall, timeliness, accuracy, helpfulness, expertise, availability of information.



Performance Summary	Green	Yellow	Red
	= Target to -5%	= Target -5% to -15%	= Target > -15%
Summary Stats:	50%	26.47%	23.53%

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	2016	2017	2018	2019	2020
Initiation of alcohol and other drug dependence treatment					
Actual	37.50%	34.40%	36.50%	37.80%	37.80%
Target	38.20%	40.20%	40.20%	40.20%	40.20%

How Are We Doing

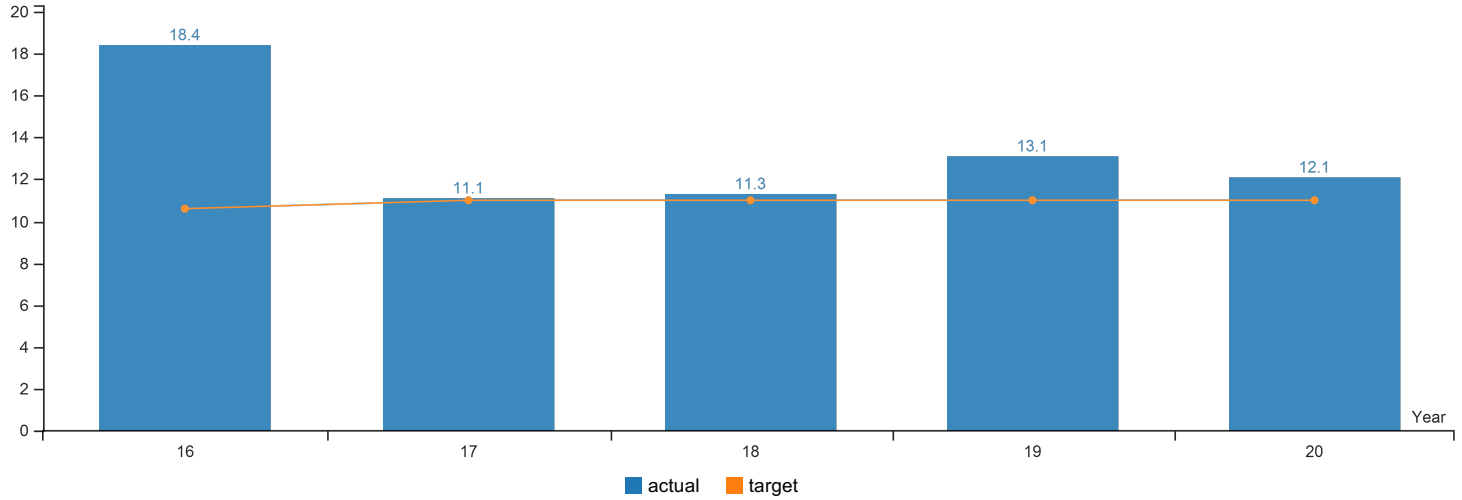
The percentage of members ages 13 and older newly diagnosed with alcohol or other drug dependencies who initiated treatment within 14 days increased from 2016-2018 (34.4% in 2016; 36.5% in 2017; and increasing to 37.8% in 2018). The percentage in 2019 was also 37.8%, but the measure methodology changed to include only members 18 and older. Therefore, 2019 is not directly comparable to previous years.

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. We may see improvement from 2020 on, as this was selected to be an incentive measure beginning in 2020, which will bring additional focus to this work.

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	2016	2017	2018	2019	2020
Engagement of alcohol and other drug dependence treatment					
Actual	18.40%	11.10%	11.30%	13.10%	12.10%
Target	10.60%	11%	11%	11%	11%

How Are We Doing

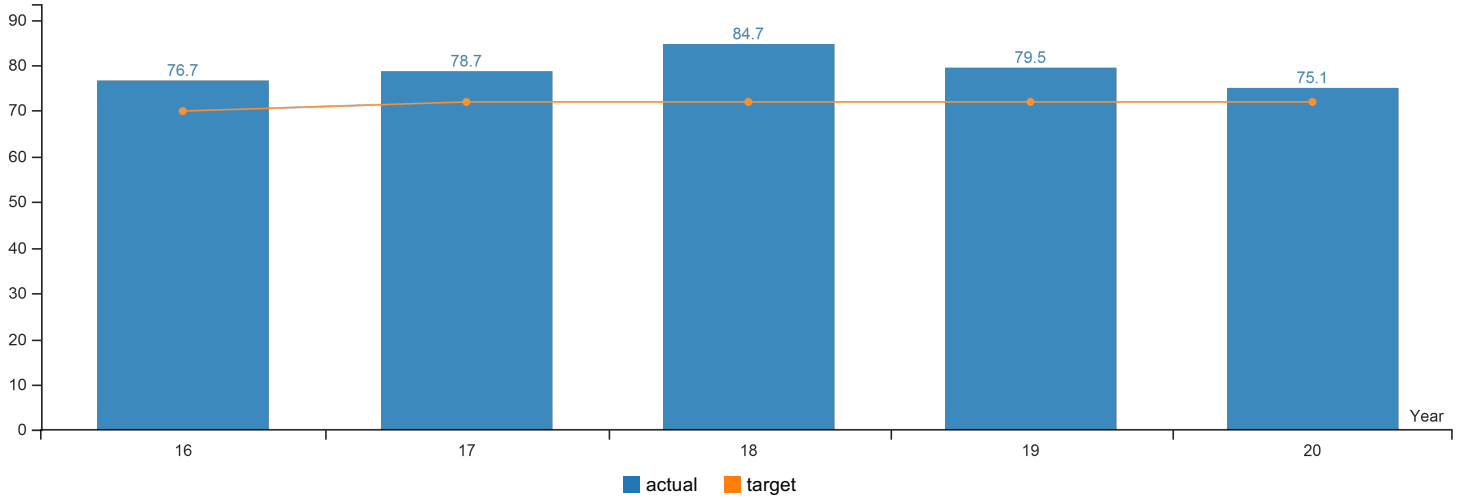
After a precipitous fall from 2013 to 2016 (from 18.9% to 11.1%), the percentage of members who continued their treatment improved from 2017 to 2018 (11.3% to 13.1%). However, this still represents a 39% decrease in statewide performance since 2013. The percentage in 2019 was 12.1%, but the measure methodology changed to include only members 18 and older. Therefore, 2019 is not directly comparable to previous years.

Factors Affecting Results

Nationally, performance on this measure is low, with a 2018 national Medicaid median of only 12.4%. We may see improvement from 2020 on in Oregon, as this was selected to be an incentive measure beginning in 2020, which will bring additional focus to this work.

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	2016	2017	2018	2019	2020
Follow-up after hospitalization for mental illness					
Actual	76.70%	78.70%	84.70%	79.50%	75.10%
Target	70%	72%	72%	72%	72%

How Are We Doing

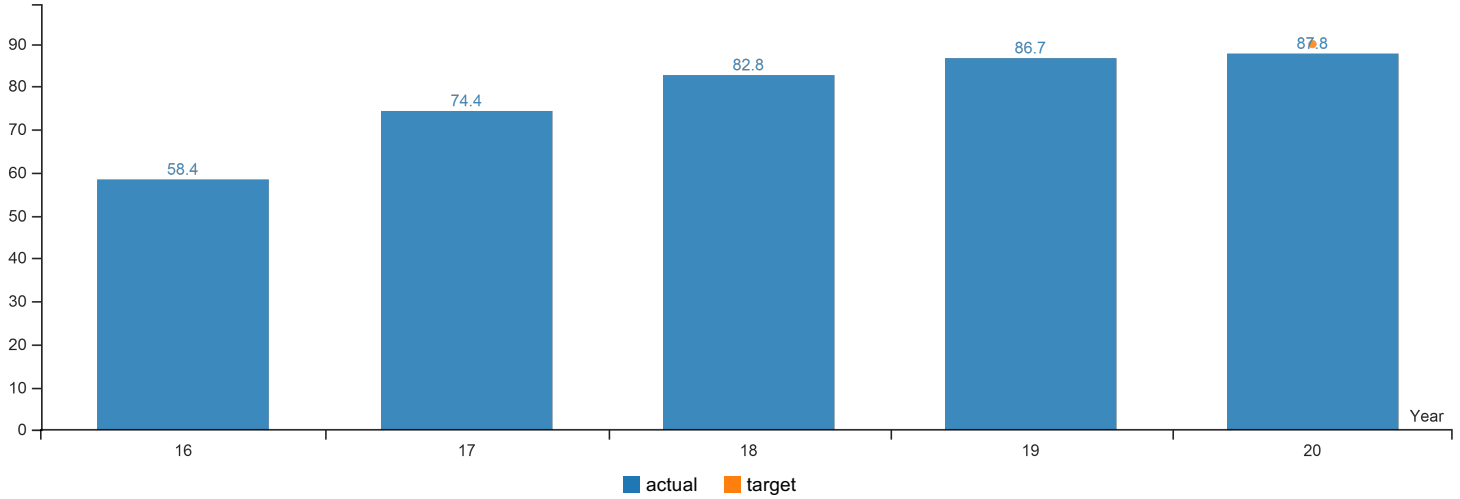
In 2019, 75.1% of CCO members (ages 6 and older) who were admitted to the hospital for mental illness received follow-up with a health care provider within seven days of discharge. This is a decline of 4.4 percentage points from 2018, when the rate was 79.5%, and the second year in a row in which we have seen a decline.

Factors Affecting Results

This measure used to be in the CCO Quality Incentive Program, for which CCOs earned incentive payments based on performance; however, in 2018 the public Metrics & Scoring Committee retired it from the incentive program. This measure should be monitored to determine if this two year decline reflects a real decline in care, or if other factors account for this change.

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	2016	2017	2018	2019	2020
MENTAL, PHYSICAL, AND DENTAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY					
Actual	58.40%	74.40%	82.80%	86.70%	87.80%
Target	TBD	TBD	TBD	TBD	90%

How Are We Doing

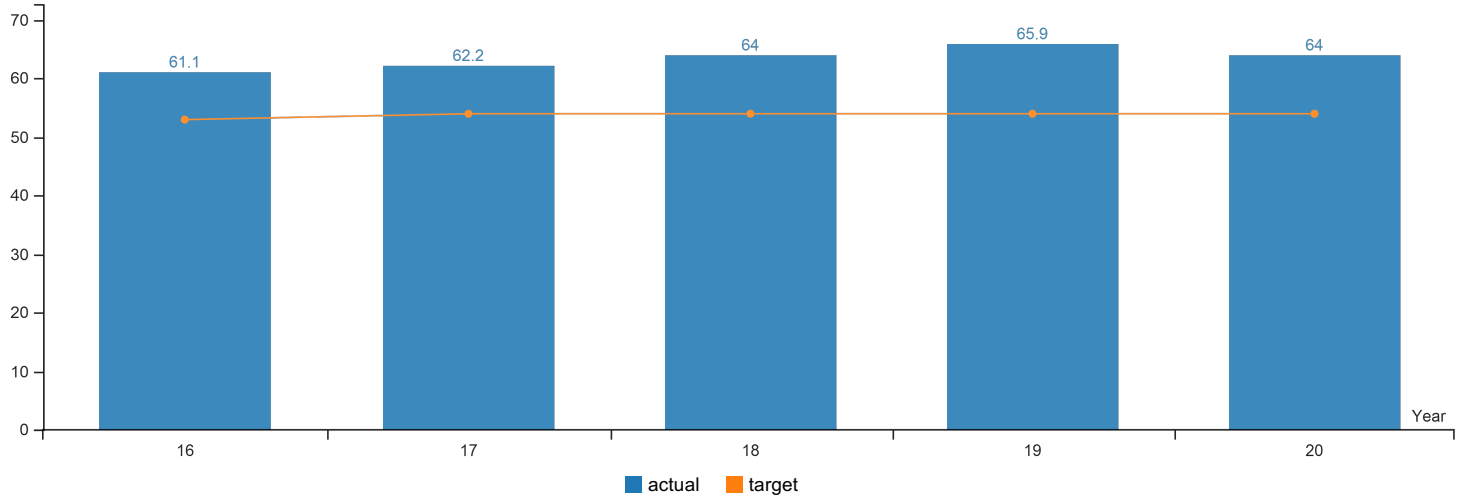
The percentage of children in foster care who received mental, physical, and dental health assessments continues to increase. CCO performance on this measure has improved by over 200% since the measure was first included in the CCO Quality Incentive Program, increasing from 27.9% in 2014 to 87.8% in 2019.

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	2016	2017	2018	2019	2020
Follow-up care for children prescribed with ADHD medication (initiation)					
Actual	61.10%	62.20%	64%	65.90%	64%
Target	53%	54%	54%	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 through 2018 (65.9%), and then declined in 2019 to 64.0%. Oregon is above the national 90th percentile for Medicaid.

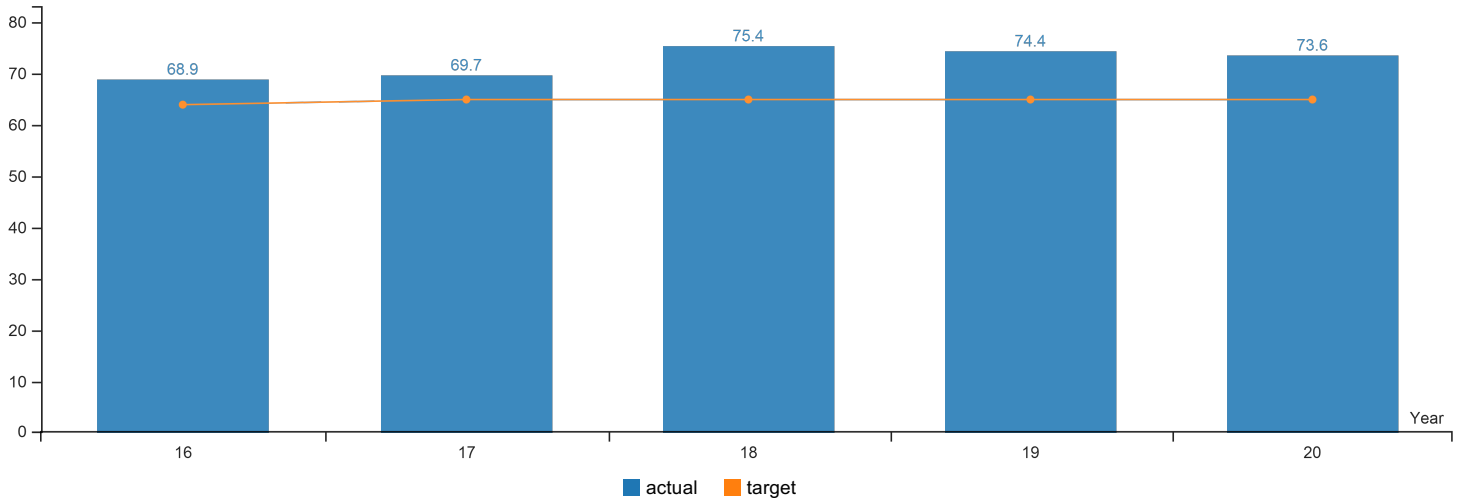
NOTE: This measure was included in the CCO Quality Incentive Program, for which CCOs can earn incentive payments based upon performance improvements, in 2013 and 2014.

Factors Affecting Results

We have heard from providers that limiting the follow up visit to within the first 30 days is not well aligned with some of the current ADHD medications, which may require a 45 day initial prescription. Children with these longer initial prescriptions would fall outside of the 30 day window for this measure.

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	2016	2017	2018	2019	2020
Follow-up care for children prescribed with ADHD medication (continuation and maintenance)					
Actual	68.90%	69.70%	75.40%	74.40%	73.60%
Target	64%	65%	65%	65%	65%

How Are We Doing

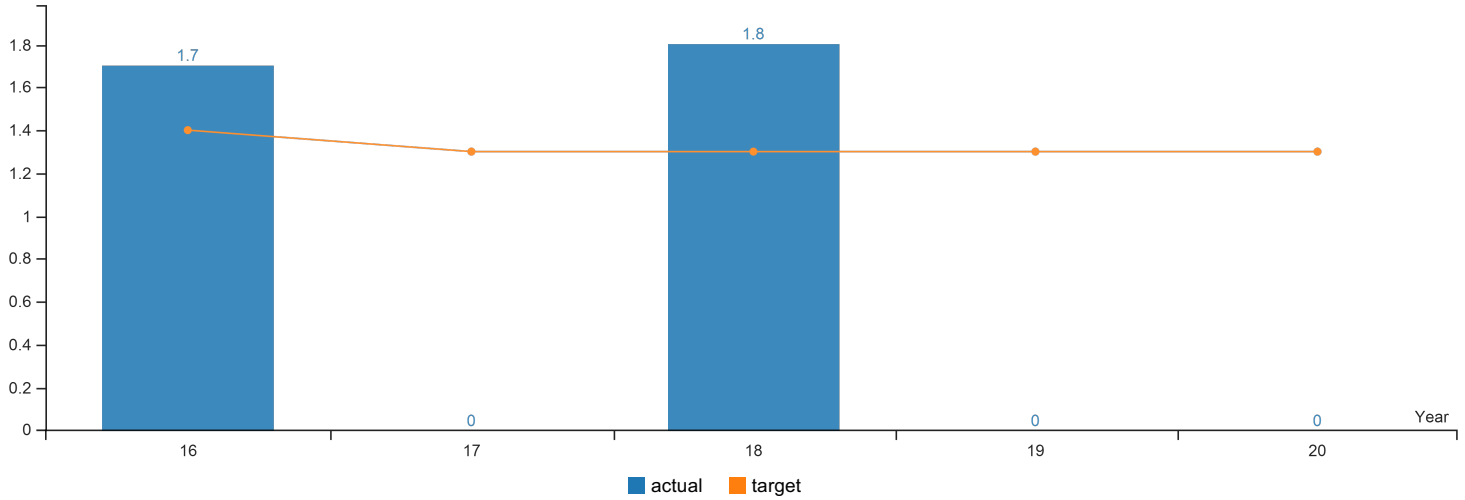
Calendar year 2011 is the baseline for this measure. In 2011, 61.0% of children who remained on ADHD medication for 210 days after receiving a new prescription also had at least two follow up visits with a provider. This rate remained fairly steady in CY's 2013 and 2014, and increased notably in CY2015, with 68.9% of children receiving continued follow-up with a provider. In CY2019 the rate was 73.6%; this is a decline in performance from CY2018, when performance was 74.4%.

Factors Affecting Results

A number of CCO incentive measures as well as initiatives including the patient-centered primary care home model put greater emphasis on preventive care and well child visits. These efforts may result in children being more likely to engage with their primary care providers, leading to greater follow-up care for children prescribed medications for their ADHD. This measure is also notable for small denominators across the CCOs (with some having fewer than 30 children that meet these criteria); data shifts are more likely given these small numbers.

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	2016	2017	2018	2019	2020
30 day illicit drug use among 6th graders					
Actual	1.70%	No Data	1.80%	No Data	No Data
Target	1.40%	1.30%	1.30%	1.30%	1.30%

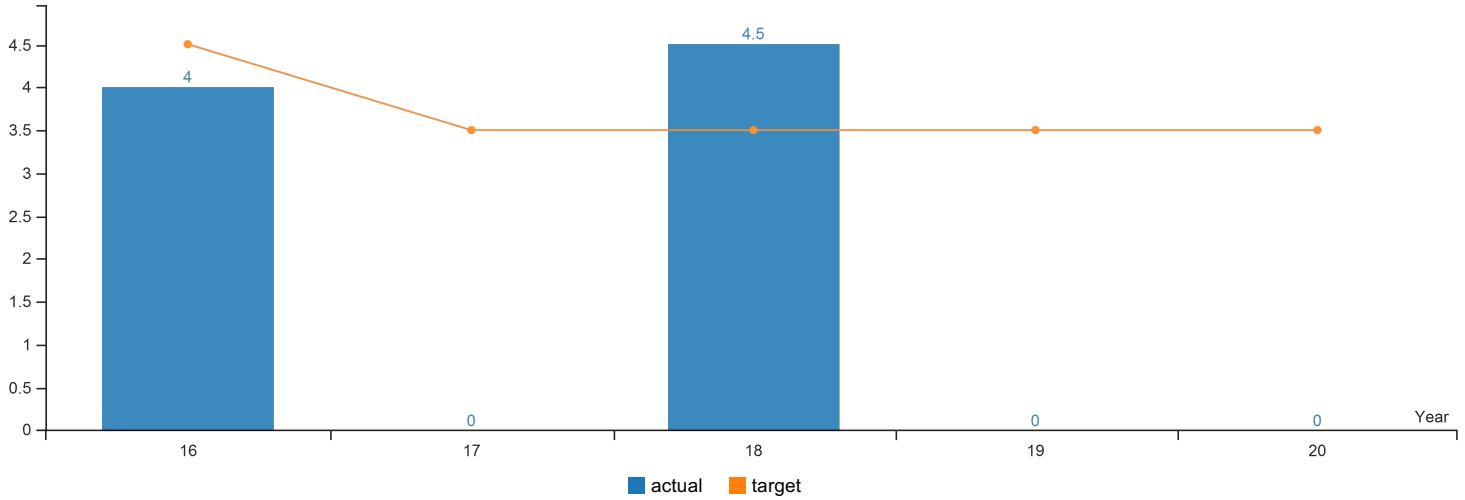
How Are We Doing

Proposed deletion: The data source for this measure no longer exists. It has changed to the Student Health Survey (SHS) and this question is not on the 6th grade version

Factors Affecting Results

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	2016	2017	2018	2019	2020
30 day alcohol use among 6th graders					
Actual	4%	No Data	4.50%	No Data	0%
Target	4.50%	3.50%	3.50%	3.50%	3.50%

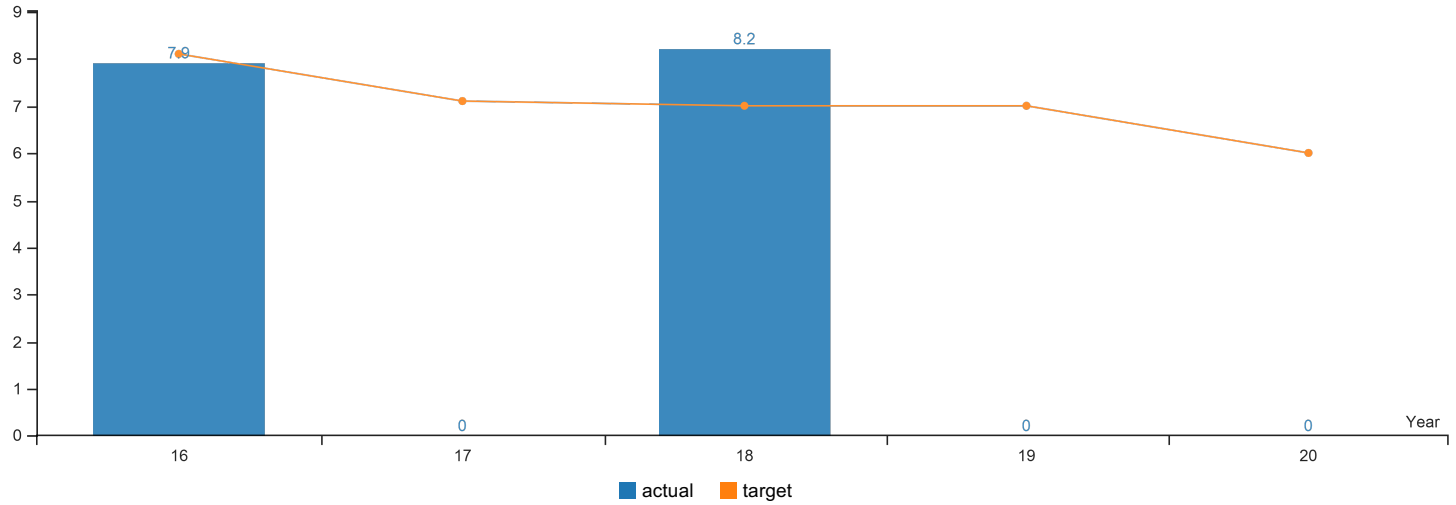
How Are We Doing

Starting in 2020, the new Student Health Survey (SHS) was planning to collect data in even years. Due to COVID19, the SHS dataset will be available at the end of spring 2021 and results available in summer of 2021.

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	2016	2017	2018	2019	2020
30 day illicit drug use among 8th graders					
Actual	7.90%	No Data	8.20%	No Data	0%
Target	8.10%	7.10%	7%	7%	6%

How Are We Doing

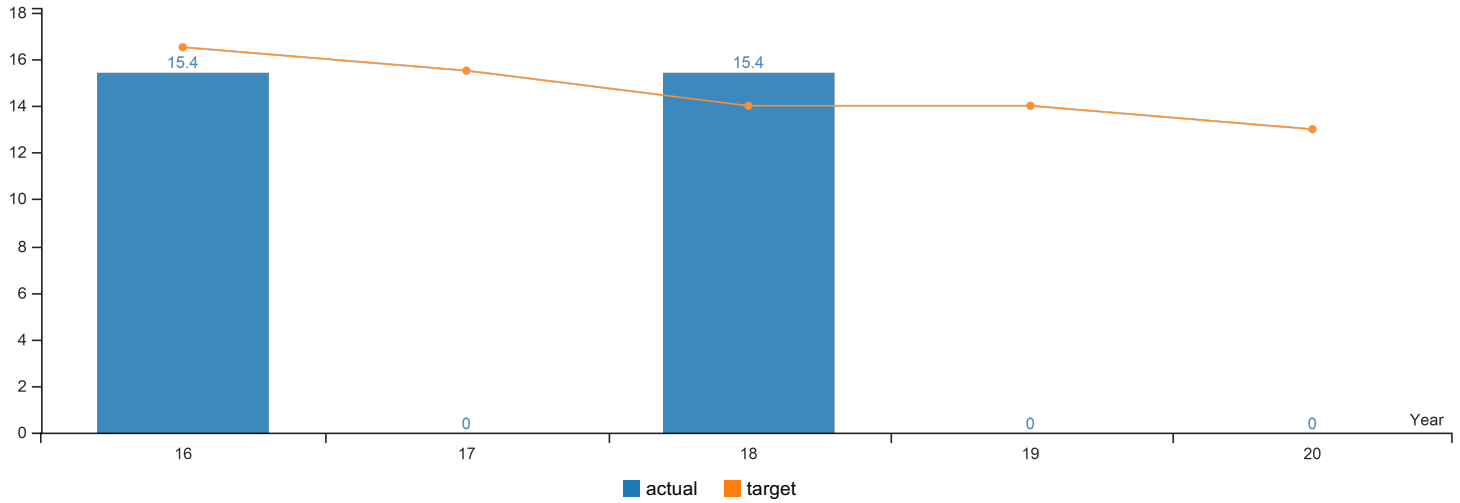
Starting in 2020, the new Student Health Survey (SHS) was planning to collect data in even years. Due to COVID19, the SHS dataset will be available at the end of spring 2021 and results available in summer of 2021.

Factors Affecting Results

The data source is the new SHS - Student Health Survey, this question on the survey no longer includes marijuana use.

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	2016	2017	2018	2019	2020
30 day alcohol use among 8th graders					
Actual	15.40%	No Data	15.40%	No Data	0%
Target	16.50%	15.50%	14%	14%	13%

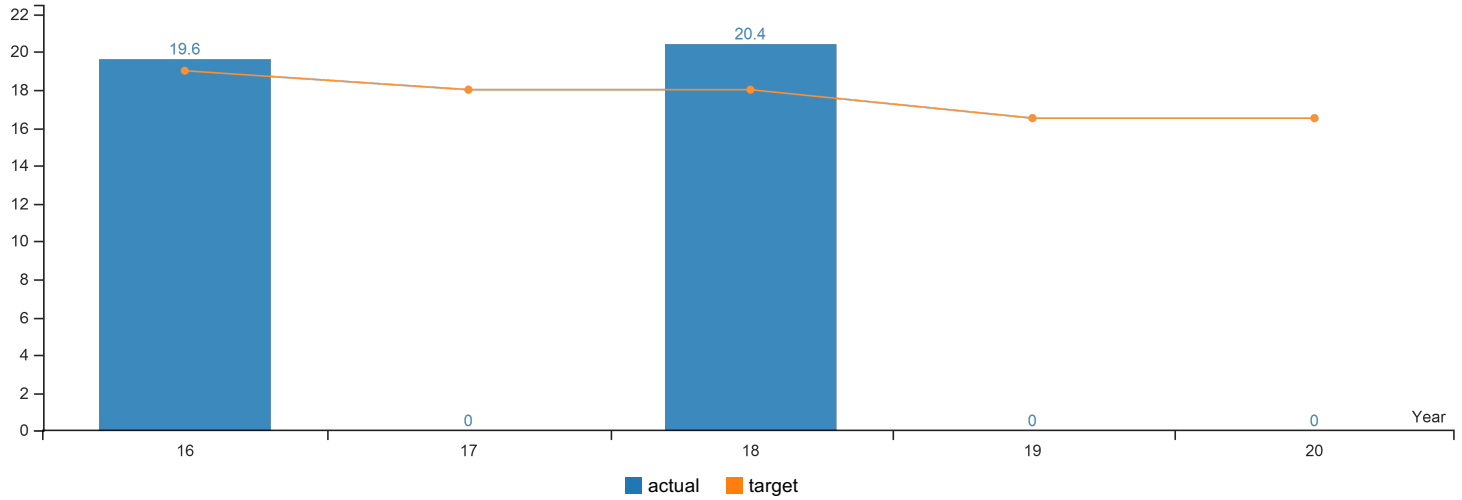
How Are We Doing

Starting in 2020, the new Student Health Survey (SHS) was planning to collect data in even years. Due to COVID19, the SHS dataset will be available at the end of spring 2021 and results available in summer of 2021.

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	2016	2017	2018	2019	2020
30 day illicit drug use among 11th graders					
Actual	19.60%	No Data	20.40%	No Data	0%
Target	19%	18%	18%	16.50%	16.50%

How Are We Doing

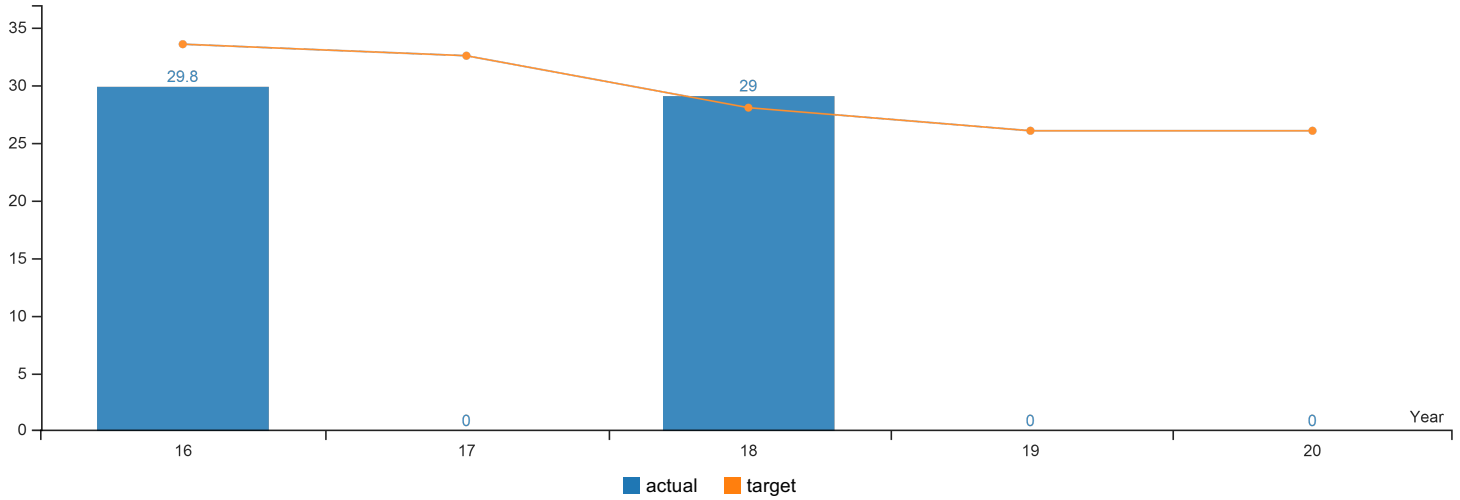
Starting in 2020, the new Student Health Survey (SHS) was planning to collect data in even years. Due to COVID19, the SHS dataset will be available at the end of spring 2021 and results available in summer of 2021.

Factors Affecting Results

The data source is the new SHS - Student Health Survey, this question on the survey no longer includes marijuana use.

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	2016	2017	2018	2019	2020
30 day alcohol use among 11th graders					
Actual	29.80%	No Data	29%	No Data	0%
Target	33.50%	32.50%	28%	26%	26%

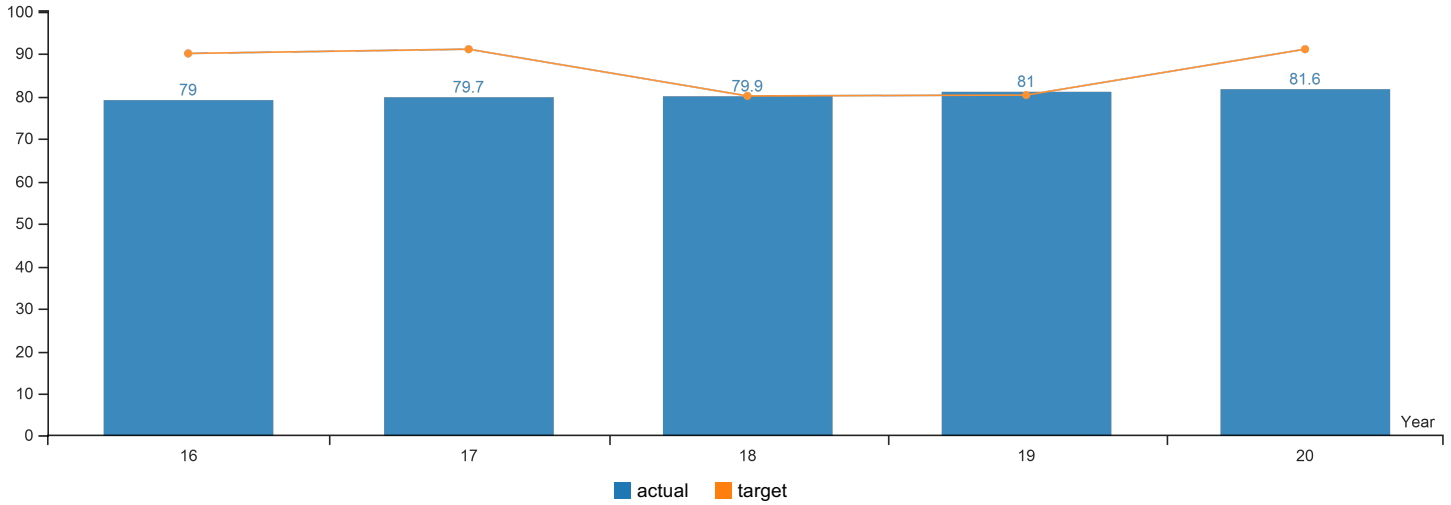
How Are We Doing

Starting in 2020, the new Student Health Survey (SHS) was planning to collect data in even years. Due to COVID19, the SHS dataset will be available at the end of spring 2021 and results available in summer of 2021.

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	2016	2017	2018	2019	2020
Prenatal care - population					
Actual	79%	79.70%	79.90%	81%	81.60%
Target	90%	91%	80%	80.20%	91%

How Are We Doing

The percentage of women initiating prenatal care during the first trimester is a marker for access to maternal health care services. This percentage has been slowly but steadily increasing in Oregon from 2015 to 2019. Early prenatal care is important to identify and treat babies or mothers at risk for health conditions that can affect the pregnancy, such as hypertension and diabetes. It is also important because health care providers can educate and assist mothers with health issues related to pregnancy including nutrition, alcohol use, smoking, exercise, and preparing for childbirth and infant care. Prenatal care is an important screening point for behavioral and social risks such as perinatal depression, intimate partner violence, and food insecurity. Babies born to women who receive prenatal care early and throughout the pregnancy are less likely to have low birth weight or to be born prematurely. Psychosocial, financial, logistical, health care provider, and many other issues can create barriers for women in obtaining early prenatal care. This indicator is used by states and at the national level, as the data is from vital statistics (birth certificates), therefore making it widely available and representative of the population. While this indicator has been traditionally used, and is widely understood, it is also valuable to examine the Adequacy of Prenatal Care Utilization Index (https://www.mchlibrary.org/databases/HSNRCPDFs/Overview_APCUIndex.pdf), which examines the number of prenatal care visits a woman has received throughout pregnancy in addition to the timing of initiation. This allows for a more thorough examination of woman's access to care. It is worth noting that the data for prenatal care used in both indicators is only available for live births, and therefore does not include information on the prenatal care of women who had a miscarriage or a still birth. The data on first trimester initiation of prenatal care is publicly released by the Oregon Center for Health Statistics in their Annual Vital Statistic Report. These reports can be found at https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/VITALSTATISTICS/ANNUALREPORTS/VOLUME1/Pages/index.aspx.

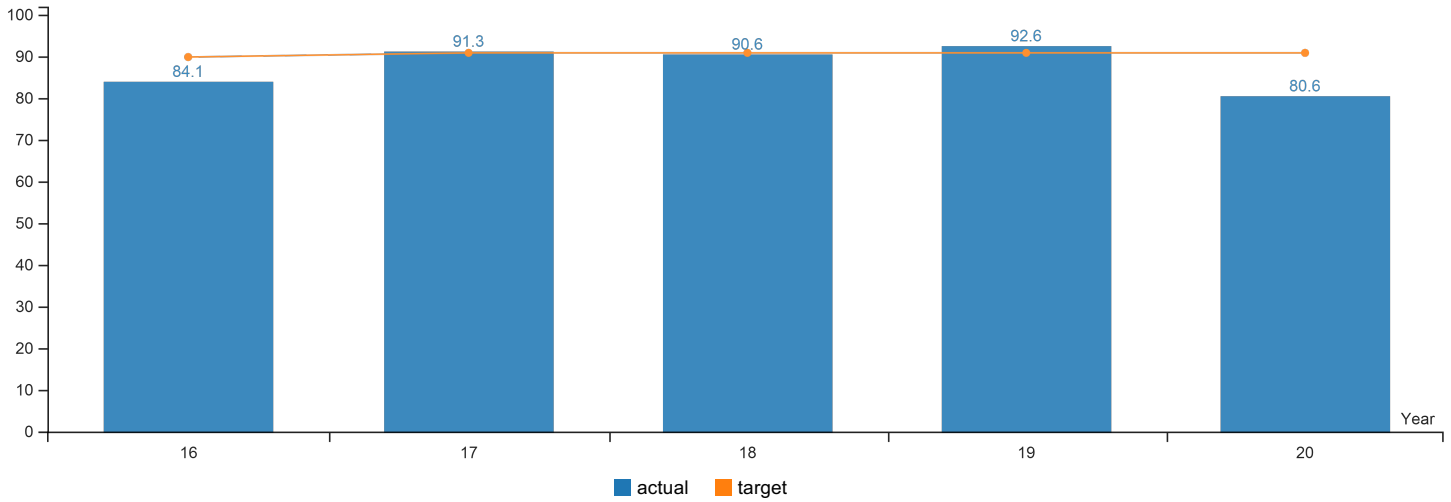
Data entered is preliminary for 2019, finalized data for 2019 will be available in December 2020.

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.

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	2016	2017	2018	2019	2020
Prenatal care - Medicaid					
Actual	84.10%	91.30%	90.60%	92.60%	80.60%
Target	90%	91%	91%	91%	91%

How Are We Doing

Performance on timeliness of prenatal care declined from 92.6% in 2018 to 80.6% in 2019.

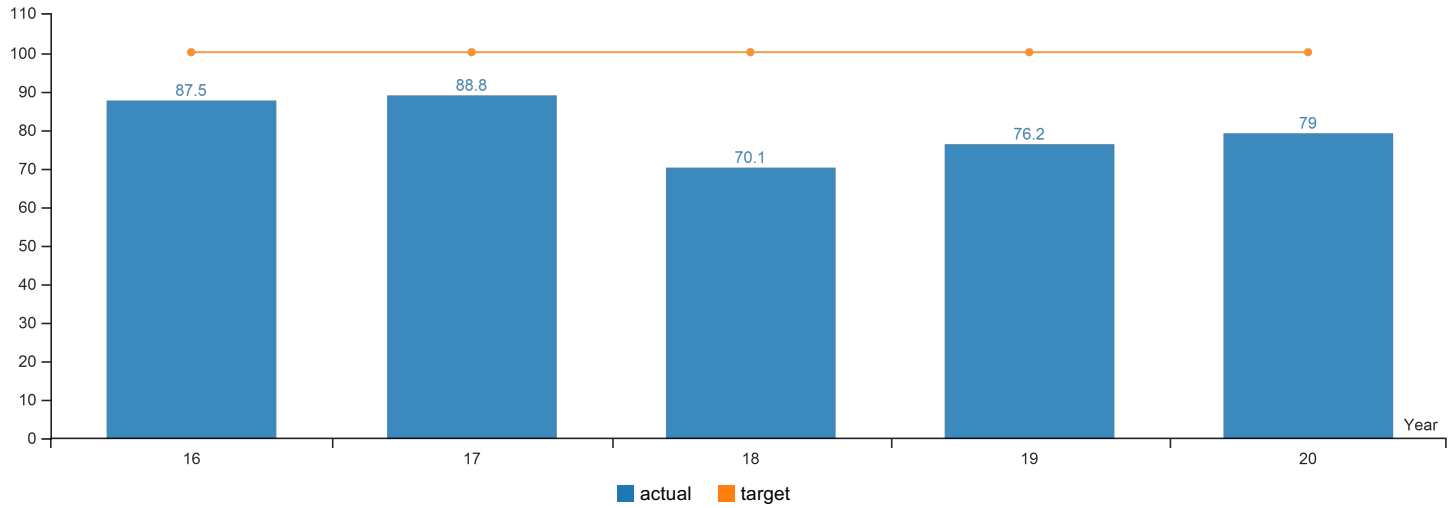
Factors Affecting Results

While this measure was an incentive measure for CY2018, in CY2019 it is no longer pay-for-performance. However, it is a state quality measure which OHA will continue to monitor and report.

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	2016	2017	2018	2019	2020
Patient centered primary care home (PCPCH) enrollment					
Actual	87.50%	88.80%	70.10%	76.20%	79%
Target	100%	100%	100%	100%	100%

How Are We Doing

This measure uses a weighted methodology to ensure members are not just enrolled in a Patient-Centered Primary Care Home (PCPCH), but are enrolled in the higher PCPCH tiers. Statewide in 2019, 96 percent of CCO members were enrolled in a PCPCH, resulting in a weighted score of 79. 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.

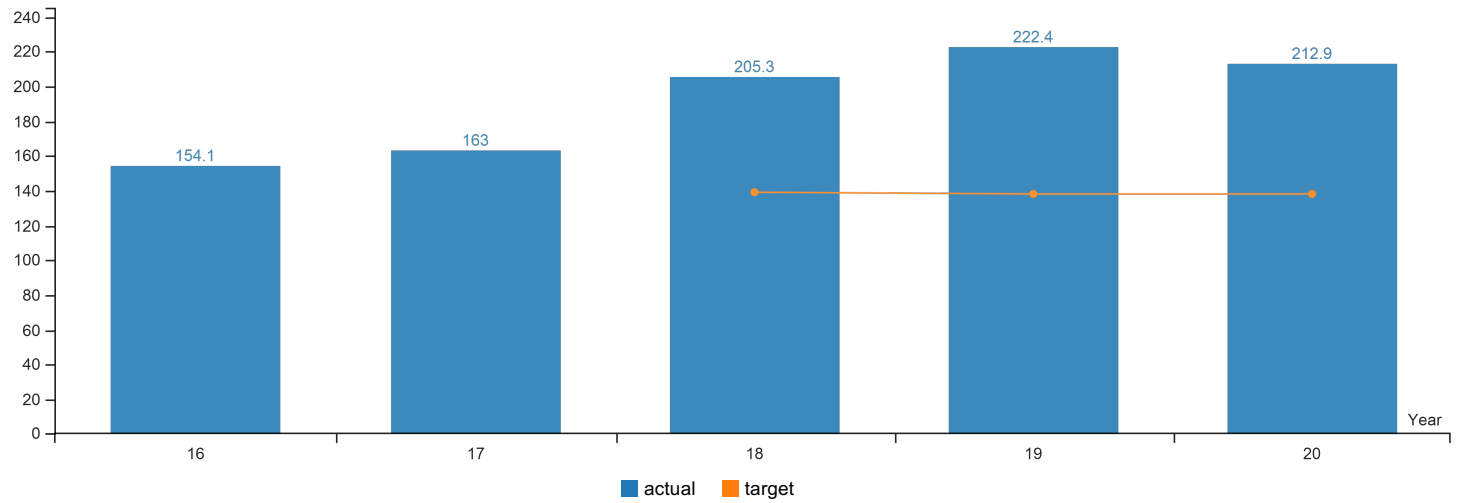
The target should be revised to 68 to match what we have used for the CCO incentive program. Note this is ***not*** a percentage, but a weighted score

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.

KPM #16	PQI 01: Diabetes Short-Term Complication Admission Rate -
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2016	2017	2018	2019	2020
PQI 01: Diabetes Short-Term Complication Admission Rate					
Actual	154.10	163	205.30	222.40	212.90
Target	TBD	TBD	139	138	138

How Are We Doing

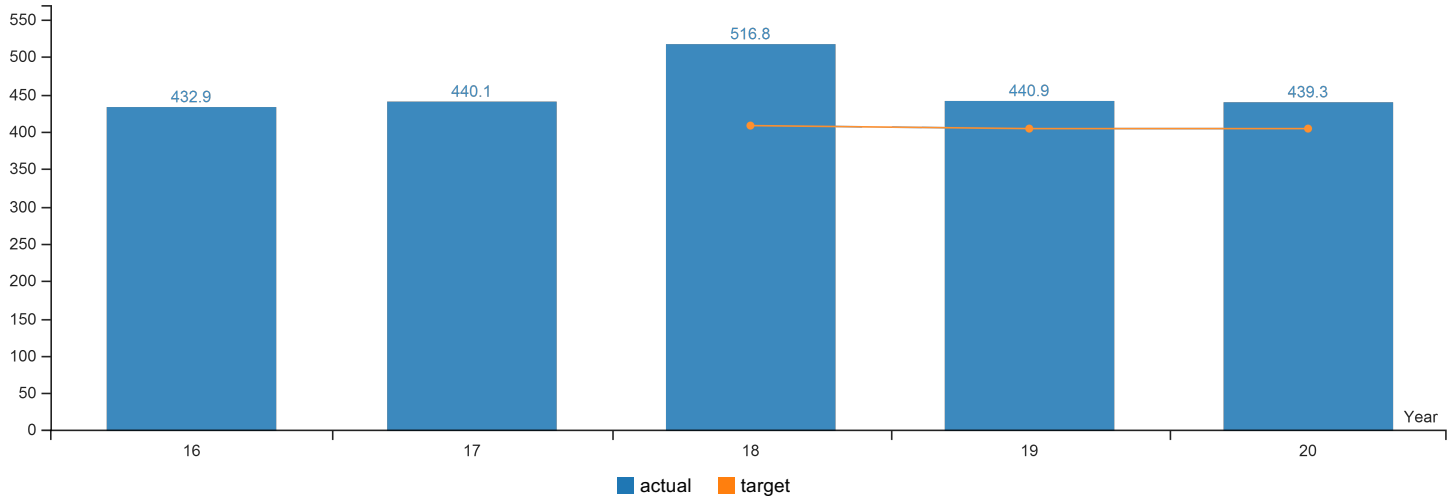
The rate of adult members with diabetes who had a hospital stay because of a short-term problem from their disease declined from 222.4 in 2018 to 212.9 in 2019. Lower is better on this measure.

Factors Affecting Results

This measure is calculated using proprietary software from AHRQ, which was updated in 2018. Because of the changes that AHRQ made to the way this measure is calculated, data prior to 2018 are not directly comparable to later years.

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	2016	2017	2018	2019	2020
PQI 05: COPD or Asthma in Older Adults Admission Rate					
Actual	432.90	440.10	516.80	440.90	439.30
Target	TBD	TBD	408	404	404

How Are We Doing

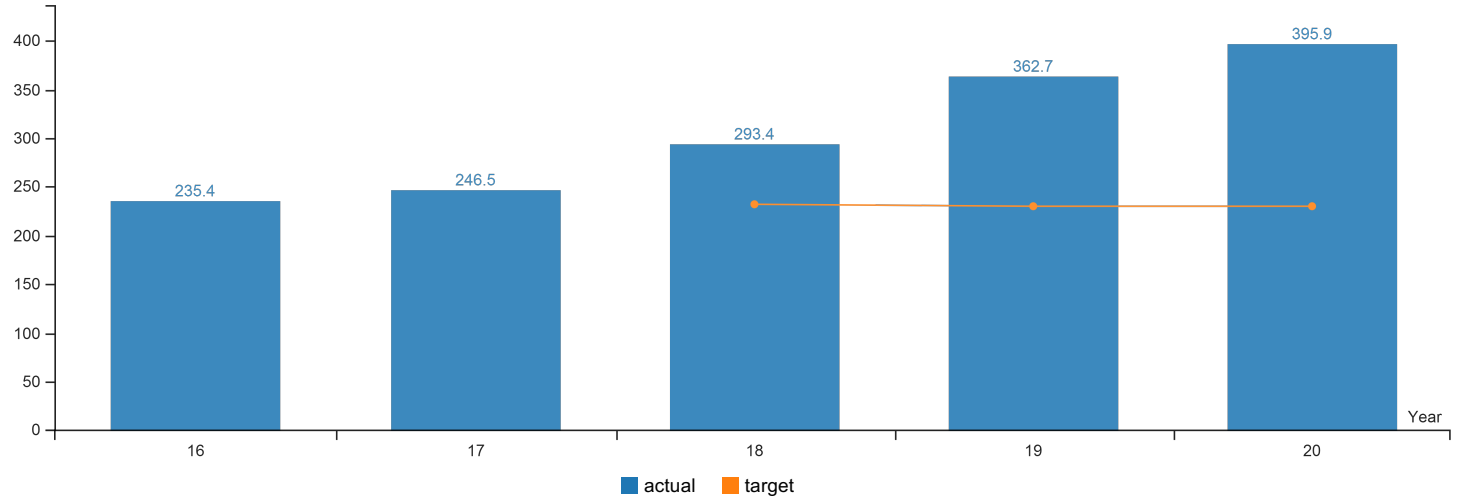
The rate of adult members (ages 40 and older) who had a hospital stay because of chronic obstructive respiratory disease or asthma decreased from 440.9 in 2018 to 439.3 in 2019.

Factors Affecting Results

This measure is calculated using proprietary software from AHRQ, which was updated in 2018. Because of the changes that AHRQ made to the way this measure is calculated, data prior to 2018 are not directly comparable to later years.

KPM #18	PQI 08: Congestive Heart Failure Admission Rate -
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2016	2017	2018	2019	2020
PQI 08: Congestive Heart Failure Admission Rate					
Actual	235.40	246.50	293.40	362.70	395.90
Target	TBD	TBD	232	230	230

How Are We Doing

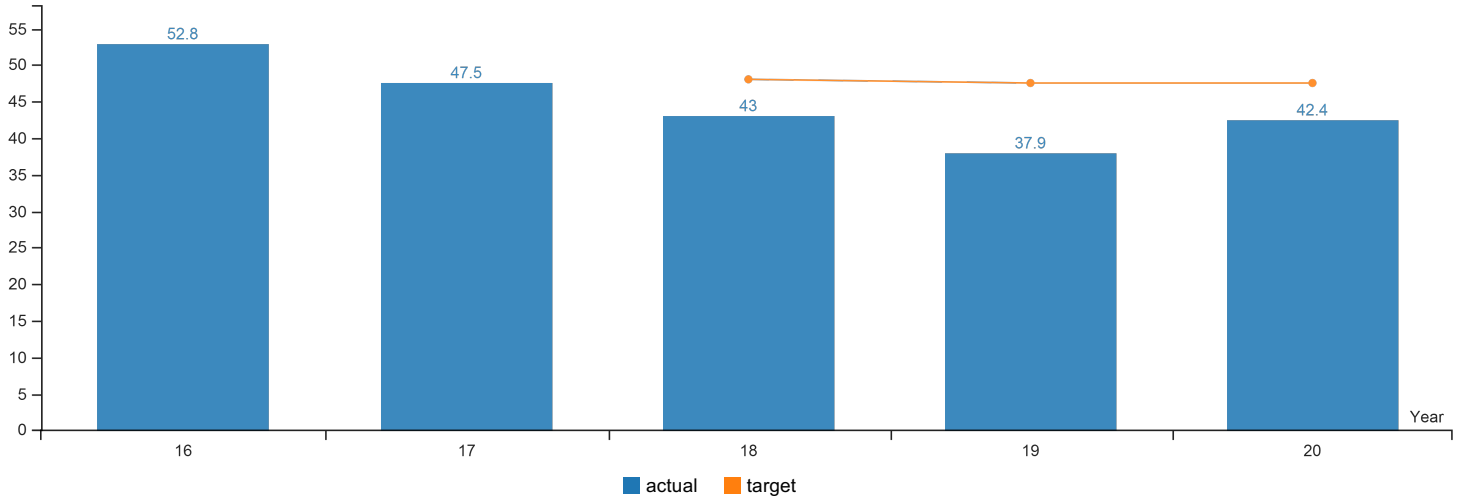
The rate of adult members who had a hospital stay because of congestive heart failure increased from 362.7 in 2018 to 395.9 in 2019. Lower is better on this measure.

Factors Affecting Results

This measure is calculated using proprietary software from AHRQ, which was updated in 2018. Because of the changes that AHRQ made to the way this measure is calculated, data prior to 2018 are not directly comparable to later years.

KPM #19	PQI 15: Asthma in Younger Adults Admission Rate -
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2016	2017	2018	2019	2020
PQI 15: Asthma in Younger Adults Admission Rate					
Actual	52.80	47.50	43	37.90	42.40
Target	TBD	TBD	48	47.50	47.50

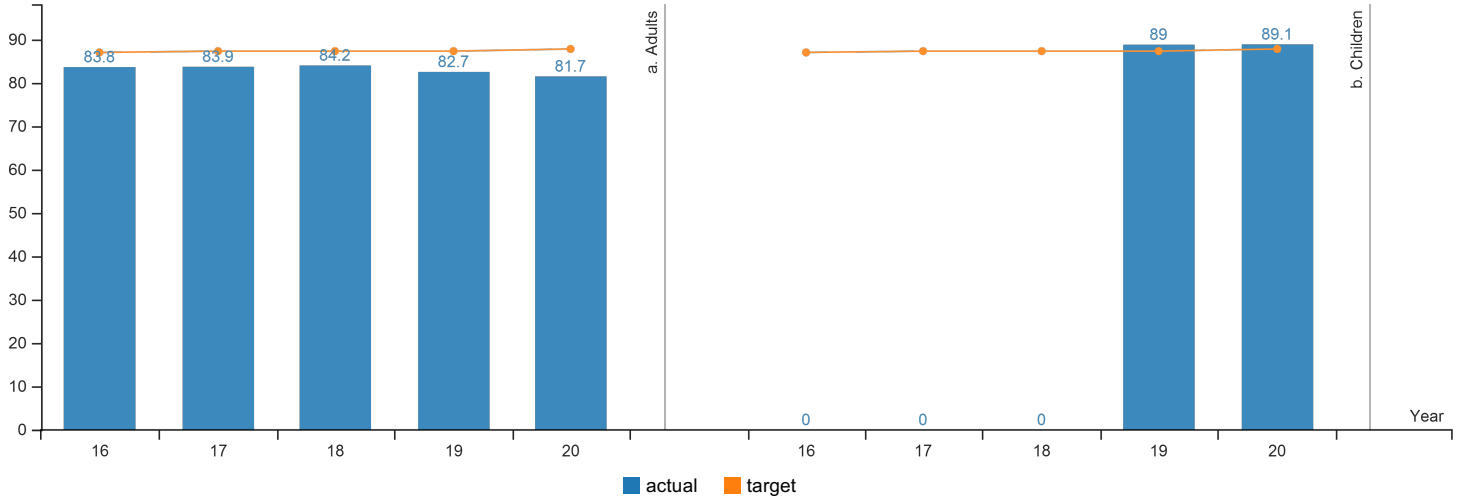
How Are We Doing

The rate of younger adult members (ages 18-39) who had a hospital stay because of asthma increased from 37.9 in 2018 to 42.4 in 2019. Lower is better on this measure.

Factors Affecting Results

This measure is calculated using proprietary software from AHRQ, which was updated in 2018. Because of the changes that AHRQ made to the way this measure is calculated, data prior to 2018 are not directly comparable to later years.

KPM #20	ACCESS TO CARE - Percentage of members who responded "always" or "usually" too getting care quickly.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2016	2017	2018	2019	2020
a. Adults					
Actual	83.80%	83.90%	84.20%	82.70%	81.70%
Target	87.20%	87.50%	87.50%	87.50%	88%
b. Children					
Actual	No Data	No Data	No Data	89%	89.10%
Target	87.20%	87.50%	87.50%	87.50%	88%

How Are We Doing

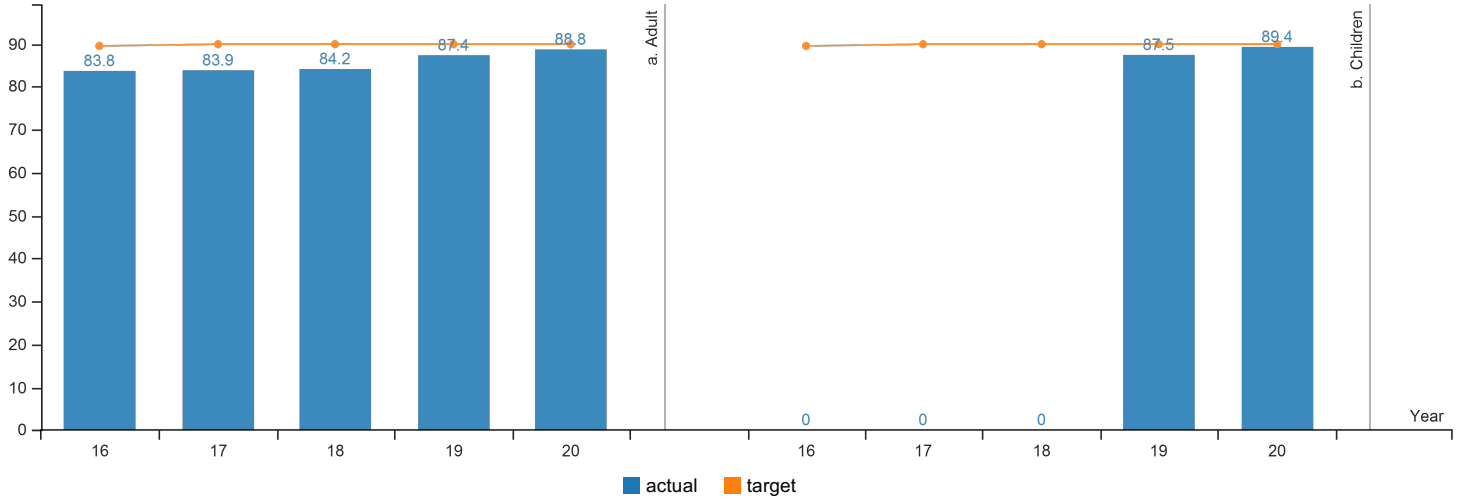
A: The percentage of adult members who thought they received appointments and care when needed decreased from 82.7% in 2018 to to 81.7% in 2019. Prior to 2018, this measure was a weighted score across children and adults. From 2018 on, however, these data are now disaggregated and reported separately for children and adults. This ensures that performance across the different age groups can be monitored appropriately and is based upon a decision from the Metrics and Scoring Committee. KPM data from prior years should not be compared to that from 2018 on.

B: The percentage of child members who received appointments and care when needed slightly increased from 89.0% in 2018 to 89.1% in 2019. Prior to 2018, this measure was a weighted score across children and adults. From 2018 on, however, these data are now disaggregated and reported separately for children and adults. This ensures that performance across the different age groups can be monitored appropriately and is based upon a decision from the Metrics and Scoring Committee. KPM data from prior years should not be compared to that from 2018 forward.

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%). This measure is included in the state's Medicaid demonstration agreement with CMS.

KPM #21	MEMBER EXPERIENCE OF CARE - Composite measurement: how well doctors communicate; health plan information and customer service (Medicaid population).
	Data Collection Period: Jan 01 - Dec 31



Report Year	2016	2017	2018	2019	2020
a. Adult					
Actual	83.80%	83.90%	84.20%	87.40%	88.80%
Target	89.60%	90%	90%	90%	90%
b. Children					
Actual	No Data	No Data	No Data	87.50%	89.40%
Target	89.60%	90%	90%	90%	90%

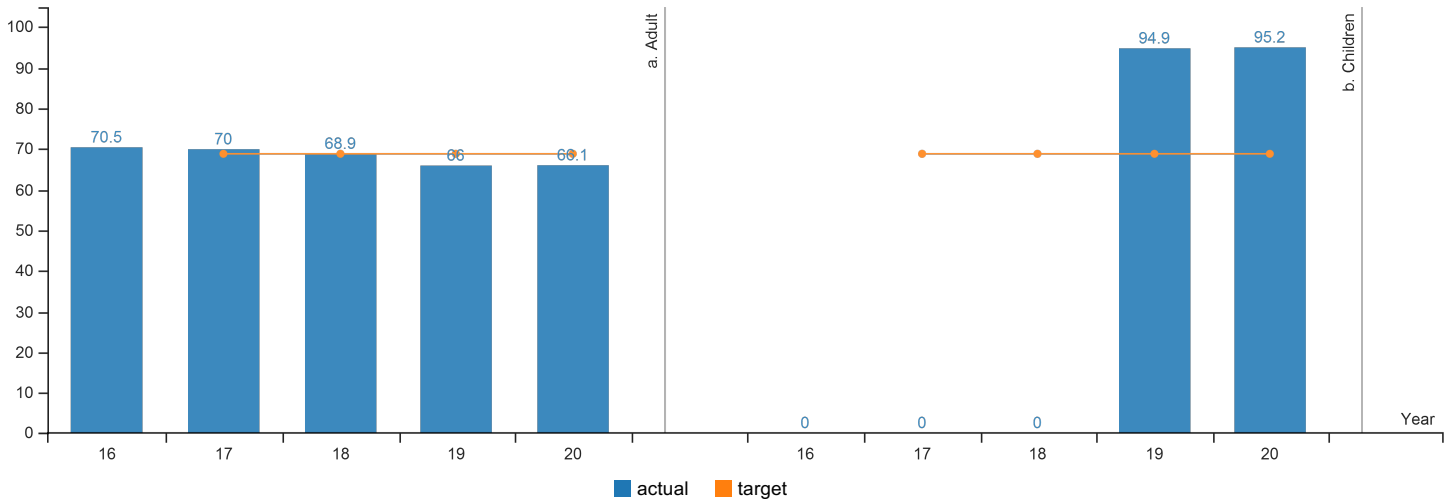
How Are We Doing

Prior to 2018, this measure was a weighted score across children and adults. From 2018 on, however, these data are now disaggregated and reported separately for children and adults. This ensures that performance across the different age groups can be monitored appropriately and is based upon a decision from the Metrics and Scoring Committee. KPM data from prior years should not be compared to that from 2018 forward.

Factors Affecting Results

NOTE: This was retired from the incentive measure set in 2017.

KPM #22	MEMBER HEALTH STATUS - Percentage of CAHPS survey respondents with a positive self-reported rating of overall health (excellent, very good, or good).
	Data Collection Period: Jan 01 - Dec 31



Report Year	2016	2017	2018	2019	2020
a. Adult					
Actual	70.50%	70%	68.90%	66%	66.10%
Target	TBD	68.90%	68.90%	68.90%	68.90%
b. Children					
Actual	No Data	No Data	No Data	94.90%	95.20%
Target	TBD	68.90%	68.90%	68.90%	68.90%

How Are We Doing

A. The percentage of adult members who rated their overall health as good, very good, or excellent slightly increased from 66.0% in 2018 to 66.1% in 2019. Prior to 2018, this measure was a weighted score across children and adults. From 2018 on, however, these data are now disaggregated and reported separately for children and adults. This ensures that performance across the different age groups can be monitored appropriately and is based upon a decision from the Metrics and Scoring Committee. KPM data from prior years should not be compared to that from 2018.

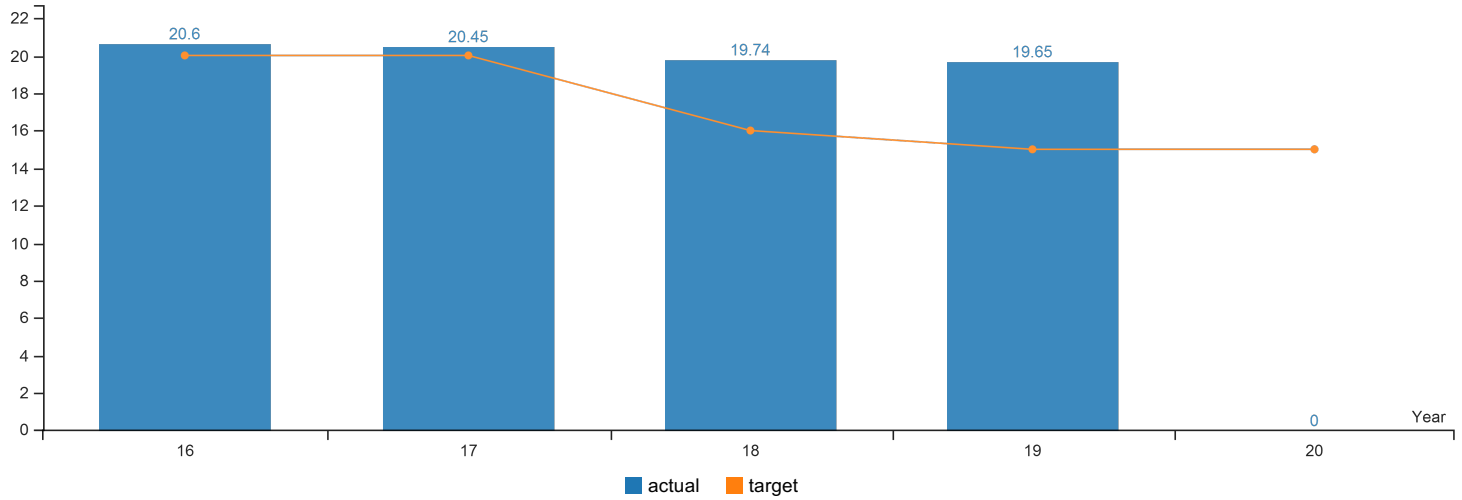
B. The percentage of children who's parents rated their overall health as good, very good, or excellent increased from 94.9% in 2018 to 95.2% in 2019. Prior to 2018, this measure was a weighted score across children and adults. From 2018 on, however, these data are now disaggregated and reported separately for children and adults. This ensures that performance across the different age groups can be monitored appropriately and is based upon a decision from the Metrics and Scoring Committee. KPM data from prior years should not be compared to that from 2018 forward.

Factors Affecting Results

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. However, there has been a decrease among adults since 2016.

KPM #23	RATE OF TOBACCO USE (POPULATION) - Rate of tobacco use among adults.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2016	2017	2018	2019	2020
Rate of tobacco use - adult population					
Actual	20.60%	20.45%	19.74%	19.65%	No Data
Target	20%	20%	16%	15%	15%

How Are We Doing

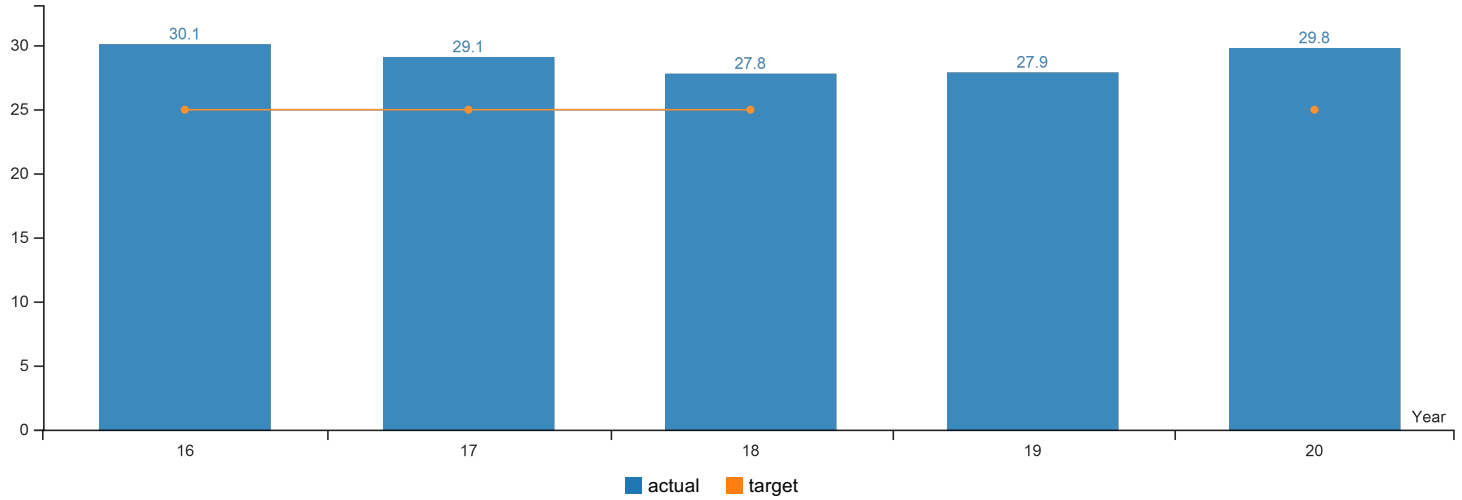
Due to COVID-19, the Behavioral Risk Factors Surveillance System dataset will be available at the end of October 2020 and results available in early November of 2020.

Factors Affecting Results

This measure reflects cigarette smoking or chewing tobacco.

KPM #24	RATE OF TOBACCO USE (MEDICAID) - Percentage of CCO enrollees who currently smoke cigarettes or use tobacco every day or some days.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2016	2017	2018	2019	2020
Rate of tobacco use - Medicaid population					
Actual	30.10%	29.10%	27.80%	27.90%	29.80%
Target	25%	25%	25%	TBD	25%

How Are We Doing

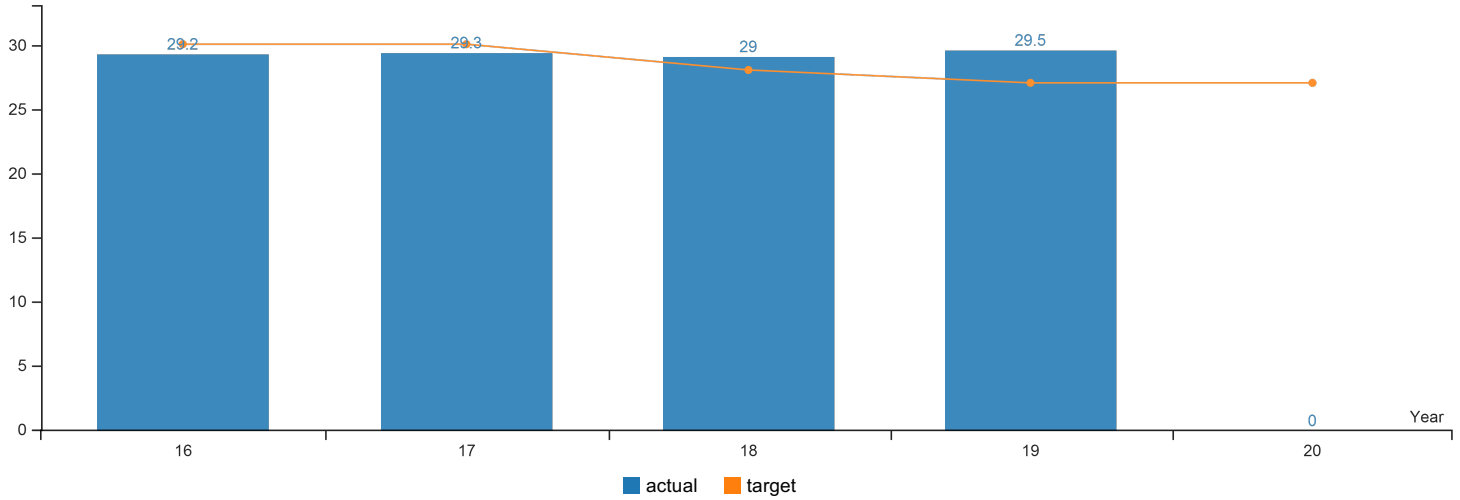
The percentage of members who self-reported smoking cigarettes or using tobacco every day or some days increased from 27.9% in 2018 to 29.8% in 2019. Lower is better on this measure.

Factors Affecting Results

This self-reported, survey-based measure was included in our previous CMS waiver, but was not included as a metric in the current 2017-2022 waiver; instead the current Medicaid waiver includes a different measure focused specifically on cigarette smoking prevalence, and sourced from electronic health records.

KPM #25	RATE OF OBESITY (POPULATION) - Percentage of adults who are obese among Oregonians.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2016	2017	2018	2019	2020
Rate of obesity - adult population					
Actual	29.20%	29.30%	29%	29.50%	No Data
Target	30%	30%	28%	27%	27%

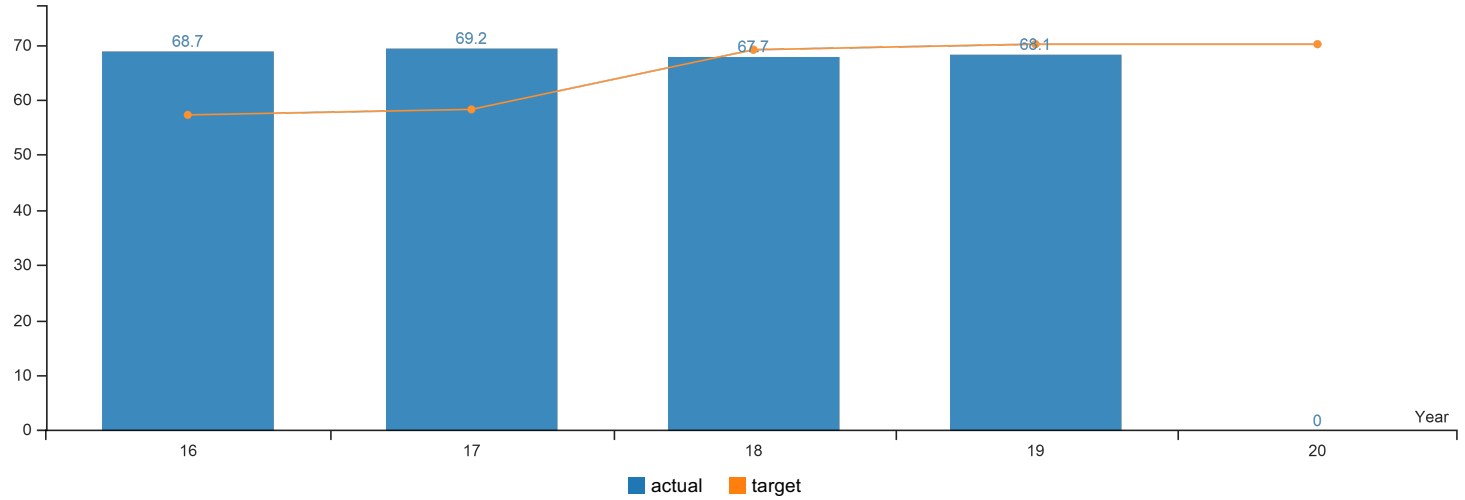
How Are We Doing

Due to COVID-19, the Behavioral Risk Factors Surveillance System dataset will be available at the end of October 2020 and results available in early November of 2020.

Factors Affecting Results

KPM #26	EFFECTIVE CONTRACEPTIVE USE (POPULATION) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2016	2017	2018	2019	2020
Effective contraceptive use - population					
Actual	68.70%	69.20%	67.70%	68.10%	No Data
Target	57.20%	58.20%	69%	70%	70%

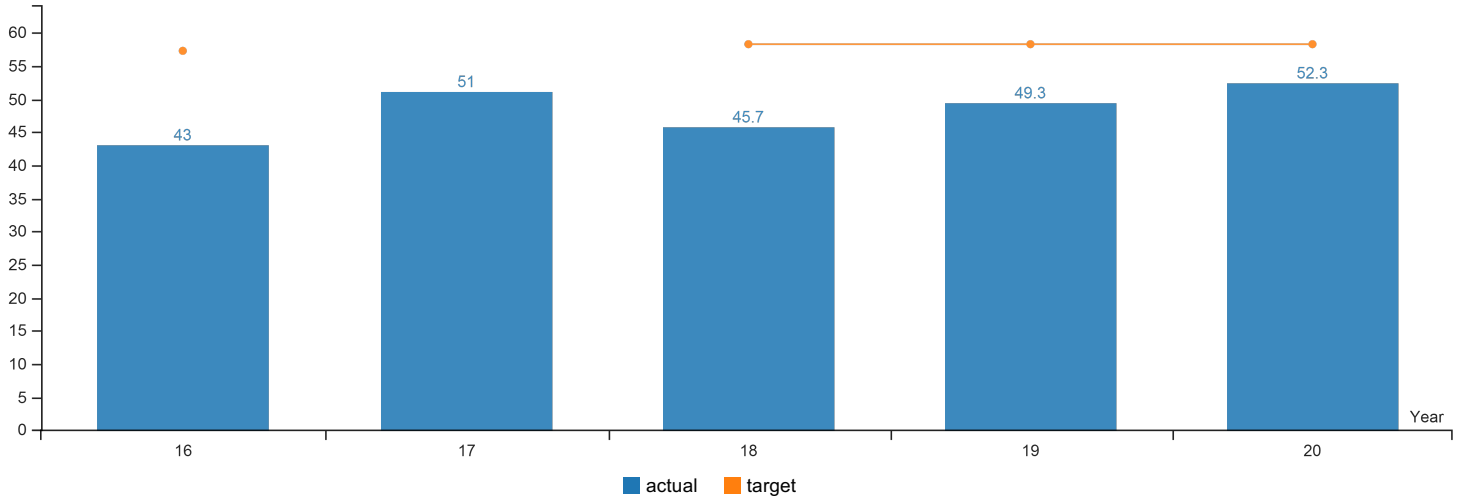
How Are We Doing

Data not yet available. The 2019 Behavioral Risk Factor Surveillance System data set is expected to be released in October 2020 and this measure will be updated at that time.

Factors Affecting Results

KPM #27	EFFECTIVE CONTRACEPTIVE USE (MEDICAID) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2016	2017	2018	2019	2020
Effective contraceptive use - Medicaid population					
Actual	43%	51%	45.70%	49.30%	52.30%
Target	57.20%	TBD	58.20%	58.20%	58.20%

How Are We Doing

Because of changes to the specifications for this measure, data prior to 2018 are not comparable to later years. However, the rate of effective contraceptive use has increased since this measure was included in the CCO Quality Incentive Program from 2015-2019; this means CCOs could earn incentive payments for improving performance during this time period.

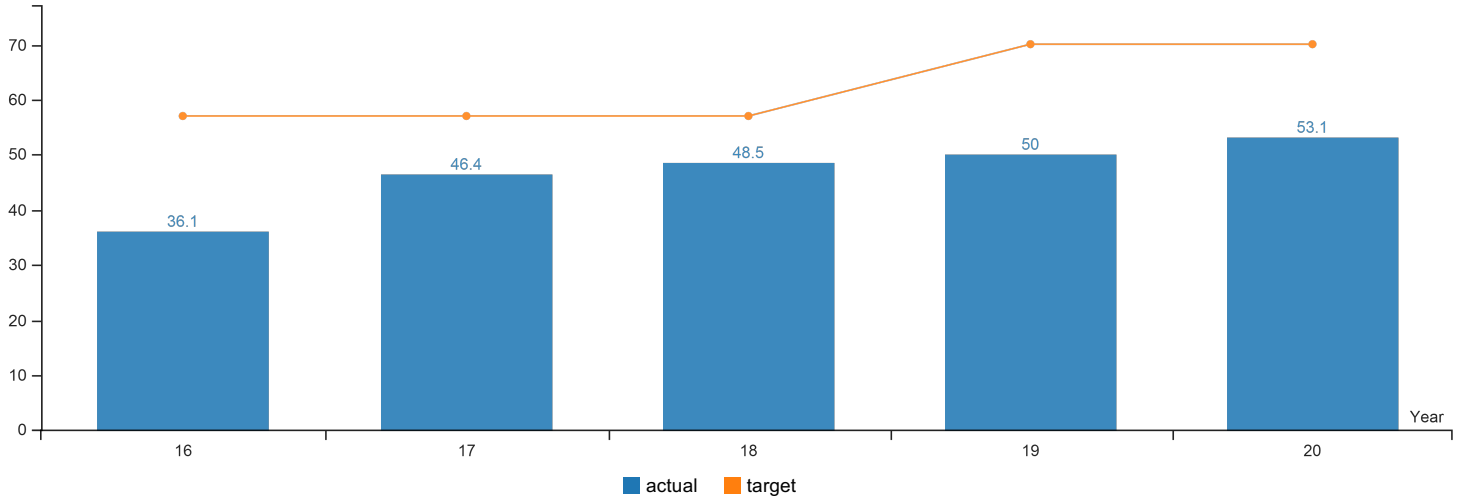
NOTE: data represents women ages 18-50

Factors Affecting Results

This was a CCO incentive measure from 2015 - 2019 (the incentive measure also included young women ages 15-17 in 2018 & 2019). The Metrics & Scoring Committee retired this measure from the incentive program in 2020.

KPM #28	FLU SHOTS (POPULATION) - Percentage of adults ages 50-64 who receive a flu vaccine.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2016	2017	2018	2019	2020
Flu shots - population					
Actual	36.10%	46.40%	48.50%	50%	53.10%
Target	57%	57%	57%	70%	70%

How Are We Doing

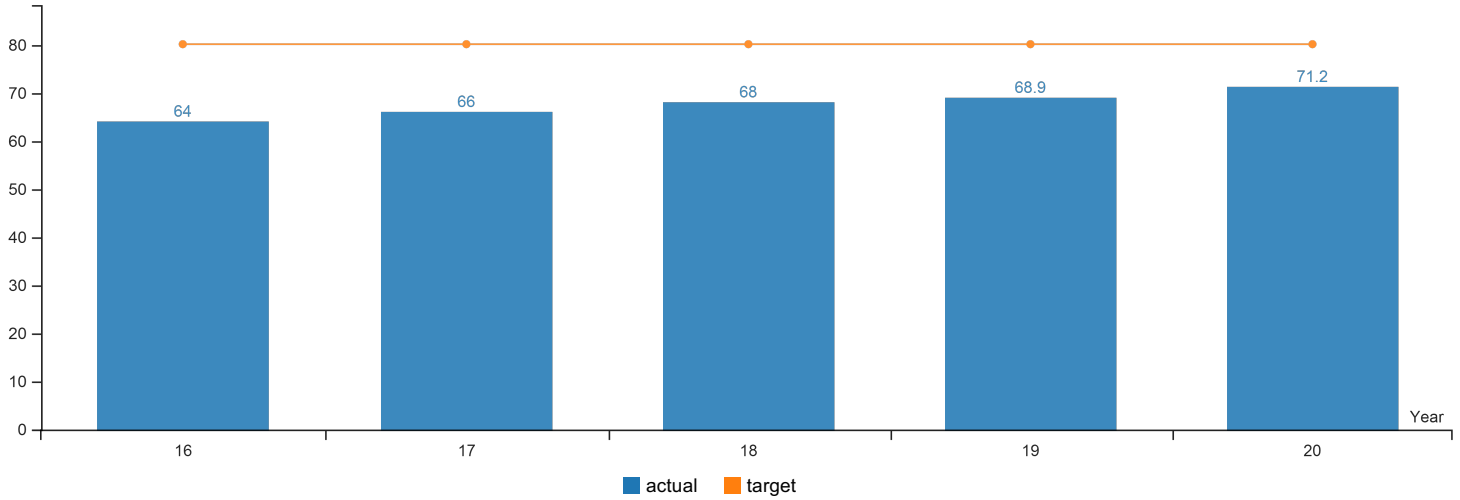
Seasonal influenza immunizations are trending upwards among Oregon adults, but still fall short of needed levels to protect against influenza disease. The source of this data is Oregon's ALERT Immunization Information System.

Factors Affecting Results

Oregon regions have marked differences in seasonal influenza immunization rates each season. In general, Southern Oregon counties and rural communities have lower adult influenza immunization rates than the Portland area, communities in the Willamette Valley, and Deschutes County. Among adults, non-senior women have higher influenza immunization rates than do non-senior men. Disparities in influenza immunization also exist based on race and ethnicity, with Latino adults having substantially lower immunization rates than other groups.

KPM #29	CHILD IMMUNIZATION RATES (POPULATION) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2016	2017	2018	2019	2020
Child immunization rates - population					
Actual	64%	66%	68%	68.90%	71.20%
Target	80%	80%	80%	80%	80%

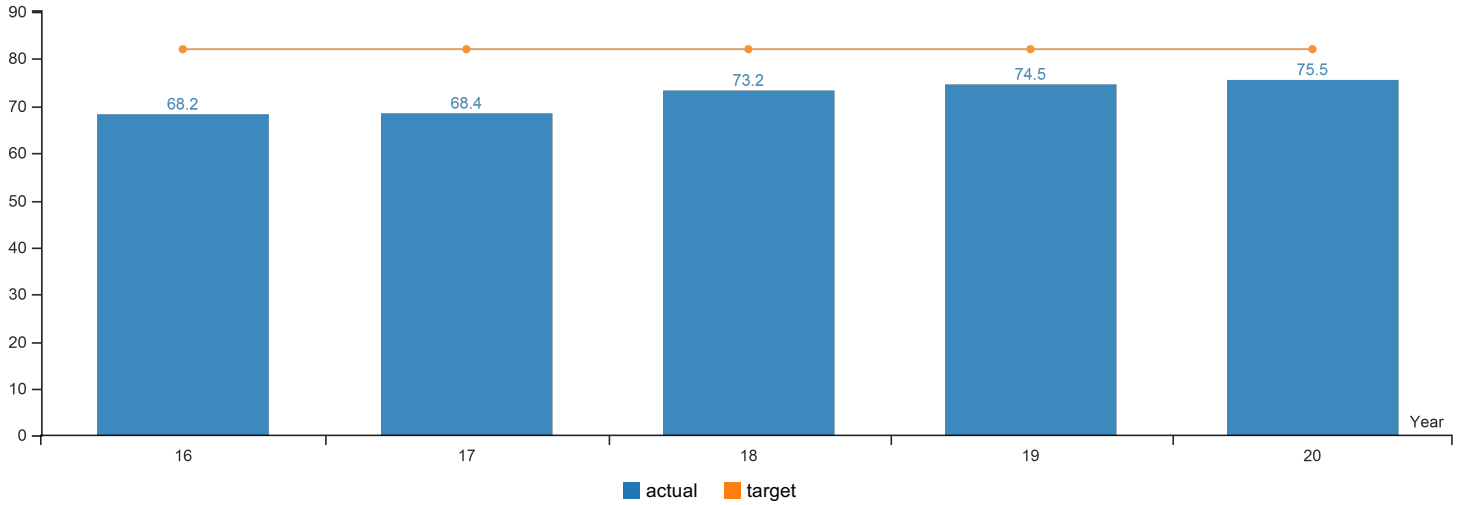
How Are We Doing

Immunization rates among two year olds in Oregon were increasing in 2019, prior to the COVID pandemic in 2020. This increase in early immunization receipt shows the value of CCO incentive measures in leveraging immunization rate increases across the population.

Factors Affecting Results

KPM #30	CHILD IMMUNIZATION RATES (MEDICAID) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2016	2017	2018	2019	2020
Child immunization rates - Medicaid population					
Actual	68.20%	68.40%	73.20%	74.50%	75.50%
Target	82%	82%	82%	82%	82%

How Are We Doing

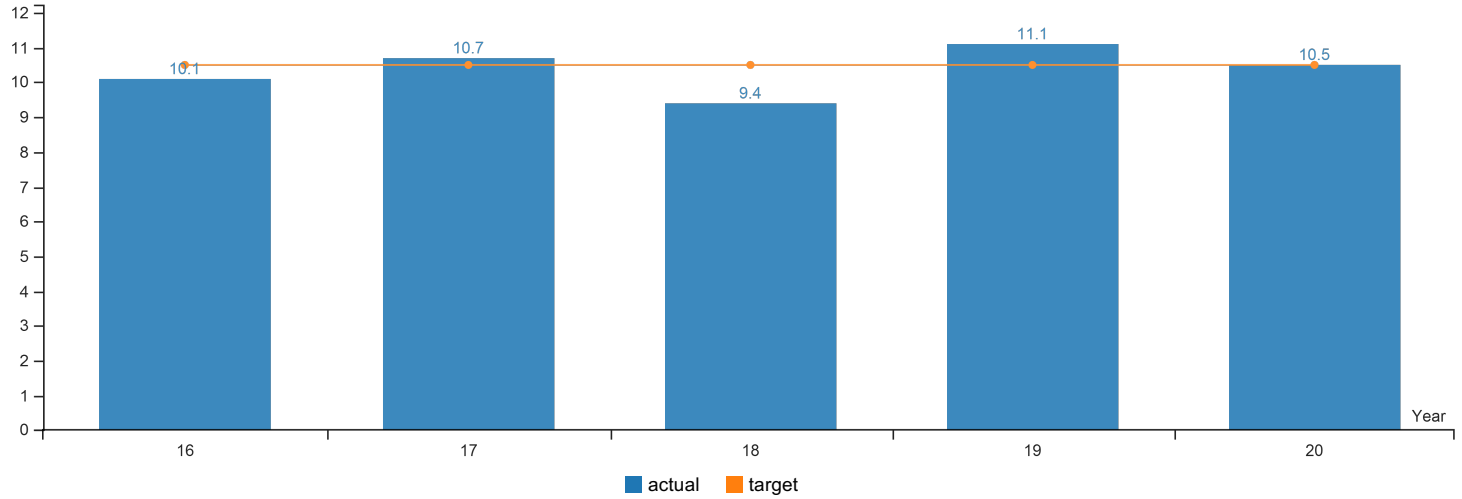
In CY2015, 68.2% of CCO members received recommended vaccines before their second birthday. Positively, this increased to 73.2% in CY2017, and continued to increase to 74.5% in CY2018 and 75.5% in CY2019.

Factors Affecting Results

Beginning 2016, childhood immunization status was added to the Quality Incentive Program, which means CCOs could earn incentives for improving performance, and which likely drove improved outreach and workflows. This measure is limited to children who turn two during the measurement year and who have been continuously enrolled in an Oregon Health Plan CCO for at least the 12 months preceding their second birthday, and may not be comparable to immunization rates for the general population.

KPM #31	PLAN ALL CAUSE READMISSIONS - Percentage of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for members 18 years and older.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2016	2017	2018	2019	2020
Plan all cause readmissions					
Actual	10.10%	10.70%	9.40%	11.10%	10.50%
Target	10.50%	10.50%	10.50%	10.50%	10.50%

How Are We Doing

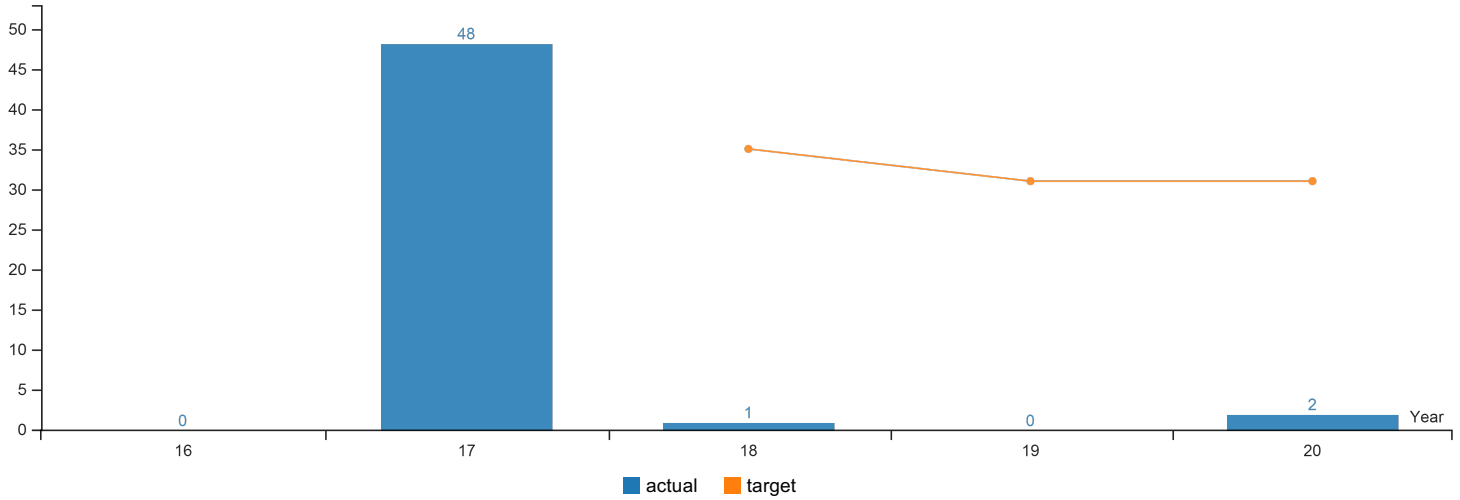
Results prior to 2016 are not directly comparable to later years due to methodological changes. Hospital readmissions continue to decline in Oregon (lower is better) and in CY2016 achieved the KPM target; this trend continued in CY2017. There was an increase in readmissions from 2017 to 2018, and a subsequent decline in CY2019 to 10.5%.

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 #32	ELIGIBILITY PROCESSING TIME - Median number of days processing time from date of request to eligibility determination.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2016	2017	2018	2019	2020
ELIGIBILITY PROCESSING TIME					
Actual	No Data	48	1	0	2
Target	TBD	TBD	35	31	31

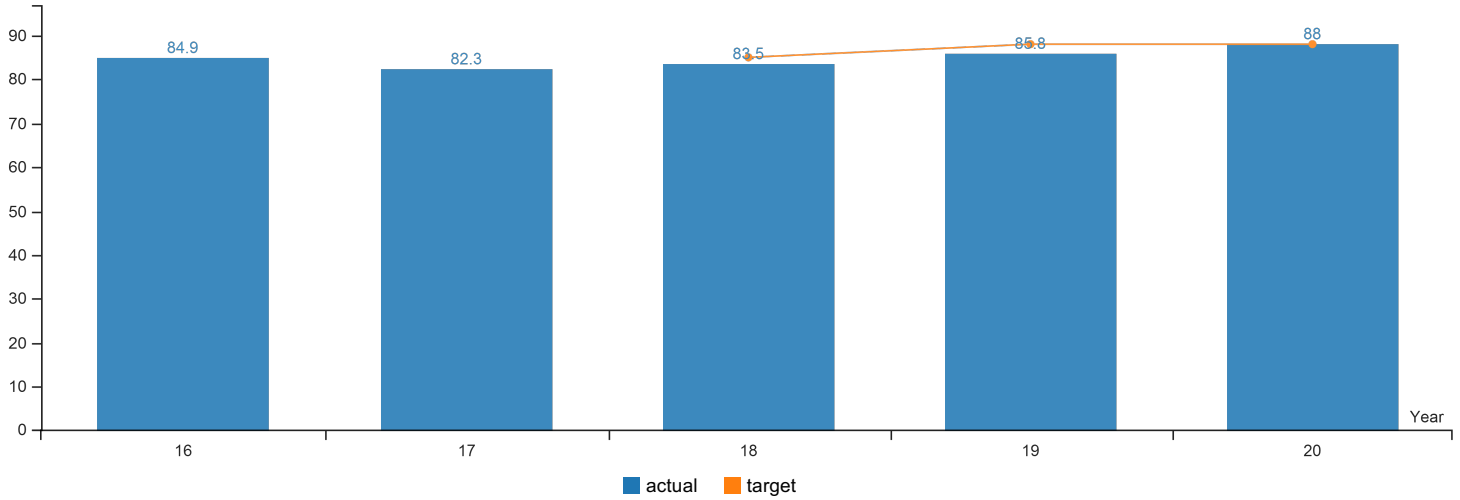
How Are We Doing

The processing time is low because Oregon uses an automated eligibility process.

Factors Affecting Results

KPM #33	OHP MEMBERS IN CCOs - Percent of Oregon Health Plan members enrolled in Coordinated Care Organizations.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2016	2017	2018	2019	2020
OHP MEMBERS IN CCOs					
Actual	84.90%	82.30%	83.50%	85.80%	88%
Target	TBD	TBD	85%	88%	88%

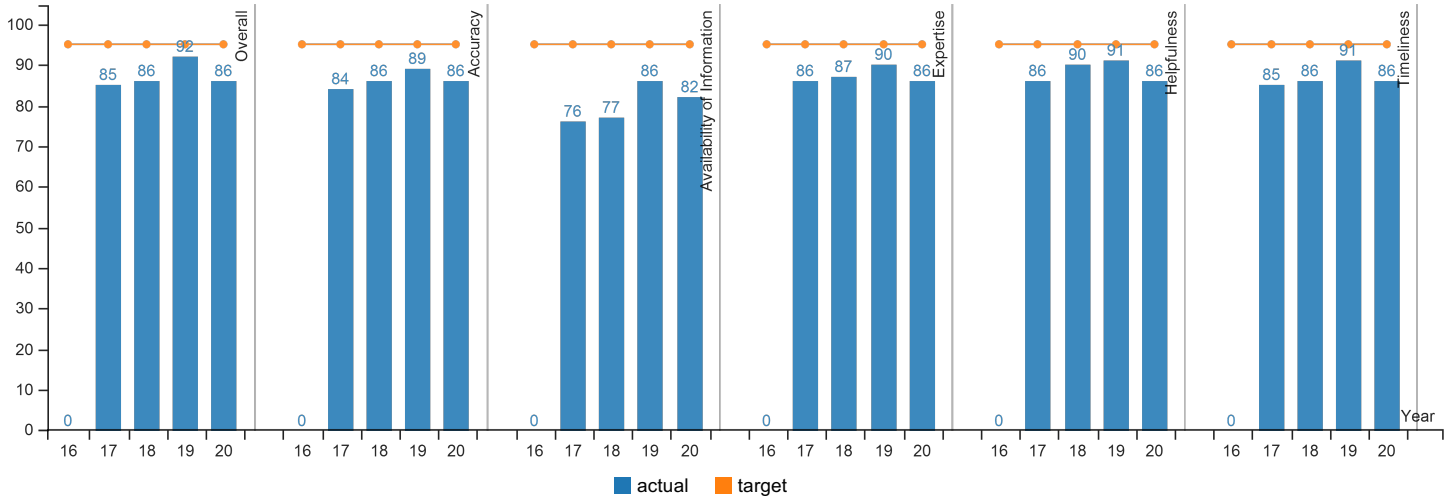
How Are We Doing

In 2019, the percent of persons on OHP that were enrolled in a CCO exceeded the goal. Starting in 2019, OHA implemented program changes that increased the number of Medicaid eligibles enrolled in CCOs. For example, OHA automatically enrolled duals into CCOs for their physical health care. This process happened as a regional roll-out, including two pilot regions in January and April of 2019. Duals had the option, at any time, to opt-out of the CCO for physical health care.

Factors Affecting Results

For the enrollment period for the 2020 plan year, the OHA's first priority in assigning members shall be maintaining, to the greatest extent practical, ongoing primary care and behavioral health relationships. After assignment, the agency shall ensure members retain the right to choose a different CCO, if more than one is available in their area. The agency reported their transition plans to interim health care committees the end of 2019.

KPM #34	CUSTOMER SERVICE - Percentage of OHA customers rating their satisfaction with the agency's customer service as "good" or "excellent" overall, timeliness, accuracy, helpfulness, expertise, availability of information.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2016	2017	2018	2019	2020
Overall					
Actual	No Data	85%	86%	92%	86%
Target	95%	95%	95%	95%	95%
Accuracy					
Actual	No Data	84%	86%	89%	86%
Target	95%	95%	95%	95%	95%
Availability of Information					
Actual	No Data	76%	77%	86%	82%
Target	95%	95%	95%	95%	95%
Expertise					
Actual	No Data	86%	87%	90%	86%
Target	95%	95%	95%	95%	95%
Helpfulness					
Actual	No Data	86%	90%	91%	86%
Target	95%	95%	95%	95%	95%
Timeliness					
Actual	No Data	85%	86%	91%	86%
Target	95%	95%	95%	95%	95%

How Are We Doing

Results declined slightly from 2018, but are about the same as 2017 and up from 2015-16.

Factors Affecting Results

The number of respondents has significantly increased (tripled) the last year or two, which could have an impact on results

Business Case for

CCWIS Modernization Program

Child Welfare,
Division, OR-Kids

Date: May 11, 2020
Version: 1.1

Authorizing Signatures

The person signing this section is attesting to reviewing and approving the business case as proposed.

This table to be completed by the submitting agency Agency Head or Designee	
(Name)	(Date)
Signature	
Agency Executive Sponsor	
Rebecca Jones-Gaston	(Date)
Signature	
Agency Chief Information Officer (CIO) or Agency Technology Manager	
(Name)	(Date)
Signature	
Business Analyst or Business Case Author	
(Name)	(Date)
Signature	

Table of Contents

[If you want the Table of Contents to update automatically, do not edit or format the table itself while working on the document. To update the table after adding text or changing headings, right-click on the table below, then select "Update Fields" from the pop-up menu. Then choose either "Update entire table" (if you have added or removed section heads from the document) or "Update page numbers only."

To ensure that all headings appear automatically in the Table of Contents, headings in the document itself must receive the style designation Heading 1, Heading 2, etc." (To see the table of pre-set styles, choose "Format," (menu above), then "Styles and Formatting…"]

Executive Summary

The mission of the DHS Child Welfare Department is to improve family capacity to provide safe and permanent living environments for children. It is a goal to reduce the number of children who experience foster care and to promote children's safety in their homes or other family environments. Some of the other goals of the department are:

- Help children who are unable to live safely in their homes live in settings that provide safety, stability and continuity with their families and begin the healing process.
- Secure safe, nurturing and legally permanent families for children who cannot be raised by their families.
- Expand program partnerships and increase the cultural competency of DHS staff and partners to better serve Oregon's diverse communities

The DHS Child Welfare Department has been under scrutiny in recent years for being disorganized, inconsistent, and representing a high risk for children in the system's care. An audit released by the Secretary of State's office in 2018 found that DHS and Child Welfare struggled with chronic and systemic management shortcomings, lacked sufficient placement options to meet the needs of at-risk children, and faced staffing challenges that compromised the program's ability to perform essential Child Welfare functions. In April 2019, the Governor issued Executive Order 19-03, *ESTABLISHING AN OVERSIGHT BOARD TO ADDRESS THE CRISIS IN OREGON'S CHILD WELFARE SYSTEM.* This Executive Order established a Governor's Oversight Board and crisis team to make and implement recommendations at DHS Child Welfare Department related to:

- Out-of-state foster child placements;
- Compliance with the Oregon Public Records Law;
- Implementation of laws prescribing the Critical Incident Response Team ("CIRT");
- Hiring and human resources practices generally;
- Building capacity for therapeutic and general foster care, as well as for a continuum of care in behavioral health services for foster children and youth that is accessible, trauma-informed and family and child-focused;
- Development of adequate in-home capacity for children and youth of color, youth with intellectual and developmental disabilities, and LGBTQ+ youth;
- Development of recommendations to address workforce challenges in provision of services to foster youth;
- Ensuring that accurate and timely data is available to improve operations and processes; and
- Other operational challenges.

OR-Kids is the State of Oregon's legacy child welfare information system, which was originally implemented to comply with the SACWIS (State Automated Child Welfare Information System) Federal framework. SACWIS systems were single centralized systems designed to help case workers manage their caseloads through automation and to comply with federal reporting requirements. Oregon will be transitioning OR-Kids into a new Federal framework known as CCWIS (Comprehensive Child Welfare Information System) that considers new child welfare practices and technologies. The CCWIS framework has been adopted by the Administration of Children and Families (ACF). ACF is the major federal partner of Child Welfare Services and provides a 60% funding match for all software development following the CCWIS guidelines. The gradual modernization and replacement of specific modules will not be a rapid process, likely requiring 4-5 years being completed in June 2023, based on the current and expected resource commitments and the scope of the work.

In addition to the change in recommended software design framework from our Federal partner, the Secretary of State's office completed an audit of the Child Welfare Information Systems (OR-Kids) and the enhancements needed to improve usability. Some of the findings from the audit to improve OR-Kids usability and data quality for Case Mangers and other Child Welfare staff include:

- continue to engage with program staff and other users to address usability concerns;
- implement a data governance function;
- fully identify critical data;
- improve the OR-Kids training programs; and
- to ensure processes and controls are in place to successfully transition OR-Kids to a Comprehensive Child Welfare Information System, the department should acquire a qualified program manager and maintain engagement with project oversight entities.

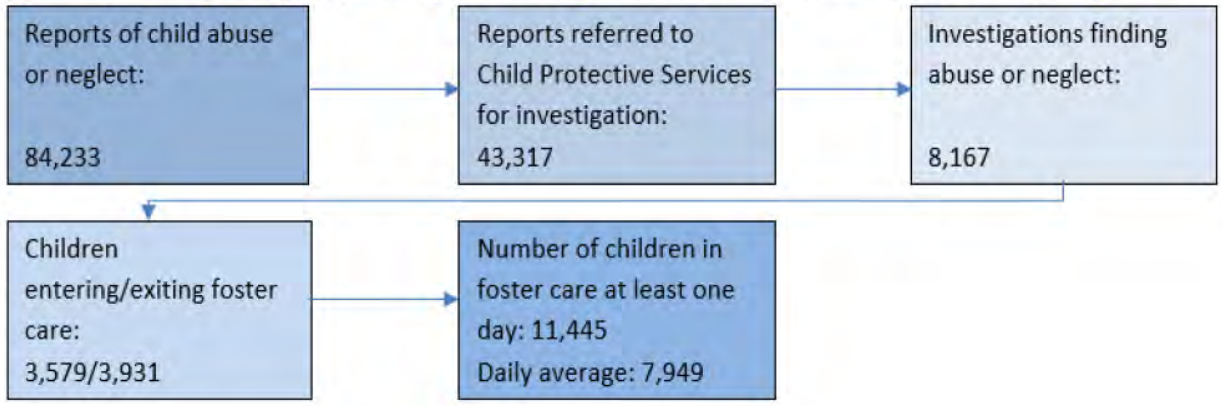
CCWIS transition and modernization will provide Oregon the opportunity to redesign the life cycle of child welfare and ultimately improve outcomes for children and families through better data interoperability, modularity, and data quality. The transition to the CCWIS framework will make OR-Kids in compliance with the guidelines of the Administration of Children and Families (ACF). ACF is a division of the Department of Health and Human Services and promotes the economic and social well-being of children, families, and communities with leadership and resources for effective delivery of human services. ACF is our federal partner and provides funding to build software that meets the CCWIS framework.

The Child Welfare Department did consider other options before embarking on this course of action. Child Welfare looked at purchasing a new OR-Kids system, but availability of commercial products was limited, the funding options available were limited, and the perceived desire for another large system implementation by the department was very low. Retaining the OR-Kids system as it was also considered. The issues identified were that it would not be CCWIS compliant, federal funds would only be available at a lower matching rate for new development and O&M, and we would not be able to meet business and reporting needs on an older technology platform. Due to these reasons it was decided that transitioning the existing OR-Kids information systems to the newer CCWIS framework provided the best option and greatest chance for success.

Current State

In the federal fiscal year ending September 30, 2018, Child Welfare served 11,445 children who spent at least one day in foster care. During that same time period, DHS received and reviewed 84,233 reports of abuse and neglect and referred 43,317 reports to Child Protective Services (CPS) workers for investigation.

Figure 1: Of the 84,233 reports, investigators in Oregon found over 8,100 instances of abuse or neglect



Source: 2018 Child Welfare Data Book

When investigators determine abuse or neglect occurred, a CPS caseworker may decide to close the investigation because the child is safe, open the case and implement an in-home safety plan, or remove the child from the home. If removed, the child enters state custody and is assigned a permanency caseworker to manage and monitor their case. After removal, the caseworker may return the child to the home with a period of monitoring, though most are placed with foster families or relatives. High-needs children and teens may be placed in more restrictive institutional settings or behavior rehabilitative programs.

A local court decides whether and for how long the child stays in state custody. Upon leaving state custody, the child may be returned to their home, become available for adoption through foster care, or enter long-term foster care or guardianship.

In addition to ensuring children are in safe and positive environments, caseworkers must also maintain voluminous documentation to satisfy state and federal requirements. The agency must comply with federal program standards, including those governing Child and Family Services; Child Support; Foster Care, Adoption Assistance and Guardian Assistance; Medicaid; Social Services Block Grant; and Emergency Assistance programs. The DHS Child Welfare program also must adhere to state laws and regulations, such as the Strengthening, Preserving and Reunifying Families law and the Interstate Compact on the Placement of Children. These laws and standards are ever-changing; for example, the Governor's recent Executive Order 19-03 established a Child Welfare Oversight Board to make and implement recommendations related to out-of-state foster child placements, building capacity for foster care, and availability of data.

DHS Child Welfare has been under scrutiny in recent years for being disorganized, inconsistent, and representing a high risk for children in the system's care. DHS and Child Welfare has struggled with chronic and systemic management shortcomings, lacked sufficient placement options to meet the needs of at-risk children, and faced staffing challenges that compromised the program's ability to perform essential Child Welfare functions. In 2018, an audit by the Secretary of State Office found that poorly planned and implemented initiatives, including the 2011 implementation of OR-Kids, undermined caseworkers' and managers' efforts to improve child safety. In addition, the ability by Child Welfare Managers to extract data for status reports and performance metrics was hampered by the convoluted software design of OR-Kids as well as the aging technology. For example, the screen size of the OR-Kids application is only two-thirds the normal size of a modern software application and the application does not have responsive design for various screen sizes and devices. Status reporting is extremely difficult because there was no data validation tools available in the older software design and critical data elements were never defined by the Program Managers. Due to the audit findings, the Governor issued Executive Order 19-03, *ESTABLISHING AN OVERSIGHT BOARD TO ADDRESS THE CRISIS IN OREGON'S CHILD WELFARE SYSTEM.*

In short, the OR-Kids information system is functional for basic case management, in that it facilitates the storage and retrieval of case information. However, it is difficult to use, which decreases caseworker efficiency and puts Child Welfare data quality at risk.

Overview and Background

Program Scope

DHS needs a robust computer system to track and manage thousands of Child Welfare cases, reports of abuse and neglect, and subsequent investigations; the agency's computer system, OR-Kids, serves this purpose. Some of the dozens of Child Welfare program functions supported by the system include provider certification, adoption work, eligibility determinations, case planning and tracking, payment processing, and federal reporting. The system's database currently contains over 400 tables containing more than 10,000 fields, which collectively contain over 600 million records, including approximately 1.8 million people associated with over 448,000 closed and 31,000 open cases.

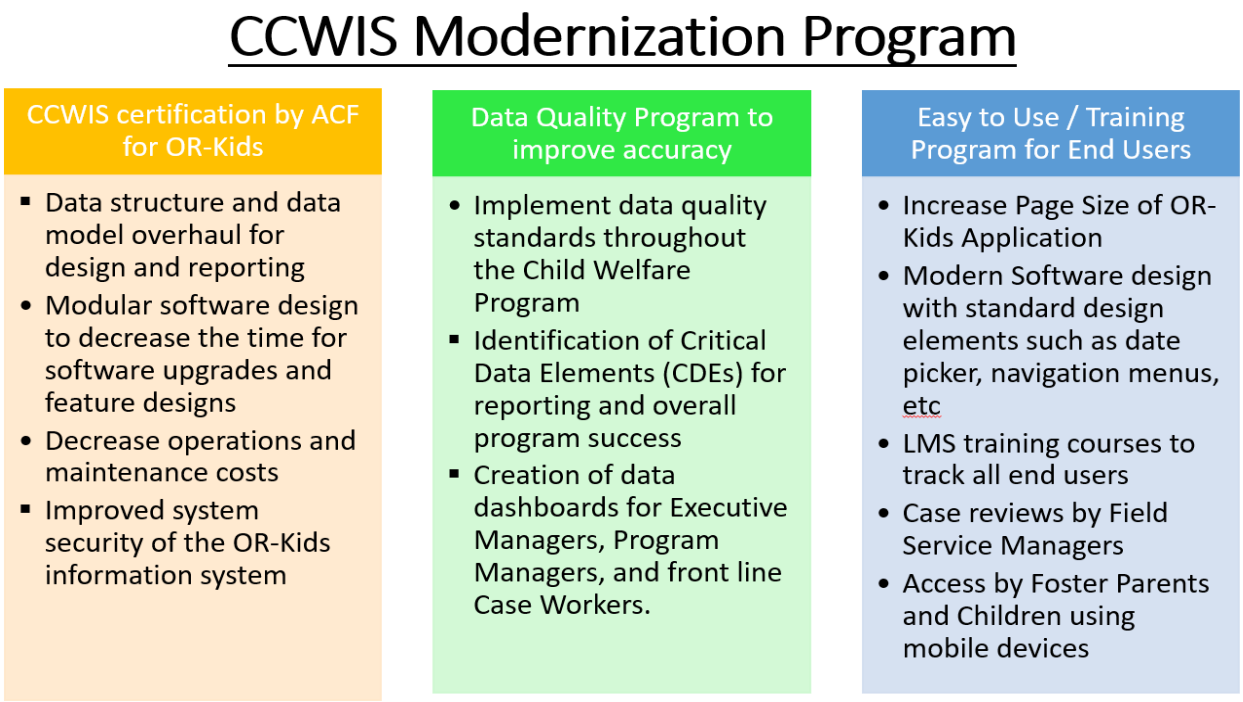
OR-Kids is the primary application for all case workers and other staff working for the Child Welfare program. With the transition to the newly recommended software design framework, OR-Kids needs to transition to a CCWIS design architecture to still be eligible for funding from ACF. This will be a multi-year effort to design OR-Kids in a more modular architecture than the current system. While there will be an opportunity to implement new features in the software, the primary concern is to transition existing features and capabilities into a CCWIS certified architecture.

The Federal Administration for Children and Families (ACF) has recently recommended a new software architecture. The new CCWIS model recommends software applications be more modular in design to allow for more flexibility of new technologies and updates/modifications to existing systems. By using the new CCWIS architecture model improvements to the OR-Kids system should lead to:

- Improved Data Quality
- Data Driven Decisions
- Reduced system overhead
- Improved User Interfaces
- Modular Components
- Public interfaces
- Reduction of Data Fixes
- Higher usability by field staff

All of these goals can be categorized into three basic areas of emphasis – data governance, user training and usability, and modern software design. OR-Kids software application should be built in such a way that the operation and maintenance cost of supporting the software is reduced, that the software use public interfaces and data standards to exchange with other information systems, and to provide high quality data trusted by all stakeholders to make data driven decisions. While these efforts may be independent efforts, they must work together to achieve a successful transition to a CCWIS compliant system.

The scope of the program is shown in the diagram below and includes the following activities:



- Data Quality Plan and implement data quality standards throughout the Child Welfare Program
- Data structure and data model overhaul for design and reporting
- Implementing a modular software design to decrease the time necessary for software upgrades and feature designs, as well as decrease operations and maintenance costs of the software application.
- Improved system security of the OR-Kids information system
- Phased replacement of OR-Kids functions with newer functionality and modular design
- Identification of Critical Data Elements (CDEs) for reporting and overall program success
- Creation of data dashboards for Executive Managers, Program Managers, and front-line Case Workers.

The program will oversee projects and work efforts to complete the transition of OR-Kids to an easy to use, fully CCWIS compliant information system. These projects will have little cross over and may not relate to each other directly, but they should work to improve the OR-Kids application. For example, one of these projects is for the Data Quality team and Executive Steering to define the Critical Data Elements (CDEs) that are used to measure success of the Child Welfare Program. Once these CDEs have been identified, then data dashboards will be built so executives and managers can review overall performance areas. A Workforce Development and Training Program Manager position were recently added to standardize business processes and to create a user training program to ensure data is entered accurately. This position will also create a standard process to implement new technology throughout the Child Welfare Department. As end users report problems where the application is too complex or difficult to record the CDEs, then the Business Analysts team can work with the end user to improve software function and design. At the same time, the software development projects such as "Family Reports" and “Foster Family Recruitment" are new modules built within OR-Kids and incorporate these features and functionality to make the new OR-Kids systems CCWIS compliant and easier for all people to use – Case Workers, Field Service Managers, Providers, Foster Families, etc.

All these projects will be approved by the Executive Steering Committee at the Program level and be coordinated throughout the Child Welfare division instead of independent data silos. The Program will provide the oversight and implementation of each of these projects coordinating each team so the new OR-Kids application is a seamless information system that captures data to be used to evaluate performance and drive policy and operational decisions.

The scope of the program does not include:

- Software maintenance releases
- System enhancements that do not support CCWIS accreditation

The following areas of scope are uncertain or have not been fully defined. More details for these projects are included in the Appendix

- Mobile solution for staff to work out of field offices while meeting clients
- Data exchange standards to facilitate sharing of structured data across multiple State systems outside of Child Welfare.
- Other projects not yet defined, that are required to achieve CCWIS accreditation.

Measurable Benefits

The CCWIS Modernization program plans will focus in the near-term on achieving CCWIS compliance, improving data structure and quality issues, and making continued enhancements for end users. Longer term, OR-Kids begins to transform into a more modern application that can meet program requirements. The team envisions a 3-year period to achieve CCWIS transition and compliance, followed by a slow process to upgrade in a modular fashion over a period of 3-4 years. Some of the benefits the program will measure are:

- Transform OR-Kids into an application about which end users consistently feel confident in completing their daily work.
- OR-Kids data is viewed as a reliable and valid basis for decision making around child safety and strategic planning for involved stakeholders.
- Business and program needs are met in weeks and months, not months and years, as OR-Kids is developed in a more modular fashion.
- Receive CCWIS accreditation and therefore still be eligible for federal matching funds for ongoing support of the OR-Kids Systems.

Identify Critical Data Elements

The Data Quality Team will work with the Child Welfare Program managers and the CCWIS Executive Steering Committee to identify a set of critical data elements to measure the success of the Child welfare program. Once these data elements are identified, a Data Dashboard showing business managers the current status of the Child Welfare system will be developed as part of the CCWIS Program. These data elements will be reviewed on an annual basis and may change as the Child Welfare requirements change over time and area of emphasis.

Training and Usability of OR-Kids Software

The Child welfare department and CCWIS program will contain training records of all Child Welfare staff and Child Welfare providers. These records will ensure that training requirements of staff members are tracked and kept current. It will also provide a training resource for new providers and provide reminders to providers when annual or new types of training are required.

Future State

The OR-Kids Business and Technical teams ("The Team") have begun to coalesce around a vision to move the application forward. Over the past 11 months, the OR-Kids Team, along with support from Oregon DHS leadership and central management, have sought to plan for the future of the application while simultaneously sharpening focus on the day to day needs of the application's 2500+ daily users. The OR-Kids staff have been successful in more deeply aligning and integrating system enhancement and planning efforts into weekly division-wide executive meetings. Going forward, a goal will be to continue to work to align improvement efforts with agency-wide goals, both internal and external, including the CFSR, APSR, and AFCARS 2.0 enhancements.

As part of a nascent agency-wide effort to focus on becoming more data-informed, and in keeping with CCWIS requirements, the Child Welfare Division has created our initial Data Quality Plan, which will inform efforts over the next biennium to address issues of validity, consistency, and timeliness with regard to critical data elements and measures important to the operation of Child Welfare and the agency's efforts to plan for the future.

Assumptions & Constraints

The project assumptions identified for this program would include the following:

- More than 60% of the program funding will be provided by ACF
- Match funding will be secured
- Establishment of a Program-level Executive Steering Committee including all Child welfare program Managers
- Establishment of a “Data Steward” program with key persons identified in each Field Service office
- Identifying and hiring the right technical resources to transition OR-Kids to modularity
- Add 9 additional positions to the Business Analyst Team
- Add 6 additional positions to the Technical Development Team

Alternatives Analysis

Options Considered:

Option	Pros	Cons
Replace OR-Kids with new CCWIS system	Not Applicable	- Commercial availability of product options is very low. - Federal match funding is not available. - Perceived low organizational appetite for another large system implementation effort.
Invest in a gradual transition of OR-Kids into a CCWIS-compliant system	- Builds on the success of a recent server modernization effort - Retains investment in the base SACWIS system - Enables leverage of the .Net investments already made in other OIS development teams - Bi-directional skill transition from Java to .Net is proven in our current staffing model	- Frequent compliance overhead, constant shifting of resources to meet new laws, regulations, and policies - The high cost of technology investment is significant to meet deadlines. - Requires dual development maintaining the current system and develop a new system simultaneously
Retain OR-Kids with no transition to CCWIS compliance	- Little compliance overhead	- Would only be able to match Federal funds at the lowest maintenance and operations level - Would not address business needs for usability, reporting and data quality. - Retains a stale technology platform.

Conclusions:

Moving into 2020, the Team intends to continue on the course of enhancing the existing the OR-Kids application in ways that are aggressively targeted at improving daily life for field end users, reducing duplicate and redundant data entry, and eliminating work-arounds that involve external tracking and systems. Simultaneously, the Team is engaged in the work of reformatting and structuring the application's data model, including bedrock Person and Case data, and starting to initiate a program to deliver the first modules, including Recruitment/Home Inquiry, Financial Processing, and a "BA" module intended to allow faster, simpler corrections to alleviate end user waits.

The 2019-20 APD outlined a number of planned initiatives to be pursued as part of initial efforts to move toward CCWIS compliance, along with long-awaited and sorely needed foundational and end-user specific enhancements.

Table 1 - Activity and Current Status

Activity	Current Status
a. CCWIS Transition Efforts are prioritized by DHS executive stakeholders	The OR-Kids modernization effort has received the strong support of Child Welfare's executive stakeholders, including the new Child Welfare Interim Director Rebecca Jones-Gaston, Child Welfare Deputy Director Jana Mclellan and DHS Director Fariborz Pakseresht. The executive team has received matching funds for

Activity	Current Status
	the 2019-21 biennium to support continued efforts toward system improvement and modularization. *A prioritized list needs to be completed by the Executive Steering Committee.*
b. Program Manager retained to lead CCWIS Transition Effort	A program manager to shepherd the many disparate parts of the CCWIS effort was completed in March 2020
c. Data Quality Plan complete and data stewardship activities underway	The Data Quality Plan was completed in January 2020 and a Data Quality Team has been established *A data stewardship program still needs to be implemented at each Field Office*
d. Role Based Dashboards for Line Managers and Staff	This effort is in process. Currently working with Data Quality Team to define Critical Data Elements and working with ORRAI to determine reporting responsibility
e. New Data Models for Person Foster Recruitment/Home Inquiry	*Expected to be completed in Q3 2020*
f. Family Report Module (Including Court Document): The Family Report represents the largest change in OR-Kids functionality around case planning and documentation since the application was implemented in 2011. A new OR-Kids Page, built in Angular JS, will allow the replacement of three existing modules (Case Plan, Child Specific Case Plan, and Court Report) and coalesce all the functions into a single workflow and document. The new function is being developed following significant staff outreach and engagement, and reflects a modern view of what stakeholders need.	This is the first module in the new CCWIS framework. The planned "Go Live" date is May 4, 2020 *Expected to be completed in Q2 2020*
g. Feasibility Study: A contracted resource will be brought in to review, assess, and provide direction around The Team's efforts to move OR-Kids towards modularity and CCWIS compliance.	Contract was awarded in March 2020. Currently, we are working with contractor to determine statement of work and start date. *Expected to be completed in Q4 2020*
h. Recruitment/Home Inquiry Module (Phase 1): A top priority for Child Welfare and the Governor, this effort will seek to improve the current workflow for staff charged with engaging and developing potential foster parents from first contact through to application and certification. i. Current OR-Kids functions do not provide a seamless view of the recruitment/ inquiry process and do not allow for all necessary data to be recorded. This enhancement will provide front-line staff with a new module/function, built in .NET, that supports their work, provides feedback on progress, nudges them to complete tasks, and supports Oregon's goal of adding and retaining new foster parents.	*Expected to be completed in Q3 2020*

Appendixes and References

1. Executive Order 19-03, ESTABLISHING AN OVERSIGHT BOARD TO ADDRESS THE CRISIS IN OREGON'S CHILD WELFARE SYSTEM
2. Secretary of State, Audit Report No. 2020-01, Oregon's Child Welfare Information System Is Adequate for Case Management, but Enhancements Are Needed to Improve Usability
3. Oregon CCWIS Data Quality Plan, Dated, 1/1/2020
4. CCWIS Final Rule Overview, Dated, June 2016
5. Annual Planning Document for the OR-Kids Application 2019-2020

EIS *IT Investment form*

Investment Name:	Child Welfare CCWIS Modernization Program	Date:	6/1/2020
Agency:	DHS	Owner / Sponsor:	Rebecca Jones-Gaston
Agency Division:	Child Welfare	Business Contact:	Lee Brown
Related Program:		IT Contact:	Mike Callaghan
Policy Option Package:		Mandate:	

Investment Type: ☐ Non-Project ☐ Project ☒ Program Initiation

Estimated Scope / Description:

Summary:

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- Reduction of Data Fixes
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Problem Definition:

An audit released by our office in 2018 found that DHS and Child Welfare struggled with chronic and systemic management shortcomings, lacked sufficient placement options to meet the needs of at-risk children, and faced staffing challenges that compromised the program's ability to perform essential Child Welfare functions. In April 2019, the Governor issued Executive Order 19-03, ESTABLISHING AN OVERSIGHT BOARD TO ADDRESS THE CRISIS IN OREGON'S CHILD WELFARE SYSTEM. This Executive Order established a Governor's Oversight Board and crisis team to make and implement recommendations at DHS Child welfare Department related to:

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- Development of adequate in-home capacity for children and youth of color, youth with intellectual and developmental disabilities, and LGBTQ+ youth;
- Development of recommendations to address workforce challenges in provision of services to foster youth;
- Ensuring that accurate and timely data is available to improve operations and processes; and
- Other operational challenges.

Opportunity Definition:

Modernizing the OR-Kids Information System makes DHS eligible to receive Federal match funding for software development costs for the life of this program.

Alternatives:

The Child Welfare Department did consider other options before initiating this program.

- Child Welfare looked at purchasing a new OR-Kids system, but availability of commercial products was limited, the funding options available were limited, and the perceived desire for another large system implementation by the department was very low.
- Retaining the OR-Kids system as it was also considered. The issues identified were that it would not be CCWIS compliant, federal funds would only be available at a lower matching

rate for new development and O&M, and we would not be able to meet business and reporting needs on an older technology platform.

Due to these reasons it was decided that transitioning the existing OR-Kids information systems to the newer CCWIS framework provided the best option and greatest chance for success.

Program Approach:

The CCWIS Modernization Program will be managed to align with the goals of the two main stakeholders. The State of Oregon Child Welfare Department is the first stakeholder with the goal of building an easier to use information system that helps with business workflow, identification of key data elements that can be used by senior managers for program reviews, data driven policy decisions, and to meet state and federal reporting requirements. The Administration of Children and Families (ACF) is the second stakeholder with their goal being to create an information system that meets CCWIS guidelines. ACF is requiring the OR-KIDS information system to transition from a large complex system to a smaller system of inter-related modules that share data elements between them and across modules. The goals of ACF are to allow states to build systems that meet their business needs, foster innovation, to allow for data to be shared between related systems (child welfare, health courts, financial, etc.), and to reduce the overall maintenance costs to support the software and information system. Each of these stakeholders have a defined process for project prioritization, oversight and review of on-going work for the CCWIS Modernization.

ACF has key requirements and an annual planning process that combine for the overall program review. ACF required that a Technology Road Map be created showing the various projects that are part of the CCWIS modernization effort and a high-level plan of how Child welfare plans to transition from the current OR-Kids software architecture to the CCWIS software architecture. ACF also required Child Welfare to create a Data Quality Plan to identify critical data that can be measured for reports and to determine success of the new system as we build it. Lastly, ACF requires Child Welfare to submit an Annual Planning Document (APD) detailing the work that was created in the past 12 months and identifying the work that is planned to occur in the next 12 months. Any modifications that occur in between the APD submission are approved as an addendum. In addition, there are monthly conference calls to review Child Welfare progress on current projects.

Child Welfare has an ISMC that meets monthly to prioritize all IT projects within the child welfare. The CCWIS Modernization program is part of this prioritization effort and several the other projects are related to OR-Kids and/or required data integration with OR-Kids. There are 3rd party interfaces that are included in the CCWIS Modernization program that are also needed with other Child Welfare projects. The ISMC reviews the CCWIS Modernization Road map and will prioritize different modules that are required by the CCWIS Modernization as well as other projects that Child Welfare is working on. For example, Child Welfare is creating an Electronic Records Management System (ERMS) to store all active case files and archive closed case files instead of storing paper files in warehouses. The ERMS project requires a data interface with OR-Kids and the same interface is required by CCWIS Modernization. This is something that the ISMC will consider when they prioritize projects. The ISMC will also consider project funding when prioritizing projects. ACF will provide 60% project funding for any project that meets Tile-IV E requirements.

EIS *IT Investment form*

The overall CCWIS Modernization Program will be comprised of several smaller projects as each module or data interface is built. The CCWIS Program will maintain oversight at the program level with a Program Management Plan, Governance Plan, Communications Plan, etc. Each of the projects will have an ITI completed and submitted to EIS for oversight. Depending on the scope and complexity of each project will determine the level of oversight required by EIS.

Assumptions:

The program assumptions identified would include the following:

- The time required to adequately research, document, design, plan and implement the program will be available.
- The Business understands and can articulate the outcome measures they require.
- Legislative mandate changes will not significantly affect the program deliverables.
- The program will be able to deliver a system that will meet all CCWIS software framework design requirements.

Estimated Schedule: Start Date: 7/1/2019 End Date: 6/30/2024

Estimated Budget:

Implementation Cost		5 –Year Operating Cost	
Hardware:	$ 57,000	Hardware:	$ 65,000
Software:	$ 255,500	Software:	$ 25,000
Contracts/Services:	$1,752,000	Contracts/Services:	$1,000,000
Personnel:	$2,555,000	Personnel:	$ 60,000
Total:	$4,619,500	Total:	$1,150,000
Funding Source:	ACF (60%) / Gen Fund 40%)	Total Cost*:	$5,769,500
Contract NTE:			

* Total cost includes implementation plus 5 years of operating cost

Security Considerations:

The data within OR-Kids is Level 3 data. Most of the data is sensitive in nature as it deals with children throughout the State of Oregon, however in certain case files there may be HIPAA protected data or CJIS information. The CCWIS Modernization Program will follow the same security guidelines as the OR-Kids Information System.

Applicable Oversight Threshold(s): (DAS Policies 107-004-130 and 107-004-150)

- ☒ ≥$150k Total Cost*
- ☒ ≥$1m Total Cost*, Internal Development
- ☒ ≥Level 3 Information Classification
- ☐ Cloud / Hosted and High Remediation Cost
- ☐ Cloud / Hosted and System of Record
- ☐ EIS Required

Instructions:

This form should be filled out early in the governance process. The information in this form helps the agency and Enterprise Information Services (EIS) appropriately resource the investment for planning and oversight purposes.

EIS *IT Investment form*

The ITI form is predominantly an on-boarding form for Senior IT Portfolio Manager (SIPM) and Business Information Security Officer (BISO) engagement.

For Project and Program investments, the information in the ITI form may be high-level or preliminary. It is expected that agency certainty regarding details will increase over time. That certainty should be reflected in additional documentation (i.e. Project Management Plan) as the project or program progresses. This document does not need to be updated unless specifically indicated by EIS.

For Non-Projects, the information in the ITI should be more thorough as the agency will likely have greater certainty about investment details. In some cases, this ITI may be the single scope/justification related artifact required for EIS endorsement, consequently it is expected that the form provide sufficient detail for future readers to understand the justification, scope, and benefit from the proposed investment.

Field	**Definition**
Investment Name	A unique name for the IT Investment.
Agency	The name of the agency.
Agency Division	The name of the department of division of the agency requesting the investment.
Related Program	If applicable, reference any related EIS approved program (defined as a group of related projects).
Policy Option Package	If applicable, reference any related Policy Option Package (POP).
Date	The date of initial ITI submission.
Owner / Sponsor	The primary owner of the IT Investment, often the Sponsor, and approving authority.
Business Contact	The primary business contact for investment questions.
IT Contact	The primary IT contact for investment questions. Typically, an IT Manager.
Mandate	If applicable, indicate the appropriate investment mandate (Federal, Legislative, Governor, etc.). If needed, use the Estimated Scope / Description space for additional mandates or supporting information.
Non-Project	An IT investment which may include purchases, subscriptions, contracts, contract amendments, contract renewals, etc. Some activities such as development of an implementation or communication plan may be required; it is expected that these activities represent a minority of non-project investment work. Typically, this work involves a limited resource commitment (i.e. fewer than 80 hours of staff time or similar threshold established by agency governance).
Project	A “temporary endeavor undertaken to create a unique product, service, or result.” (PMBOK Guide, 6th edition, p.715) Typically, projects have project

	managers assigned, are approved by agency governance, and are officially chartered.
Program Initiation	Indicate if this ITI is an initial submission for a new Program. A Program is "defined as a group of related projects, subsidiary programs, and program activities managed in a coordinated manner to obtain benefits not available from managing them individually." (PMBOK Guide, 6th edition, p.11) Programs may include any number of project and non-project investments. Typically, individual program investments will share a program-level Business Case.
Estimated Scope / Description	Provide a brief description of the investment. This should detail, at a high level, the estimated scope of the investment and provide a brief justification for the investment. A more thorough justification should be included when a corresponding Business Case is not expected, for example when an investment is part of a program or when infrastructure/lifecycle level 1 oversight is likely.
Start Date	For Projects this represents the estimated date of Project Charter. For Non-Projects this represents the estimated date of contract signature, purchase, subscription start, etc. For Programs this represents the estimated date of Program Charter.
End Date	For Projects this represents the estimated date of Project close-out. For Non-Projects this represents the estimated date of contract signature, purchase, subscription start, etc. For Programs this represents the estimated date of Program close-out.
Hardware	The cost, either initial or 5-year operating, for estimated hardware purchases. *
Software	The cost, either initial or 5-year operating, for estimated software purchases. *
Contract/Service	The cost, either initial or 5-year operating, for estimated contracting costs. This cost should include maintenance contracts, subscriptions, development contracts, etc. *
Personnel	The cost, either initial or 5-year operating, for estimated personnel costs. *
Total	The total cost, either initial or 5-year operating, for all estimated expenses. *
Funding Source	Indicate the primary funding source for the investment.
Total Cost	The total of initial and 5-years operating cost estimates. Do not include potential revenue or savings. *

EIS *IT Investment form*

Contract NTE	For Non-Project Investments related to a contract (contract, contract amendment, contract renewal, etc.), include the Not-To-Exceed amount of the current contract and amendments.

Security Considerations	Briefly describe the following: ▪ Expected security controls required to protect state data against unauthorized access (Confidentiality, Integrity, and Availability) ▪ Any known business requirements for availability (e.g. acceptable downtime) ▪ Cloud / Hosted environment: hosted inside or outside the United States ▪ Highest level of data classification (Reference Policy 107-004-050) o Level 1 – Published: Information that is not protected from disclosure, that if disclosed will not jeopardize the privacy or security of the agency employees, clients, and partners. o Level 2 – Limited: Information that may be protected from public disclosure, but if made easily and readily available, may jeopardize the privacy or security of agency employees, clients or partners. o Level 3 – Restricted: Information intended for limited business use that may be exempt from public disclosure because, among other reasons, such disclosure will jeopardize the privacy or security of agency employees, clients, partners, or individuals who otherwise qualify for an exemption. Information may be accessed and used by internal parties only when specifically authorized to do so in the performance of their duties. External parties requesting this information for authorized agency business may be under contractual obligation of confidentiality with the agency prior to receiving it. o Level 4 – Critical: Information that is deemed extremely sensitive and Is intended for use by named individual(s) only. This information is typically exempt from public disclosure because, among other reasons, such disclosure would potentially cause major damage or injury up to and including death to the named individual(s), agency employees, clients, partners, or cause major harm to the agency. ▪ Restricted data types: o HIPAA (Protected Health Information) o CJIS (Criminal Justice Information) o IRS Publication 1075 (Federal Tax Information) o FERPA (certain education records) o PCI DSS (Payment Card Industry Data Security Standard) o SSA (Social Security Administration) o FISMA (Federal Information Security Modernization Act) o MARS-E (Minimum Acceptable Risk Standards for Exchanges) o OCIPA (Oregon Consumer Information Protection Act) o Other (identify the specific rule or standard)

EIS *IT Investment form*

≥$150k Total Cost	Investments exceeding a cost of $150,000, unless the investment is an agency-staffed application development project. **
≥$1m Total Cost, Internal Development	IT Investments exceeding a cost of $1,000,000 for agency-staffed application development projects. **
≥Level 3 Information Classification	It will store, process, or transmit data of Information Asset Classification Level 3 (Restricted; reference Policy 107-004-050) or higher, or information for which special protection standards apply by law or contract. ***
Cloud / Hosted and System of Record	It will be the authoritative source for information that is difficult, expensive, or infeasible to replace or recreate. ***
Cloud / Hosted and High Remediation Cost	A sustained interruption of the Service would have a significant impact on agency operations and/or those served by the agency. ***
EIS Required	Any IT Investments where EIS determines that oversight, review, or approvals is in the best interest of state government. **

* IT Investment is the planned or actual commitment of funds for IT-related expenditures including, but not limited to personnel, contractors associated with projects, products, services, or contracts and contract renewals and other amendments. **Cost of an IT Investment includes the cost of any services and/or supplies purchased and five years of anticipated operational costs** (e.g., licensing costs, and hardware/software maintenance).

** For more detail on oversight thresholds see DAS Policy 107-004-130

*** For more detail on Cloud and Hosted thresholds see DAS Policy 107-004-150

DHS Oregon Department of Human Services

Oregon Health Authority

DHS|OHA

Business Case

COMPASS Modernization Portfolio

VERSION LOG

Version	Description	Author	Date
1.0	Initial Draft	G. Mason	5/17/18
1.1	Edits and Review	S. Weeks, K. West	5/18/18
1.2	Revised	G. Mason, A. Bellair	5/21/18
2.0	Final Draft	S. Weeks, K. West, G. Mason	5/23/18
2.1	Edits based on discussion with DAS Oversight	D. Southmayd	3/5/19
2.2	Completed Section 4 the Alternative Analysis	D. Martushev	12/3/19
2.3	Accepted Track changes by M. Callaghan & R. Richey	D. Martushev	01/25/20
2.4	Updated to reflect Steve W. input. Removed subtitle “BH Data Warehouse and MOTS replacement” from cover page and added an alternative analysis disclaimer in section 4.6.	D. Martushev	02/10/2020

SIGN-OFF

Version	Role	Name	Comments	Date
2.3	EIS Analyst	Shelly Lofgren		1/31/2020
2.3	Process Owner	Steve Westberg		02/10/2020

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1. Business Case Summary

1.1. Executive Summary

COMPASS (Community Outcome Management and Performance Accountability Support System) is a collaborative information technology approach to the administration, planning and monitoring of Substance Use Disorder and Mental Health treatment programs. The purpose of COMPASS is to collect data from a variety of internal and external data systems and electronic health records systems and provides multi-functional reporting to support OHA, treatment providers and state and federal stakeholders. By aligning business processes and data, the system will facilitate cooperation and collaboration between stakeholders and improve reporting of, and access to contract and client encounter information in compliance with HIPAA and 42CFR regulations.

The current COMPASS software applications are running on a mixture of platforms and languages. Most are outdated and in need of upgrading or decommissioning. The underlying data storage for the applications is incomplete, insular, outdated, and expensive to maintain. The current database design contains some gaps in which referential integrity has been compromised, creating data quality issues. These data design issues have been masked by their current applications, creating a heavy reliance on these applications to provide the necessary context for the data. This makes integration and reporting from the data difficult, inaccurate, and time consuming.

Modernization of the COMPASS universe would significantly improve interoperability of OHA's data systems and could be leveraged across numerous program areas. The current lack of integration with other state data systems creates barriers and challenges for service providers to report data to OHA. In addition, OHA personnel have additional workload and must manually perform required tasks to meet agency, state, and federal reporting requirements.

The COMPASS modernization project supports the following initiatives, missions and strategic technology plans by ensuring efficient data collection, management, system integration, and data reporting on behavioral health service outcomes for Oregonians.

1. 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.

2. Health and Human Services Agencies Information Resource Management 2017-2019, Governor Brown's Strategic Initiatives for Healthy, Safe Oregonians:
    a) Ensure that every Oregonian who needs alcohol and other drug treatment or mental health services can easily get it.
    b) Ensure all Oregonians have equitable and appropriate access to affordable, high quality health care.
    c) 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.

3. OHA Mission: Helping people and communities achieve optimum physical, mental, and social well-being through partnerships, prevention and access to quality, affordable health care.

4. DHS/OHA Strategic Technology Plan:
    a) 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.
    b) Enable Business Automation via workflows and business rules, reducing manual, paper-based processes while increasing effectiveness.
    c) 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.
    d) Use Dynamic Services Supporting Dynamic Needs by supporting provider modular, common services and capabilities, which promote agility, reuse, and best practices leveraging enterprise capabilities.

Improved data collection and integration of the COMPASS software applications would allow the agency to improve reporting on outcomes, expenditures and contract compliance as well as collaborate with providers to track the implementation and effectiveness of services, identify service gaps, predict the specific timing of service needs, and better request and allocate funding to facilitate individual's progress through the system.

2. Background

COMPASS is a collaborative information technology approach to the administration, planning and monitoring of Substance Use Disorder and Mental Health treatment programs. The purpose of COMPASS is to collect data from a variety of internal and external data systems and electronic health records systems and provides multi-functional reporting to support OHA, treatment providers and state and federal stakeholders. By aligning business processes and data, the system will facilitate cooperation and collaboration between stakeholders and improving reporting of, and access to contract and encounter information securely and in compliance with HIPAA and 42CFR regulations.

The Oregon Health Authority (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:

1. Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant.
2. U.S. Department of Justice (USDOJ) Performance Plan.
3. Oregon State Police reporting to the NICS database for background checks.
4. Treatment Episode Data Set (TEDS), including National Outcome Measures (NOMs)

OHA has been unable to comply with the monthly data submissions required by SAMHSA. Continued noncompliance with this requirement places millions of dollars for mental health and addictions services at risk.

The behavioral health care delivery system in Oregon has changed dramatically with the integration of new partners into a comprehensive care model. Additionally, recent legislative changes require that the agency find a solution for real time tracking of the availability of some behavioral health services. The emphasis on Coordinated Care Organization (CCO) metrics and the ability to track both quality of care and service outcomes makes the ability to gather and analyze data across systems an integral need for OHA programs.

The COMPASS constellation is comprised of many data systems used internally by OHA and externally by contracted partners. See *Appendix A – Current Business System Areas Supported* for a complete list of systems and their respective area of focus. The COMPASS applications are intended to be an essential behavioral health data collection system for the Health Systems Division (HSD). Originally designed to improve data collection for Medicaid and non-Medicaid behavioral health care provided by programs licensed by the Health Systems Division, the stand-alone systems are aging and exist on platforms that are outdated, expensive to service or modify, and difficult to acquire technical support.

A new solution is required to collect necessary data from multiple sources, consolidate data systems, interface with external systems, and integrate into the enterprise environment. Existing data systems need to be retired and a new solution implemented with the agency's long-term enterprise technology strategy.

2.1. Stakeholders

Primary stakeholders include, but are not limited to:

1. OHA, Health Systems Division
2. OHA, Health Policy & Analytics
3. OHA, Oregon State Hospital
4. OHA, Office of Information Services
5. OHA, Office of Budget and Forecasting
6. OHA, Office of Contracts and Procurement
7. Federal partners: Substance Abuse and Mental Health Services Administration (SAMHSA) and U.S. Department of Justice (USDOJ)
8. Oregon State Police
9. Electronic Health Record (EHR) and other software providers
10. Providers of behavioral health services
11. Clients receiving behavioral health services
12. Providers of substance use treatment services
13. Clients receiving substance use treatment services

2.2. Other Considerations/Drivers

The agency is at risk of losing grant funds, including the State Targeted Response grant, the Medication Assisted Treatment – Prescription Drug and Opioid grant (both dealing with opioid addiction), and not being able to forecast general fund need accurately and in a timely manner. The agency is currently behind or using complicated and time-consuming workarounds to meet mandatory federal reporting of behavioral health data for SAMHSA, both the mental health substance abuse block grants (NOMs/TEDS) and the USDOJ Oregon Performance Plan.

Recent reviews and process changes at OHA determined that COMPASS systems are not receiving and maintaining sufficient documentation to support data being provided to Oregon State Police (OSP) for the National Instant Criminal Background Check System (NICS). A scheduled audit in June 2018 by the Federal Bureau of Investigation (FBI) could result in penalties or sanctions against the agency for failing to address the flawed data systems.

3. Problem and Opportunity Definition

3.1. Problem Definition

With Oregon's Health Care Transformation, the introduction of Coordinated Care Organizations (CCOs), and investments in Electronic Health Record (EHR) systems, the current data environment does not allow for data integration to meet the need for reporting on treatment outcomes and investment efficiency. Many of the COMPASS systems were designed to measure outcomes based on a different funding model from the service element model currently in use. In addition, the system requirements and data elements were not fully defined in the original build.

In 2017, the OHA COMPASS Task Force identified issues with disjointed and siloed data from systems for HSD Contracting, Licensing and Certification, and Client Outcomes. Additional operational deficiencies were noted in the following areas of the COMPASS universe:

1. Contract deliverables are not met and/or enforced and data is not validated as accurate;
2. Subcontractors cannot be identified in collected data;
3. Provider licensing and certification is not integrated with current data systems;
4. Data systems lack defined relationship and correlation between data elements;
5. Missing data elements in collection and reporting process;
6. Difficulty assessing if contracted services are provided in compliance with contract.

OHA is unable to conduct mandated state and federal reporting. OHA and our partners at DHS continue to fall short of the expectations of advocates by failing to meet the needs of transitioning clients; this leaves the agency with continuing risk of additional investigation and potential litigation. OHA remains unable to adequately forecast service need or coordinate treatment for individuals entering and leaving the state hospital. *Olmstead v. LC*, a US Supreme Court ruling, requiring states to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs. Inability to appropriately forecast need for state

hospital resources puts the agency at risk of losing needed budget and Oregonians at risk of inadequate care.

The COMPASS data systems lag behind OHA business partners who are further down the integrated systems path. The file structure and business process are a couple of generations behind the EHR industry and has proven challenging for some partners to provide data to OHA for that reason. Separate work flows are required for COMPASS data applications as they do not compliment or integrate with normal EHR operations.

The current Health Systems Framework applications are running on ColdFusion. The underlying data storage for the COMPASS applications resides in several DB2 databases running on AIX servers, which are outdated and expensive to maintain. The current database design contains gaps in which referential integrity has been compromised, creating data quality issues. These design problems have been masked by the application, creating heavy reliance on the application to provide necessary context for the data.

The tightly-coupled relationship between the database and the application makes improvement and integration projects more difficult because it restricts the developer within the confines of both an aging toolset and a flawed data model. This data model makes integration with other systems and utilization of the data for reporting by Business Objects and other reporting engines more problematic. As new projects are undertaken using the tightly-coupled architecture in COMPASS, they will become riskier as the number of records and users increase, while the toolset falls further out of support.

Over time, the IT system-related risks will increase as the number of developers knowledgeable in older Cold Fusion/DB2 development projects dwindles, and it becomes a specialty realm for contract support. Add to this the growing number of retiring mainframe, Rbase and other legacy applications that will need to be integrated into the Health Systems Framework, and the question of available qualified in-house resources becomes critical going forward.

3.2. Opportunity Definition

Alignment with client need, the ability to track available resources, CCO reporting requirements and the analysis and tracking of behavioral health data across systems will be critical to the successful integration of behavioral health treatment into the CCO environment.

Modernization of the COMPASS universe of systems will:

1. Increase the agency's ability to measure and report on behavioral health outcomes.
2. Increase the agency's ability to tie reporting deliverables to payment.
3. Improve the standardization of data in the agency.
4. Increase the agency's ability to track outcomes by client, demographic group, or location of clients.
5. Permit the agency to meet required reporting responsibilities.
6. Develop a standardized reporting system for behavioral health services.
7. Support the provision of more timely, appropriate, cost-effective services for Oregonians.
8. Reduce the administrative burden on contracting providers.

9. Streamline and update business processes
10. Improve the standardization of data in the agency.
11. Collect data to increase the agency's ability to measure and report on behavioral health outcomes.
12. Implement a solution that includes data elements necessary for tracking outcomes and providing non-Medicaid data for a 360 view of the client.
13. Permit the agency to meet required reporting responsibilities.
14. Build a data warehouse that allows interfaces from a variety of systems to meet data quality standards, to create a 360 view of the client, and to include data necessary for accurate cross-agency reporting.

The 2017 COMPASS Task Force report provided opportunities including:

1. Replace COMPASS systems to reflect the present continuity of care model and reexamine old business processes.
2. Improve and update business processes to better align with COMPASS systems.
3. Align siloed systems to integrate CCO data into the service delivery environment.

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.

The project and resulting system should provide a variety of business support functions including the following:

1. Compliance with Personally Identifiable Information (PII) Privacy Act;
2. Compliance with Health Insurance Portability and Accountability Act (HIPAA);
3. Compliance with Health Information Technology for Economic and Clinical Health (HITECH) Act;
4. Reduce silos around system maintenance in OHA's OIS team;
5. Increase the agency's ability to tie contract deliverables / reporting responsibilities to payment;
6. Improve the standardization of data in the agency;
7. Increase the agency's ability to measure behavioral health outcomes for individual clients and groups;
8. Reduce the administrative workload on contracting providers and staff;
9. Create integrated and adjustable reports that meet federal reporting requirements;
10. Upgrade requirements for federal and state legislation, rules, and business needs;

11. Migrate data from or interface with multiple data collection systems including, but not limited to: Consolidated Database (CDB), Acute Care Reporting (ACR), Medicaid Management Information System (MMIS);
12. Streamline and update business processes;
13. Provide ongoing maintenance and support; and
14. Support required functionality for 5 – 10 years.

The redesign of the COMPASS constellation provides OHA with an opportunity to examine and update business process and better align to the agency's current vision and the continuity of care model. Part of this business process alignment will include the interface of provider reporting and contracting requirements, ensuring that the agency is better tracking the services it is paying for and that Oregonians are receiving the benefit of service dollars contracted through the agency. OHA has the opportunity to reduce silos and begin the process of integrating CCO's into the behavioral health service delivery model.

The COMPASS modernization project supports the following missions and strategic technology plan by ensuring efficient data collection, management, system integration, and data reporting on behavioral health service outcomes for Oregonians.

1. 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.

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    b) Enable Business Automation via workflows and business rules, reducing manual, paper-based processes while increasing effectiveness.

c) 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.
d) Use Dynamic Services Supporting Dynamic Needs by supporting provider modular, common services and capabilities, which promote agility, reuse, and best practices leveraging enterprise capabilities.

4. Alternatives Analysis

4.1. Assumptions

The Project assumptions identified would include the following:

1. There is more than one qualified vendor.
2. Total cost of project and 5-year maintenance and operations will be within available funding.
3. Only purchase a solution using OIS supported technology or include funding to for contracted O&M by vendor for operations and maintenance support for the selected technology support.
4. Modular solution with major components as individual modules.
5. Agile approach is preferred in order to receive functionality throughout the system development.
6. The time required to adequately research, document, design, plan and implement the projects as described will be available.
7. The Business understands and can articulate the outcome measures they require.
8. Legislative mandate changes will not significantly affect the project deliverables.

4.2. Constraints

Below is a list of known constraints:

- Internal resources have limited availability (Program Support, Program) to support implementation.
- No funding to support implementation in biennium 2019/2021

4.3. Selection Criteria and Alternatives Ranking

The core criteria that we are using to compare alternatives are:

- Time to implement (duration)
- Cost (both project costs and ongoing annual costs)
- Benefits
- Risks

4.4. Solution Requirements

OHA requires the following system functionality:

- Secure data intake, storage, and output
- Data quality and validation processes that does not let providers enter inaccurate information
- Data gathering processing functions like versioning, creating crosswalks, data dictionary, de-duplication of data submissions.
- Secure, unobstructed, and quick access to data warehouse by role-based credentials
- Multi-functional reporting ability to create accurate reports with reliable data.: scheduled and ad hoc reporting
- Cloud based solution providing the ability to support future program data collecting and behavioral health reporting needs.
- Application Programing Interface (API) for any other data systems to send the data to the BH data warehouse.
- Behavioral Health (BH) data warehouse with the ability to accept data from other data systems.
- Provide training and training material to OHA staff and Providers
- Bi-Directional interface to obtain master client unique ID
- One-way interface with the following existing internal and external data systems:
    - Electronic Health Records (EHR) systems and health information data exchanges (ex. OWITS)
    - AMHI/Choice Model – Community Mental Health
    - Avatar the Oregon State Hospital's Electronic Health Record system.
    - Justice or State Patrol for Criminal History
    - Medicaid Management Information System (MMIS)
- 5 years of on-going operations and maintenance (O&M) support

**For more detailed solution requirements see Behavioral Health Data Warehouse Project Solution requirements and MOTS Replacement solution requirements.*

4.5. Vendor Requirements

OHA seeks to obtain the services of a data vendor with the capacity and technical expertise to perform all Behavioral Health data collection, aggregation, enhancement, and quality assurance functions. This includes but is not limited to: design, development and implementation of the vendor's solution, migrating the existing data hosted at the state Data Center Services (DCS) to the new solution; secure and streamline data collection and aggregation; processing and validating data submissions; providing data access and reports to approved users; and optimizing data for mandated reports. Mandatory tasks include:

Project Planning and Implementation
The Contractor chosen by OHA will be required to provide detailed documentation to OHA including a project plan that includes standard technical documentation covering Design Development and Implementation (DDI) of the proposed solution, a comprehensive transition-in plan and an extensive Data Quality and Business Rules document that details all methodologies used to enhance and validate data submissions. As part of this task, a new Contractor must

securely transfer all data from the DCS and in doing so, retain processed historic data, but also reprocess raw historic data. Finally, the Contractor must provide expert project management and technical support across all activities throughout the contract term.

Data Management
The Contractor will be responsible for all Behavioral Health front-end data collection and aggregation. As part of this task, the contractor must implement and manage data intake processes; perform regular extract, transfer, load (ETL) processes; actively manage data collection; implement pre-load quality assurance checks; and participate in data submitter relations and engagement. After data collection, the contractor must perform data enhancement tasks like creating member, provider, and facility crosswalks; claims processing and de-duplicating; as well as other value-added components like creating benchmarks. Finally, the Contractor must warehouse the processed data and perform post-load quality assurance on the data.

Data Access and Reporting
The Contractor must provide to OHA complete access to all levels of the data warehouse in a secure, unobstructed, and efficient manner. Part of this will be to provide role-based credentials and access to a shared work area within the data environment for users to develop and save tables, cubes, program code, etc. The Contractor must also provide detailed data warehouse documentation, training, and technical support as well as furnish prescribed data sets on a quarterly basis and produce additional data extracts as needed.

Data for Public Mandated Reports
The Contractor must work closely with OHA to optimize the Behavioral Health data for creating and standardizing Mandated reports (SAMHSA) based on stakeholder feedback, content development, and ongoing operations.

4.6. Alternatives Identification

OHA has considered the following alternatives:

- Alternative 1: Status Quo
- Alternative 2: Build - Integrate Existing System
- Alternative 3: Buy - RFP COTS SaaS
- Alternative 4: Build – OIS Development Build
- Alternative 5: Build – Basecamp Development
- Alternative 6: Build – Transfer Technology State

**The Alternatives captured in this analysis is for the Behavioral Health Data Warehouse and MOTS Replacement projects. Alternative Analysis will be completed for each project under the Compass Modernization Portfolio.*

4.7. Alternatives Analysis

Alternative 1: Status Quo (Not Selected)

- Description: Continue to use existing systems and tools to support programs.
- Implementation Duration: 0 months
- Total Cost: $8,432,178
    - Implementation Cost: $0
    - 5 Years of O&M: $8,432,178
- Benefits:
    - No changes needed.
    - Lower cost in short term.
    - Funding can be re-assigned to other Behavioral health needs
- Risks:
    - Unable to achieve all solution requirements
    - Continue to experience pain points:
        - Not meeting reporting needs
        - Not meeting operational needs
        - Receiving incomplete and inaccurate data
        - Complex manual data submissions
        - Missed grant funding (Fed, State, Foundation) opportunities because unable to provide reports and outcomes

Alternative 2: Build - Integrate Existing System (Not Selected)

- Description: Gathering the business requirements and building (writing code) an interface between existing systems using OIS Resources
- Implementation Duration: 48 months
- Total Cost: $17,853,047
    - Implementation Cost: $ $9,131,386
    - 5 Years of O&M: $8,721,661
- Benefits:
    - Lower cost
    - Lower implementation duration
    - Improves the ability to provide data needed for “telling a story” or any future reporting needs.
- Risks:
    - Existing systems are too old to support APIs or integration and will need extensive re-work to be accomplished.
    - Unable to meet all reporting requirements (data elements missing)
    - Unable to support scalability for future technology needs (mis. Paper is one of the systems).

Alternative 3: Buy - RFP COTS SaaS (Selected)

- Description: Utilize Request for Proposal (RFP) to procure and execute a new contract for development and implementation of a Commercial off the Shelf (COTS)/Software As A Service (SAAS) and modify using OIS Resources
- Planning Duration: 21 months
    - *Note: Implementation duration will be determined through RFP. According to the market analysis research implementation duration provided by a vendor ranges between 12-18 months.*

- Total Cost: TBD
  - Planning Cost: $1,979,606
  - Implementation Cost: To Be Determined through RFP
  - 5 Years of Maintenance and Operations: To Be Determined through RFP
  - *Note: According to the market analysis research implementation cost provided by a vendor ranges between $1M - $2.5M and 5 years of O&M ranges between $2.5M-$4M.*
- Benefits:
  - Possibility for lower cost
  - Possibility for better support
  - Implementation duration is less
  - Use of most up to date technology
  - Supports scalability for enterprise needs:
    - Expansion within BH domain
    - Expansion within external agencies (DHS)
    - Supporting BH Technology Roadmap
- Risks:
  - Project takes an additional 6-12 months for RFP effort.
  - Customizations increase implementation & O&M costs
  - Technology solution and data is owned by the vendor and changes to the system must be made by the vendor which increases costs.

Alternative 4: Build – OIS Development Build (Not Selected)

- Description: Build new system using OIS Resources
- Implementation Duration: 54 months
- Total Cost: $27,364,225
  - Implementation Cost: $15,286,399
  - 5 Years of O&M: $12,077,826
- Benefits:
  - Allocated resources used to support O&M and enhancements resulting in lower long-term costs
  - Address new regularity requirements faster (no amendments required)
- Risks:
  - High degree of customization needed which drives up cost and timeline to implement.
  - Time to complete the project may increase because same resources provide operations support for these specific State software applications
  - Other higher priority project may affect the resource availability to support the project and extend project timeline.

Alternative 5: Build – Basecamp Development (Not Selected)

- Description: Using external contracting resources to build (writing code) a system that would meet all your requirements to do work, run reports and track clients.
- Implementation Duration: 54 months
- Total Cost: $29,101,831
  - Implementation Cost: $17,024,005

  - 5 Years of O&M: $12,077,826
- Benefits:
  - Allocated resources used to support O&M and enhancements resulting in lower long-term costs
  - Address new regularity requirements faster (no amendments required)
- Risks:
  - The following activities increase cost and duration:
    - High Customizations
    - Contract resource turnover
    - Contract administrative support
  - Same resources used to support project and O&M which may result in project delays.

Alternative 6: Build – Transfer Technology State (Not Selected)

- Description: Acquire other state solution and have OIS customize solution
- Implementation Duration: 66 months
- Total Cost: $29,703,015
  - Implementation Cost: $17,625,189
  - 5 Years of O&M: $12,077,826
- Benefits:
  - Solution already built and in production with “lessons learned”
  - Ability to share knowledge and compare reports with other state organizations
- Risks:
  - Longer duration and higher cost
  - May have to customize software because of state laws, process differences
  - May require State to purchase other integrated software not currently owned.

4.8. Cost

The below implementation cost analysis and 5 years of O&M includes a breakdown for each alternative by the following categories:

- **Program Resources** are the Behavioral Health program subject matter experts
- **Program Support Resources** are the Business Analysts working with the program subject matter experts. Resources are from the Compass Support team within Oregon Health Authority and Covendis Contractors.
- **State Resources** are the technical resources such as technical manager, project managers, project coordinator, security analyst, DAS procurement services, and OIS Business Operations.
- **Vendor Resource** is for a Quality Assurance vendor.
- **Software** for developing the technology solution (W) MSDN Visual Studio, (W) Visio x 5, (W) Password Agent, (W) Toad, (W) Beyond Compare (W) XML Tool,
- **Hardware** are servers that are currently hosted at the Data Center Services (DCS)
- **DCS Operations** is the service cost for hosting the technology solution.

Implementation Cost and Duration Summary:

COMPASS Modernization Alternatives High Level Cost and Duration Estimates Summary (50%+/-)

	Implementation								
Alternatives	**Program Resource Cost**	**Program Support Resource Cost**	**State Resources Cost** (OIS, DAS, ESO, OC&P)	**Vendor Resources Cost**	**Purchased Software Cost (Original Fee)**	**Hardware Cost**	**DCS Operations Cost**	**Total Implementation Cost**	**Implentation Duration (Months) *RFP only**
1 Status Quo	$ -	$ -	$ -			$ -	-	$ -	0
2 Integrate Existing System (Build)	$ 742,020	$ 2,035,922	$ 5,148,589	$ 570,710	$ 128,348	$ 346,522	$ 159,274	$ 9,131,386	48
*3 COTS/SaaS - Buy - (RFP)	$ 171,935	$ 611,701	$ 1,195,970	TBD	TBD	TBD	TBD	$ 1,979,606	21
4 OIS Development Build	$ 2,626,608	$ 4,303,176	$ 6,660,915	$ 978,530	$ 128,348	$ 429,547	$ 159,274	$ 15,286,399	54
5 BaseCamp Development (Build)	$ 2,047,607	$ 4,286,214	$ 8,823,376	$ 1,091,318	$ 186,669	$ 429,547	$ 159,274	$ 17,024,005	54
6 Transfer Techology from another State	$ 2,688,589	$ 5,033,274	$ 8,050,544	$ 1,135,613	$ 128,348	$ 429,547	$ 159,274	$ 17,625,189	66

*Please note alternative *3 COTS/SaaS – Buy (RFP) only includes Total Implementation cost estimates through planning.*

5 Years of Operations and Maintenance Summary:

	5 Years of Operations & Maintenance (O&M)							
Alternatives	**Program Resource Cost**	**Program Support Resource Cost**	**State Resources Cost**	**Vendor Resources Cost**	**Purchased Software Cost (Annual Fee)**	**Hardware Cost**	**DCS Operations Cost**	**5 Years Total O&M Cost**
1 Status Quo	$ 55,178	$ 3,152,958	$ 4,590,131		$ 128,348	$ 346,289	$ 159,274	$ 8,432,178
2 Integrate Existing System (Build)	$ 1,714,992	$ 409,567	$ 5,962,957		$ 128,348	$ 346,522	$ 159,274	$ 8,721,661
*3 COTS/SaaS - Buy - (RFP)	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
4 OIS Development Build	$ 1,452,553	$ 4,980,947	$ 4,927,156		$ 128,348	$ 429,547	$ 159,274	$ 12,077,826
5 BaseCamp Development (Build)	$ 1,452,553	$ 4,980,947	$ 4,927,156		$ 128,348	$ 429,547	$ 159,274	$ 12,077,826
6 Transfer Techology from another State	$ 1,452,553	$ 4,980,947	$ 4,927,156		$ 128,348	$ 429,547	$ 159,274	$ 12,077,826

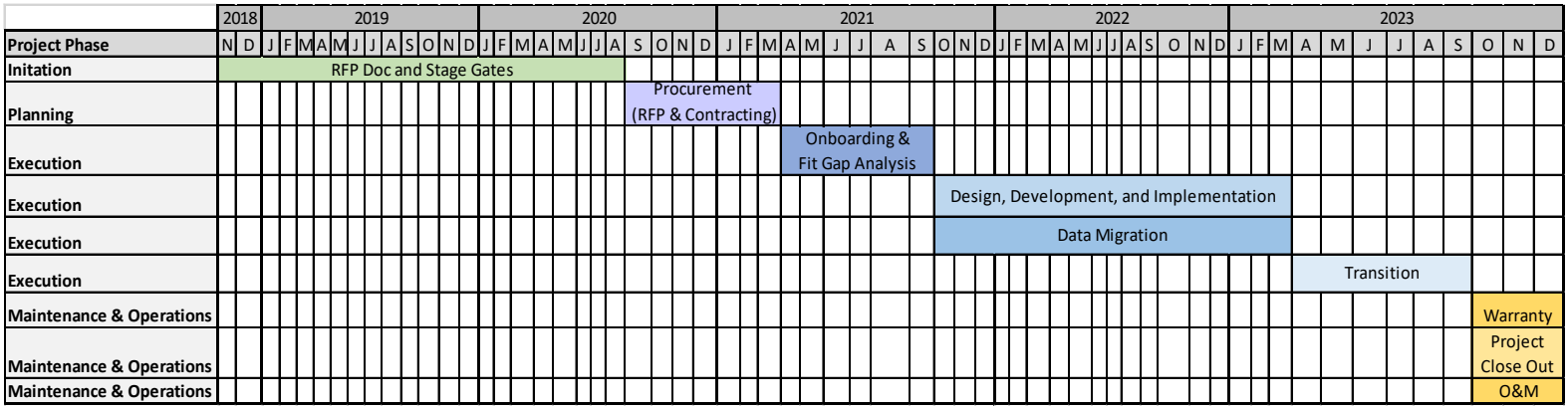
Implementation and 5 Years of Operations and Maintenance Cost Summary:

Alternatives	Total Implementation Cost	Implentation Duration (Months) *RFP only	5 Years Total O&M Cost	Grand Total
1 Status Quo	$ -	0	$ 8,432,178	$ 8,432,178
2 Integrate Existing System (Build)	$ 9,131,386	48	$ 8,721,661	$ 17,853,047
*3 COTS/SaaS - Buy - (RFP)	$ 1,979,606	21	TBD	TBD
4 OIS Development Build	$ 15,286,399	54	$ 12,077,826	$ 27,364,225
5 BaseCamp Development (Build)	$ 17,024,005	54	$ 12,077,826	$ 29,101,831
6 Transfer Techology from another State	$ 17,625,189	66	$ 12,077,826	$ 29,703,015

*Please note alternative *3 COTS/SaaS – Buy (RFP) Total Implementation only includes cost estimates through planning.*

4.1. Timeline

Below is a high-level estimate of the project schedule, and a narrative description of the key activities in each phase.



Stage/Phase	Key Tasks	Description	Timeline
Initiation	• Set up Project • Secure Planning Funds • Create current state process maps and reports • Create solution requirements • Create business case • Market research and alternatives analysis • Develop RFP and secure approvals • Secure Stage Gate endorsement	OHA is required to provide 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, U.S. Department of Justice (USDOJ) Performance Plan, Oregon State Police reporting to the NICS database for background checks OHA's main goal with this project is to choose a data vendor that ensures the best overall return on investment. OHA is developing an RFP that outlines the minimum necessary requirements and will help staff evaluate proposals.	November 2018 —August 2020
Planning	• Post RFP • Review proposals • Select vendor • Execute new contract • Finalize Budget and Schedule • Secure Implementation Funding	This phase will see the review and selection of a data vendor based on the proposals received. A new contract will be executed that outlines tasks and deliverables to be supplied to OHA.	September 2020 – March 2021
Execution	• Onboard Vendor to access Project Site • Complete Fit Gap Analysis	Starting in April 2021 the new data vendor will start delivering tasks and products outlined in the new contract.	April 2021 – September 2023

Stage/Phase	Key Tasks	Description	Timeline
	• Transition data from DCS to new data vendor • Monitor kick-off tasks and receive deliverables from new vendor • Quality test new data vendor and its processed data • Monitor transition activities and artifacts such as Finalize Implementation Plan, Transition Plan, User Manuals, Disaster Recovery Plan, Training Plan, etc.	Starting in October 2021 vendor will work with DCS to transfer historic data and processing it using data vendor's methodology. MOTS will continue to collect, load, and process current data submissions until March 2023 which will also eventually be transferred to the new data vendor. During this phase, OHA will be working with the new data vendor to ensure that historic and current data are being transitioned and processed appropriately.	
Project Close	• 90 Day Warranty Period • Lessons learned • Project closeout activities • Start O&M phase of new contract	OHA will embark on evaluation of the project and document successes, failures, and lessons learned and transition to O&M support.	October 2023 – December 2023

4.2. Funding

The project has secured $1.8 million of funding for the Compass Modernization project already; however there are still some decisions that will be made by Legislative in February 2021 short session to obtain the balance of the funds needed for biennium 2019/2021.

Funding sources include:

- General funds - $1.5M

Implementation funds for the project will be requested in a new POP for session 2021/2023.

4.3. Critical Success Factors

For Initiation, success will be measured by:

- Approval of the business case and risk assessment
- Obtain necessary program approvals
- Secure funding
- Completion of RFP
- DAS OSCIO Stage Gate 1 and 2 endorsement

For Project Planning, success will be measured by:

- Release of RFP and selection of vendor
- DAS OSCIO Stage Gate 3 endorsement
- Execution of new contract for implementation and 5 years M&O

For Project Execution, success will be measured by:

- Transfer of data from DCS is completed with minimal disruption of service to data submitters, OHA, and data users
- All functionality and other requirements described in contract Statement of Work are delivered and approved by OHA in timeframe outlined
- All test exit criteria have been met
- Data submitters are able to submit data with the new technology solution, as necessary.
- OHA has full access to data as outlined in the requirements

For Overall Project Phases:

- Project scope met, within 15% +/- approved budget and schedule.

Long term project benefits will be measured by:

- 95% of the time completing SAMHSA reports on time.
- 100% of the time completing OHA dashboards and standardized reports on time.
- 100% of existing manual reports will be automated or eliminated and also meeting the "Must have" requirements.
- More reliable data – measured by number of data issues identified from current MOTS quality assurance reports.

5. Conclusions and Recommendations

5.1. Conclusions

OHA is currently attempting to aggregate data from seven behavioral health reporting systems, including at least three legacy systems and one system designed for reporting on a different funding mechanism than the one currently in use by the agency. The disparate systems further complicate data validation. It is impossible to correlate provider licensing and contracting requirements with treatment outcomes thereby ensuring value for the payment of contracted services. The current administrative burden for providers and OHA staff creates inefficiencies and puts the agency at risk of providing inadequate services to clients and providers, risks losing providers and staff, and risks the agency's image and funding.

A comprehensive analysis of the agency's business need is required with the expectation of creating and implementing a system designed to be flexible and aligned with the enterprise technology vision. This work will create efficiencies for providers and agency program staff; free the agency from committing OIS staff to the maintenance and operations of expensive and outdated systems; allow the agency to meet state and federal requirements to maintain funding; and improve both service delivery and budget forecasting.

5.2. Recommendations

Acquire or construct a technology solution for behavioral health reporting that allows the agency to interface with multiple systems currently in place. This would include:

1. Meeting with Behavioral Health leadership to understand the future vision for behavioral health services in order to promote and align systems work with business vision.
2. Collaborating with business teams on business process improvement and documentation of processes related to contracting and reporting.
3. Collaborating with Behavioral Health teams to define required reporting data for evaluation of contract fulfillment and agency metrics around successful service recipient outcomes.
4. Collaborating with HPA and HSD teams to define reporting requirements for SAMHSA.
5. Collaborating with teams in HPA and HSD to standardize data field definition for entry into the data warehouse and aligning those with contract specifications.
6. Assessing existing “out-of-the-box” systems for suitability for agency use and making recommendations.
7. Assisting with the creation of RFP and scoring model or project plan for procurement of resources if custom build.
8. Assisting with procurement of goods or services to complete project.
9. Assisting with the development of internal and external training resources for successful launch of the new system and business processes.

5.3. Consequences of Failure to Act

Failure to conduct a wide-ranging upgrade of the COMPASS systems and related business processes will result in devastating impacts to Oregon’s most vulnerable population including:

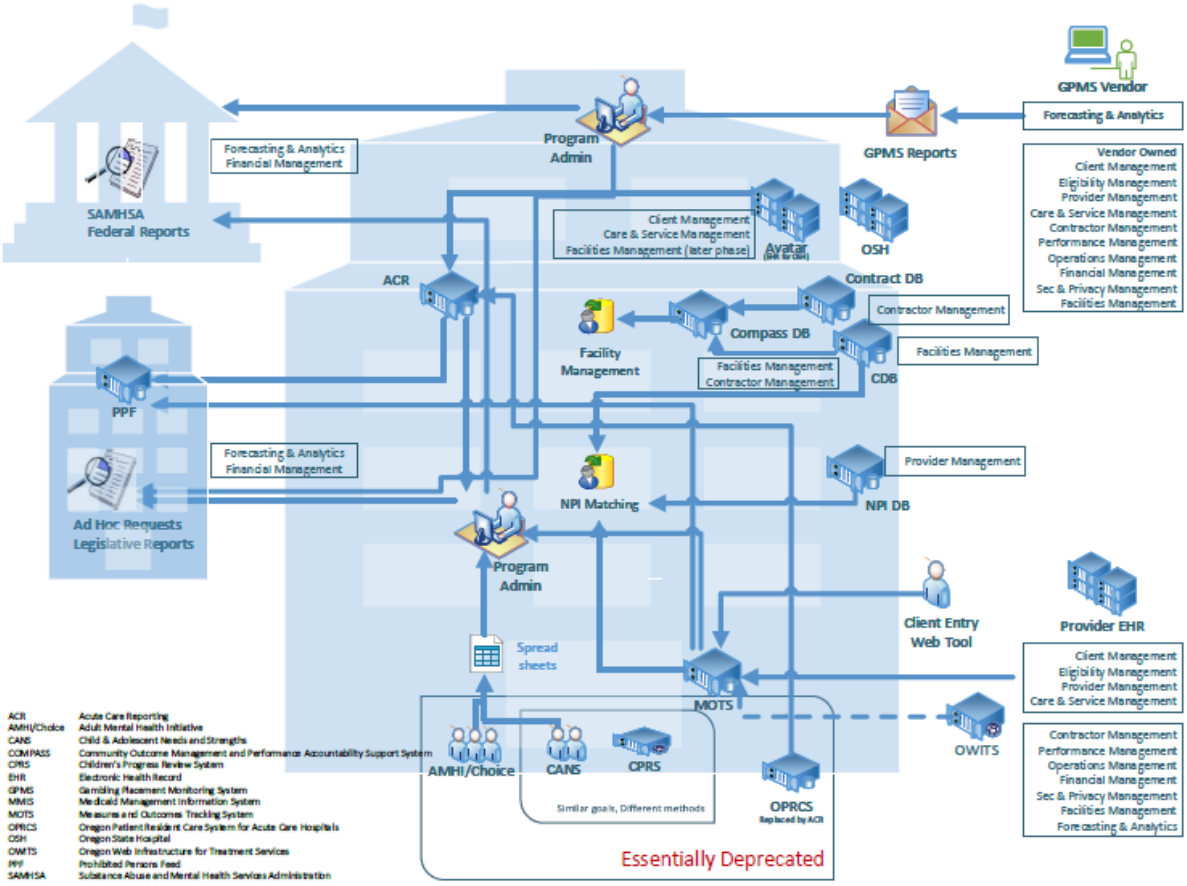
1. Poor coordination of care between facilities and providers
2. Delay or failure to receive treatment or services
3. Increased length of hospital commitment
4. Potential for civil rights violations

Without a change to the current behavioral health data systems, challenges to the State and its external partners will continue to compound in the following areas:

1. Increased administrative burden for CCO’s and other behavioral health providers
2. Lack of compliance with legal and federal requirements
3. Lack of IT staff resources to support outdated and ineffective data systems
4. Loss of state and federal funding
5. Loss of public trust

6. Appendixes and References

Appendix A – Current Business System Areas Supported



Appendix B – COMPASS Task Force Report

The 2017 COMPASS Task Force report is provided externally to this business case.

OSCIO IT Investment form

IT Investment Name:	Compass Modernization	Date:	2/27/19
Agency:	OHA	Division:	Behavioral Health
Agency Contact:	Dale Southmayd	Phone Number:	541-884-5960
Approving Business Owner:	Keely West	Phone Number:	503-945-6292
Approving Technology Mgr:		Phone Number:	

Approving Business Owner Date

Approving Technology Manager Date

Information Technology Investment Type(s):

☒ New Investment ☐ Renew/Life Cycle Replacement ☐ Other:

Information Technology Investment Description (What is being proposed and why):

Summary:

COMPASS (Community Outcome Management and Performance Accountability Support System) is a collaborative information technology approach to the administration, planning and monitoring of Substance Use Disorder and Mental Health treatment programs. The purpose of COMPASS is to provide software that directly interfaces with a variety of internal and external data systems and electronic health records systems and provides multi-functional reporting to support OHA, treatment providers and state and federal stakeholders. By aligning business processes and data, the system will facilitate cooperation and collaboration between stakeholders and improving reporting of, and access to contract and encounter information securely and in compliance with HIPAA and 42CFR regulations.

The current COMPASS applications are running on a mixture of platforms and languages. All are outdated and in need of upgrading or decommissioning. The underlying data storage for the applications is insular, outdated, and expensive to maintain. The current database design contains some gaps in which referential integrity has been compromised, creating data quality issues. These data design issues have been masked by their current applications, creating a heavy reliance on these applications to provide the necessary context for the data. This makes integration and reporting from the data difficult, inaccurate, and time consuming.

Modernization of the COMPASS universe would significantly improve interoperability of OHA's data systems and could be leveraged across numerous program areas. The current lack of integration with other state data systems creates additional workload for service providers and OHA personnel who must manually perform required tasks outside of those systems to meet agency, state, and federal reporting requirements.

The COMPASS modernization project supports the following initiatives, missions and strategic technology plans by ensuring efficient data collection, management, system integration, and data reporting on behavioral health service outcomes for Oregonians.

1. 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.

2. Health and Human Services Agencies Information Resource Management 2017-2019, Governor Brown's Strategic Initiatives for Healthy, Safe Oregonians:
    a) Ensure that every Oregonian who needs alcohol and other drug treatment or mental health services can easily get it.
    b) Ensure all Oregonians have equitable and appropriate access to affordable, high quality health care.
    c) 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.

3. OHA Mission: Helping people and communities achieve optimum physical, mental, and social well-being through partnerships, prevention and access to quality, affordable health care.

4. DHS/OHA Strategic Technology Plan:
    a) 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.
    b) Enable Business Automation via workflows and business rules, reducing manual, paper-based processes while increasing effectiveness.
    c) 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.
    d) Use Dynamic Services Supporting Dynamic Needs by supporting provider modular, common services and capabilities, which promote agility, reuse, and best practices leveraging enterprise capabilities.

Improved data collection and standardization in the COMPASS systems would allow the agency to improve reporting on outcomes, expenditures and contract compliance as well as collaborate with providers to track the implementation and effectiveness of services, identify service gaps, predict the specific timing of service needs, and better request and allocate funding to facilitate individual's progress through the system.

Problem Definition:
With Oregon's Health Care Transformation, the introduction of Coordinated Care Organizations (CCOs), and investments in Electronic Health Record (EHR) systems, the current data environment does not allow for data integration to meet the need for reporting on treatment outcomes and investment efficiency. Many of the COMPASS systems were designed to measure outcomes based on a different funding model from the model currently in use. In addition, the system requirements and data elements were not fully defined in the original build.

In 2017, the OHA COMPASS Task Force identified issues with disjointed and siloed data from systems for HSD Contracting, Licensing and Certification, and Client Outcomes. Additional operational deficiencies were noted in the following areas of the COMPASS universe:

1. Contracting process, tracking, and enforcement are not integrated with data systems;
2. Subcontractors cannot be identified in collected data;
3. Provider licensing and certification is not integrated with current data systems;
4. Data systems lack defined relationship and correlation between data elements;
5. Missing data elements in collection and reporting process;
6. Difficulty assessing if contracted services are provided in compliance with contract.

The lack of integrated behavioral health treatment data exposes the State to potential federal litigation related to violation of an individual's second amendment rights. Recent reviews and process changes at OHA determined that COMPASS systems are not receiving and maintaining sufficient documentation to support data being provided to Oregon State Police (OSP) for the National Instant Criminal Background Check System (NICS). A scheduled audit in June 2018 by the Federal Bureau of Investigation (FBI) could result in penalties or sanctions against the agency for failing to address the flawed data systems.

Further, OHA is unable to conduct mandated state and federal reporting. OHA and our partners at DHS continue to fall short of the expectations of advocates by failing to meet the needs of transitioning clients; this leaves the agency with continuing risk of additional investigation and potential litigation. OHA remains unable to adequately forecast service need or coordinate treatment for individuals entering and leaving the state hospital. *Olmstead v. LC*, a US Supreme Court ruling, requiring states to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs. Inability to appropriately forecast need for state hospital resources puts the agency at risk of losing needed budget and Oregonians at risk of inadequate care.

The COMPASS data systems lag behind OHA business partners who are further down the integrated systems path. The file structure and business process is a couple of generations behind the EHR industry and has proven challenging for some partners to provide data to OHA for that reason. Separate work flows are required for COMPASS data applications as they do not compliment or integrate with normal EHR operations.

The current Health Systems Framework applications are running on ColdFusion, which is no longer supported by the vendor. The underlying data storage for the COMPASS applications resides in several DB2 databases running on AIX servers, which are outdated and expensive to maintain. The current database design contains gaps in which referential integrity has been compromised, creating data quality issues. These design problems have been masked by the application, creating heavy reliance on the application to provide necessary context for the data.

The tightly-coupled relationship between the database and the application makes improvement and integration projects more difficult because it restricts the developer within the confines of both an aging toolset and a flawed data model. This data model makes integration with other systems and utilization of the data for reporting by Business Objects and other reporting engines more problematic. As new projects are undertaken using the tightly-coupled architecture in COMPASS, they will become riskier as the number of records and users increase, while the toolset falls further out of support.

Over time, the IT system-related risks will increase as the number of developers knowledgeable in older Cold Fusion/DB2 development projects dwindles, and it becomes a specialty realm for contract support. Add to this the growing number of retiring mainframe, Rbase and other legacy applications that will need

to be integrated into the Health Systems Framework, and the question of available qualified in-house resources becomes critical going forward.

Opportunity Definition:
Alignment with client need, the ability to track available resources, CCO reporting requirements and the analysis and tracking of behavioral health data across systems will be critical to the successful integration of behavioral health treatment into the CCO environment.

Modernization of the COMPASS universe of systems will:

1. Support the provision of more timely, appropriate, cost-effective services for Oregonians.
2. Reduce the administrative burden on contracting providers.
3. Increase the agency's ability to tie reporting responsibilities to payment.
4. Improve the standardization of data in the agency.
5. Increase the agency's ability to track outcomes.
6. Permit the agency to meet required reporting responsibilities.
7. Develop a standardized reporting system for behavioral health services.
8. Eliminate the use of four to five outdated systems, reducing silos around system maintenance in OHA's OIS team.

The 2017 COMPASS Task Force report provided opportunities including:

1. Replace COMPASS systems to reflect the present continuity of care model and reexamine old business processes.
2. Improve and update business processes to better align with COMPASS systems.
3. Align siloed systems to integrate CCO data into the service delivery environment.

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.

The project and resulting system should provide a variety of business support functions including the following:

1. Compliance with Personally Identifiable Information (PII) Privacy Act;
2. Compliance with Health Insurance Portability and Accountability Act (HIPAA);
3. Compliance with Health Information Technology for Economic and Clinical Health (HITECH) Act;
4. Reduce silos around system maintenance in OHA's OIS team;
5. Increase the agency's ability to tie reporting responsibilities to payment;
6. Improve the standardization of data in the agency;
7. Increase the agency's ability to measure behavioral health outcomes;

8. Reduce the administrative burden on contracting providers and staff;
9. Create integrated and adjustable reports that meet federal reporting requirements;
10. Upgrade requirements for federal and state legislation, rules, and business needs;
11. Migrate data from multiple data collection systems;
12. Streamline and update business processes;
13. Provide ongoing maintenance and support; and
14. Support required functionality for 5 – 10 years.

The redesign of the COMPASS constellation provides OHA with an opportunity to examine and update business process and better align to the agency's current vision and the continuity of care model. Part of this business process alignment will include the interface of provider reporting and contracting requirements, ensuring that the agency is better tracking the services it is paying for and that Oregonians are receiving the benefit of service dollars contracted through the agency. OHA has the opportunity to reduce silos and begin the process of integrating CCO's into the behavioral health service delivery model.

Alternatives:
A complete alternatives analysis has not been conducted for this project.

Assumptions

The Project assumptions identified would include the following:

1. The time required to adequately research, document, design, plan and implement the projects described will be available.
2. The Business understands and can articulate the outcome measures they require.
3. Legislative mandate changes will not significantly affect the Project deliverables.

Solution Requirements

Solution requirements have not been fully defined at this time.

Alternatives Identification

Alternative 1: No Replacement of Existing COMPASS systems

Alternative 2a: Replace COMPASS with solution developed in house

Alternative 2b: Replace COMPASS with solution procured from third party vendor

Alternatives Analysis

No alternatives analysis completed at this time.

Cost

Initial estimates of cost for the COMPASS modernization project is between $4 and $7 million. Work is ongoing to finalize the project scope, after which we will analyze alternatives. Better cost estimates will be available at that time.

OSCIO IT Investment form

POP 414 has been submitted as part of the Governor's budget for the 2019-2021 State of Oregon Budget. The POP requested amount is $6,739,793.

		Yes	*No*
1)	Is the investment a project?	☒	☐
2)	Will the investment have a Project Manager?	☒	☐
3)	Will the investment include other agencies?	☐	☒
4)	Will the investment include Information Asset Classification Level 3 or 4 data? (see DAS Policy 107-004-050)	☒	☐
5)	Will the investment be for Cloud Services (as defined in Policy #107-004-150)	☐	☐

IT Investment Estimated Cost Summary

Hardware:	TBD	**Software:**	TBD
Services/Maintenance (projected over five years):	TBD	**Personnel (Project):**	TBD
Source of Funding:	General Fund	**Deadline for fund use:**	mm/dd/yyyy
Anticipated Start Date:	7/1/19	**Anticipated End Date:**	TBD
		TOTAL:	**TBD**

DHS Oregon Department of Human Services

Oregon Health Authority

DHS/OHA Office of Information Services Issue Brief

Enterprise Collection Management System

DHS/OHA – Shared Services: Shawn Jacobsen OFS, Nicky Jeffreys OPAR

Overview

The Office of Financial Services (OFS) is a Shared Service that provides full financial cycle accounting to the Department of Human Services (DHS) and the Oregon Health Authority (OHA). This work is accomplished through a combination of agency-supported program-specific data systems and the Oregon Statewide Financial Management Application (SFMA). OFS supports programs throughout both agencies to identify, invoice, and manage accounts owed to the agencies. Revenue generated from these activities is essential to meeting outcomes for various services and programs throughout the agency.

The Office of Payment Accuracy and Recovery (OPAR) is a Shared Service that provides recovery and collection services to both the Department of Human Services and the Oregon Health Authority. OPAR ensures program integrity by improving payment accuracy and recovering overpayments of both clients and service providers. Funds recovered by OPAR are returned to the various DHS/OHA programs, allowing these funds to be available for current and future clients.

Both OFS and OPAR are working towards a shared goal of identifying an Enterprise Collection Management solution to replace the Integrated Collection Management System (ICM) currently in use by OPAR. This new Enterprise solution would provide the integration needed for both groups to reduce redundant system updates and manual workarounds to optimize their business deliverables and workload.

OFS requests ISMC approval for a solution that will enable the Enterprise Collection Management System to be the primary source system for accounts receivable transactions generated in the new OFS Enterprise Financial system (as identified in the OFS Policy Option Package) for interfacing with SFMA.

OPAR requests ISMC approval for an Enterprise Collection Mangement System that meets regulatory needs, provides improved automation in order to lower costs, and utilizes state of the art technology to assist in settling collections.

Background

OFS: OFS invoices for agency services such as newborn screening, background checks, licensing and overpayments. The billing and account management requests are received through a variety of methods, such as Excel documents, emails, and the use of payment subsystems. Many DHS/OHA programs manage a portion of the receivables process before referring the account to OFS. These requests can be initiated for at any time during the receivables process. The receivables process is as follows:

- Identification of amount owed, notification to debtor (invoice)
- Management of account notices and repayment options
- Adjusting existing receivables
- Referral for collections to the Department of Revenue – Private Collections

Most of these requests are then entered in SFMA manually or through a macro and then invoices, if needed, are manually generated using a template in Excel. Direct payments are received through a lockbox, meaning

checks sent to bank, or credit card transaction. Transfers from other agencies, including the Department of Revenue, are also received. Posting these payments to accounts in SFMA is a manual process.
Ease of payment is challenging at best. Only two options exist to make payments: checks and credit cards. For credit cards, reaching the portal is outdated and does not retrieve current account information. Requests for account balances for those with payment plans must be created manually.

Many DHS/OHA programs extract information from program databases and send it to OFS, creating unnecessary reentry of data. For programs that require updated payment information to manage their business relationships, read-only access is granted in SFMA and account information is relayed back to the program so the account can be viewed. Otherwise, data reports are generated for the program on demand.

The financial accounting of receivables in our agencies' business environment is complicated due to the federal and state regulations, federal matching rates, and required statewide accounting practices.

OPAR: In 2013 when the FICO system contract was created, the Office of Information Services (OIS) team assisted in developing an in-house application that would support OPAR's needs.
The current FICO system is a robust application for which OPAR only requires a portion of the functionality to execute its program deliverables. The system does not effectively support OPAR business needs and some features of the system are more focused towards an agent debt collection system. FICO does not offer auditing or compliance functionality, critical components of OPAR business flow.
The support received from FICO is very limited and is not meeting OPAR business needs. The OIS Solution Development and Delivery team has had to build around the current FICO system to incorporate smaller in-house applications to meet business needs. The FICO system is used by multiple units within OPAR and causes some of these teams having to manage two different systems to complete their work. Workflow duplications within OPAR would include these systems:

- Personal Injury Liens- MMIS
- Estate Administration Unit - MMIS, DSURS
- Overpayment Writing Unit - PIPS

Future Vision and Scope

OFS: An agency receivables system should meet the needs of our business partners, allowing ease of upload and retrieval of information.

The system should enable:

- Single data entry of account information that can be used to generate invoices
- Manage account balances
- Generate reports
- Research history
- The system must allow for entry of account at any point in the receivables process
- Generate reports, documents and templates, as well as management reports either from the system or from a query tool

- Needs to meet all current OFS business rules
- System must interface with SFMA
- System must be compatible with any future agency-wide financial application
- Must meet all statewide reporting needs including counts and reason codes
- Have the flexibility for modification as data needs change
- The accounting rules for the system will be similar, if not identical, for client and provider billings (OPAR and OFS).

OPAR: In partnership with the OIS Solution Development and Delivery team, a new system could be built to meet all the business needs, incorporate all the smaller add ons that were needed due to FICO not meeting 100% of business needs.

The new solution would include these capabilities:

- Amount owed
- Payments
- Sends notices, automatic, OnDemand
- Day to day activities
- Narration – TRACS
- Maintain workload

Other Considerations/Drivers

OFS: DHS and OHA are currently preparing a Policy Option Package request for a planning effort defining the criteria to develop a cross-agency financial system and modernize the underlying technology.

In developing a receivables system, many agency business partners may be interested in interfacing with other regulatory systems to exchange data and meet their strategic objectives.

OPAR: The current contract with FICO has approximately two years remaining is identified as a two-year project. We may possibly need to amend the current contract again to extend the time, which will add additional costs.

The FICO production site is an issue for the following reasons:

- Written in Java J2EE – This is not a good fit for the team to support as they are not versed in this technology and it no longer aligns with current technology strategy of the organization.
- The system is supported in Windows using technologies that do not support Windows as their primary platform, often requiring installation of custom versions/builds into the computing environment.
- We don’t use the same technologies in other supported systems – this is a “one off” in our current environment.
- We were required to purchase and maintain a costly RedHat subscription for the last and all future upgrades.

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Enterprise Collection Management System

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- Additional Java licensing will be required for any future upgrades.
- We currently use less than 30% of the existing functionality.
- The Debt Manager product is geared towards private collections. It is moving further away from programming that adheres to governmental needs. Each new upgrade brings with it features that, while useful to other companies, cause additional complications to our agency.
- The older versions of software required for FICO Debt Manager creates technical debt for Shared Services necessitating expensive rework as versions are deprecated.
- The system has poor data entry edits, necessitating OIS to create compensating software outside FICO Debt Manager to help monitor data quality and integrity
- The vendor only provides full support for the current version of Debt Manager. Updates released multiple times a year, OIS staff must constantly rebuild and reinstall FICO Debt Manager in order to upgrade the system and take full advantage of our support agreements.
- Upgrade packages for FICO Debt Manager often contain incomplete, out-of-date, or missing documentation, making updates very risky and error prone.
- Upgrades for FICO Debt Manager have a high degree of complexity, since FICO Debt Manager bundles over two dozen 3rd-party software products (both commercial and open-source) that are needed to operate the system.
- FICO only provides bug fixes for previous versions of FICO Debt Manager in extraordinary circumstances.
- FICO introduced a new, vendor-owned rules engine (Blaze) into the product with our most recent upgrade replacing a previous, 3rd party rules engine. This required the agency business rules to be rewritten to the new product.
- FICO had issues providing training on the new rules engine to agency staff. The agency had to pay FICO for conversion of the rules to the new engine since training could not be provided.
- FICO has not been able to provide bug fixes or mitigations for all issues that have been discovered in FICO Debt Manager. As a result, some issues have remained open with FICO for multiple years, with currently very little expectation of resolution.
- FICO does not have a normal practice of communicating known bugs and issues to customers. When the agency discovers a bug or other issue, some of these are only communicated as previously known issues after a support ticket has been opened and potentially charged to the agency.
- The agency currently has 5 outstanding product modification requests for FICO Debt Manager that date back to 2013.

Proposed Approach, Actions and Outcomes

The proposed approach for this request is to develop a new Enterprise Collection Management System that supports an updated and integrated modular solution to address the needs of OFS and OPAR, to meet regulatory needs, and adhere to business rules. If ISMC approval is reached, this request would be reviewed for approval at the DHS Technology Council for prioritization for OIS resource assignment.

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Enterprise Collection Management System

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Estimate for Proposed Action

Estimating this project to span over a two-year timeframe, utilizing the resources below +/- 100%:

Technical Resources:

- ISS8 Architect, fully loaded – 10% Team Lead and COLA included for 24 months = $342,502 Hourly = $82.33
- ISS8 Developer, fully loaded – top step with COLA included for 24 months = $308,256 Hourly = $74.10
- ISS7 Developer, fully loaded – top step with COLA included for 24 months = $291,393 Hourly = $70.04
- ISS7 BA/Developer, fully loaded – top step with COLA included for 24 months = $291,393 Hourly = $70.04
- PM3 at 90%, fully loaded – top step with COLA included for 24 months = $267,387.00 Hourly = $71.42
- PM1 at 50%, fully loaded – step 2 with COLA included for 24 months = $91,684.00 Hourly = $44.08
- **Total = $1,592,615.00**

OPAR Business Resources:

- Revenue Agent 2 – Tester
- Operation & Policy Analyst 2/ICM SME – 85%
- Operation & Policy Analyst 2/ICM SME – 75%

Estate Administration Unit:

- Administrative Specialist 1 LW – 15%
- Compliance Specialist 2 LW – 15%
- Compliance Specialist 3 LW – 15%

Personal Injury Liens Unit:

- Compliance Specialist 2 – 15%
- Administrative Specialist 1 – 15

OFS Business Resources:
Systems

- Operations and Policy Analyst 3/Systems SME – 85%
- Accountant 2/Systems SME – 85%

Accounts Receivable

- Accountant 3/AR SME – 75%
- Accountant 2, tester
- Accountant 1, tester

Receipting

- Accountant 3/Receipting SME – 75%

DHS/OHA

ONE IE & ME Project Business Case

Department of Human Services

Oregon Health Authority

ONE Integrated Eligibility & Medicaid Eligibility Project (ONE IE & ME)

Version Log

Version	Description	Author	Date
1.0	Initial Draft	Karl Olmstead	11/24/2015
1.1	Revised based on feedback from Ed Arabas	Karl Olmstead	12/15/2015
1.2	Revised Draft preparing for Stage Gate 3 Submission Incorporated changes from Sarah's review	Karl Olmstead	7/9/2016
1.3	Updated high-level requirements language. Finished M&O strategy section	Karl Olmstead	7/10/2016
1.4	Swapped in high-level requirements language to align with final SOW; expanded risk section and revised M&O strategy per SM	Karl Olmstead	7/12/2016
1.5	Added financial table attachment; revised cost numbers and narrative elsewhere; cleaned up for submission for QC review	Karl Olmstead	7/13/2016
1.6	Final edits; labeled final draft; awaiting final financial numbers only.	Sarah Miller	7/21/2016
2.0	Version for Stage Gate 3 Submission	Karl Olmstead	7/22/2016
2.1	General updates from Wayne Haddad	Rick Schlachter	3/31/2017
2.2	Re-baseline updates	Rob Midtun	7/7/2017
2.3	Updates from PMO, IPD, and 2017 federal IAPDU submission.	Rob Midtun	8/2/2017
2.4	Updates from Management Team review	Rob Midtun	8/18/17
3.0	Updated to incorporate System Integrator Amendment #4 and Quality Assurance Amendment #3; Revalidates Stage Gate 3 Authorization	Tony Black	2/2/18

SIGN-OFF

Version	Role	Name	Comments	Date
3.0	Governance	Exec Steering Committee	Approvals via email	2/12/2018

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1 Business Case Executive Summary

1.1 Overview

The purpose of the Oregon Department of Human Services (DHS) OregONEligibility Integrated Eligibility & Medicaid Eligibility (ONE IE & ME) Project or, the "Project," is to extend the Modified Adjusted Gross Income (MAGI) Medicaid enrollment and eligibility determination functionality to include Non-MAGI Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Employment-Related Day Care (ERDC). Combining these disparate systems into a single, integrated solution, will create a seamless end-to-end service offering with multiple access methods for eligible enrollees. This new system will also provide checks and balances to ensure that Oregonians who qualify for benefits receive accurate and timely payments, and to ensure that those who don't qualify for services do not receive benefits.

This business case update is intended to articulate changes in Project scope, schedule, and budget to inform the Project Team, governing bodies, stakeholders, and decision-makers of changes that deviate from prior versions of this document.

The last iteration of the Project schedule indicated completion of design, development, and implementation (DDI) on Non-MAGI Medicaid, SNAP, TANF, and ERDC in June 2019. This update describes an extension of this timeline to commence Pilot implementation in late August 2019. The Pilot implementation will be deployment of the new system to both Jackson and Josephine Counties, followed by a statewide roll-out in three waves that will be completed in late July 2020. This added duration of the Project was the combined result of extending System Integration Testing (SIT) from two months to five months, extending User Acceptance Testing from four months to six months, extending the Pilot phase from three months to five months, adding a one-month stabilization period after each of the three roll-out waves, and increasing the number of data conversion mock runs from three to five.

As many of the System Integrator (SI) Deliverables were shifted from the 17-19 biennium to the 19-21 biennium, the Project Team is estimating an ending balance for this biennium to be approximately $30 million, with a Project spend of approximately $165 million vice the budgeted $195 million. The Project Team is estimating the need for $144 million in the 19-21 biennium for data conversion, testing, and implementation, and an additional $44 million for Maintenance and Operations (M&O) and enhancements after Project close.

With the expiration of the OMB A-87 cost allocation exception in December 2018, the Team is projecting the Federal portion of this $188 million for the 19-21 biennium to be approximately $134.8 million. If approved, the State funding will consist of approximately $39.2 million in bond sales and approximately $15.6 million General Fund.

1.2 Background

In January 2015, a project was initiated to modernize MAGI Medicaid eligibility determinations and enrollment. This was called OregONEligibility, or simply the "ONE" system. This system development was approached by utilizing code similar in desired functionality from the State of Kentucky, which they call *kynect*.

In June 2015 during the ONE system Design, Development, and Implementation (DDI), House Bill (HB) 2219 was signed into law. This bill directed DHS to convene a work group with staff

from human service agencies, including: The Housing and Community Services Department, the Oregon Health Authority, the Department of Education, the Employment Department, the Office of Child Care (inside the Early Learning Division), and the Higher Education Coordinating Commission, as well as, the State Chief Information Officer and other individuals who the department deemed necessary. The work group was to study how to create a consolidated application process for residents of the state to apply for and obtain assistance in accessing food, housing, medical care, education, employment services, child care and other social services. The work group was tasked with developing and submitting a recommendation to the Legislative Assembly by September 15, 2016.

In December 2015, the ONE system was placed into production. Also in December 2015, version 1.1 of this business case was submitted to the Office of the State CIO (OSCIO) and to the Legislative Fiscal Office (LFO). It was this version of the business case that received Stage Gate 2 endorsement to continue planning to extend the functionality of the ONE system to include Non-MAGI Medicaid, SNAP, TANF, and ERDC programs. A copy of business case v1.1 is attached as Appendix D.

In August 2016, an update to this business case, version 2.0, was submitted to the OSCIO and LFO, and was used to obtain Stage Gate 3 approval to commence execution of the new ONE IE & ME Project. Again, the software development methodology was to capitalize on additional code from the State of Kentucky they had used to assimilate similar programs. Kentucky called this integrated eligibility system *benefind*, which they have shared with the State of Oregon. A copy of business case v2.0 is attached as Appendix E.

Also in August 2016, the Project Team reported back to the Legislative Assembly on HB 2219 with recommendations including the development of a single application for financial eligibility for the Department of Human Services (DHS) and Oregon Health Authority (OHA) programs. Consolidating the application process for multiple programs among two large state agencies was an incremental step in the vision towards a single application for all health and human service programs. A copy of this report is attached as Appendix F.

In late 2016 and early 2017, the pace of the Project slowed while there were leadership changes at the Director level in both DHS and OHA, and with the Independent Project Director (IPD). In March 2017, a Memorandum of Understanding (MOU) was signed by Agency Directors and by the State CIO to jointly govern the Project as the Joint Governance Board (JGB). In May 2017, the Project Team received go-forward authorization from the Executive Steering Committee (ESC) and the JGB. It was soon thereafter that negotiations commenced to update SI and QA contracts. These Amendments are now complete (pending federal approval of the QA Amendment) and the Team has re-baselined the Project's scope, schedule, and budget accordingly. These Amendments effectively pushed the Production Pilot and roll-out to September 2019, completing implementation across the State in July 2020.

1.3 Problem Definition

This Project is about serving the most vulnerable of Oregonians in their times of need. Oregon, like most of the nation, has continued to work through the cyclical nature of recessions and budgetary uncertainty. Most of the financial benefits DHS and OHA provide to Oregonians is off-cycle. When the State is in a recession and budgets are tight, DHS and OHA often require more funding to provide safety net and stabilization services for Oregonians. This balancing can place strain on any system.

Oregon is also continuing to grow both in age and in the general population served. Since 2010, Oregon has experienced a 3% per year growth rate over the national average in the population over the age of 65. Oregon's total population has grown by 1.6%. Like previous years, the majority of this growth (88%) is coming from people moving or migrating to Oregon.

DHS and OHA have seen policy shifts with the implementation of MAGI Medicaid, Cover All Kids, and other program policy changes which continue to provide opportunities for more individuals to receive services. In parallel with this population growth, the complexity of the rules and those served continues to grow. DHS and OHA serves over a million Oregonians through Medicaid, which has multiple programs with different rules about how to determine income, what sources to use, what to include, what to look at, and when to look at it. Family dynamics continue to change, with more and more multi-generational family groups and cases where parents and children can be in multiple households and geographic locations.

DHS and OHA staff currently use multiple systems for eligibility determination for Medicaid, SNAP, TANF and ERDC benefits. Eligibility data are often duplicated within multiple, disparate systems and are not easily shared between these systems. As such, eligibility determinations are not made in a standardized and timely manner and, in some cases, an individual's data needs to be manually entered in more than one system. There are currently few checks and balances across systems to ensure those who are eligible for benefits receive them and, conversely, those who are not eligible don't receive benefits. Some of the systems were designed and implemented in the 1970s and early 1980s. Many have been repeatedly modified from their original format to address the vast number of eligibility, service authorization and payment changes that have occurred over the decades following initial release. Business process improvements have been stifled because of keeping these antiquated systems operational and in compliance with policy changes.

These factors lead to issues with accuracy and access. Oregonians today must go to multiple offices to apply for the same benefits. They provide verifications to multiple sources and are often confused about who needs what, who has shared what, and what their next steps are. While Oregon has continued to remain below the national average for errors in traditional Medicaid systems and the SNAP program, there have been increasing quality control issues causing public discussions on the accuracy of Medicaid determinations. The latter has been an issue of trying to coordinate between IT systems and various agencies to solve who is providing which services and where an individual is being served, causing issues around capitation and reimbursement.

Over the last two years, DHS leadership have heard from staff, advocates, and community members the words, "I don't know". This includes families in crisis looking for services, who cannot answer a question about who they are working with. They receive letters from multiple local offices and messaging from various systems, all directing them to either call, come in, or go on-line. This leaves Oregonians confused, unsure of benefits, afraid of failing or taking the necessary steps to become more self-reliant, or to leave an abusive situation because they don't know what is available, who to talk to, or where to go for help. Staff have also complained about having to say, "I don't know." During the roll-out of MAGI Medicaid, over 1,000 Oregonians a month would come into DHS offices to ask about their MAGI benefits. Some Workers couldn't see into the ONE system, and many of them had their access to MMIS removed because they were not considered a covered entity. This created a system where

workers would have to say, “I don’t know,” and place the Oregonian on hold for long periods of time, or needing to fax information to the branch processing MAGI Medicaid.

1.4 Opportunity Definition

The ONE system is currently being used to process eligibility determinations for MAGI Medicaid. Oregon has taken the opportunity to extend ONE for eligibility determinations of additional programs by utilizing updated code from the State of Kentucky called *benefind*. Additionally, the Office of Management and Budget (OMB) circular A-87 exception to cost allocation rules was extended by CMS from December 2015 to December 2018. This provides the State of Oregon the opportunity to provide enrollment and eligibility determination services with a single, integrated system utilizing enhanced federal funding for much of the Project cost.

ONE IE & ME SYSTEM	6-Year TCO			Funding Sources		
	DDI	M&O	Total	Federal	State GF	Bonds
15-17 Actuals	33.6	0.0	33.6	28.5	0.5	4.6
17-19 Projected Actuals	164.7	0.0	164.7	148.0	2.3	14.4
19-21 Budgeted	146.0	43.6	189.6	134.8	15.6	39.2
Total Project Cost	**344.3**	**43.6**	**387.9**	**311.3**	**18.4**	**58.2**

DHS and OHA serves over 1 million Oregonians through the Medicaid program. These agencies also serve over 308,000 kids, over 81,000 Children’s Health Insurance Program (CHIP) kids, over 20,000 Foster Medical kids, over 128,000 aged, blind, or disabled Oregonians through traditional Medicaid, and an additional 420,000 adults or parent-caretaker relatives through MAGI Medicaid. On top of this is an additional 41,000 Citizen/Alien-Waved Emergency Medical (CAWEM) individuals, and over 150,000 Oregonians receiving assistance with their Medicare through a Medicare Savings Program, including Dual Eligible individuals. Each of these systems are requiring more complex logic to determine what information to accept and when. This requires worker intervention at an increasing rate.

Beyond Medicaid, there is SNAP, TANF, and ERDC which serve approximately 400,000 Oregonians. In a calendar year, DHS and OHA will serve approximately 1.6 million Oregonians, with individuals coming on and off programs, processing around 2.1 million applications each year. Over 65% of these individuals are applying for multiple programs.

Applicants must apply to multiple offices with multiple workers through various channels, and must provide the same information over and over, which is then stored in different systems that don’t interoperate well. By integrating our systems and service delivery model, Oregon has an opportunity to coordinate benefits. These benefits are currently calculated manually. Workers take information and put it into various systems. There are over 30 Legacy systems needed to complete the work related to these programs, followed by manually determining which exclusions to apply, what benefits should be associated, what the outcome is, and what notices to be sent.

While Oregon has had relatively high accuracy rates in contrast to national averages, moving into a system with automated rules provides opportunities for DHS to work on standardization and coordination to limit the risks identified.

The greatest opportunity is that DHS will be able to better serve Oregonians. Any integration of systems is difficult but with the integration of enrollment and eligibility systems, there will exist standardized processes to apply for Medicaid, SNAP, TANF, and ERDC. Oregonians will be able to apply online or in an office, provide changes and updates from their homes, and see a single coordinated output of what benefits they are eligible for. They will be able to talk to workers who will be cross-trained on programs and able to view information from a single system for most of the financial eligibility benefits individuals are applying for. DHS and OHA will have an updated platform that can conform to federal and State expectations, and allow for opportunities over the next decade to increase automation and access for Oregonians in ways that cannot be offered today. Ultimately this solves the greatest problem and provides the greatest opportunity for eliminating an answer of, “I don’t know.” A single system, a coordinated approach to eligibility, and a stable platform of care for Oregonians that is about serving them in the way they want to be served, will allow us to focus on accurate and effective customer service for some of the most vulnerable Oregonians.

1.5 Alternatives Analysis

Both business case versions 1.1 and 2.0 explored the four Alternatives identified below:

1. Implement Non-MAGI Medicaid Eligibility Determination into the ONE System
2. Implement Integrated Eligibility Determination into the ONE System
3. Acquire External Eligibility Determination Services from another State
4. Do Nothing

Alternative #1 was originally estimated to cost $80.3 million and conclude in December 2018. Additional costs would be incurred now because the *benefind* code would have to be reworked to eliminate the functionality associated with SNAP, TANF, and ERDC. There would be the loss of a significant investment already made in terms of fit-gap, design, development, and human resource to incorporate these additional programs into an integrated system.

Alternative #2 was selected in both cases and the Project Team proceeded accordingly. Given that this Project is now approximately 35% complete, with initial system design nearly complete, and with code development in progress, there is significant risk and cost associated with each option that deviates from the current course, or Alternative #2.

Alternative #3 is not a viable option as there are no service models across the nation that support Oregon acquiring services from another State.

Alternative #4 would require continued spending for Project shutdown activities and vendor contract resolution but the cost of system design and development would be stopped. This Alternative would likely prompt several federal audits that would jeopardize current program funding streams until complete. Oregon would likely be required to pay back federal funds expended to date. Overall, this is the least desirable Alternative of those identified.

1.6 Conclusions and Recommendations

Continuing with Alternative #2 DDI is the best option at this stage of the Project. It is supported by agency leadership and Project governance. Given the ONE system as a stable base to build from and the shared code from Kentucky (*benefind)*, the methodology employed has been proven successful, using the ONE System as an example. With continued availability of enhanced federal funding, timing is right to offset significant Project cost ($282.1 million federal funding of the estimated $342.1 million total Project cost). The Project Team can now also manage the Project against a solid and actionable scope, schedule, and budget. Failure to act now on this opportunity would have significant adverse effects, such as:

- Service delivery would continue in the current model, meaning the same frustration with the system from end-users and clients would persist, as well as error rates and lack of checks and balances.
- There would be a loss of federal funding and it is likely audits would be triggered.
- There would be a loss of confidence in the State's ability to execute a modernization program.
- There would be damage to the reputation of the State of Oregon.
- There may be accompanying increases in operational costs because of lost federal funding and continuing to operate antiquated systems.
- There would be a loss of the investment already made in delivering intended functionality to Oregonians.

The Project Team is highly recommending continuation of Project execution in alignment with Alternative #2. Cost detail for this Alternative can be found in the Project Budget attached as Appendix C.

2 Background

2.1 Current State of DHS Eligibility Work

Most of the systems supporting DHS eligibility determination processes were designed and built in the 1970s and early 1980s. Many of these systems have been modified repeatedly to address the vast number of eligibility, service authorization, and payment rule and policy changes that have occurred since then.

2.2 MAGI Medicaid Eligibility Operations

2.2.1 Kentucky Transfer System (*kynect*)

In 2013, Kentucky's Cabinet for Health & Family Services (CHFS) embarked on an ambitious information technology (IT) modernization program to replace a collection of legacy systems that supported Health and Human Services programs. The cabinet's goal was to modernize IT solutions to improve delivery of services and increase worker productivity while maximizing the funding opportunities available from the Affordable Care Act and CMS 90/10 funding. The modernization program, called Kentucky Connect (kynect) included implementation of a state-based Health Insurance Market Place, an eligibility and enrollment system for MAGI Medicaid applicants, and several other enterprise IT capabilities. Kentucky will realize the following outcomes as a direct result of the modernization program:

- *Streamlined Field Operations*– Increased worker productivity, simplified process steps, reduced case processing cycle times, and reduction in total administrative costs of delivering benefits.
- *Transformed Service Delivery* – Transformed service delivery, providing multiple channels of access (walk-in, online, mail, call centers, fax, mobile, imaging, etc.), and interactive processing across geographic units.
- *Program Compliance and Monitoring of Fraud and Error* – Flexibility for worker performance while maintaining strict adherence to program mandated compliance through checkpoints and controls for measurement and proactive response.

As Oregon's designated Medicaid agency, OHA recently implemented a new system for MAGI Medicaid eligibility determinations. That system is called OregONEligibility, or ONE, and is the result of the State of Kentucky sharing the *kynect* code base with the State of Oregon. Originally built by Deloitte Consulting, *kynect* operated as the MAGI Medicaid eligibility determination system of record for more than a year before OHA signed an agreement with the Kentucky Cabinet for Health & Family Services to share their code and associated documentation with the State of Oregon. Oregon then performed a Fit-Gap analysis on Kentucky's code in relation to Oregon's needs. The transferred code was modified as necessary and is now operating as a production system in Oregon's State Data Center. The ONE system will be used by OHA to make approximately 900,000 individual MAGI Medicaid eligibility determinations and redeterminations each year.

OHA accepted the *kynect* production system as meeting the bulk of its business needs and therefore made very few technical changes to the system, instead focusing on making policy and process changes to its business wherever feasible to minimize the risk with the initial system implementation in Oregon.

2.2.2 Phased Implementation

OHA implemented the ONE system in phases. First, in December 2015, it enabled the Worker Portal for use by eligibility workers to determine MAGI Medicaid eligibility for applicants who apply by mail, fax, phone, or through the Federally Facilitated Marketplace (FFM) at Healthcare.gov.

In February 2016, it implemented a customer facing Applicant Portal, initially limiting access to certain community partners that help Oregonians with MAGI Medicaid benefits and to report changes. The Applicant Portal went live to all Oregonians in December 2016. The Applicant Portal allows Oregonians and community partner assistors to enter and update income, family composition, address and other eligibility-related information, upload documents, communicate with workers assigned to their cases, and participate in re-certification activities, all without having to fill out paper forms, visit a field office, or contact a call center. Over 850,000 Oregonians are now receiving benefits through the ONE system.

2.3 *kynect* becomes *benefind*

The Kentucky state-based marketplace preferred *kynect* to have the look and feel of searching for private insurance rather than state programs, so they developed a separate applicant portal for other human service programs and called it *benefind*. The *benefind* system code was also shared with the State of Oregon as the basis for extending eligibility and enrollment determinations to include Non-MAGI Medicaid, SNAP, TANF, and ERDC. See Appendix G for functionality included in the *kynect/benefind* system. Appendix H, comparing Oregon's needs to Kentucky's *benefind* system, was used to determine if there were enough similarities between the two state's programs to justify obtaining this code as a transfer solution and performing the subsequent Fit-Gap Analysis.

2.4 Non-MAGI Medicaid Eligibility Operations

DHS and AAA staff make more than 150,000 Non-MAGI Medicaid eligibility determinations every year. DHS and OHA's Forecast for the 2017-2019 Biennium estimates the following caseloads:

- Clients of Aged, Blind, and Disabled programs (84,533 cases as of December 2017)
- Clients of the Old Age Assistance program (44,418 cases as of December 2017)
- Clients of the Qualified Medicare Beneficiaries program (27,469 cases as of December 2017)
- Medicare Part A and Medicare Part B supplemental payments (103,461 cases as of December 2017)

Roughly half of those determinations are made by DHS staff in local offices of the department's Aging and People with Disabilities (APD) program. The remainder are made by Area Agency on Aging (AAA) staff in Marion, Polk, Yamhill, Tillamook, Clatsop, Multnomah, Lane, Linn, Lincoln and Benton counties. (Area Agencies on Aging are typically county-chartered organizations that provide assistance and services for people over the age of 65 and people with disabilities who need assistance. In the Oregon counties listed above, AAA deliver DHS's APD Medicaid program under contract with the department, including making initial and ongoing financial eligibility determinations.)

The Non-MAGI Medicaid eligibility caseload is projected to grow about nine percent over the next four years. Without any improved efficiency in making eligibility determinations, the added case load could require 25 or more eligibility workers at a cost of over $2 million annually to be hired, trained, and deployed across the state to come into standard with the current workload model.

The process of taking applications, reviewing them, and making Non-MAGI Medicaid eligibility determinations is often expensive, slow, and error-prone. For example, recent measures of Non-MAGI Medicaid cases found workers spend an average of 28 minutes screening each application and taking another 110 minutes to make the eligibility determinations. This is for a case that doesn't take coordination. If the case has a connection to a MAGI or medical case, then there is an average of 5 touches back and forth between different workers before a decision to move forward is completed. After the coordination is completed there is, according to a program integrity review, at least a 15% chance that the change won't take effect because of system issues in attempting to integrate across multiple systems (ONE, IE, CM, ORKids, and MMIS).

2.5 Integrated Eligibility (SNAP, TANF, ERDC) Operations

DHS and AAA staff make approximately 130,000 SNAP eligibility determinations every year for APD program clients. (Those 130,000 households include roughly 155,000 individuals.)

Self-Sufficiency Program (SSP) staff make the remainder of the eligibility determinations for SNAP, and make eligibility determinations for the TANF and ERDC programs. The SSP caseload is approximately:

- SNAP: ~285,000 cases (~580,000 individuals)
- TANF: ~23,800 cases (62,800 individuals)
- ERDC: ~7,700 cases (23,545 individuals)

The Spring 2016 DHS/OHA Caseload Forecast predicts a decline in the average number of SNAP cases between the 2015-2017 biennium and the 2017-2019 biennium (from roughly 406,000 households to approximately 371,000 households). The proportion of SNAP cases that are managed in APD/AAA offices is expected to continue to grow. The forecast projects a decline in the number of TANF cases from roughly 23,500 to 20,600 over the same period.

Errors occur in these programs as well. Recent internal quality control review data for the SNAP program found that in a sample of cases where applicants were determined to be ineligible, that decision was inaccurate more than 19 percent of the time. In a sample of SNAP-eligible cases, the difference between the benefit amount awarded and the correct amount averaged a little less than 3 percent of the benefit amount. (Some errors were overpayments. Others were underpayments.) In the TANF program, the difference between the amount awarded and the correct amount exceeded 28 percent of the benefit amount.

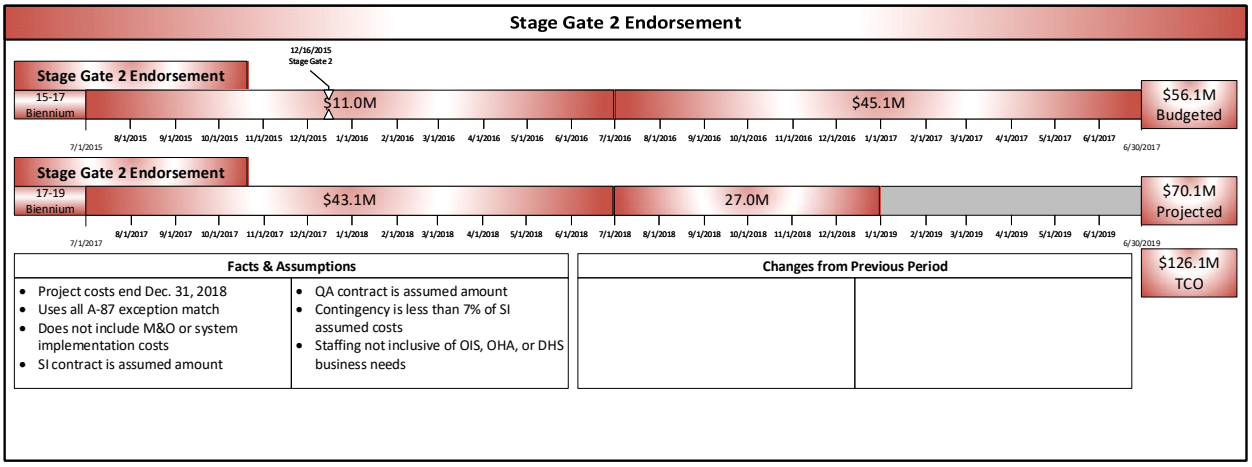
2.6 Schedule Changes Since Last Update

The project timeline has been updated from previous submissions. As Oregon explored work through the iterative design sessions, it became apparent that we needed a shift in our operational model. A decision was made to delegate all Medicaid eligibility determination work

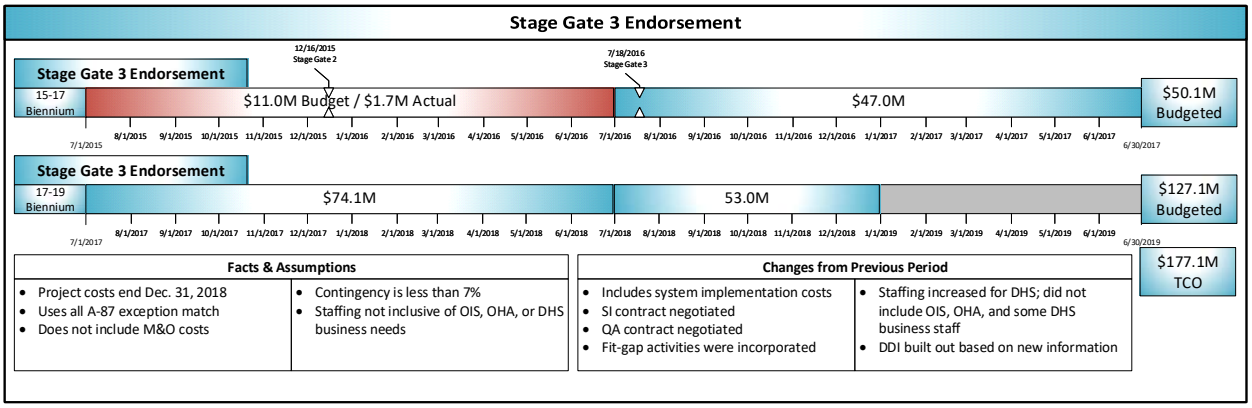
to DHS. As OHA and DHS further engaged with the design and explored opportunities and lessons learned from the initial ONE implementation and other States' experience, Oregon updated the schedule. Additional time for pilot, testing, and the wave roll-outs were added to the schedule. Oregon also contracted with Deloitte to assist with the Legacy Design work with the intent of insuring that Oregon's Office of Information Services (OIS) understands the total scope of work needed and to avoid issues that other States experienced with their projects. As this work continues, Oregon may adjust the Project schedule to ensure that we are accounting for all the opportunities we need to consider in ensuring a quality product is delivered and ultimate accountability to our federal partners and Oregonians is met.

2.7 Project Changes Since Initiation

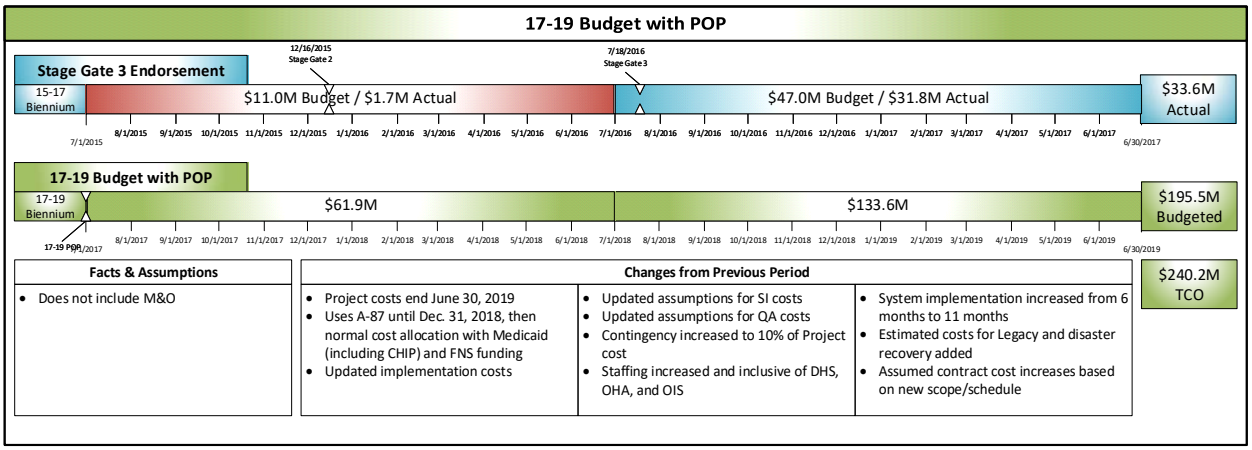
Business Case version 1.1, dated December 16, 2015, was utilized for Stage Gate 2 endorsement. As indicated in the graphic below, there was an estimated Project cost of $126 million with a plan for product availability in December 2018. Product implementation and people readiness activities were not incorporated in this version.



Business Case version 2.0, dated July 18, 2016, was an update for Stage Gate 3 endorsement. The graphic below estimates Project cost to be $177.1 million with a plan for implementation through December 2018. This plan refined SI and QA contract costs and incorporated fit/gap activities. In this estimate were increased staffing for DHS but did not include many needed OIS or business resources from OHA and some of DHS.

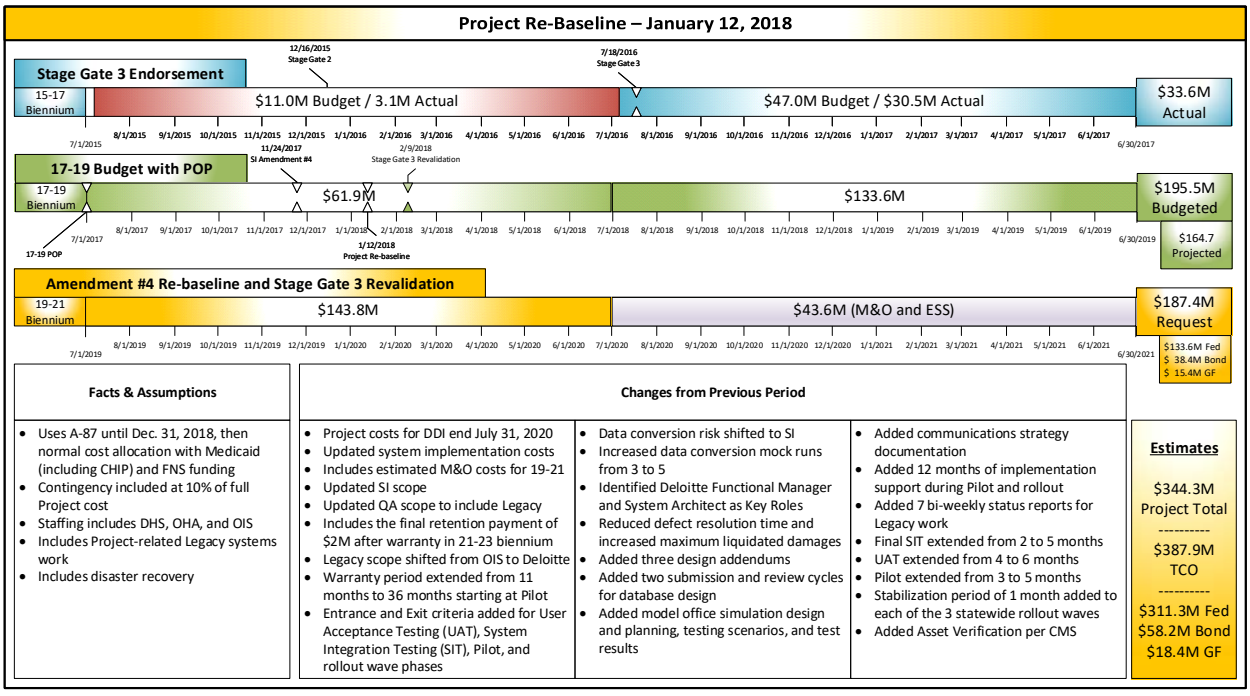


In the 17-19 budget development process, the Project Team received go-forward approval from Project governance after an impact analysis and risk assessment were conducted to validate the viability of a go-forward option. There was an additional $63 million cost identified to extend the Project duration to June 2019, and to incorporate additional staffing needed for an implementation that was increased from 6 months to 11 months. Additionally, Legacy systems design and development were added for both the State and the SI, as well as funding needed for disaster recovery. The SI contract Amendment amount was approximated. Contingency funds were also added to the budget to reflect a 10% prudent person reserve. The total Project cost was estimated to be $240.2 million with $195 million needed for the 17-19 biennium.



The SI contract Amendment was completed in November 2017. The duration of the Project was again extended such that Pilot implementation will begin in September 2019, followed by 3 one-month waves of roll-out and one month stabilization period between each wave. This schedule indicates a complete state-wide deployment by the end of July 2020. There were also extensions of time by adding two extra data conversion mock runs (from 3 to 5), adding 3 design addendums, increasing final System Integration Testing (SIT) from 2 months to 5 months, Pilot implementation from 3 months to 5 months, and User Acceptance Testing (UAT) from 4 months to 6 months. Other additions to scope included the addition of Model office simulation design and planning, communications strategy documentation, updates to QA scope to include ONE/ESS and Legacy design and development, warranty period extension from 11

months to 36 months, and other items identified in the graphic below. These changes increased the Project cost from $240.2 million to an estimated $344.3 million, but with the schedule extension, some of the SI and QA deliverable costs were shifted from the 17-19 biennium to the 19-21 biennium. As such, the Project Team is estimating an ending balance of approximately $30 million at the end of the 17-19 biennium. The 19-21 budget request will be further refined prior to the budget development process but acknowledges there will be funding needed to complete testing and implementation, as well as for Maintenance and Operations (M&O) and Enhancement Support Services (ESS).



3 Problems and Opportunity Definition

3.1 Problems

One of the most common complaints from both clients and workers is the lack of integration between and across DHS and OHA systems, resulting in the need for the same information to be provided and entered into multiple systems. Clients are frequently frustrated with having to provide the same demographic and financial information over and over when applying for different program benefits. Caseworkers are frustrated by the lack of client and case visibility across programs. That forces them to open many systems and juggle many views into those systems simultaneously as they interview clients and process cases. Oftentimes, they don't have access to systems or parts of systems that are needed to support clients effectively.

A good example of this is cases where a worker in an APD/AAA office evaluates a client's eligibility for medical assistance and SNAP and determines the client is SNAP-eligible only. This case will be referred from the APD/AAA office to an SSP office for ongoing case management. The information system used in the APD office (OregonAccess) does not have an interface to the system used in the SSP office (TRACS) so data must either be transferred with a cut-and-paste operation, re-entered from a paper application, or collected from the client again.

Case transfers in the opposite direction (from an SSP office to an APD or AAA office) are also problematic. Anecdotal reports include times where these transferred cases went unnoticed for three to six months. This problem should be resolved by integrating the systems such that handoffs to other agency processing centers is no longer required. Additionally, the new system is tasked based vice case based, meaning workers will monitor a queue that is shared by all. Other reports noted that the likelihood of fraud increases when a household is split between an SSP branch and an APD/AAA branch due to the absence of connections between the systems.

Similar, and often more complicated, coordination problems arise for clients of the Intellectual and Developmental Disabilities (IDD) program. The case managers who provide case coordination for long term care or support in the IDD program are predominantly employees of local county-run Community Developmental Disabilities Programs (CDDP) and Adult Support Service Brokerages. While these offices are under contract with DHS to provide case coordination for IDD services, they do not manage the Medicaid financial eligibility case for their clients. This leaves clients and their families in the position of having to contact and work with the APD or AAA branch closest to their home location. Because service cases are managed in multiple legacy systems, which differ from the systems in which the medical eligibility cases are managed, complex and time-consuming human intervention is required to assure both medical and long-term service benefits are maintained and managed correctly.

3.2 Opportunities

In an integrated solution, the problems described above no longer exist because caseworkers will enter client data once for all in-scope eligibility determinations and they will be cross-trained on these DHS and OHA eligibility-based systems such that clients do not need to be redirected to a different field office. There are other factors identified below that make now the right time to continue expanding the ONE system to include eligibility and enrollment functionality for Non-MAGI Medicaid, SNAP, TANF, and ERDC systems, at a minimum.

3.2.1 MAGI Medicaid Eligibility System

The ONE system has been in production since December 2015 and has undergone many enhancements and upgrades since that time. There is now opportunity to extend this system to align with the intended outcomes of the IE & ME Project. Examples include:

- Oregonians can set-up an account, apply for and receive real-time eligibility determinations for Medicaid (both MAGI and Non-MAGI), SNAP, TANF, and ERDC using a single application via the Applicant Portal
- Coordination of eligibility determination work between DHS and OHA for mixed households
- Electronic verification information sources minimize documentation that the client will be required to provide
- Operational reports that will allow for workload management across eligibility determination caseloads
- Single system for eligibility determination data for accurate reporting to federal partners
- Centralized and verified enrollment data available for Coordinated Care Organizations for MAGI & Non-MAGI clients
- Consistent high-quality data source for reporting CMS-mandated operational statistics
- Automating manual processes in order to:
    - Reducing the elapsed time between completing an application and making an eligibility determination
    - Reducing staff time spent creating, reviewing, and acting on each application
    - Reducing error rates in making eligibility determinations

3.2.2 Federal Partnership

3.2.2.1 A-87 Cost Allocation Exception

On August 10, 2011, three federal agencies, CMS, FNS, and ACF announced a time-limited, specific exception to the cost allocation requirements set forth in Office of Management and Budget (OMB) Circular A-87 (Section C.3) and Section 200.405 of the superseding “Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards” (2 CFR 200 issued December 19, 2014). These provisions generally require the costs associated with building shared state-based information technology systems to be allocated across all benefitting programs. The exception reflected a federal focus on streamlining enrollment and eligibility determinations in health and human services programs while leveraging funding efficiencies at the state-level.

3.2.2.2 Timeline Extension

The original timeline allowed human services programs to benefit from investments in the design and development of state eligibility-determination systems for state-operated Marketplaces, Medicaid, and the Children’s Health Insurance Program (CHIP), through December 31, 2015. On July 20, 2015, the three agencies extended that timeline for an additional 3 years, through December 31, 2018.

The A-87 exception extension, along with an indefinite extension of enhanced Federal funding for Medicaid systems, will enable states to fund the initial development costs needed to retire their legacy eligibility determination systems and to integrate this functionality into new and improved systems. Moreover, the extension will provide states more time to develop, refine, or test integrated systems to fully comply with Affordable Care Act requirements.

In support of DHS' integrated ONE IE & ME Project, CMS will fund all system components necessary for Medicaid eligibility determinations, including those components that also serve other programs, at its 90/10 match rate. FNS will fund SNAP-only components at its 50/50 match rate, and ACF will allow the state to utilize TANF and ERDC funds to support the development of components that were confined to those programs. After December 2018, CMS will continue to fund Medicaid components at the 90/10 match rate but functionality benefitting all enrollment and eligibility determination programs will need to be allocated at 90/10 Medicaid and 50/50 for SNAP, TANF, and ERDC.

CMS and FNS approved federal fiscal year 2017 funding for project design and development work. The Project Team has regular monthly status reports and status meetings with these federal partners.

3.2.3 System Design

IE & ME Core Design, Conversion Design, and Legacy Design is approximately 90% complete with scheduled completion at the end of March 2018. There is now a greater understanding of system functionality, requirements, and outcomes.

3.2.4 Contract Amendments

3.2.4.1 System Integrator Contract Amendment #4 with Deloitte Consulting.

The SI Amendment #4 to Statement of Work (SOW) #2 for design, development, and implementation (DDI) of the ONE IE & ME system was crafted to capture changes that had been presented to the Legislature during the 17-19 biennium budget process in the form of a Policy Option Package (POP) that extended the duration of the Project and associated costs. This Amendment effectively shifted design scope of the larger and/or more complex Legacy systems from State staff to the SI. Additionally, this Amendment provided the following benefits:

- Contract language position improvements:
    - Warranty Period extended from 11 months to 36 months starting at Pilot.
    - Entrance and Exit criteria added for User Acceptance Testing (UAT), System Integration Testing (SIT), Pilot, and rollout wave phases.
    - Data conversion risk reduction:
        - If the data conversion approach fails to deliver results in accordance with the design or the mock run targets, then the SI will bear its own costs relating to revisions in the data conversion design and the data conversion source code.
        - Increased the number of data conversion mock runs from three to five.
        - Resolved differing opinions regarding the scope of the SI's data conversion extraction and transformation services for Other Related Individuals.
    - Identified two additional SI roles (Functional Mnaager and System Architect) as Key Persons.
    - Service Level Agreements (SLAs): Reduced resolution time for Severity Level 3 Defects and increased the maximu liquidated ddamages per incident form some metrics.
- Deliverable adjustments:

  - Added three design addenda to incorporate limited functional modifications, as prioritized by the State, to meet business requirements and complete system implementation.
  - Added two submission and review cycles for the Database Design – Data Dictionary, Logical Design, and Physical Design.
  - Added Model Office Simulation design and planning, testing scenarios, and test results.
  - Added communications strategy documentation.
  - Added twelve months of implementation support services during the Pilot and statewide rollout.
  - Added seven bi-weekly status reports to the legacy documentation and design work (SOW #3).
- Increase to Other Support Services:
  - Added $6 million to the Other Support Services funds.
- Schedule adjustments:
  - Final SIT duration extended from two months to five months and aligned with legacy system availability to enable end-to-end testing.
  - UAT duration extended from four months to six months.
  - Pilot duration extended from three months to five months.
  - A one-month stabilization period has been added to each of the threed statewide rollout waves.

The cost for SI services with this Amendment increased from $100 million to $166 million.

Responsibilities between the State and Deloitte in the execution of this Amendment are included as Appendix J.

3.2.4.2 Quality Assurance Contract Amendment #3 with Public Knowledge, LLC.

The QA Amendment #3 to SOW #2 expanded the scope of QA services provided by Public Knowledge, LLC to include modifications to impacted legacy systems, the incorporation of the ONE System Enhancements, and other changes to align with the revised scope and schedule of the Project. ONE System Enhancements means enhancements made to the ONE System through either maintenance and operations (M&O) releases or enhancement support services (ESS) releases. This Amendment has been approved by CMS. FNS approval is pending.

The cost for QA services with this Amendment increased from $4 million to $8.6 million.

3.2.5 Re-Baselined Scope, Schedule, and Budget.

With the Amendments above, the scope, schedule, and budget were re-baselined. These Project artifacts are attached as Appendices A, B, and C respectively.

3.2.6 *benefind* Code Availability.

As the State of Kentucky expanded their enrollment and eligibility services from their *kynect* product, new functionality they called *benefind* became available for State of Oregon use. This transfer solution is being put in place to the maximum extent practicable in the build of Oregon's new integrated system.

3.2.7 House Bill 2219 (2015) – Single Streamlined Application for Human Service Programs

HB 2219, effective June 2, 2015, required DHS to convene a work group consisting of "human service agencies" to study consolidation of application processes for human and social services and to report recommendation to the Legislative Assembly. This report was submitted to the Legislature on August 15, 2016. In this report, four recommendations were identified and are summarized below:

> Recommendation 1: Develop a single application for financial eligibility for DHS and OHA programs. Convene a cross organization recommending body to develop criteria for the sequence and addition of other agency programs.
>
> Recommendation 2: Take the opportunity with the IE & ME Project to review and revise the application language. Application assistors have provided feedback that current application language can be confusing and potentially trigger trauma for applicants.
>
> Recommendation 3: Utilize the HB2219 work group to research the health and human services program screening tool(s) currently being used in Oregon and explore their functionality, accuracy, maintenance and usage.
>
> Recommendation 4: Continue the HB2219 work group to research and explore the possibility of sharing basic applicant information across programs/agencies, when applicable, to reduce duplication and enhance services to Oregonians.

The consolidated application will allow people to apply for and obtain assistance in accessing food, housing, medical care, education, employment services, child care and other social services. A consolidated application process is expected to: 1) decrease the time an applicant spends filling out similar paperwork for different programs, 2) decrease the time agency staff spend processing paperwork, 3) reduce the burden on applicants to navigate their own way through a complex system of programs, and 4) correctly and appropriately determine eligibility through a common, standards-based process. Eligible Oregonians would get a quick and accurate determination, and those who are not eligible would be promptly notified.

3.2.8 Meeting Citizen Expectations

Today's consumers increasingly communicate in real time via web-based services accessed from virtually anywhere. Technological advances and experiences in consumer marketplaces have resulted in DHS customer expectations that are much higher than they were just a few years ago. Citizens expect to be able to access information about government programs simply and quickly. They expect to be able to find information and connect with programs without needing to first figure out which programs and benefits are administered by which agencies and levels of government. Some people are beginning to demand virtual "one stop shops" where they can connect with government programs from all agencies that serve people in circumstances like theirs. They expect to access benefits and services without having to report physically to a field office or having to fill out paper forms. They expect online government services to set and meet the highest possible standards for security, confidentiality, and data privacy.

With the new integrated system and associated Applicant Portal, Oregonians will be able to apply for benefits, update case information, upload documents, and determine eligibility across multiple systems from anywhere in the world that they can obtain Internet connectivity.

3.2.9 Field Operations Efficiencies

Eligibility decisions will occur in a timelier fashion with the delivery of an integrated eligibility system. Workers will not be downloading paper applications, manually entering information into multiple screens, or performing manual verification checks in multiple systems. This will result in fewer processing errors and greater integrity of the data in the system. Accuracy of eligibility decisions and benefit amounts will also increase with automation of these activities.

DHS and OHA will be updating the service delivery model to include two levels of office interaction. Virtual Eligibility Centers (VEC) will be established in rural communities where workers will process information coming through the phone or an online application. This creates rural jobs and will build an infrastructure to support the growing movement away from brick-and-mortar offices. Oregonians will continue to have access to offices where services are currently provided. They will also have 24-hour access to information about the status of their eligibility cases. The ability for customers to update their own personal information, with automated processing of those updates, will save worker time in the DHS offices. It will also allow for more efficient communications between workers and their assigned customers, with the ability for customers to email their worker at any time of the day with information or questions about their case.

Staff in DHS and AAA offices will be able to spend more time with people, assisting them with their needs, and less time with paper processes and files. Additionally, DHS staff who are serving customer needs in their own homes, or places of residence, will be able to access information from those locations and update information. This allows for the worker to save time once they are back in the office, as the updates will already be complete. They will no longer have to upload and update information upon return to the office.

While we expect these efficiencies and opportunities, the majority of these will not be seen for at least 18 months, post implementation. In order to automate eligibility and allow Oregonians to be able to provide information, additional questions and functionality is required. These additional fields, which don't exist today and therefore cannot be data converted into the ONE

system, along with change management have been correlated nationwide with longer eligibility determination times for the first year and a half.

3.2.10 Alignment with Strategic Technology Plan

The DHS/OHA Strategic Technology Plan (STP) includes many strategies that the ONE IE & ME Project will support. Strategy #1 in that plan is titled Business Automation and calls for the automation of workflows, decision-making, and business rules while reducing manual, paper-based processes. This project will automate workflows and the application of business rules in each of the programs within its scope. Strategy #2, Dynamic Needs Supported by Seamless Services, is evident in that this project includes many programs in its “one stop shop” for citizens. Similarly, an integrated eligibility system will provide advances in pursuit of Strategy #5, which calls for assembling a “comprehensive view of clients.” The STP also calls for enabling connectivity “anytime, anywhere,” encouraging the development of on-line self-service capabilities for clients and mobile virtual workplaces for agency staff. An integrated eligibility determination system will provide that functionality. More information related to Project alignment with the STP is attached as Appendix I.

4 Alternatives

In version 1.1 of this business case, which was utilized for Stage Gate 2 endorsement, four alternatives for the Project were identified and analyzed. They were:

- Implement Non-MAGI Medicaid Eligibility Determination into the ONE system
- Implement Integrated Eligibility Determination into the ONE system
- Acquire External Eligibility Services from Another State
- Do Nothing

The second option was selected, meaning the intent was to extend the functionality and derived benefits of the ONE system to include Non-MAGI Medicaid, SNAP, TANF, and ERDC. Business case v1.1 is included in this document for reference as Appendix D.

In version 2.0 of this business case, which was utilized for Stage Gate 3 endorsement, these same four alternatives were recognized but only options #2 and #4 above were compared further. Business case v2.0 is included for reference as Appendix E.

This version of the business case contains updated information about changes to scope, schedule, budget, and risks. Assumptions and constraints have been updated, validated, and utilized to determine the best course of action (Alternative) going forward.

4.1 Assumptions and Constraints

Below are assumptions considered in the Alternatives Analysis (Section 4.4).

- DHS and OHA leaders support a strategy of minimizing the amount of customization when transferring Kentucky's solution to Oregon. This requires a willingness to change policies and procedures rather than changing the system whenever practicable.
- The Project Team will sufficiently orchestrate the ONE operations and maintenance work, the ONE MAGI enhancement efforts, and the IE & ME system development such that none prevent the others from being successful.
- CMS and FNS will provide timely approval plans for the IE & ME system development throughout the duration of the Project. The approval process is at least 60 days, with the review cycle restarting if there are document revisions.
- The legislature will continue to financially support the IE & ME Project, including providing necessary funding for the maintenance and operations of the new system.
- Per the MOU between OHA and DHS signed in April 2017, OHA will delegate Medicaid eligibility determination to DHS. This transition will occur before the new system goes live.
- A separate open and competitive RFP will be issued for the long-term Maintenance and Operations (M & O) of the new system after Project completion. Deloitte Consulting will provide these services by way of a contract Amendment until a new contract is awarded.
- MAGI Medicaid-related enhancements to the ONE System will be performed by Deloitte Consulting.

- The Legacy systems documentation will be updated in a timely manner to support the design of the IE & ME system and its interfaces.
- Case management will still be performed in Legacy systems such as TRACS and ORACCESS and will be shared with the new system with interfaces, as appropriate.
- Deloitte will assist in documenting the design of key Legacy system changes and interfaces to support their use with the Integrated ONE System.
- Appropriate modifications to the existing service delivery model and business processes will enable Oregonians to access benefits via Storefronts, the Applicant Portal, or through Virtual Eligibility Centers (VECs).
- Training will be holistic. It will encompass enrollment, eligibility, and benefit issuances in both the new ONE system and the modified Legacy systems.
- The existing ONE system will be merged into the new IE & ME system.
- The roll-out will be conducted in a phased approach. There will be a five-month Pilot period, implementing the new system in both Jackson and Josephine Counties. Following the Pilot, implementation in the remainder of the State will be accomplished in three one-month waves with a one-month stabilization period following each wave.
- Key staff (business leaders, program and policy experts, field/operations representatives, technical experts, clients and potential clients, community partners, counties, and tribes) will be made available in sufficient numbers to the Project when they are needed.
- Changes to the MMIS system will be completed in a timeframe consistent with the IE & ME schedule.
- People readiness for field/operations representatives and other stakeholders will be achieved throughout the IE & ME Project, and will be completed prior to “go-live.”
- DHS and OHA will continue to receive authority to connect, and to utilize the Federal Marketplace.
- ETS will provide timely and consistent services throughout the life of the IE & ME Project and will provide necessary services for the implementation, operation, and maintenance of the new Integrated ONE system.
- There will be continued gubernatorial, OSCIO, and legislative support for the Project.
- All parties to the MOU will continue to abide by the agreement.

The project is subject to these constraints:

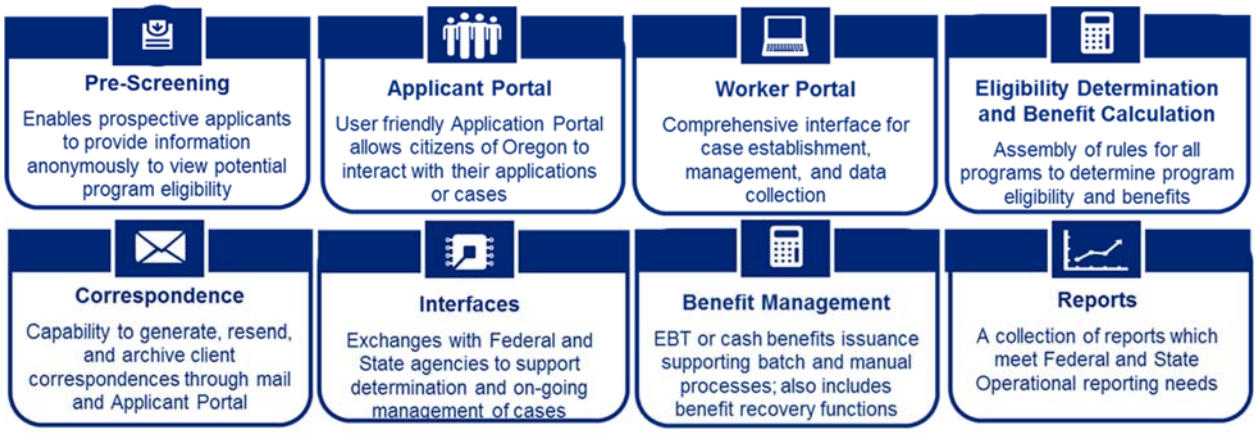
- CMS will not provide enhanced funding for a Non-MAGI Medicaid solution that is separate from ONE.
- The exception to the OMB Circular A-87 cost allocation requirements to support integration of other human service programs into the ONE system will expire at the end of December 2018.
- The IE & ME System Integration Testing #2 cannot be performed until ONE, Legacy, and MMIS development and testing is complete.

- State and Federal mandates that require changes will need to be implemented during the Project if they cannot be deferred.

4.2 Solution Requirements

4.2.1 High Level Functional Requirements

The following represents the IE & ME Project high-level business functionality:



Pre-Screening – The Pre-Screening module in the Applicant Portal enables prospective applicants to provide a minimal set of information to the system anonymously to see the programs for which they may qualify. The module will include assessment capabilities for all programs offered by Integrated ONE, including Medicaid (MAGI & Non-MAGI), SNAP, TANF, and ERDC. It is important to note that the pre-screening process is not an official eligibility determination and individuals must formally apply in the Applicant Portal or by contacting a DHS or an OHA office. The data collected during Pre-Screening will be saved.

Applicant Portal (AP) – The Applicant Portal enables the registered users' access to the system to apply for benefits as well as to enable them to take action on their ongoing benefits. The applicant portal allows users to apply for Medicaid (MAGI & Non-MAGI), SNAP, TANF, and ERDC as a part of an Integrated ONE application. The citizens will be able to take actions on their ongoing applications or cases including to report a change, to recertify, to withdraw an application, to discontinue an ongoing program, to upload documents, to view Request for Information (RFI) notices, and/or to start a new application. It will also include additional functionality such as the ability to request an appeal or hearing, to request an EBT or Medicaid Card, to view claims or facts regarding disqualification, to view a TANF summary, and/or to submit a SNAP application. The applicant portal will provide role-based dashboards and will incorporate the user account creation process that is currently established in the MAGI Medicaid ONE system Applicant Portal.

Worker Portal (WP) – Worker Portal allows case workers to manage the lifecycle of an application or case by providing functionality to perform intake on new applications, to determine eligibility and benefit amounts based on the data provided during intake, and/or to disburse benefits and process case changes. It also contains modules for support-functions like

appointments, task management, hearings and appeals, and complaints to help the workers perform daily activities.

Eligibility Determination and Benefit Calculation (EDBC) – As the central repository for business rules defined by policy and administrative procedure, EDBC is the module where the Integrated ONE system determines each person's eligibility and benefit level based on the information collected through the worker or applicant portal and verification status of key data elements that affect eligibility (income, resources, citizenship, etc.) For Medicaid programs, eligibility determination is limited to financial eligibility for Medicaid. Service eligibility determination and authorization for Medicaid and other SSP case management services are not in scope for the initial implementation. For the purposes of determining financial eligibility, the eligibility rules engine will evaluate individuals and households through multiple modules to confirm their compliance with both state and federal program rules. All eligible individuals will be included in the benefit group which will be used to determine the benefit amount or ERDC days of care the individual may receive.

Correspondence – The correspondence module generates the notices required to support a case life cycle. Integrated ONE system generates the notices, which are automatically forwarded to the State's centralized print center for printing and mailing. Case Workers will have the ability to review the notices and determine the accuracy before these notices are mailed out as part of the nightly batch processing cycle.

Interfaces – Interfaces are a critical component of the Integrated ONE system. Interfaces are required to share data with federal agencies, other State agencies and systems, and Trusted Data Sources (TDS) to support critical business processes such as verification, fraud detection, federal reporting, benefit issuance, and recovery. The system will use both batch and real-time interfaces to meet the business needs.

Benefit Management – The Benefit Management module supports two key functions – benefit issuance and benefit recovery. The benefit issuance function allows for automatic benefit issuance through Electronic Benefit Transfer (EBT) cards, checks and direct deposit through Electronic Fund Transfer (EFT). The function also allows authorized users to issue benefits manually outside the constraints of eligibility, if necessary.

The Benefit Recovery function determines overpayments against issued benefits because of case changes. Overpayments are referred to the ICM (Claims Management) System for establishing and maintaining claims. A certain portion of the benefit amount is recouped from future benefits based on the outstanding claims amount received from ICM.

Reports – This module focuses on generating Operational, federal and State reports necessary for the administration of the APD and SSP programs. The operational reports are generated from key business processes that include:

- New Applications
- Reporting a Change
- Redeterminations
- Task Management
- Reports required for audits and quality assurance
- Interface Activity Reports

The above functionality will be provided in the new system by integrating components of several disparate systems identified below.

- Modified Adjusted Gross Income (MAGI) Medicaid. This program helps low-income people in Oregon with health insurance. MAGI medical benefits can cover working families, children, pregnant women, single adults, and more. This functionality is currently in the ONE system.
- Non-MAGI Medicaid. This includes Oregon Supplemental Income Program (OSIP) Medical, also known as the Aged, Blind, Disabled Medical or SSI based Medical programs, Medicare Savings Programs, and Refugee Medical. These services are currently processed in ORAccess, CM, and MMIS. Scope does not include Hospital Presumptive, Extended Medical, and the Breast and Cervical Cancer Program.
- Supplemental Nutrition Assistance Program (SNAP). This is a federally funded program which offers nutrition assistance to millions of eligible, low-income individuals and families. SNAP is the largest program in the domestic hunger safety net. Scope includes all services provided by SNAP other than the Summer Meals program.
- Temporary Assistance for Needy Families (TANF). This program provides cash assistance to low-income families with children while they strive to become self-sufficient. Cash assistance is intended to meet a family's basic needs such as food, shelter and utilities. Most cash benefits in Oregon are issued via an Electronic Benefit Transfer (EBT) card. This is also known as an Oregon Trail card. Scope does not include case management.
- Employment Related Day Care (ERDC). This is a child care subsidy program for working families.
- Temporary Assistance to Domestic Violence Survivors (TA-DVS). This program provides temporary financial help to support families whose safety is at risk due to domestic violence. Most often, this is when the domestic violence survivor and the children are fleeing domestic violence or at risk of retuning to an abusive situation.

4.2.2 High Level Non-Functional Requirements

High level non-functional requirements include the following:

Security – Provisioning of a secure system with corresponding authority to connect to the federal market place.

Reliability and Availability – The system must meet service level requirements for accessibility and up-time. Maintenance windows must be clearly communicated and be strictly adhered to.

Scalability – The system must scale to meet demand. As demographics change, it is anticipated that the preferred method of accessing services will also change. The system must accommodate this shift.

Performance – The system must meet performance specifications such that the user experience is acceptable with any method of interaction with the system.

Capacity – System design must accommodate the anticipated volume of cases end-to-end, including interactions with Legacy systems case management functionality.

Recoverability – The system must be recoverable within a reasonable Recovery Time Objective (RTO) with tolerable data loss specified with a Recovery Point Objective (RPO). RTO and RPO will be articulated as part of the Disaster Recovery and Business Continuity business case.

Serviceability – The system must be developed utilizing industry best practices and standard tools and methodologies to be easily maintained, including the application of patches, upgrades, and enhancements.

4.3 Alternatives Identification

In each iteration of this business case, the Project Team explored four alternative courses of action. With more than two years of activity and approximately $57 million invested to date on this Project, it is now approximately 35% complete, including over 90% of design completion. As such, not all the previously developed Alternatives make sense or are even possible. Current state Alternatives are now identified as follows:

Alternative #1: Implement Non-MAGI Medicaid Eligibility Determination into the ONE System
This Alternative is unchanged from prior business case versions and extends the current ONE system to support Non-MAGI Medicaid eligibility determinations and service authorization to community-based care programs only. This approach limits the scope of DHS and OHA programs that would be affected. It requires transfer of the Kentucky system, removal or disabling of the functionality in that system supporting programs like SNAP, TANF, and ERDC, and customization for Oregon's Non-MAGI Medicaid program.

Alternative #2: Implement Integrated Eligibility Determination into the ONE System

This Alternative is also unchanged from prior business case versions and represents the current course of action on this Project. This Alternative extends the current ONE system to support Non-MAGI Medicaid eligibility and SNAP, TANF, and ERDC determinations, as well as providing service authorizations for community-based care programs. This approach involves a wider range of DHS and OHA programs. It avoids the risk and expense of removing functionality for these programs from the Kentucky system. It requires potential customization of a larger number of Oregon programs than Alternative #1.

Alternative #3: Acquire External Eligibility Determination Services from another State

This is not a viable Alternative as there are no service models across the nation that support Oregon acquiring services in this manner.

Alternative #4: Do Nothing

This Alternative requires no additional investment in further development of the ONE system. However, resources with skills needed to deal with contract issues and federal audits would be needed. Improvements to current processes would be limited to those that arise naturally through DHS's continuous improvement program.

4.4 Alternatives Analysis

In each prior version of this business case, Alternative #2 - Implement Integrated Eligibility Determination into the ONE system, was selected as the best go-forward option. In this business case, Alternatives #1 and #4 are revisited and reviewed against the foundational assumptions and constraints. Consideration is given to the work performed to date in the realization of expected outcomes and factors such as cost, benefit, and risk identified with each alternative.

Alternative #1: Implement Non-MAGI Medicaid Eligibility Determination and Service Automation Only

Cost – The estimated total cost of implementing this Alternative was $80.3 million. (See estimate details in Business Case v1.1, Appendix D.) Compared to the Integrated Eligibility Alternative #2, this Alternative would have minimized the overall costs of Fit-Gap analysis, design, configuration, customization, testing, and training by removing scope for all components other than Non-MAGI Medicaid. Savings would be reduced by the cost of removing or disabling SNAP, TANF, and ERDC from the Kentucky system code. Nearly $60 million invested to-date for enhanced eligibility determination functionality would produce little or no value.

Benefits – This Alternative will achieve the high-level requirements associated with the Medicaid program. Clients seeking Non-MAGI Medicaid eligibility will be able to apply online and they will receive faster eligibility determinations. Non-MAGI Medicaid eligibility workers in APD and AAA offices will be more productive and make fewer eligibility determination errors. Problems associated with the handoff of cases between DHS and OHA will be reduced, if not eliminated.

Risk – This Alternative has the risks associated with large information technology projects involving complex requirements and a lengthy schedule. This Alternative will impose substantial policy and procedure changes on Non-MAGI Medicaid eligibility workers. The need to remove substantial components from an existing application adds some technical risk that is not present in the other alternatives. DHS workers will need to use two or more systems to provide some clients with basic case management. There is also significant risk in splitting APD cases from SNAP cases.

Alternative #2: Implement Integrated Eligibility Determination

Cost – The five-year total cost of ownership between August 2015 and June 2020 is estimated to be $334 million. (See Appendix C, Project Budget). This alternative includes the full cost of Fit-Gap analysis, design, configuration, customization, testing, and training for the SNAP, TANF, and ERDC programs. Also Non-MAGI Medicaid all modifications to 35 Legacy systems, and disaster recovery.

Benefits -

- Clients seeking Medicaid eligibility (either MAGI or Non-MAGI) and/or SNAP, TANF, and ERDC eligibility will be able to apply on-line.
- Clients applying for medical assistance and for one or more of SNAP, TANF, and ERDC will make a single application regardless of programs they are applying for.
- There will be fewer eligibility determination errors in and between the programs due to the single shared data source and integration between systems.
- Problems associated with the handoff of cases between OHA and DHS will be reduced or eliminated, as will problems with handoffs among APD/AAA offices and SSP offices.

- This approach allows for the retirement of the Caseworker Application Processing Interface (CAPI), and the Food Stamp Management Information System (FSMIS).

Risk - This project has the risks associated with large information technology projects involving complex requirements and a lengthy schedule. There are many stakeholders involved or impacted. New business processes will impose substantial policy and procedure changes on Non-MAGI Medicaid eligibility workers in APD/AAA offices and on SNAP, TANF, and ERDC eligibility workers in SSP offices. By eliminating antiquated information systems and reducing the scope of others, this approach reduces long-term risks that system failures will interrupt the delivery of DHS programs.

Project leadership is tracking several high probability/impact risks. They are summarized here:

- Focus on preferring policy and process change before technology change reduces technical risk but substantially increases the amount of process change that must be undertaken.
- Legacy subproject that includes modifications to 35 subsystems is still in design so is not yet fully understood.
- Data conversion mock runs have not yet begun so data quality is not yet fully understood.
- Data quality in Legacy systems might make it difficult to cleanse and populate data from Legacy into the new system.
- The Office of Information Services (OIS), which supports many affected Legacy information systems, may not have capacity to simultaneously participate in this Project, and support on-going operations, maintenance, and enhancement of Legacy systems that will remain after the ONE IE & ME project.
- The project's Technology Management Plan would impose security requirements on DHS and OHA's directory services that may not yet be supportable.
- There may be a lack of capacity for business leaders, track leads, and other Project staff to accommodate the volume of action items, change requests, and decisions required for the Project.

Alternative #3: Acquire External Eligibility Determination Services from another State

Cost, benefit, and risk are difficult to quantify given there is no existing model for obtaining services in this manner.

Alternative #4: Do Nothing

Cost – Spending for additional system functionality would stop but additional costs to shut down the Project would continue until all vendor contracts were terminated and all audits were conducted. There would be no value derived from the investment of approximately $300 million already made.

Benefits – There is no beneficial by-product from this Alternative.

Risk – It is estimated federal audits would take years and that federal program subsidization would come to a stop until audit findings were satisfactorily addressed by the State. There would also likely be significant dissatisfaction from all Project stakeholders, potentially resulting in not having another opportunity to fix current state problems into the foreseeable future.

5 Conclusions and Recommendations

5.1 Conclusions

Development of an Integrated Eligibility Determination system continues to be the leadership vision for Oregonians, DHS, OHA, and for eligibility workers and the prudent course of action, given the investment of time and resources to date. With the continuation of the OMB Circular A-87 cost allocation exception and the active support of our CMS and FNS partners, any action contrary to continuing with the Project will have significant negative consequences, as identified below.

The State of Oregon has an opportunity to continue expansion of the MAGI Medicaid eligibility system (ONE) as a stable base, utilizing code from the State of Kentucky system called *benefind*.

Much of the design of the new system, including Legacy design is complete. Given new contract Amendments with our SI and QA vendors, there is a solid scope, schedule, and budget to manage the Project to. There is also current work with Gartner to validate this schedule and budget against anticipated Project outcomes, scheduled for completion in February 2018.

The efficiencies gained in the field offices in serving Oregonians enrollment and eligibility needs for Medicaid, SNAP, TANF, and ERDC is undetermined during the first year of deployment. Factors such as the quality of data conversion and the readiness of eligibility workers will impact operations. However, data will be more reliable and checks and balances are being built into the system for accuracy and error reduction. It is in the best interest of the State of Oregon to continue the ONE IE & ME Project on its current course on behalf of all Oregonians.

5.2 Consequences of Failure to Act

There has been ongoing effort to modernize enrollment and eligibility programs. Both agencies in cooperation are dedicated to removing obstacles, incorporating lessons learned, and finding success for this project. DHS and OHA signed an MOU to solidify that understanding and to provide a foundation for success. All parties clearly understand that there is significant negative impact in failure or in doing nothing. This section lists those consequences.

1. Oregonians lose. We have a current system that doesn't serve Oregonians well. Medicaid financial eligibility is divided in delivery methodologies and access for Oregonians, SNAP, TANF, and ERDC benefits are not coordinated with Medicaid benefits. Oregonians expect better service from their State government.
2. CMS is continuing to fund the majority of the DDI work through December 31, 2018 for the ONE IE & ME project because non-MAGI is being added to the system that contains MAGI eligibility. Without non-MAGI eligibility CMS will not pay for the shared components and the State's portion would increase for SNAP, TANF, and ERDC functionality.
3. It is possible that the State of Oregon would not risk another project to provide this functionality into the foreseeable future. Changes at the federal level, and differing priorities amongst agencies and programs provide substantial risk in the future.
4. Continued reliance on dated Legacy systems and manual processes. Currently eligibility outside of ONE requires the workers to access seven different subsystems.
5. Loss of CMS/FNS confidence in the State of Oregon (potential impact on future funding).

6. Further loss of Oregon's reputation for being able to implement successful IT projects.
7. Potential contractual termination issues with current contracted entities including Deloitte, and Public Knowledge.
8. Negative impact to service delivery to Oregonians who rely on DHS and OHA for services;
    a. Service delivery times;
    b. Redundant processing requirements for customers and state staff;
    c. No decline in error rates;
    d. Possibility of overpayments or not getting timely benefits;
    e. No enhanced checks and balances between programs.
9. Impacts on the One system. Without bringing in the additional programs, there will continue to be data for individuals that doesn't match. This could result in a worker not acting on the most recent information for an individual, and not performing appropriate due process.
10. Loss of employment to both state and vendor staff.
11. Possible increased DHS and OHA operational costs.
12. There would be a loss of the investment already made in system development.

6 Appendixes and References

6.1 Appendix A – Project Scope

6.1.1 Design sessions revealed additional scope for this Project, such as Non-Citizen, other income types, Real+D, Mass Update triggers, and task management. Scope also includes financial eligibility determination for the following DHS and OHA programs:

DHS Self-Sufficiency Programs	**Type of Assistance (TOA)**	**Description**
Supplemental Nutrition Assistance Program (SNAP)	CTCE	Categorical Eligibility
	EXCE	Expanded Categorical Eligibility
	BBCE	Broad Based Categorical Eligibility
	SNAP	Supplemental Nutrition Assistance Program
	ESNP	Expedited SNAP
	DSNP	Disaster SNAP
	ABAWD	Able Bodied Adults without Dependents Requirements
	OFSET	Oregon Food Stamp Employment Transition Program
Temporary Assistance for Needy Families (TANF)	TANF	TANF
	EPPT	Employment Payments
	TDVS	TANF Domestic Violence
	TJPI	Jobs Participation Incentive
	PSSI	State Family Pre-SSI
	JOBS	Jobs Opportunities and Basic Skills Note - Only determination of JOBS mandatory individuals and assessment status, not ongoing case management
Child Care Program (CCPG)	ERDC	Employment-Related Day Care
	CCTN	Child Care Supportive Service for TANF Recipients
REF	REFG	Refugee program for individuals seeking Assistance and otherwise ineligible
Summer Meals	SEBTC	Summer Electronic Benefit Transfer for Children

DHS Aging and People with Disabilities (APD) Programs	**Type of Assistance (TOA)**	**Program Description**
Non-Modified Adjusted Gross Income (Non-MAGI) Medicaid	QMB-BAS	Qualified Medicare Beneficiaries – Basic
	QMB-SMB	Qualified Medicare Beneficiaries - Special Limited Medicare Beneficiaries
	OSIPM-SSI	Oregon Supplemental Income Program Medical - Supplemental Security Income

	OSIPM-1619B	Oregon Supplemental Income Program Medical - 1619B
	OSIPM-Survivor Widows	Oregon Supplemental Income Program Medical - Survivor Widows
	DAC	Disabled Adult Children
	Pickle	Pickle Amendment Clients
	OSIPM-AB	Oregon Supplemental Income Program Medical - Aid to the Blind
	OSIPM-OAA	Oregon Supplemental Income Program Medical - Old Age Assistance
	OSIPM-AD	Oregon Supplemental Income Program Medical - Aid to the Disabled
	OSIPM-Acute Care	Oregon Supplemental Income Program Medical - Acute Care
	OSIPM-EPD without Services	Oregon Supplemental Income Program Medical - Employed Persons with Disabilities not receiving services
	OSIPM-EPD with Services	Oregon Supplemental Income Program Medical - Employed Persons with Disabilities receiving services
	QMB-DW	Qualified Medicare Beneficiaries - Disabled Worker
	Special Needs	Special Needs
	QMB-SMF	Qualified Medicare Beneficiaries - Qualified Individuals
	Services - LTC/Waiver	Services – Long Term Care or Waiver
	OSIPM-IC	Oregon Supplemental Income Program Medical - Independent Choices program
	REF	Refugee Medical Program

OHA Programs	**Type of Assistance (TOA)**	**Program Description**
Modified Adjusted Gross Income (MAGI) Medicaid	ADLT	Oregon Health Plan (OHP) Plus Adult
	CHIP	OHP Plus CHIP
	CHL1	OHP Plus Child under age 1, under 185%
	CHL4	OHP Plus Child, age 1 through 18, under 133%
	EMAD	Citizen Alien Waived Emergent Medical (CAWEM) Adult
	EMC1	CAWEM Child under age 1, under 185%
	EMC4	CAWEM Child age 1 through 18
	EMPC	CAWEM Parent or other Caretaker Relative

	EMPP	CAWEM Plus Pregnant Parent or other Caretaker Relative
	EMPR	CAWEM Plus Pregnant Woman
	EMPW	CAWEM Pregnant Woman
	FFCC	OHP Plus Former Foster Care Youth
	HIA1	Hospitalized Adult inmate
	HIA2	Hospitalized Pregnant Woman inmate
	PACA	OHP Plus Parent or Other Caretaker Relative
	PCPR	OHP Plus Pregnant Parent or Other Caretaker Relative
	PREG	OHP Plus Pregnant Woman
	TP45	OHP Plus Assumed Eligible Newborn

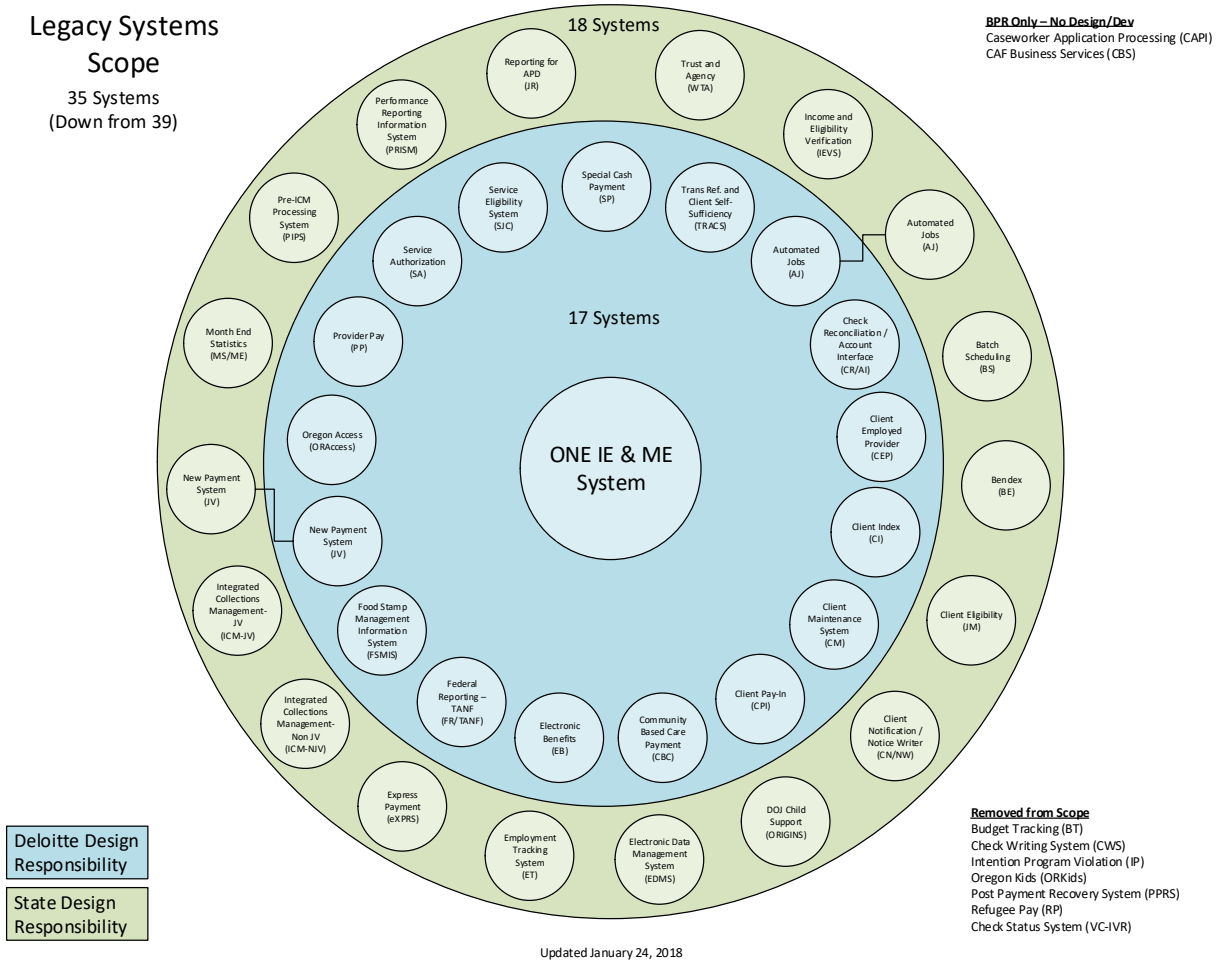
6.1.2 **Legacy Systems Scope**

There are 35 of the original 39 systems remaining as in scope for the Legacy subproject. 17 of these systems are now in scope for the SI to document the design, with the state to conduct all development, testing, and deployment. These 17 systems are identified in the following table.

1. Automated Jobs (AJ)
2. Community Based Payment (CBC)
3. Client Employed Provider (CEP)
4. Client Index (CI)
5. Client Maintenance System (CM)
6. Client Pay-in (CPI)
7. Check Reconcile/Acct. Interface (CR/AI)
8. Electronic Benefits (EB)
9. Food Stamps (FSMIS)
10. JV (New Payment Systems)
11. ORAccess (OA)
12. Provider Pay (PP)
13. Service Authorization (SA)
14. Service Eligibility System (SJC)
15. Special Cash Payment (SP)
16. Federal Reporting-TANF (FR/TANF)
17. Trans. Ref. & Client Self-Sufficiency (TRACS)

18 Systems are in-scope that the state is responsible for design documentation, development, testing, and deployment.

1. Bendex (BE)
2. Batch Scheduling (BS)
3. Client Notice Writer (CN/NW)
4. Dept. of Justice (DOJ) Child Support (ORIGINS)
5. Electronic Data Management System (EDMS)
6. Express Payment and Reporting System (eXPRS)
7. Integrated Collections Management (ICM)--INBOUND/OUTBOUND FROM IE (NON-JV)
8. Integrated Collections Management (ICM)--INBOUND FROM JV
9. Unearned Income Verification (IEVS/SX/SSA)
10. Client Eligibility (JM)
11. Month-End Statistics (MS/ME)
12. Pre ICM Processing System (PIPS)
13. Trust and Agency (WTA)
14. Reporting for APD (JR)
15. Performance Reporting Information System (PRISM)
16. Employment Tracking System (ET)
17. Automated Jobs (AJ)
18. New Payment System (JV)


Legacy Systems Scope
35 Systems
(Down from 39)
18 Systems
17 Systems
ONE IE & ME System
Reporting for APD (JR)
Trust and Agency (WTA)
Income and Eligibility Verification (IEVS)
Automated Jobs (AJ)
Batch Scheduling (BS)
Bendex (BE)
Client Eligibility (JM)
Client Notification / Notice Writer (CN/NW)
DOJ Child Support (ORIGINS)
Electronic Data Management System (EDMS)
Employment Tracking System (ET)
Express Payment (eXPRS)
Integrated Collections Management-Non JV (ICM-NJV)
Integrated Collections Management-JV (ICM-JV)
New Payment System (JV)
Month End Statistics (MS/ME)
Pre-ICM Processing System (PIPS)
Performance Reporting Information System (PRISM)
Deloitte Design Responsibility
State Design Responsibility
BPR Only – No Design/Dev
Caseworker Application Processing (CAPI)
CAF Business Services (CBS)
Removed from Scope
Budget Tracking (BT)
Check Writing System (CWS)
Intention Program Violation (IP)
Oregon Kids (ORKids)
Post Payment Recovery System (PPRS)
Refugee Pay (RP)
Check Status System (VC-IVR)
Updated January 24, 2018

Appendix B – Project Schedule

The project timeline has been updated from previous submissions. As Oregon explored work through the iterative design sessions, it became apparent that we needed a shift in our operational model. A decision was made to delegate all Medicaid eligibility determination work to DHS. As OHA and DHS further engaged with the design and explored opportunities and lessons learned from the initial ONE implementation and other States' experience, Oregon updated the schedule. Additional time for pilot, testing, and the wave roll-outs were added to the schedule. Oregon also procured Deloitte to assist with the Legacy Design work with the intent of insuring that Oregon's OIS understands the total scope of work needed and to avoid issues that other States experienced with their projects. As this work continues, Oregon may adjust our project schedule to ensure that we are accounting for all of the opportunities we need to consider in ensuring a quality product is delivered and ultimate accountability to our federal partners and Oregonians is met. As you can see, the Design phase will be followed by two iterative development phases, and then system implementation supporting a ONE System upgrade to an integrated ONE System, a DHS production pilot (Production Pilot) and three implementation waves.

The Project's two iterations will enable:

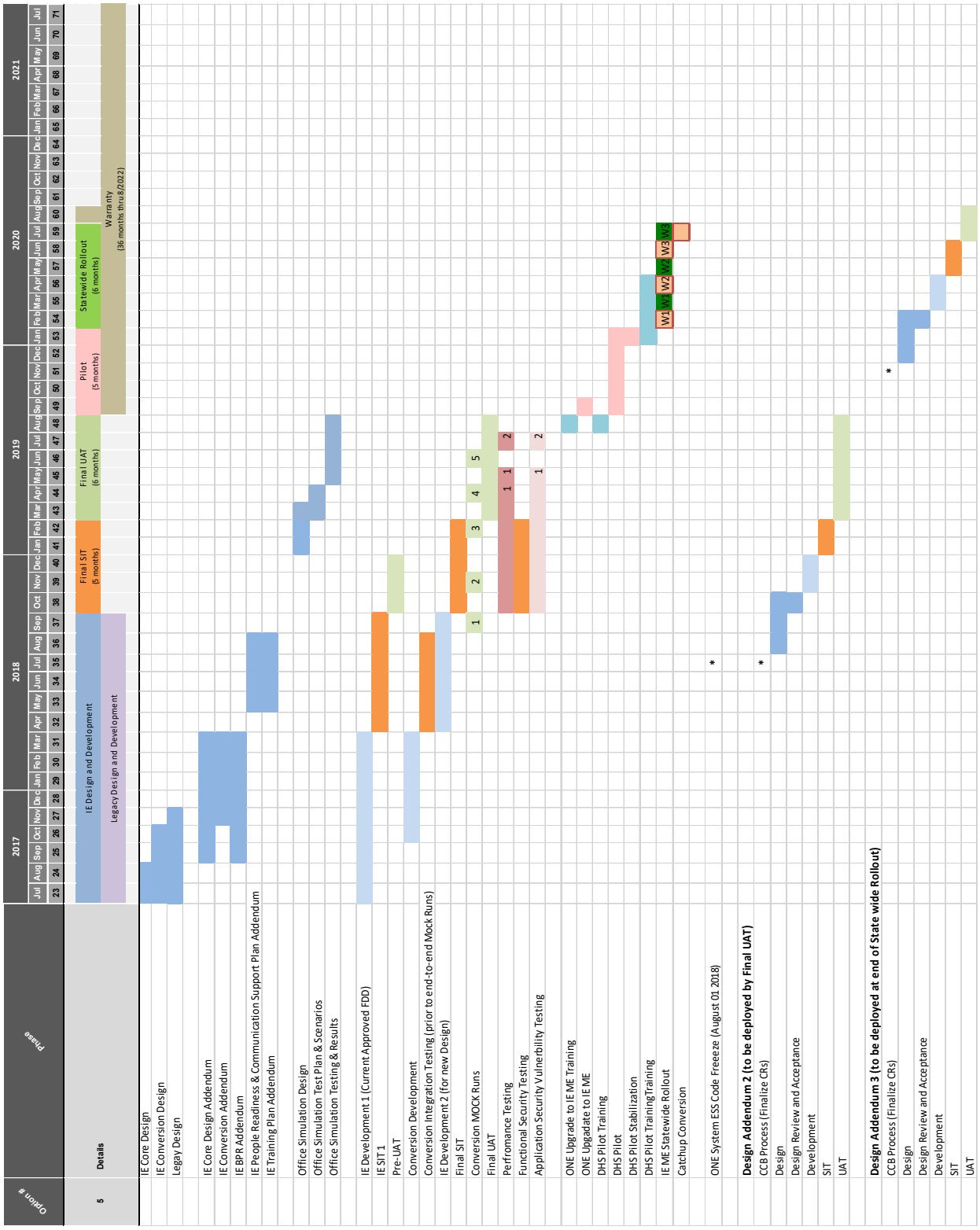
- Oregon's business needs to be met by changes to the application,
- Underlying COTS software components to be upgraded to State approved versions, and
- ONE functionality to be preserved to avoid service disruption to Oregonian's receiving services for MAGI Medicaid.

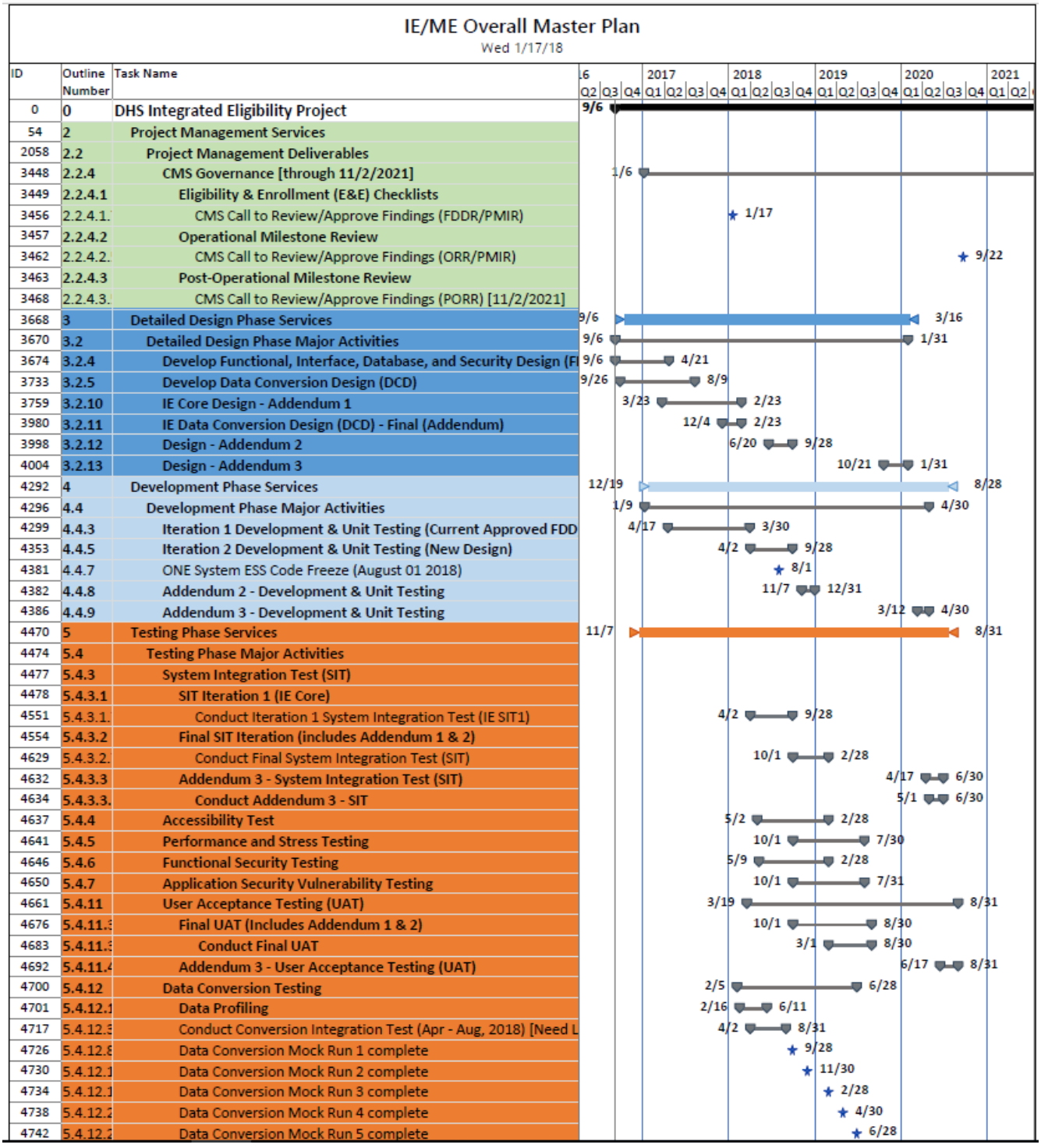
Each iteration will be followed by Contractor testing and validation testing by the State. At the completion of the development phase, the State will have at least six months dedicated to User Acceptance Testing (UAT) (increased from four months with Amendment #4).

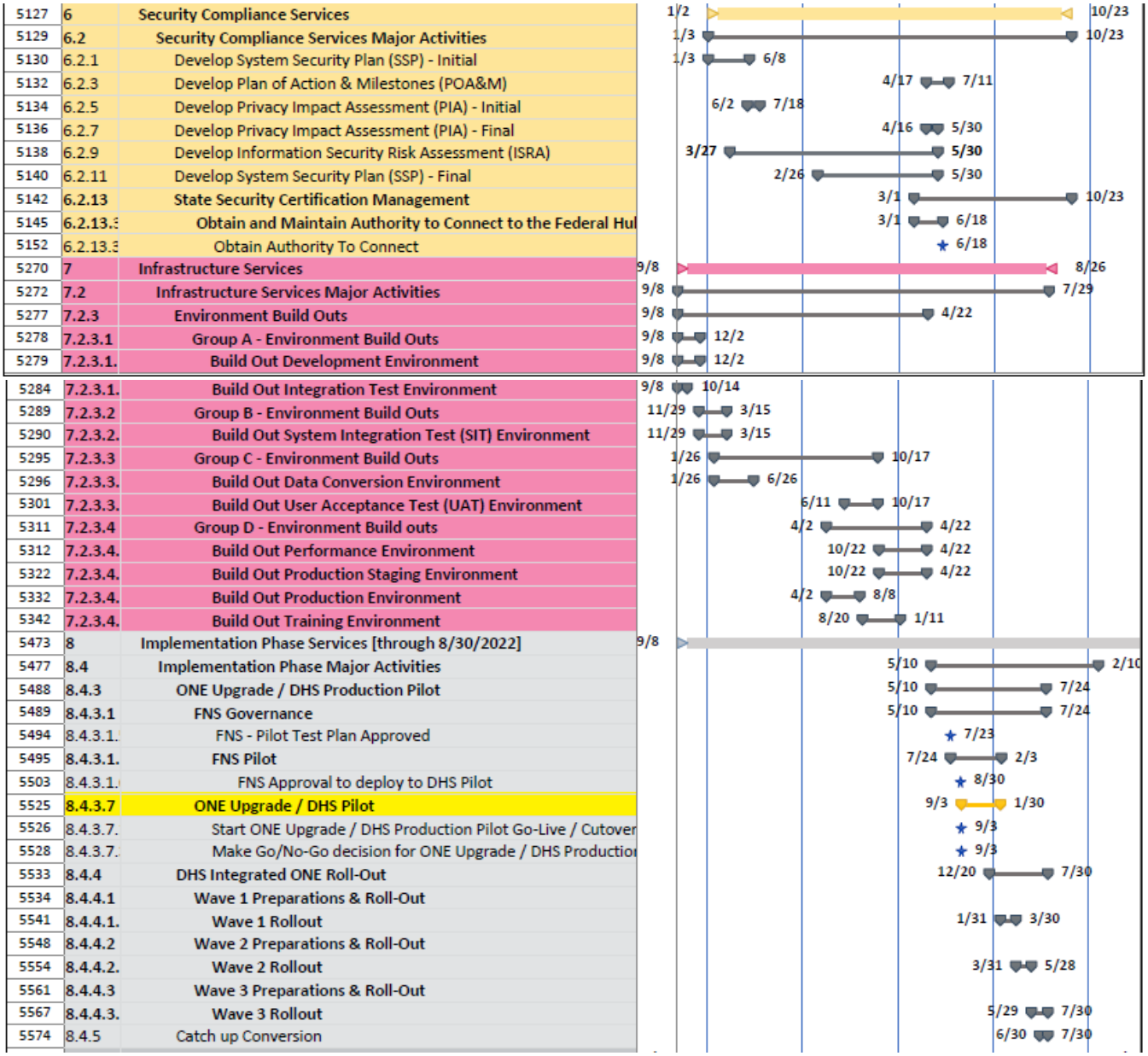
Once DHS issues a notice-to-proceed the Project will then transition to the implementation phase which includes:

- Upgrading the current OHA MAGI Medicaid ONE System with integrated ONE System
- A minimum of five-month Production Pilot (increased from three months with Amendment #4), and
- Three geographically appropriate waves (for the 150 field offices)

The following chart lays out a high-level schedule for the project.




IE/ME Overall Master Plan
Wed 1/17/18
ID
Outline Number
Task Name
2017
2018
2019
2020
2021
0 0 DHS Integrated Eligibility Project 9/6
54 2 Project Management Services
2058 2.2 Project Management Deliverables
3448 2.2.4 CMS Governance [through 11/2/2021] 1/6
3449 2.2.4.1 Eligibility & Enrollment (E&E) Checklists
3456 2.2.4.1. CMS Call to Review/Approve Findings (FDDR/PMIR) 1/17
3457 2.2.4.2 Operational Milestone Review
3462 2.2.4.2. CMS Call to Review/Approve Findings (ORR/PMIR) 9/22
3463 2.2.4.3 Post-Operational Milestone Review
3468 2.2.4.3. CMS Call to Review/Approve Findings (PORR) [11/2/2021]
3668 3 Detailed Design Phase Services 9/6 3/16
3670 3.2 Detailed Design Phase Major Activities 9/6 1/31
3674 3.2.4 Develop Functional, Interface, Database, and Security Design (F 9/6 4/21
3733 3.2.5 Develop Data Conversion Design (DCD) 9/26 8/9
3759 3.2.10 IE Core Design - Addendum 1 3/23 2/23
3980 3.2.11 IE Data Conversion Design (DCD) - Final (Addendum) 12/4 2/23
3998 3.2.12 Design - Addendum 2 6/20 9/28
4004 3.2.13 Design - Addendum 3 10/21 1/31
4292 4 Development Phase Services 12/19 8/28
4296 4.4 Development Phase Major Activities 1/9 4/30
4299 4.4.3 Iteration 1 Development & Unit Testing (Current Approved FDD 4/17 3/30
4353 4.4.5 Iteration 2 Development & Unit Testing (New Design) 4/2 9/28
4381 4.4.7 ONE System ESS Code Freeze (August 01 2018) 8/1
4382 4.4.8 Addendum 2 - Development & Unit Testing 11/7 12/31
4386 4.4.9 Addendum 3 - Development & Unit Testing 3/12 4/30
4470 5 Testing Phase Services 11/7 8/31
4474 5.4 Testing Phase Major Activities
4477 5.4.3 System Integration Test (SIT)
4478 5.4.3.1 SIT Iteration 1 (IE Core)
4551 5.4.3.1. Conduct Iteration 1 System Integration Test (IE SIT1) 4/2 9/28
4554 5.4.3.2 Final SIT Iteration (includes Addendum 1 & 2)
4629 5.4.3.2. Conduct Final System Integration Test (SIT) 10/1 2/28
4632 5.4.3.3 Addendum 3 - System Integration Test (SIT) 4/17 6/30
4634 5.4.3.3. Conduct Addendum 3 - SIT 5/1 6/30
4637 5.4.4 Accessibility Test 5/2 2/28
4641 5.4.5 Performance and Stress Testing 10/1 7/30
4646 5.4.6 Functional Security Testing 5/9 2/28
4650 5.4.7 Application Security Vulnerability Testing 10/1 7/31
4661 5.4.11 User Acceptance Testing (UAT) 3/19 8/31
4676 5.4.11.3 Final UAT (Includes Addendum 1 & 2) 10/1 8/30
4683 5.4.11.3 Conduct Final UAT 3/1 8/30
4692 5.4.11.4 Addendum 3 - User Acceptance Testing (UAT) 6/17 8/31
4700 5.4.12 Data Conversion Testing 2/5 6/28
4701 5.4.12.1 Data Profiling 2/16 6/11
4717 5.4.12.3 Conduct Conversion Integration Test (Apr - Aug, 2018) [Need L 4/2 8/31
4726 5.4.12.8 Data Conversion Mock Run 1 complete 9/28
4730 5.4.12.1 Data Conversion Mock Run 2 complete 11/30
4734 5.4.12.1 Data Conversion Mock Run 3 complete 2/28
4738 5.4.12.2 Data Conversion Mock Run 4 complete 4/30
4742 5.4.12.2 Data Conversion Mock Run 5 complete 6/28


5127 6 Security Compliance Services
5129 6.2 Security Compliance Services Major Activities
5130 6.2.1 Develop System Security Plan (SSP) - Initial
5132 6.2.3 Develop Plan of Action & Milestones (POA&M)
5134 6.2.5 Develop Privacy Impact Assessment (PIA) - Initial
5136 6.2.7 Develop Privacy Impact Assessment (PIA) - Final
5138 6.2.9 Develop Information Security Risk Assessment (ISRA)
5140 6.2.11 Develop System Security Plan (SSP) - Final
5142 6.2.13 State Security Certification Management
5145 6.2.13.3 Obtain and Maintain Authority to Connect to the Federal Hul
5152 6.2.13.3 Obtain Authority To Connect
5270 7 Infrastructure Services
5272 7.2 Infrastructure Services Major Activities
5277 7.2.3 Environment Build Outs
5278 7.2.3.1 Group A - Environment Build Outs
5279 7.2.3.1. Build Out Development Environment
5284 7.2.3.1. Build Out Integration Test Environment
5289 7.2.3.2 Group B - Environment Build Outs
5290 7.2.3.2. Build Out System Integration Test (SIT) Environment
5295 7.2.3.3 Group C - Environment Build Outs
5296 7.2.3.3. Build Out Data Conversion Environment
5301 7.2.3.3. Build Out User Acceptance Test (UAT) Environment
5311 7.2.3.4 Group D - Environment Build outs
5312 7.2.3.4. Build Out Performance Environment
5322 7.2.3.4. Build Out Production Staging Environment
5332 7.2.3.4. Build Out Production Environment
5342 7.2.3.4. Build Out Training Environment
5473 8 Implementation Phase Services [through 8/30/2022]
5477 8.4 Implementation Phase Major Activities
5488 8.4.3 ONE Upgrade / DHS Production Pilot
5489 8.4.3.1 FNS Governance
5494 8.4.3.1. FNS - Pilot Test Plan Approved
5495 8.4.3.1. FNS Pilot
5503 8.4.3.1. FNS Approval to deploy to DHS Pilot
5525 8.4.3.7 ONE Upgrade / DHS Pilot
5526 8.4.3.7. Start ONE Upgrade / DHS Production Pilot Go-Live / Cutover
5528 8.4.3.7. Make Go/No-Go decision for ONE Upgrade / DHS Productio
5533 8.4.4 DHS Integrated ONE Roll-Out
5534 8.4.4.1 Wave 1 Preparations & Roll-Out
5541 8.4.4.1. Wave 1 Rollout
5548 8.4.4.2 Wave 2 Preparations & Roll-Out
5554 8.4.4.2. Wave 2 Rollout
5561 8.4.4.3 Wave 3 Preparations & Roll-Out
5567 8.4.4.3. Wave 3 Rollout
5574 8.4.5 Catch up Conversion
1/2 10/23
1/3 10/23
1/3 6/8
4/17 7/11
6/2 7/18
4/16 5/30
3/27 5/30
2/26 5/30
3/1 10/23
3/1 6/18
6/18
9/8 8/26
9/8 7/29
9/8 4/22
9/8 12/2
9/8 12/2
9/8 10/14
11/29 3/15
11/29 3/15
1/26 10/17
1/26 6/26
6/11 10/17
4/2 4/22
10/22 4/22
10/22 4/22
4/2 8/8
8/20 1/11
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5/10 2/10
5/10 7/24
5/10 7/24
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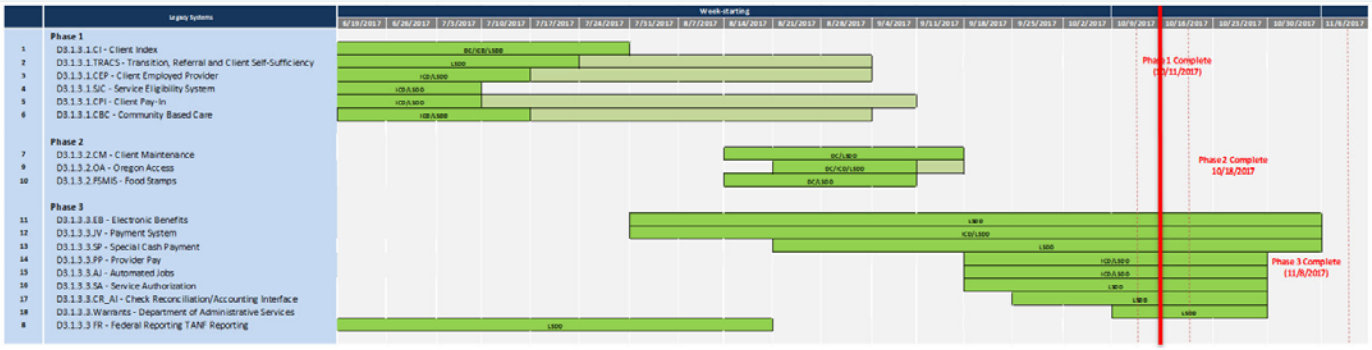
7/24 2/3
8/30
9/3 1/30
9/3
9/3
12/20 7/30
1/31 3/30
3/31 5/28
5/29 7/30
6/30 7/30

5576	8.5	Business Operations Implementation Services	9/8 – 2/10
5578	8.5.2	Business Operations Major Activities	9/8 – 3/19
5589	8.5.2.2	Statutory, Plan, and Policy Changes	9/8 – 1/29
5607	8.5.2.2.	Freeze Policy/Procedure Changes (10/31/2018)	★ 9/3
5629	8.5.2.3	Conduct IE Business Process Mapping Sessions	12/19 – 3/9
5689	8.5.2.7	Develop Office Simulation Design and Plan	
5691	8.5.2.7.	Conduct Office Simulation Design Sessions [Insert sessions h	12/7 – 3/29
5693	8.5.2.8	Develop Office Simulation Business Testing Scenarios	
5694	8.5.2.8.	Conduct Office Simulation Business Training Sessions (Test Plan & Scenarios) [Insert sessions here]	3/1 – 4/30
5696	8.5.2.9	Execute Office Simulation Business Testing Scenarios	
5697	8.5.2.9.	Office Simulation Test Cycle #1	5/1 – 6/28
5698	8.5.2.9.	Office Simulation Test Cycle #2	7/1 – 8/30
5700	8.5.2.10	Develop Phased Rollout Plan	
5702	8.5.2.10	Develop deployment approach, processes and schedule	4/2 – 6/29
5938	8.6	People Readiness Implementation Services	9/8 – 4/1
5940	8.6.2	People Readiness Major Activities	9/8 – 2/26
5959	8.6.2.3	Train-the-Trainer training	5/6 – 8/2
5964	8.6.2.3.	Conduct Train-the-Trainer Training	7/9 – 8/2
5965	8.6.2.4	End User Training (EUT)	7/31 – 2/26
5972	8.6.2.4.	Conduct EUT for ONE Upgrade for OHA	8/5 – 8/30
5974	8.6.2.4.	Conduct EUT for Production Pilot	8/5 – 8/30
5976	8.6.2.4.	Conduct EUT for Wave 1	10/7 – 12/2
5978	8.6.2.4.	Conduct EUT for Wave 2	12/3 – 1/7
5980	8.6.2.4.	Conduct EUT for Wave 3	1/8 – 2/11
6160	8.7	System Implementation Services [through 8/30/2022]	8/7 –
6175	8.7.3	Warranty Services [36 months through 8/31/2022]	9/3 –
6176	8.7.3.1	Start Warranty Services (36 months)	★ 9/3
6387	10	Legacy System Integration	
6388	10.1	DDI SOW3 - Legacy System Design (Phase 1, 2 & 3)	2/20 – 2/6
6831	10.2	Phase 4 - Legacy Systems Design	7/10 – 3/30
7089	10.4	Develop & Unit Test Legacy Components	11/10 – 6/19
7130	10.5	Legacy Systems SIT	5/7 – 8/3
7186	10.8	Legacy Systems UAT	6/18 – 9/17
7250	11	Integrated ONE DDI Warranty Complete [8/31/2022]	

Phase
Summary
Project Summary
Milestone Complete
Future
Milestone Late
Milestone future
Milestone Complete (new)
Milestone Late (new)

Legacy High Level Design Timeline



* Timeline is intended as high-level overview only. Schedule detail including specific start and end dates for each activity is in the Integrated Project Schedule (IPS).

6.2 Appendix C – Project Budget

This budget reflects changes to scope and schedule reflected in the SI and QA contract Amendments. Approximately 1 year was added to the schedule to provide a more realistic timeline for completion of activities such as data conversion, SIT and UAT testing, wave roll-outs with corresponding stabilization periods, design addendums, and Model Office simulation. Approximately one-half of the Legacy design work was shifted from internal State staff to the SI, increasing these costs by $66 million. The QA contract also increased approximately $4 million to accommodate the longer project duration and to incorporate ONE ESS and Legacy design and development into their QA work.

DRAFT

	DDI			DDI	M&O	Total	DDI	DDI
	AY17-19	POP 17-19	Increase (Decrease)	AY19-21	AY19-21	AY19-21	AY21-23	Total
State Staff								
State Staff and S&S	26,057,885	34,976,631	(8,918,746) -	27,614,590	10,038,868	37,653,458	0	53,672,475
Professional Services								
Other	4,328,439	0	4,328,439	11,625,806	0	11,625,806		15,954,245
Q&A and IV&V	7,047,551	4,565,696	2,481,855	10,019,890	0	10,019,890		17,067,441
PMO	2,833,333	0	2,833,333	2,166,667	0	2,166,667		5,000,000
SI Deloitte (net)	88,382,527	103,215,794	(14,833,267)	49,026,544	17,600,000	66,626,544	2,100,000	139,509,070
Trainers (see training below)	0	0	0	0	0	0		0
Contingency	11,269,330	11,846,739	(577,409)	9,286,961	1,936,000	11,222,961	267,750	20,824,041
Professional IT Services	113,861,180	119,628,229	(5,767,049) -	82,125,867	19,536,000	101,661,867	2,367,750	198,354,797
Software								
Software	3,687,662	6,598,022	(2,910,360) -	6,002,596	3,330,000	9,332,596	0	9,690,258
Hardware								
Hardware	45,265	0	45,265 -	45,100	55,500	100,600	0	90,365
State Governmental Services								
Hosting	6,374,957	13,306,550	(6,931,593) -	6,630,260	7,326,000	13,956,260	0	13,005,217
Training								
Training	1,060	2,220,000	(2,218,940) -	2,255,000	0	2,255,000	0	2,256,060
Total	150,028,008	176,729,432	(26,701,424) -	124,673,413	40,286,368	164,959,781	2,367,750	277,069,172
	(0)			(0)	(1)		0	(1)
Issuance Costs	615,000	615,000	0	0	0	0	0	615,000
Legacy								
Personnel and S&S	6,549,125	7,322,899	(773,774)	2,661,925	0	2,661,925	0	9,211,050
Professional Services	2,033,776	1,479,871	553,905	0	0	0	0	2,033,776
Contingency	1,067,099	958,797	108,302	339,395	0	339,395	0	1,406,494
Total	9,650,000	9,761,567	(111,567) -	3,001,320	0	3,001,320	0	12,651,320
	(1)			(0)				(1)
Disaster Recovery								
Personnel and S&S	248,822	286,145	(37,323)	161,734	131,150	292,884	0	410,556
Professional Services	3,000,000	6,285,044	(3,285,044)	4,416,667	2,500,000	6,916,667	0	7,416,667
Hosting	666,667	1,000,000	(333,333)	866,667	350,000	1,216,667	0	1,533,333
Contingency	499,225	824,449	(325,224)	694,246	327,926	1,022,173	0	1,193,471
Total	4,414,713	8,395,638	(3,980,925) -	6,139,314	3,309,076	9,448,390	0	10,554,027
	(0)			0				(0)
Asset Verification System (AVS)				10,000,000	0	10,000,000	0	10,000,000
Total	164,707,721	195,501,637	(30,793,916) -	143,814,047	43,595,444	187,409,491	2,367,750	310,889,519
			-				AY15-17	33,593,837
							Project Total	344,483,356
								2

	DDI			DDI	M&O	Total	DDI	DDI
	AY17-19	POP 17-19	Increase (Decrease)	AY19-21	AY19-21	AY19-21	AY21-23	Total
Total federal	130,747,648	147,597,021	(16,849,373)	105,603,908	28,037,921	133,641,829	1,770,949	238,122,506
Total state	33,345,073	47,289,616	(13,944,543)	38,210,139	15,557,524	53,767,662	596,801	72,152,012
Issuance Costs	615,000	615,000	0	0		0	0	615,000
	164,707,721	195,501,637	(30,793,916)	143,814,047	43,595,444	187,409,491	2,367,750	310,889,518

6.3 Appendix D – IE Business Case V1.1 – Stage Gate 2 Submission

IE_Business_Case_v 1.1-SG2.pdf

6.4 Appendix E – IE Business Case V2.0 – Stage Gate 3 Submission

Integrated_Eligibilit y_Determination_Bu

6.5 Appendix F – HB2219 Legislative Report

HB2219 Legislative Report.pdf

6.6 Appendix G – Kentucky System Components

Key application components in the *kynect/benefind* system for integrated eligibility determination are described in the following table.

Title	Description
Worker Portal	Module used by the State Agency workers to collect individual/family information to process SNAP, TANF, and/or Medicaid applications. Individuals can apply for one or more programs in a single application, and the module has a capability to interactively ask questions during the interview process based on the programs applied. Throughout the interview process, the modules call interfaces to verify information, as needed.
Eligibility Determination (Rules engine)	Rules base eligibility determination module to determine eligibility for main program and the sub programs to provide best possible benefits for the applicants. For example, when an individual applies for Medicaid, the rules engine cascade down through the Medicaid program hierarchy to provide best Medicaid coverage for the individual.
Benefit Issuance	This module manages daily or monthly issuances for SNAP/TANF/ERDC programs that are issued to individuals/vendors to support initial, monthly or supplemental payments.
Benefit Recovery	This module provides end to end management of SNAP, TANF, ERDC claims. It computes discrepancy, establish claim and start recoupment either through the benefit reduction process or other processes such as tax intercept.
Correspondence	This module manages generation of consolidated correspondences that are issued to the applicants and other stakeholders like vendors.
Task Management	A comprehensive task management module that supports key business processes. The module allows management of human services case management functions as a coordinated set of tasks.
Quality Assurance and Quality Control (QA/QC)	Module to create Random/Targeted sample universes for worker to review SNAP, TANF and Medicaid cases
Hearing/Appeals	Implements end-to-end work flows to support the hearings and appeal process. This module is also integrated with task management module.
Business Intelligence/Management Reports	This module implements operational reports, analytical reports and provides the framework and infrastructure required for several adhoc reporting needs.
Authentication and Identity proofing service	System for authorization and authentication services for users requesting access to various modules of the system.

Title	Description
Document Management Services	Implements electronic case files functionalities where all documents submitted to the agency are indexed and filed for easy access.
Mobile and Tablet Application	Mobile app with full application features for citizens, community partners (application assisters) to apply for health coverage
Self Service Portal for Human Service programs	Self Service Portal for citizens to apply for SNAP, TANF and Medicaid programs.
Medicaid Waiver Management Application (MWMA)	A complete waiver workflow management module to determine eligibility for Medicaid waiver programs and enrollment into waiver services.
Master Client Index module (MCI)	Master client index module which uniquely identifies citizens. It also provides a 360-degree view of citizen enrolled in public assistance program(s).
Interfaces	Implements all required State & Federal Interfaces. Interfaces module also implements an integration framework that supports several integration patterns.
Medicaid Managed Care Enrollment Management	Module for auto assignment and management of Medicaid enrollees in managed care plans (MCOs)

6.7 Appendix H – Kentucky to Oregon Functionality Comparison

As evident in the tables below, the programs are similar in their overall business requirements.

Supplemental Nutrition Assistance Program

Program Eligibility Comparison for Supplemental Nutrition Assistance Program

Eligibility Criterion	Kentucky Supplemental Nutrition Assistance Program	Oregon Supplemental Nutrition Assistance Program
Family Composition and Residency	• Recipients must live in Kentucky • Recipients must be U.S. citizens or certain legal foreign residents of the United States • A household is any person, family or group of people who live and buy and eat food together • The following people must be included in one household account, regardless of whether they purchase and prepare meals separately: o A spouse of any household member o Parents living with their natural, adopted or stepchildren who are age 21 or younger o Children younger than 18 who are dependents of an adult household member	• Recipients must live in Oregon; does not require intent to remain to establish residency • Recipients must be U.S. citizens or certain legal foreign residents of the United States • Filing group consists of members of a household group who choose to apply together or customarily purchase and prepare meals together • The following people must be included in one household account, regardless of whether they purchase and prepare meals separately: o A spouse of any household member o Parents living with their children who are under the age of 22 o Children younger than 18 who are financially dependent of an adult household member
Income	• Less than 130% of FPL for most households; 165% for elderly/disabled	• Less than 185% of 2015 FPL
Resources	• A household may have no more than $2,000 in assets OR $3,250 if a member of the household is 60 or older • Cash and bank accounts are counted; the dwelling, its contents and personal belongings, and vehicles are excluded	**Non-Categorically eligible households** • Have a resource limit of no more than $2,250 in resources OR $3,250 if a member of the household is 60 or older or disabled • Checking accounts, saving accounts, cash on hand, stocks and bonds, equity in vehicles, real property, etc., are counted. **Categorically eligible households** • Have a resource limit of $25,000 in liquid assets (checking accounts, savings accounts, cash on hand)
Employment	• Anyone in a household who is 16 to 60 years old and can work must register for, look for, and accept work. There are some exceptions to this requirement.	**OFSET (Employment and Training)** • Clients deemed mandatory because they do not meet an exemption must participate in a jobs activity for an eight week period every 12 months • Must accept bona fide offers of employment, even if it's part-time

Eligibility Criterion	Kentucky Supplemental Nutrition Assistance Program	Oregon Supplemental Nutrition Assistance Program
		ABAWDS (Abled Bodied Adults without Dependents) • Only applicable in Multnomah and Washington counties, as the rest of the state is under a waiver • Requires those aged 18-49 without a filing group member under the age of 18, who do not meet an exemption, to participate a minimum of 20 hours a week, an average of 80 hours a month of special work requirements
Benefits	• Benefits are issued on an Electronic Benefit Transfer (EBT) card • The benefit amount depends on income and household size. • Benefits may be used to purchase almost any food item, except ready-to-eat hot foods • Benefits may be used to buy seeds and plants to grow fruits and vegetables • Benefits may not be used to buy tobacco, alcohol, pet food, soap and other household products, medicines, and other non-food items	• Benefits are issued on an Electronic Benefit Transfer (EBT) card • The benefit amount depends on income, household size and minus any applicable deductions • Benefits may be used to purchase almost any food item with a nutrition label, except ready-to-eat hot foods • Benefits may be used to buy seeds and plants to grow fruits and vegetables • Benefits may not be used to buy tobacco, alcohol, pet food, soap and other household products, medicines, and other non-food items • There is a cash out program in Multnomah, Washington, Columbia and Clackamas Counties for seniors and people with disabilities
Certification Periods	• Varying lengths of certification periods depending on household characteristics • Periodic reports required at least once every six months, except for elderly or disabled (12 months)	• Varying lengths of certification periods depending on household characteristics • Periodic reports required at least once every six months, except for elderly or disabled (12 months)
Deductions	• Utilizes Standard Utility Allowance (SUA) instead of actual utility costs. • Students are ineligible unless working 20 or more hours per week or have a child under age 6 or are a single parent of a child under age 12 and going to school full time • Must meet with a worker or do interview over the phone. Must be able to provide identification, social security numbers for everyone applying, proof of who lives in your home (can be written statement), proof that you live in Kentucky, proof of child care costs or child support paid, proof of living expenses, and proof of money you have received in the past 60 days, including pay stubs.	• Utilizes Standard Utility Allowance (SUA) instead of actual utility costs • Students aged 18 to 49 attending a higher education program that requires a diploma or GED at least half time must meet additional special criteria • Must meet with a worker or do interview over the phone. Must be able to provide identification, social security numbers for everyone applying, verification of income for recent representative month, and for non-citizens proof of lawful immigrant status of each household member seeking benefits

Eligibility Criterion	Kentucky Supplemental Nutrition Assistance Program	Oregon Supplemental Nutrition Assistance Program
Other	• For ineligible non-citizens, income and deductions are prorated for both groups, which includes counting all income and deductions, or a prorated share. As well as, counting none of the income and deductions (with the allotment capped at the level that an all-eligible household would get), or a prorated share. • May disqualify applicants or recipients who fail to perform actions required by other means-tested program, primarily TANF.	• For ineligible non-citizens, income and deductions are prorated for both groups, which includes counting all income and deductions, or a prorated share. As well as, counting none of the income and deductions (with the allotment capped at the level that an all-eligible household would get), or a prorated share. • May disqualify applicants or recipients who fail to perform actions required by other means-tested program, primarily TANF.

Temporary Assistance for Needy Families

Program Eligibility Comparison for Temporary Assistance for Needy Families

Eligibility Criterion	Kentucky Temporary Assistance for Needy Families	Oregon Temporary Assistance for Needy Families
Family Composition and Residency	• Recipient must be a US citizen • Family must have a child under 18 living in the home OR Pregnant woman must be within one month of her due date • Children must be citizens or have eligible alien status • Children must be 18 years old or younger OR Children must be full time student with expected graduation date before age 20	• Recipient must be a US citizen or have qualified non-citizen status (may be waived temporarily if domestic violence is a factor) • Family must reside in Oregon • Family must have a caretaker relative and a child under 18 living in the home OR Pregnant woman must be within one month of her due date (may be earlier if domestic violence is a factor) • Caretaker relative must meet certain blood, adoption, marriage relationship requirements • Children must be citizens or have qualified non-citizen status • Children must be under 18 years old OR 18 years old and a full-time student in HS or GED • Until March 2016, a child must be deprived of parental support due to continued absence, incapacity, or under/unemployment
Income	• Your family must earn less than a certain amount of money per month	• To qualify for TANF, families must have very few assets and little or no income. • Your family must earn less than a certain amount of money per month
Resources	• Countable assets must be $2,000 or less and licensed vehicles needed for individual's subject to the work requirement may not exceed $8,500	• Countable assets must be $2,500 or less for applicants, for individuals in sanction status, and for families with no caretaker relative in the need group • Countable assets must be $10,000 or less for all other recipients • Exclude up to $10,000 equity value of all motor vehicles; remaining equity counts toward asset limit • Applicants and recipients must pursue alternative assets available to them • Applicants and recipients must assign their support rights to, and cooperate with, child support

Eligibility Criterion	Kentucky Temporary Assistance for Needy Families	Oregon Temporary Assistance for Needy Families
Employment	• Adults in families receiving cash assistance must work or participate in work related activities for a specified number of hours per week depending on the number of work-eligible adults in the family and the age of children	• Adults in families receiving cash assistance must work or participate in work-related activities for a specified number of hours per week depending on the number of work-eligible adults in the family, the age of children, and the family situation • Caretaker relatives must not be separated from their most recent employment due to discharge without good cause, or due to voluntarily quitting without good cause • Needy caretaker relatives must complete an employability screening
Benefits	• The current maximum monthly benefit for a family of 3 with a monthly gross income of $974, is $262	• The current maximum monthly benefit for a family of three is $506.
Certification Limits	• A family may receive benefits for no more than 60 total months. The 60 months needs not be consecutive	• Eligibility must be recertified every 6 months for families who have an open JOBS plan and are not participating or an active JOBS disqualification OR Eligibility must be recertified every 12 months • Recertification may be done earlier if deemed necessary by the case manager or to align with SNAP benefits • Heads of household may receive benefits for no more than 60 total months. The 60 months need not be consecutive. There are hardship exemptions that can stop the clock or extend benefits beyond 60 months. Children are not subject to the time limit.
Other	• Recipient must have a social security number	• Recipient must have a social security number

Employment-Related Day Care

Program Eligibility Comparison for Employment-Related Day Care

Eligibility Criterion	Kentucky Child Care Assistance Program	Oregon Employment-Related Day Care Program
Family Composition and Residency	• Recipient must be resident of KY • Child must be a U.S. citizen or a qualified alien • Child must be under 13 or be 13-19 and physically or mentally incapable of self-care • Recipient must be parent by blood, by marriage, or by adoption, or recipient must be the legal guardian or standing *in loco parentis* in relationship to child	• Recipient must be a resident of OR • Child must be a U.S. citizen or qualified non-citizen (includes non-citizens who are at risk for, or currently the victim of domestic violence, and victims of severe trafficking) • Child must be under 12 or be 12-17 and receiving care due to special circumstances and needs • Recipient must be a parent or caretaker who has care, control, and supervision of the dependent child (not required to be a relative)
Income	• Less than 150% of 2011 FPL (On-line calculator considers earned income, net child support, social security, TANF, and "other sources")	• (At initial certification) Less than 185% of 2015 FPL (Application asks for all sources) • (On-going and at recertification) Less than 250% of FPL and less than 85% of the state median income
Resources	• No requirement	• No requirement
Employment	• Must be employed and average at least 20 hours per week for a single parent or average 40 total hours per week for a couple OR A teen parent attending high school or pursuing a GED OR Participating in the Kentucky Works Program OR Have a child protective or preventive services authorization	• Must be employed (no minimum number of hours) and if a couple, both must work and schedules must overlap (unless one parent cannot provide care due to a verified medical condition) Oregon does not cover teen parents attending high school or pursuing a GED, participants in an Oregon employment program, or parents who have children in protective or preventive services authorizations.
Benefit	• The program pays the provider's bill—less a copay—up to a maximum rate that depends on the age(s) of the child and the provider type • Recipient pays a copay that depends on income plus any part of the provider's rate that exceeds the maximum rate	• The program pays the provider's bill—less a copay--up to a maximum rate that depends on the age(s) of the child, provider type, location, and special care needs • Recipient pays a copay that depends on family size and income plus any part of the provider's rate that exceeds the maximum rate
Other	• Must use a provider that is licensed, certified, and registered	• Must use a provider that meets DHS requirements (includes licensed and licensed exempt providers)

6.8 Appendix I – Alignment with Strategic Technology Plan

The table below summarizes the various components of the STP that an integrated eligibility system will satisfy.

Comprehensive View of Clients	o Supports use of a master client record o Single location for verified client data (e.g. financial, eligibility, benefit etc.) o Facilitate future view of an integrated case and payments through integration with legacy case management and payment systems
Trusted Sources for Health & Human Service Data	o Reduce data duplication and entry into multiple systems through single application for various programs. o Reduce data inconsistencies and inaccuracies through workflow automation o Trusted source for verified client data (e.g. financial, eligibility, benefit etc.) o Improve data access and data share across programs through integration with other DHS systems. o Role based data access and security improves data protection and compliance. o Consistent and accurate data reporting and analysis o Field-level audit and reporting capabilities
Business Automation	o Automated workflows using task queues inside the Worker Portal o Automated decision making and business rules using the business rules engine o Reduced manual and paper based processes o Real time determination of eligibility and benefit amount o Automated verification of client information o Interface with legacy systems
Connectivity Anytime, Anywhere, in Multiple Ways	o Applicant and worker portal allows real-time, 24/7 access to application, eligibility, and benefit information. o Clients can apply, update information, report change in circumstances, and communicate with their assigned case workers through multiple channels. o Multiple device and browser agnostic capability supports connectivity from anywhere
Dynamic Needs Supported by Seamless Services	o Industry best practices and standards based modular architecture and design (e.g., Service Oriented Architecture (SOA), Enterprise Service Bus (ESB) etc.) enables to leverage existing functionality and also expose functionality through web services

6.10 Appendix J – Responsibilities

Agency and Contractor responsibilities as identified in the SI SOW #2, Amendment #4, are grouped by category below.

Project Area	Agency Responsibilities	Contractor Responsibilities
Planning & Project Management	Participate in and support timely and satisfactory completion of all Contractor Tasks included in the scope described in Section 2.1 of this SOW #2 • State-designated Project Director, in consultation with DHS leadership and the Contractor's Engagement Manager, will have overall responsibility and authority for driving all Project decisions; reviewing and approving all Deliverables; facilitating discussion and communication among the parties as needed; and securing any required State or third-party resources • Manage Joint Agency Governance Structure for ONE/Integrated ONE system (including vendor management structure)	Perform timely and satisfactory completion of all Contractor Tasks included in the scope described in Section 2.1 of this SOW #2 • Engagement Manager, in consultation with Contractor leadership and State Project Director, will have overall responsibility and authority for driving all Contractor decisions; facilitating discussion and communication among the parties as needed; and securing any required Contractor resources. Meet on an agreed upon frequency with key stakeholders to review project performance and resolve issues between the Contractor and the State

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Project Area	Agency Responsibilities	Contractor Responsibilities
	• Subject matter specialists assigned to the Project will have the necessary time commitments to attend meetings, workshops and other Tasks. DHS and OHA personnel will have the role and authority to represent their various functions, and they will also be responsible to speak for, approve on behalf of, and communicate to and from their respective business units for the Tasks defined in SOW #2 • Allocate State resources based on work streams, as defined in the IPS, to allow multiple concurrent sessions to occur during SOW#2. Based on the current high-level timeline outlined in Appendix A, up to three concurrent work streams may be actively engaged at a point in time during the SOW #2 • Contribute to development and management of the IPS: o Identify State-owned tasks and work with the PMO to finalize relevant attributes required for each task o Collaborate with Contractor on understanding Contractor tasks and their attributes in the IPS, integrate timing between State-owned and Contractor tasks o Report progress on State-owned tasks weekly per the processes and cadence in the IMPF o Work collaboratively to identify corrective actions for slippages while reducing impact upon go-live dates • Manage and share schedule for work with implementation dependencies (i.e. legacy design and development). • Complete assigned tasks in the approved IPS in accordance with the baseline finish dates • Analyze Project risks and issues and work with the Contractor to approve issue resolutions and risk mitigations. Communicate risk and issue status discussed at the Executive Steering Committee meetings in consultation with the Contractor • Review and approve the proposed Deliverable Expectation Documents (DEDs) and Deliverable documents, consistent with the Project Management Plan	• Participate as requested in Joint Agency Governance Structure for ONE/Integrated ONE system • Contractor personnel assigned to the Project will have the appropriate experience, availability and skills to perform their function(s) • Follow established onboarding and off boarding processes, complete required privacy and security training; comply with building and server access and use rules • Allocate Contractor resources based on work streams to allow multiple (up to three) concurrent sessions to occur during SOW#2. Propose meeting schedule that takes into consideration the number of concurrent meetings due to State resource availability during the preparation period of the SOW #2 • Develop the IPS by: o Identify Contractor-owned tasks and work with the PMO to finalize relevant attributes required for each task o Collaborate with State on understanding State tasks, managed by the State and their finalization in the IPS; integrate timing between Contractor and State-owned tasks o Reporting progress on Contractor-owned tasks weekly per the processes and cadence in the IMPF o Work collaboratively to identify corrective actions for slippages while reducing impact upon go-live dates • Complete assigned tasks in the approved IPS in accordance with the baseline finish dates • Identify and help mitigate risks and issues related to the Project (scope, schedule, resources), using the agreed-upon Project processes • Prepare a Deliverable Expectation Document (DED) and submit for

Project Area	Agency Responsibilities	Contractor Responsibilities
	• For each deliverable, participate in working sessions to provide input on deliverable content, provide direction, and vet content as it is being development • Analyze and approve proposed Project scope of work changes. Approve Change Orders and operational procedure changes • Coordinate the necessary State and federal reviews and assessments • If there is a conflict among the governing regulations regarding a specific standard, State will provide the statutory interpretation to resolve the perceived conflict to Contractor • Provide 24/7 access to facilities, servers, and environments for Contractor's Project team. This is subject to the planned maintenance and downtime necessary for servers and environments. Sufficient system and network access will be provided for a minimum number (##) Contractor resources • Maintain Project SharePoint as central document repository • Use PMC in accordance with processes documented in the approved PMFP • Follow Project management and quality management processes as defined in PMFP • Consult with the Contractor on quality improvement measures and determination of areas to be reviewed • Provide notice to the Contractor of inadequate performance; request, review, approve, and monitor proposed corrective actions taken by the Contractor • Protect any Confidential Information, including that of citizens and employees (e.g. limit the amount of data provided to Contractor, use secure channels or ways of sharing data, protect data that resides within the State's operating and IT environments). DHS/OHA will provide Contractor with access to conversion data on a State-provided network device. The State will not knowingly provide PHI, PII or FTI data, except as provided for data conversion activities at Contractor's request and as requested in writing by the Contractor's Project Manager	Acceptance from the State for the content and format of each Deliverable at least two weeks before beginning significant work on the Deliverable as per the dates in the approved IPS (or Section 3 until the IPS Acceptance occurs). • Prepare proposed Project scope of work changes, initiate Change Orders, and recommend operational procedure changes • Participate in State and federal reviews and assessments, as necessary • If there is a conflict among the governing regulations regarding a specific standard, Contractor shall identify perceived conflict and will seek guidance from Agency • Contractor is also responsible for ensuring that personnel use reasonable efforts to maintain property • Submit formal Project documentation to the State SharePoint domain, with access provided to Contractor and State staff. Access restrictions may apply to some documentation such as folders containing security, financial or contract information. All documentation restrictions shall be approved by the State Project Director prior to loading of documents on the SharePoint • Maintain PMC for Project • Implement and maintain Project management and quality management processes as defined in PMFP • Consult with the State on quality improvement measures and determination of areas to be reviewed • When provided notice by Agency of inadequate performance, Contractor will identify, submit for Acceptance, and implement proposed corrective actions to be taken by the Contractor • Handle any Confidential Information to which Contractor has access, in

Project Area	Agency Responsibilities	Contractor Responsibilities
		accordance with the terms of the Contract
Detailed Design Phase	Participate in and support timely and satisfactory completion of all Contractor Tasks included in the scope described in Section 2.2 of this SOW #2 • Actively participate in functional and technical design sessions based upon detailed schedules • Support development of design specifications with functional and technical SMEs that are familiar with legacy systems • Based upon approved design specifications, develop technical design for legacy side of interfaces, legacy application changes, and conversion extract routines	Perform timely and satisfactory completion of all Contractor Tasks included in the scope described in Section 2.2 of this SOW #2 • Schedule and lead functional and technical design sessions with State SMEs • Develop design specifications that describe interfaces (including file formats) and conversions (including file formats) • Support State technical resources in developing technical designs for legacy side of interfaces, legacy application changes, and conversion extract routines
Development	Participate in and support timely and satisfactory completion of all Contractor Tasks included in the scope described in Section 2.3 of this SOW #2 • Review and provide inputs to the Application Development Plan • Provide inputs to functional clarifications and decisions raised during the course of Application Development • Develop interface components per design specified in the Interface Design Control Document (ICD) associated with connecting legacy systems and coordinate with interfacing agencies as defined in Appendix B of this SOW #2. • Provide files generated per the specifications of the interface components in accordance with Accepted design, for integration during development phase. • Provide data extraction files based upon Accepted Data Conversion Plan. • State will provide sample legacy data extracts with confidential information removed or masked for data quality assessment purposes • State SMEs will confirm data models, data definitions and provide available data dictionary documentation for source systems • Perform purification/cleansing of data required for conversion in legacy systems	Perform timely and satisfactory completion of all Contractor Tasks included in the scope described in Section 2.3 of this SOW #2 • Develop the Application Development Plan • Develop the System in accordance with the Accepted Functional Design Document and proactively raise necessary clarifications to the State business and technology teams as applicable. • Recommend specifications for interfaces between the Integrated ONE system and in-scope legacy systems • Execute validation routines against conversion extracts and provide reports of data that fails validations • Advise State in defining data extract criteria for each legacy system • Assist with obfuscation protocols if needed • Advise State in conducting purification/cleansing of data in legacy systems required for conversion • Assist State by implementing Accepted conversion software (Deliverable 2.3.3) to support legacy data conversion and cleansing

Project Area	Agency Responsibilities	Contractor Responsibilities
	• Develop daily extracts to support interim conversion process based on the Accepted Data Conversion Design or addendum. • Process the flagging files generated post conversion to update information in the legacy source systems per the Accepted Legacy Data Conversion Design Deliverable or addendum.	• Generate flagging files post conversion run to indicate successful conversion • Develop conversion routines to support the interim conversion process • Perform calculations, modifications, or sorting required to further identify and extract data from the State-provided data files to support phased rollout, including 'other related individuals' tied to converted data.
Testing	Participate in and support timely and satisfactory completion of all Contractor Tasks included in the scope described in Section 2.4 of this SOW #2 • Participate in mock conversions by providing extracts, reviewing error reports, and validating converted data • Participate in security testing of IAM COTS products and support determination of recommendations and execution of corrective actions resulting from security tests • Coordinate with stakeholders that are participating in test activities to connect their system test and User Acceptance test environments with the Integrated ONE system test and User Acceptance Test Environments, respectively. • Document its test plan, including tests cases based upon the Accepted design and execute Pre- and User Acceptance Testing per the current Accepted schedule in IPS • Plan review sessions, conduct review of test plans SIT test plans, and test cases in accordance to the timeline defined in the current Accepted IPS • Participate in performance, stress/load, security, and end-to-end system integration test activities as defined in the applicable Accepted test plans • Review System Integration Test results and prioritize items for remediation or determine risk acceptance • Review in accordance with the Acceptance provisions the Test Plan(s) and other Testing Phase Deliverables • Schedule, coordinate, and manage IV&V independent testing to support alignment with	Perform timely and satisfactory completion of all Contractor Tasks included in the scope described in Section 2.4 of this SOW #2 • Conduct security testing of IAM COTS products • Provide Agency and Agency partners that are participating in System test activities with access to relevant Test Environment(s) and coordinate testing schedule in support of data exchange. Test Plan and Test Cases as documented in relevant Deliverables will also be made available as additional references • Conduct and complete, in accordance with Agency accepted Test Plans, the performance, stress/load, security, and end-to-end system Integration Tests • Conduct test plan review sessions and finalize the test cases • Conduct testing activities defined in the Accepted test plans and report Test results for QA review • Update the RTM Deliverable to reflect refinements identified during system integration Testing that are mutually determined by the parties to be necessary to exit system integration test • Provide Defect triage, reporting, and the necessary application development support to the State in Pre-UAT and User Acceptance Testing as specified in Section 2.4 of the SOW • Participate in IV&V independent testing by preparing the system, provisioning tester access, and reviewing test results

Project Area	Agency Responsibilities	Contractor Responsibilities
	the approved design and adherence to approved IPS go-live dates	
Security	Participate in and support timely and satisfactory completion of all Contractor Tasks included in the scope described in Section 2.5 of this SOW #2 • State, DHS and supporting agencies will participate in work sessions and review sessions for the system Security Plan (SSP), Privacy Impact Assessment (PIA), Plan of Action & Milestones (POA&M) and Information Security Risk Assessment (ISRA) documents and assign owners, develop work plans, and resource estimates to address gaps that are identified. DHS will review and approve final CMS SSP and POA&M to CMS • Obtain required training on the Security related COTS products (CA IAM suite, QRadar, DataPower and Optim) from product vendor or another Vendor • Hardening server and desktop operating systems and network devices for the Integrated ONE system including patch management and perform penetration testing of the hosted infrastructure according to standards that align with those listed in NIST Vulnerability Security Configuration Standards as required for CMS security requirements • Lead the communication with CMS related to the review of security artifacts as part of the ATC process • Obtain and configure Secure Socket Layer (SSL) certificates on the Integrated ONE system infrastructure • Provide input to the Application Configuration Management Plan and Technology Management Plan deliverables for infrastructure security components of the DHS solution (e.g. Firewalls, Intrusion Detection/Intrusion Prevention systems, Anti-Virus, etc.) • Develop agreements with Federal Data Services Hub (FDSH) including the Interconnection Security Agreement (ISA), Business Associate Agreements (BAA's), Memorandums of Understanding (MoU's), Data Exchange Agreement (DEA), and Computer Matching Agreement (CMA) • Create or modify security and privacy policies and/or procedures for the State, with the	Perform timely and satisfactory completion of all Contractor Tasks included in the scope described in Section 2.5 of this SOW #2 • Develop the system Security Plan, Plan of Action & Milestones), Privacy Impact Assessment, and Information Security Risk Assessment in accordance with CMS MARS-E 2.0 requirements. Prepare an initial SSP and a Final SSP and POA&M (which includes the input from SAR, ISRA, and PIA) in preparation of sending to State Acceptance for CMS submission • Provide suggestions for potential vendors, if required • Provide compliance requirements for operating systems and standards for infrastructure hardening components based upon CMS/NIST configuration standards • Provide security support for the artifacts as required • Provide server information for supporting the request for SSL certificates • Develop the Application Configuration Management Plan and Technology Management Plan • Provide input as required from the SSP documentation for the ISA and data agreements for the Integrated ONE system • Address questions related to the security requirements as required • Participate in the security sessions to review questions and direction from CMS and the State that impact the CMS SSP and security related artifacts as required for ATC • Collaborate with independent vendor hired to conduct independent security testing by preparing for and supporting test execution

Project Area	Agency Responsibilities	Contractor Responsibilities
	exception of operational procedures for security products installed by Contractor • Conduct review sessions with CMS and State Security Information Security Officer (CISO) • Hire an independent vendor to conduct independent security testing per relevant federal and State requirements • Hire an Independent third-party vendor to be responsible for completing the Security Assessment Report (SAR) • Maintain and operate DHS security products other than the CA IAM products and associated supporting components • Submit quarterly updates of the POAM, and annual updates of the ISRA and PIA, following obtainment of Authority to Connect for the Integrated ONE system	• Provide information needed to support the third party security assessments as required by CMS and FNS. • Maintain and operate CA IAM • Provide information for security gaps assigned to the Contractor for responsibility for remediation identified on the POAM • Perform design, configuration, testing and integration of security COTS products (e.g., CA IAM, QRadar, DataPower, Optim) with the Integrated ONE system components • Design, build test and deploy in-scope application security roles • Perform application vulnerability and application security code testing for the Integrated ONE system and provide support for tracking of open application vulnerabilities and support for remediation
Infrastructure	Participate in and support timely and satisfactory completion of all Contractor Tasks included in the scope described in Section 2.6 of this SOW #2 • State will be responsible for acquisition and configuration of servers and operating software needed to stand-up new environments for the Integrated ONE system based upon the approved Technology Management Plan and Contractor Specifications • The State will coordinate the timing of hardware acquisition and environment preparation with the Contractor • Provide access to Contractor in order to enable the hardware and software necessary to use the Integrated ONE systems environments • Implement firewall rules and network access control list modifications to accommodate the flow of network traffic for the security products to function to address business and regulatory requirements • Maintain the Hardware and Software at the SDC including OS-level, and software licensing, and patches for such as maintained by State (for example, Active Directory, DataPower, etc.) • Plan, install and verify OS patches, security system patches, and hardware related upgrades	Perform timely and satisfactory completion of all Contractor Tasks included in the scope described in Section 2.6 of this SOW #2 • Contractor will be responsible for installation and configuration of database, application, and COTS software into new environments • The contractor will participate with State in the coordination of the timing and availability of new environments • Contractor will send State requests for access to the Integrated ONE system environments with reasonable prior notice • Document infrastructure gaps to be addressed to support the flow of network traffic for the security products based upon business and regulatory requirements • Maintain the COTS products and patches in collaboration with State for products identified in the Accepted Technology Management Plan • Plan, install and verify COTS mutually agreed upon patches and upgrades

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Project Area	Agency Responsibilities	Contractor Responsibilities
	required to maintain ETS standards including existing ONE system environments, VDI infrastructure, and end user desktops • Agency will work with Contractor to reasonably schedule downtime for system maintenance and will provide prompt notification of emergency unplanned maintenance • Provision compute and network capacity for development machines (VDI) as defined in the Accepted Technology Management Plan to enable onsite and offsite team members' daily activities with reasonable hardware/virtual machine performance • Collaborate with State ETS and Contractor to configure and monitor server backups and conduct server recovery tests	required to maintain vendor support without impacting the approved IPS • Work with Agency to reasonably accommodate requested downtime for scheduled maintenance • Create and submit Deliverables as per approved timeline and DEDs • Collaborate with State and provide inputs regarding performance of development machines (VDI) and document the finalized capacity requirements in Technology Management Plan. • Conduct application and COTS validation after successful recovery of servers
Business Operations Implementation	Participate in and support timely and satisfactory completion of all Contractor Tasks included in the scope described in Section 2.7.1 of this SOW #2 • Provide leadership direction, input and session participants necessary to support the development, execution, evaluation, and Acceptance of the Business Operations Implementation Services plans • Make cross-program operational and policy SMEs available for to-be process model working sessions. SMEs will have detailed knowledge of current business processes and preferences for the proposed business processes for the Integrated ONE system • State leadership will be closely involved to confirm key decisions made and help assess and accept their impact on the current system and business operations • Revise and publish policy changes as required to align with approved system and process designs • Leadership will communicate any modifications to future DHS vision, including timing and schedule modifications • Identify resources for business operations implementation services deliverables so that they align with the on-going work of the DHS Business Transition Team responsible for integration of OHA to DHS operations • Responsible for communicating in a timely manner any decisions regarding integration of	Perform timely and satisfactory completion of all Contractor Tasks included in the scope described in Section 2.7.1 of this SOW #2 • Lead business transition planning tasks • Discuss Integrated ONE program policies and operational practices, and help document key transition items • Review and notify the state of any inconsistencies on Policy draft alignment with System design • Coordinate with functional team to communicate potential design impacts as a result of business process redesign

Project Area	Agency Responsibilities	Contractor Responsibilities
	OHA operations into DHS operations including timing of activities • Responsible for integrating current OHA eligibility center operations to DHS operations • Provide operational performance data including baseline data for SSP, APD/AAA offices to support Business Operations Implementation services activities	
People Readiness	Participate in and support timely and satisfactory completion of all Contractor Tasks included in the scope described in Section 2.7.2 of this SOW #2 • Collaborate with the Contractor People Readiness team to plan the people transition to Integrated ONE by providing input into and approval of the People Readiness and Communications Support Plan (PR&CSP) deliverable. • Collaborate with the Contractor People Readiness team to provide input into the ongoing quarterly updates of the PR&CSP • Lead the people readiness activities, per the strategy defined in the People Readiness and Communications Support Plan • Identify stakeholders with knowledge and availability to execute the people readiness activities, per the strategy defined in the People Readiness and Communication Support Plan • Develop and maintain primary responsibility for executing an Integrated ONE system Communications Plan • Provide guidance and requested information (demographics, facilities, technical, current skills) as input to Training Plan • Support development of training material based upon the approved Training Plan and identify resources for any review or dry-runs of content under development • Provide support for determination of training data • Identify and staff sufficient trainers to receive train-the-trainer training • Conduct sufficient instructor lead training deliveries to support the approved IPS • Provide Learning Management System (LMS) or other training materials storage and delivery	Perform timely and satisfactory completion of all Contractor Tasks included in the scope described in Section 2.7.2 of this SOW #2 • Lead development of the People Readiness and Communications Support plan deliverable • Collaborate with the State People Readiness team to provide quarterly updates of the PR&CSP • Collaborate with the State by attending events and meetings where People Readiness activities are occurring • Collaborate with the State People Readiness Team on the execution of the people readiness activities, such as providing feedback on State People Readiness materials • Develop Training Plan, describing the approach, the curriculum (including description, durations, delivery method, audience, and learning objectives of each course); includes train-the-trainer approach and roles and responsibilities for training material development and training delivery; materials to be provided from the Integrated ONE perspective and designed to be incorporated into State's comprehensive training that combines information technology, policy, and practice • Develop training material based upon the approved Training Plan and schedule reviews or dry-runs of content under development o Coordinate the identification and population of training data • Leverage State designated storage and delivery mechanisms for training

Project Area	Agency Responsibilities	Contractor Responsibilities
	mechanism and any system requirements needed for coordinated development • Provide Train-the-trainer and End User Training scheduling tools; manage registration for TTT and End User Training class delivery; train Contractor resources on provided tools; and monitor and confirm WBT training compliance • Participate in a pilot of the Training program prior to Train-the-trainer launch • Provide the necessary facilities, network access, printed materials and tools to support Train-the-trainer and End User Training sessions • Deliver end user training based upon the approved IPS and communicate feedback on training results and issues • Provide and prepare 1 business process and policy SME for each class during Train-the-trainer and end user training sessions • Collaborate with the Contractor People Readiness team in the development of the Phased Rollout Support Plan deliverable • Provide access to accurate and timely data on headcount in each of the on-site support offices for planning and deployment • Deploy State resources to support the delivery of on-site support 4 weeks after Pilot and for each go-live, per Contractor and State agreed upon support resources and timeframes • Collaborate and Coordinate with the Contractor People Readiness Team to prepare resources to provide onsite support	materials and web-based training content • Leverage provided Train-the-trainer scheduling tool to schedule Train-the-trainer sessions • Deliver a pilot of the train-the-trainer program to designated State trainers, prior to UAT as per the Accepted Training Plan Deliverable. • Deliver Train-the-trainer training to designated State trainers, prior to Pilot go live as per the Accepted Training Plan Deliverable. • Provide feedback to the State regarding document training delivery logistics checklist, which defines requirements on facilities, printed materials, and tools • Collaborate with State to address issues related to the training environment and questions about the training materials during End User Training • Provide TTT reference materials and conduct a review session to prepare State business process and policy SMEs who will participate in training delivery • Lead the development of the Phased Rollout Support Plan deliverable. Collaborate with the State Business Transition Team to plan on-site support needs prior to, during and immediately after go-live • Deploy Contractor resources to support the delivery of on-site support for the duration of the Pilot and 4 weeks after go-live for each wave, per Contractor and State agreed upon support resources and timeframes. The following number of contractors will be deployed: o Pilot + ONE Upgrade: up to 11 o Wave 1: up to 31 o Wave 2: up to 33 o Wave 3: up to 26

Project Area	Agency Responsibilities	Contractor Responsibilities
		• Prepare State and Contractor resources in the activities to be performed at each site
System Implementation	Participate in and support timely and satisfactory completion of all Contractor Tasks included in the scope described in Section 2.7.3 of this SOW #2 • Establish criteria for go/no-go implementation decisions and make go/no-go implementation decisions as appropriate • Provide resources to support the development of cutover plan • Provide resource to support the approved cutover plan • Provide a Command Center Manager with the authority to make decision while the Command Center is effective	Perform timely and satisfactory completion of all Contractor Tasks included in the scope described in Section 2.7.3 of this SOW #2 • Participate in and make recommendations as input into go/no-go decisions • Develop cutover plan in collaboration with State • Lead execution of cutover based upon approved cutover plan • Provide leadership presence onsite for command center meetings.

Table 4: Responsibilities

Parking Lot

Integrated ONE System Functionality includes:

- Workflow automation inside the Worker Portal
- Automated business rules using Corticon Rules Engine – including real time eligibility determination to support the Applicant Portal
- Automated notice generation using HP ExStream
- Address validation service using Melissa Data
- Automated verification interfaces with the Federal Data Services Hub, the state Medicaid Enrollment System (MMIS), and the Oregon Employment Department
- Automated Bi-Directional Account Transfer with the FFM & Minimum Essential Coverage check for Medicaid benefits
- Integration with the existing document management service provided by DHS Imaging and Records Management System
- Integration of Computer Associates Identity & Access Management Solution to provide single sign-on integration with OHA's Active Directory

3.6.2 Key Performance Indicators: Measures of Business Success

The following Key Performance Measures are routinely collected by DHS's Performance Excellence Office. Implementation of a new Integrated Eligibility system is expected to "move the needle" on these indicators in the desirable direction:

- Customer Satisfaction: % of DHS Customers that rank the quality of DHS Service as good or excellent
- Employee Engagement: % of DHS staff that report medium-high or high level of engagement
- Accuracy:
    - % of SNAP PER QC reviews for SSP branch offices where accuracy measures 95% or better
    - % of TANF QC reviews for SSP branch offices where accuracy measures 95% or better
    - % of ERDC QC reviews for SSP branch offices where accuracy measures 95% or better
    - % of APD QC and QA reviews for APD branch offices where accuracy measures 95% or better
- Timeliness:
    - % of new SNAP Expedited and Non-Expedited applications meeting processing timelines
    - % of new SNAP Benefits issued within 0-1 days
    - % of APD cases with a redetermination date that is current or less than 1 month overdue compared to the total cases with a review date

3.6.3 Measures of Project Success and Completion

Project Success Measures:

•

• Project is completed on time in comparison to the latest approved baseline schedule.
• The last approved baseline schedule does not deviate by more than 10% from the schedule projected at Stage Gate 3.

• Project is completed within budget in comparison to the latest approved baseline budget.
• The latest approved baseline budget does not deviate by more than 10% from the budget projected at Stage Gate 3.
• The system satisfies all of the requirements in the Requirements Traceability Matrix at Stage Gate 3 as subsequently modified through the project's change management criteria.
• At the close of the warranty period, there are no Critical or Major defects remaining and the ratio of Minor defects remaining to the size of the system is below industry averages.

Project Completion Criteria
The project will be complete when all of the following are true:
• System has been in production through a six-month warranty period
• All contracted work has been completed and accepted, and final payments have been made to all vendors
• The Office of the State Chief Information Officer and the Legislative Fiscal Office have approved the project's Stage Gate 4 submission
• A steward for Operations and Maintenance is identified and has formally accepted handoff of the system
• The position responsible for post-project monitoring and reporting on measures of success has been identified and its occupant has formally accepted the handoff
• Final reports required by funders of the system, if any, have been delivered and accepted
• Project documentation has been assembled and archived consistent with agency and state records retention policies

DHS
Oregon Department
of Human Services

DHS|OHA

Information Resource Request

Department of Human Services
Integrated Eligibility Determination Project

VERSION LOG

Version	Description	Author	Date
1.0	Initial Draft	Karl Olmstead	12/02/2015
1.1	Revisions based on comments from Ed Arabas	Karl Olmstead	12/15/2015
1.2	Update to schedule	Karl Olmstead	1/15/2015
2.0	Updates to Schedule/budget due to re-baseline	Rob Midtun	2/28/2018

SIGN-OFF

Role	Name	Version	Comments	Date
Independent Project Director	Tony Black	2.0	Appoval via email	2/28/2018
Chief Information Officer DHS/OHA	Kristen Duus	2.0	Approval via email	2/28/2018

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1 DAS Information Resource Request

State of Oregon **Information Resource Request**

PROJECT NAME	**Integrated Eligibility Determination Planning Project**		
AGENCY	**Department of Human Services**	**DATE**	**11/24/2015**
DIVISION	**Director's Office, Office of the Chief Operating Officer for Technology**	**DAS Control #**	
AGENCY CONTACT	**Trisha Baxter**	**PHONE NUMBER**	**503-580-7853**

SERVICES SUMMARY

- ✓ System Design Programming
- ☐ Planning and Project Management
- ✓ Project Review
- ☐ LAN Consulting
- ☐ Education and Training
- ☐ Maintenance
- ☐ Other _____

PROJECT COST SUMMARY
(Including development and operating costs)

ITEM	V1.2	UPDATE V2.0
Hardware	$ 0.0M	$ 2.7M
Software	$ 3.5M	$ 11.7M
Services	$ 101.6M	$ 218.9M
Other	$ 21.0M	$ 111 M
TOTAL	$ 126.1M	$ 344.3 M

_____
Agency Business Owner date

_____
Agency Technology Manager date

ATTACHMENTS
☐Statement of Work ✓ Business Case Analysis ☐ Feasibility Study
☐ Strategic Plan ☐ Other _____

DAS COMMENTS:

_____
CIO Analyst date

_____
State CIO (or designee) date

NOTE: Guidelines for completing this form are contained in the DAS/Information Technology Investment Review/Approval Policy

PROJECT NAME	Integrated Eligibility Determination Planning Project		
AGENCY	Department of Human Services	DATE	11/24/2015
DIVISION	Director's Office, Office of the Chief Operating Officer for Technology	DAS Control #	
AGENCY CONTACT	Trisha Baxter	PHONE NUMBER	503-580-7853

PROBLEM STATEMENT ***(Identify problem, opportunity, or mandate [legislative, Federal, etc.]. Include summary statement of business process(es) and stakeholders affected.)***

Background

Oregonians do not currently have the ability to apply for Non-Modified Adjusted Gross Income (Non-MAGI) Medicaid through a self-service portal via an on-line application. Additionally, while individuals currently may utilize an on-line application for Oregon's Supplemental Nutritional Assistance Program (SNAP) or with manual process supplementation for Temporary Assistance to Needy Families (TANF) or Employment Related Day Care (ERDC), the systems supporting the application does not link to a benefit authorization system. Department of Human Services (DHS) eligibility workers must engage in manual application processing activities, with little to no automation. Changes to regulations from federal agencies present challenges for eligibility workers when applying those regulations to each applicant's unique situation.

Oregon Department of Human Services seeks to reduce manual processing and reduce the reliance on legacy systems in support of Non-MAGI Medicaid, SNAP,TANF and ERDC eligibility determinations. The purpose of this project is to assess possible alternatives for the automation of eligibility processing, determine and develop the legacy system interface requirements to reduce or eliminate manual input, and provide a web-based front-end applicant portal to support customer self-service for at-minimum, Non-MAGI Medicaid, and potentially other human service programs (i.e., SNAP, TANF, Employment Related Day Care).

Opportunity Definition

The Oregon Health Authority (OHA), the state's designated Medicaid agency, has recently implemented a new system for MAGI Medicaid eligibility determinations. That system is called Oreg**one**ligibility, or ONE, and is the result of transferring the State of Kentucky's Affordable Care Act compliant state-based marketplace solution (*kynect*) for use in Oregon.

In late 2015, Kentucky rolled out an extension to the system that OHA has transferred to Oregon. That extension supports eligibility determinations for the following programs:

- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance to Need Families (TANF)
- Medicaid Waiver Management Applications
- Child Care

Given CMS direction that it will only provide enhanced funding match for extending the ONE system, the time is clearly right to consider extending ONE to support Non-MAGI Medicaid eligibility determinations and eligibility determinations for other DHS Human Service programs too.

The high-level business objectives driving this effort are:

- Allowing applicants to apply for benefits on-line, reducing the need to travel to local offices and reducing the need to provide duplicate information when applying for benefits from more than one program
- Automating manual processes in order to:
    - Reduce the amount of time that elapses between completing an application and making an eligibility determination
    - Reduce the amount of time that staff must spend creating, reviewing, and acting on each application
    - Reduce the rates of errors in making eligibility determinations
- Allowing for seamless sharing of information and transfer of cases among program staff

On August 10, 2011, three federal agencies (Centers for Medicare and Medicaid Services (CMS), Food and Nutrition Services (FNS) and the Administration for Children & Families (ACF)) announced a time-limited, specific exception to the cost allocation requirements set forth in Office of Management and Budget (OMB) Circular A-87. These provisions generally require the costs associated with building shared state-based information technology systems to be allocated across all benefitting programs. The exception reflected a federal focus on streamlining enrollment in health and human services programs while leveraging funding efficiencies at the state-level. On July 20, 2015, the three agencies extended the exception for an additional 3 years, through December 31, 2018, and provided additional guidance on how states may take advantage of it to leverage these investments to better serve consumers' multiple programs and needs.

AGENCY ANALYSIS ***(Identify alternatives considered and significant reasons for the alternative chosen. Include summary of agency analysis related to cost/benefit, feasibility, risk assessment, impacts on current environment, and other relevant business factors.)***

The CMS policy to fund only a single financial eligibility system per state and the fact that Medicaid Title XIX will provide 90 percent of the funds needed for the system means that Oregon's only viable alternative to the status quo must include enhancement of the ONE system to support Non-MAGI Medicaid eligibility determinations. DHS has explored four possible courses of action, including continuing in the current state. These are the alternatives:

Alternative #1: Implement Non-MAGI Medicaid Eligibility Determination into the ONE System
Under this alternative, the ONE system would be extended to support Non-MAGI Medicaid eligibility determinations and service authorization to community-based care programs only. This approach limits the scope of DHS programs that would be affected. It requires transfer of the Kentucky system, removal or disabling of the functionality in that system supporting

programs like SNAP and TANF, and customization for Oregon's Non-MAGI Medicaid program. This approach would use 90/10 federal funding.

Alternative #2: Implement Integrated Eligibility Determination into the ONE System
Under this alternative, the ONE system would be extended to support Non-MAGI Medicaid eligibility determinations and SNAP, TANF, and ERDC determinations, as well as service authorizations for community-based care programs. This approach involves a wider range of DHS programs. It avoids the risk and expense of removing functionality for these programs from the Kentucky system. It requires potential customization for a larger number of Oregon programs. This alternative could be rolled out all at once or it could be phased-in program-by-program. This approach would use Medicaid 90/10 federal funding to the benefit of other programs, which would only have to fund parts of the solution that were benefitting those programs exclusively.

Alternative #3: Acquire External Eligibility Determination Services from another State
Just like Alternative #1, this alternative would extend ONE to support Non-MAGI Medicaid eligibility determinations only. Like Alternative #2, it would support eligibility determinations for the SNAP, TANF, and ERDC programs. However unlike Alternative #2, that support would be outside of ONE. In this alternative, DHS would contract with another state to support SNAP, TANF, and ERDC eligibility decisions. At a minimum, that would involve modifying the partner state's system for those programs to accept applications from Oregonians and make eligibility determinations based on Oregon's rules. Limiting factors include lack of integration of Non-MAGI Medicaid program eligibility with MAGI program eligibility and recording of Oregon-specific MAGI, CHIP, and CAWEM rules. The project team was unable to identify a state where this approach is being used. Therefore, cost estimates for this alternative were unattainable.

Alternative #4: Do Nothing
Under this alternative, there would be no additional investment in the ONE system and no acquisition of eligibility services from another state. Improvements to current processes would be limited to those that arise naturally through the DHS's continuous improvement program. This alternative means losing the opportunity for enhanced federal funding to improve IT systems and thus results in greater cost in state funding for future enhancements.

Section 4 of the attached business case describes the costs, benefits, and risks of each of the alternatives. They are summarized here:

Cost, Benefits, and Risks Summary

Alternative	Project Cost	Program Benefits from Project	Overall Risk
1. Implement Non-MAGI Medicaid Eligibility Determinations	~$80.3M	Medicaid	Low
2. Implement Integrated Eligibility Determinations	~$126.1M	Medicaid, SNAP, TANF, ERDC	Medium
3. Acquire Eligibility Determination Services from Another State	Unknown	Medicaid, SNAP, TANF, ERDC	High
4. Do nothing	~$4.0M		High

Based on that analysis, DHS intends to pursue Alternative #2, Implement Integrated Eligibility Determination. This means extending the ONE system by transferring, configuring, and customizing Kentucky's Non-MAGI Medicaid, SNAP, TANF, and ERDC eligibility system to Oregon.

PROJECT SUMMARY ***(Provide summary narrative of the current project. Include summary statement of work, community/stakeholder impact, enterprise implications and opportunities, and alignment with the*** **State of Oregon Enterprise Information Technology Strategy** ***and published enterprise architecture and standards.)***

Section 5 of the business case sets out a tentative schedule that would implement the expanded, integrated eligibility determination system in mid-2018. These are the key project milestones.

Schedule Milestone v1.2	**Expected Date**
Stage Gate 2 Approval	December 2015
Independent Quality Assurance Vendor Under Contract	December 2015
Stage Gate 3 Approval	February 2016
System Integrator Under Contract/Fit-Gap Analysis Begins	March 2016
Fit-Gap Analysis Complete; Design/Development Begins	July 2016
Re-Baseline Based on Fit-Gap Findings	August 2016
Design and Development Iteration #1 Complete	April 2017
Design and Development Iteration #2 Complete	July 2017
Design and Development Iteration #3 Complete	November 2017
End-to-End User Acceptance and Regression Testing Complete	May 2018
Pilot Implementation Begins	July 2018
Roll Out Begins	September 2018
Stage Gate 4 Approval	June 2019
Project Complete	June 2019

Schedule Milestone v2.0 Re-Baseline	Expected Date
Project Planning Begins	July 2015
Stage Gate 1 & 2 Submission	December 2015
Stage Gates 1 & 2 Approval; Federal Advance Planning Document Approval	February 2016
System Integrator under Contract; Fit-Gap Analysis Begins	April 2016
Stage Gate 3 Submission	July 2016
Stage Gate 3 Approval, LFO Approval, Federal Approval of DDI SOW	September, 2016
Design Phase (Core)	September 2016 - March 2018
Iteration #1 Development & SIT Phase	April 2017 – September 2018
Iteration #2 Development & SIT Phase	April 2018- March 2019
End-to-End User Acceptance Testing Prep & Execution	October 2018- August 2019
OHA Upgrade & Production Pilot Period	September 2019-December 2019
Phase Implementation (3 waves)	February 2020 - July 2020
Roll Out Complete	August 2020
Stage Gate 4 Approval; Project Complete	January 2021
Warranty Complete	August 2022

These are the principal stakeholders:

- ***Oregonians applying for Non-MAGI Medicaid, SNAP, TANF and ERDC benefits***
- ***DHS Aging and People with Disabilities (APD) Field Offices*** statewide & ***Area Agencies on Aging (AAA)*** which are typically county-chartered organizations and under contract with the department. Collectively they deliver DHS's Non-MAGI Medicaid program including making initial and ongoing financial eligibility determinations for people over the age of 65 and people with disabilities who need assistance.
- ***DHS Self-Sufficiency Program (SSP) Field Offices*** which deliver DHS' SNAP/TANF/ERDC eligibility determinations
- ***Federal Partners, including Centers for Medicare and Medicaid Services, Food and Nutrition Services, Administration for Children and Families***

The proposed solution will be fully consistent with state and department IT architecture and standards.

Does this project conform to program and information technology related statutes, administrative rules, executive orders, and statewide policies? ✓ Yes ☐ No ☐ Don't Know
If not, please provide justification: _____

BUDGET IMPACT ***(Provide summary narrative of the budget and resource implications of this project, as well as its relevance to the core mission of the agency.)***

The preliminary estimate of the cost to implement the system in mid-2018 and operate it through June of 2019 is $126.1 million. Details and assumptions behind that estimate can be found in the attached business case.

Most of the cost will be eligible for a 90 percent federal match. Other portions will be eligible for a 50 percent match. The total state share will not exceed 20 percent.

A more detailed budget estimate will be developed as part of preparing for Stage Gate 3 review. That work will include establishing a precise expectation about the state share of the total cost.

Update February, 2018 v2.0 Re-Baseline:
The total Project one-time costs are estimated to be $344.3 million (July 2015-July 2020). This estimate includes the design, development, and implementation of the ONE IE & ME systems, the legacy systems work, the disaster recovery sub-project, all personal services (salary and benefits), IT professional services, hardware and software costs, hosting services, and training. Stage Gate 3 foundational documents have been updated and uploaded to OSCIO's enterprise Project and Portfolio Management (PPM) system such as an updated Business Case, v 3.0.

FUNDING SOURCE ✓ **General Funds** ✓ **Federal Funds** ☐ **Lottery Funds** ☐ **Other Funds**
If Other Funds, please identify source _____

CONTRACT SUMMARY ***(attach statement of work from procurement document)***
✓ **Personal Services** ☐ **Goods** ☐ **Trade Services** ✓ **PO/CRO/Task Order**
Contract Amount TBD **End Date** 12/31/2018 **Amendment #** _____

PRODUCT/HARDWARE SUMMARY	**HOST-BASED SOFTWARE**
Please indicate required hardware (if known):	☐ **System** _____ ☐ **LAN/WAN** _____ ☐ **Development** _____ ☐ **DBMS** _____ ☐ **Application** _____ ☐ **Other** _____

IRR COMPLETION PROCESS

At the commencement of an information technology-related project, agency prepares form, business case and any supporting documentation required.

Agency obtains Agency Business Owner and Agency Technology Manager signatures or e-mail approvals.

Agency sends IRR, business case and any supporting documentation to:

Department of Administrative Services
Chief Information Office
155 Cottage Street NE (4th Floor)
Salem, OR 97301

or by e-mail to: **IT_Investment.Review@das.state.or.us**

DAS will review and provide analysis related to completeness of the IRR and business case based on the context of the Information Technology Review/Approval Policy and potential enterprise applications and impact on enterprise programs.

If form is complete, IRR and accompanying analysis is forwarded to the State CIO for approval

OR

If form is not complete, documentation is returned to Agency with explanation.

After documentation is approved, the IRR is returned to the Agency with DAS Control Number.

Agency forwards approved IRR with procurement documents to Dept. of Justice and DAS State Procurement Office

Total Project Cost or Purchase Price:	Agency-Provided Supporting Documentation	Approval required
≥ $150,000	**Conform with Information Technology Investment Review/Approval Policy** **Information Resource Request** **Business Case** **Any additional supporting documentation**	State CIO
NOTE:	**Some projects may require Independent Quality Assurance Reviews as per the Technology Investment Strategy Development And Quality Assurance Reviews Policy Circumstances may include the following:** **Those projects that are required by legislative action or executive mandate to have independent reviews, and information technology projects that meet three of the following criteria, shall provide for an independent quality assurance review.** **The system, application or infrastructure affected by the project is considered mission critical by the affected agency or DAS.** **The project schedule exceeds one year in duration.** **The project scope includes changes or enhancements to systems, applications or infrastructure managed or maintained by more than one state agency or government entity.** **The complexity of the project is deemed medium or higher using the Department of Human Services, Business and Technical Assessment (Exhibit A) or similar tool that has been approved by DAS.** **The total project costs are estimated to be greater than $1,000,000.**	State CIO

Business Case for Medicaid Modularity Planning

Office of Information Systems

Date: 03/25/2020
Version: 2.0
Author: Sophia E. Grant

Business Case – Authorizing Signatures

PROPOSAL NAME AND DOCUMENT VERSION #			
AGENCY		DATE	
DIVISION		DAS CONTROL #	
AGENCY CONTACT		PHONE NUMBER	

The person signing this section is attesting to reviewing and approving the business case as proposed.

This table to be completed by the submitting agency Agency Head or Designee	
Name	
Signature	
Agency Executive Sponsor	
Name	(Date)
Signature	
Agency Chief Information Officer (CIO) or Agency Technology Manager	
Name	
Signature	
State Data Center Representative, if required by the State CIO	
Name	(Date)
Signature	

This Section to be completed by DAS Chief Information Office (CIO) IT Investment and Planning Section DAS CIO Analyst	
(Name)	(Date)
Signature	
State CIO	
(Name)	(Date)
Signature	

Executive Summary

The OHA Office of Information Services (OIS) is a shared-service information technology organization supporting Oregon's two largest state agencies: the Oregon Health Authority (OHA) and the Department of Human Services (DHS). OHA is Oregon's single State Medicaid agency responsible for ensuring access to health services is available to Oregonians, while DHS is the agency responsible for providing access to all other public assistance benefits. The partnership between OHA and DHS and their alignment with business operations and technology services unites these two agencies in their common goal to establish streamlined Medicaid eligibility, improve access to care and service delivery, and expand coverage to more Oregonians.

Current Oregon MMIS is a monolithic system implemented in 2008. CMS has indicated that eligibility for continued federal funding is dependent on compliance with CMS mandates and evidence that states are committed to a thorough planning effort supporting a modular future state. The goal of the Oregon Medicaid modularity program is to move from a monolithic system to a modular Medicaid environment that facilitates efficient administration of Oregon's Medicaid program. Since Oregon does not need to replace its current MMIS in the immediate (near term) future, the focus of the Oregon Medicaid modularity program is to evaluate Oregon Medicaid enterprise architecture for possible improvements; and develop a strategy and plan for the Medicaid modularity activities. The Modularity program planning effort provides a long term roadmap for modernization of Medicaid related systems.

The goal of the proposed program is to support DHS and OHA in crucial planning activities to achieve compliance with CMS requirements and improve interoperability and sustainability of the technology solutions supporting Medicaid service delivery. Federal government will support funding of modularity 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 5-7 years while shouldering only 10% of the primary costs.

Purpose and Background

Oregon's current MMIS is based on the DXC Technology Services LLC interChange Healthcare platform implemented in 2008. The MMIS was designed to support a fee-for-service model; there were extensive modifications implemented later to support Oregon's Coordinated Care Organization (CCO) capitation-based model. OHA intends to create an enterprise vision for transforming the way services and programs are delivered to Oregon citizens, going beyond technology. This encompasses a re-evaluation of processes and organization structures used to manage and deliver program services, efforts to work across organizational boundaries to more effectively manage and deliver health and human services (HHS) in Oregon, and transition from current operating models to an outcomes-based focus. This program supports core value of Innovation for both OHA (https://www.oregon.gov/oha/Pages/Portal-About-OHA.aspx) & DHS (https://www.oregon.gov/DHS/ABOUTDHS/Pages/index.aspx)

In 2016, the federal Centers for Medicare & Medicaid Services (CMS) issued regulations which represent a fundamental shift in the approach states must use to procure, implement, and obtain certification for their MMIS. The new modular approach championed by CMS involves packaging a business process or group of processes into a distinct "module" with open interfaces which can easily be integrated with other modules to

create a flexible, service-oriented architecture. Because the modules are independent components, they can be replaced in the future more easily and with lower risk and duration than a traditional "big-bang" MMIS replacement or the modernization overhaul.

The underlying rationale for Medicaid Modularity planning effort supports the fundamental principles of the OHA & DHS Strategic Plan to: 1) "*provide the agencies with tools & capabilities to automate workflows, decision making & business rules, while reducing manual, paper-based processes & increasing efficiency & effectiveness*" (https://teams.dhsoha.state.or.us/sites/ois/SiteCollectionDocuments/DHS_OHA%20Strategic%20Technology%20Plan%202013.pdf p 15) : 2) "*provide modular, common services & capabilities which promote agility, re-use, & capitalize on best practices leveraging enterprise capabilities*" https://teams.dhsoha.state.or.us/sites/ois/SiteCollectionDocuments/DHS_OHA%20Strategic%20Technology%20Plan%202013.pdf, p 15).

The modular approach also enables Agency to design and conduct a sequenced procurement and deployment of an end-to-end MMIS solution, prioritizing the implementation of modules based on business needs. Modularity offers many benefits to Agency, such as the ability to adapt to changes in state and federal policy, new programs and initiatives, and technological advancements in a timely and cost-effective manner and to increase innovation and potentially lower costs through new market entrants and greater competition. It allows Agency to focus on "best-of-breed", interoperable solutions.

Problem or Opportunity Definition

Oregon made numerous enhancements to its current MMIS. These changes impact 1,800 state users, 17,000 provider users, and over 1 million Oregonians receiving healthcare services. Despite various improvements, large sections of Medicaid enterprise system are from legacy technologies. In order to continue supporting its business mission, OHA needs to transform its business operations and modernize its IT ecosystem to align to rapid changes in healthcare delivery system.

Medicaid Modularity planning is highlighted in Healthy People IRM 2019-2021 (Sec 4.3.1, p 29) as this program responds to several key drivers of the Strategic Information Management Framework, identified in the Healthy People IRM 2019-2021. These drivers include: Federal mandates (sec 2.1.3 p 12), Modernization (Sec 2.1.5 p 13), Health System Transformation (Sec 2.1.7 p 14) and the Overall Driver of Aligning Strategy, Priorities & Plans (Sec 2.2 pp 14-15). The program aligns with the overall Agency vision of investing for sustainability & agility (Sec 2.4 p 17). Planning effort will comply with all relevant federal, state, and agency requirements, including OHA 2019-21 Affirmative Action Plan, DHS office of Equity & Multiculturalism Policy & Processes and DHS-OHA Reasonable Accommodation policy.

OHA completed its first MITA SS-A in 2013 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 implemented in 2008 is unlikely to meet future business needs of OHA. An update to MITA SS-A will identify the current level of maturity of a broad range of organizational processes and include organizational change management recommendations to improve its level of maturity across a broad spectrum of Organizational Change Management practices.

The move to modularize Oregon Medicaid Enterprise Systems (MES) is federally mandated through a letter issued to State Medicaid Directors on Aug 16, 2016. CMS requires all states to plan for and implement modular technology solutions in support of Medicaid programs. Oregon MES needs to be updated with modular functionality to eliminate redundancy, duplication of effort and waste of IT assets. Modularity planning effort will be led by vendor resources and agency FTEs that will be dedicated to this effort. The planning activities have been scheduled considering other large agency-wide strategic initiatives to ensure critical business resources will be available to support the planning effort. Agency has an established appropriate governance structures to adequately oversee this investment, as outlined here: https://dhsoha.sharepoint.com/teams/Hub-SS-OIS/SitePages/IT-Governance.aspx Additional processes will include the following elements: engaged executive sponsorship, steering committee, vendor and contract management, change control and stakeholder representation processes.

OHA is soliciting for planning consulting services around Medicaid modularity. Consultant will be tasked with several critical activities: 1) update of the current MITA State Self-Assessment (SS-A), 2) create of the strategic modernization roadmap and 3) prepare for procurement activities to solicit for and acquire services of SI & PMO vendors for Medicaid Modularity along with individual module acquisition strategy that meets Agency needs.

Medicaid Modularity planning will take a holistic approach, looking at a broad range of technological, budgetary and business process challenges OHA will face as it moves from a single MMIS into the modular environment to address the wide variety of business needs. The consultant will produce a roadmap of modernization projects that span multiple biennia, which will allow for long term budget planning, using the approach that considers:

- Agency's short- and long-term goals and priority initiatives and the vision and expected outcomes of the Medicaid modularity.
- The ability of the market to support Agency's vision for the Medicaid modularity with modular offerings versus custom development.
- The grouping and sequencing of modules for federal funding requests, procurement, and implementation to support the Medicaid modularity.

Alternatives Analysis

Two other (*less desirable*) alternatives include:

Do Nothing – continue to extend the existing support contract with DXC (that, per CMS guidelines, cannot be continued *indefinitely*). The current MMIS was implemented 12 years ago with optional M&O contract that will expire in 2022. Maintaining the current state will cause Oregon to miss a unique opportunity to streamline Medicaid related systems while taking advantage of enhanced FFP. CMS expects Oregon to demonstrate a strong commitment to plan and execute a modular Medicaid Enterprise environment in compliance with CMS mandates. Non-compliance with CMS mandates will lead to significant negative financial ramifications for Oregon – loss of enhanced funding for enhancements or renewal of the system and doubling of state fund requirements for M&O expenditures.

Implement another State's planning approach

Oregon could choose to bypass its own planning efforts and implement the planning approach of another state, leveraging its planning outcomes and RFPs to procure new modular solutions. This approach will likely result in a lack of a cohesive roadmap and executable plan to meet Oregon-specific needs and increase the overall risk of this crucial program. It is also likely, that the solutions adopted by another state either would require significant modifications to address Oregon-specfic requirements or would require significant business process and operational workflow reengineering.

Consequences of Failure to Act

- Lost opportunity to develop a modern, sustainable and scalable solution environment supporting Oregon Medicaid service delivery.
- Lost opportunity to leverage CMS enhanced 90% funding for future replacement of existing aging Medicaid supporting technology. In just 5 more years, the current MMIS solution will be 17 years old and will be approaching its end of life. The typical cost to replace MMIS systems is over $150 million. Without enhanced funding, the general fund share of a replacement would be over $75 million, compared to $15 million.
- Lost opportunity to negotiate competitive maintenance and operations vendor support as a result of increased competition. The current contract with DXC for maintenance and operations increases by 2% 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 funds 75% or approximately $15 million. If Oregon lost CMS enhanced funding, the federal funding level will drop from 75% to 50%. This will increase Oregon's need for GF for annual maintenance and operations from $5 million to $10 million per year.
- Potential significant financial impact due to loss of CMS enhanced funding support for system change requests and for major enhancement projects. System change requests average $10 million annually. Major enhancement projects range between $5-20 million. CMS currently pays 75% of the cost of system change requests and 90% of the cost of major enhancements. If Oregon lost CMS enhanced funding, the federal funding level will drop to

50%. This will increase Oregon's typical annual general fund change request and enhancement projects cost from under $4 million to over $11 million.

Conclusions and Recommendations

It is essential for OIS to engage in this federally funded effort to transform business and technical architecture of the Medicaid Enterprise Systems. The Strategic Advisor consultant is expected to provide experience and technical expertise and successfully develop Medicaid modularity roadmap for OHA. The underlying rationale for this planning effort supports the fundamental principles of the OHA & DHS Strategic Plan to: 1) "provide the agencies with tools & capabilities to automate workflows, decision making & business rules, while reducing manual, paper-based processes & increasing efficiency & effectiveness" (https://teams.dhsoha.state.or.us/sites/ois/SiteCollectionDocuments/DHS_OHA%20Strategic%20Technology%20Plan%202013.pdf, p 15) : 2) "provide modular, common services & capabilities which promote agility, re-use, & capitalize on best practices leveraging enterprise capabilities" https://teams.dhsoha.state.or.us/sites/ois/SiteCollectionDocuments/DHS_OHA%20Strategic%20Technology%20Plan%202013.pdf, p 15).

Medicaid Modularity planning will facilitate search for solutions that leverage investments to avoid silos and redundant expenditures and maximize the return on investment, while improving interoperability and sustainability of technology solutions that support Medicaid service delivery.

Business Case for *OEBB & PEBB New Benefit Management System*

Oregon Health Authority, Health Policy & Analytics, OEBB/PEBB

Date: June 2018
Version: 1.0
Author: Alice Vetter

(503) 991-3825
Alice.vetter@DHSOHA.STATE.OR.US

Business Case – Authorizing Signatures

PROPOSAL NAME AND DOCUMENT VERSION #	**Business Case for OEBB & PEBB New BMS**		
AGENCY	OHA	DATE	
DIVISION	Health Policy & Analytics	DAS CONTROL #	
AGENCY CONTACT		PHONE NUMBER	

The person signing this section is attesting to reviewing and approving the business case as proposed.

This table to be completed by the submitting agency Agency Head or Designee	
(Name) Ali Hassoun	(Date)
OEBB-PEBB Interim Director	
Signature	
Agency Executive Sponsor	
(Name)	(Date)
Signature	
Agency Chief Information Officer (CIO) or Agency Technology Manager	
(Name) Kristen Duus	(Date)
DHS/OHA CIO	
Signature	
State Data Center Representative, if required by the State CIO	
(Name)	(Date)
Signature	

This Section to be completed by DAS Chief Information Office (CIO) IT Investment and Planning Section DAS CIO Analyst	
(Name)	(Date)
Signature	
State CIO	
(Name)	(Date)
Signature	

Table of Contents

Executive Summary

The Oregon Educators Benefit Board (OEBB) and Public Employees' Benefit Board (PEBB) are the divisions of the Oregon Health Authority (OHA) charged with providing certain employee benefits to educators, state, and local government employees, respectively[1]. Over 283,000 Oregonians annually use the OEBB and PEBB Benefit Management Systems (BMS) to access benefit selections and enroll in benefits during their respective open enrollment periods. Members also use the BMSs throughout the year to select benefit plans and coverage levels upon hire, or update selections in response to qualifying events.

OEBB and PEBB's current BMS were developed ten (10) and fifteen (15) years ago respectively, and have undergone continuous development and enhancements over those periods. Maintenance and operational support, as well as annual updates to support benefit enrollment is currently provided by Perspecta (formerly DXC). Due to the number of changes made to the systems since their implementation, as well as custom written code, the systems have become costly to continuously update and maintain to provide the needed functionality.

The extension through June 30, 2021 of the existing Maintenance and Operation (M&O)/enhancements contract with Perspecta secured continued stability and support of the systems while alternatives could be assessed. OEBB and PEBB can now turn their focus to the long-term goal of replacing the existing systems with a robust, centralized, sustainable, and scalable benefits management solution, supporting the unified PEBB and OEBB business practice.

OEBB and PEBB are evaluating a longer-term strategy for a BMS replacement solution through the following objectives:

- Conduct preliminary market research – identify potential Benefits Management Solutions options and assess whether COTS, SaaS, Transfer System, or other alternatives provide the capabilities needed by OEBB and PEBB in administration of benefits.
- Evaluate the impact of State legislation – in the 2017 legislative session, Senate Bill 1067 directed OEBB and PEBB to merge administrative functions effective immediately; OEBB and PEBB are determining how the merger will inform future OEBB and PEBB benefits management contracts, and potential Request for Proposals (RFPs).
- Determine funding needs – the agency must assess the budget required to support planning and implementation of a new solution supporting benefits management and enrollment for PEBB and OEBB (including resources required), determine the source of funding, and secure such funding for the duration of the project.
- Issue a competitive solicitation (RFP) – the solicitation will be inclusive of fully detailed technical documentation of the solution (including any enhancements over the life of the contract), comprehensive Business Continuity/Disaster Recovery planning and services, and will consider the capabilities available in best-of-breed benefits management solutions. The outcome of this process will provide a secure foundation to procure and implement a new BMS solution, and resources to support implementation and ongoing maintenance and operations.

[1] See ORS 243.135 and 243.866

Purpose and Background

Purpose

OHA's Health Policy and Analytics (HP&A) Division is submitting this Business Case on behalf of its OEBB and PEBB programs in support of comprehensive planning analysis, for the purpose of developing a request for proposal (RFP) for a benefit management system replacement project. The system project would be jointly administered by both programs.

Background

OEBB and PEBB are the divisions of OHA charged with providing certain employee benefits to educators, state, and local government employees, and handle benefits administration for these members through separate benefits management solutions. OEBB and PEBB incorporate utility-like fees for members and entities/agencies in rates charged for benefits administration, including use of these systems - see ORS 243.061-243.302, and OAR Chapter 101 and Chapter 111. In August 2002, PEBB contracted with Saber Software, Inc. (Saber) to design, develop, and implement an integrated BMS called pebb.benefits (or PDB) for the Public Employees Benefit Board. In April 2008, OEBB contracted with Saber to design, develop, and implement an equivalent BMS called MyOEBB based upon the PBD system. These systems provide benefits selection and management for more than 283,000 Oregonians representing most state agencies and education districts. After several acquisitions and company mergers, Perspecta is now the contracted service provider of maintenance, support, and enhancements for both OEBB and PEBB's Benefit Management Systems.

OEBB and PEBB benefit management systems have been in service over ten years and are highly customized with nearly all code tailored for each program's customer based needs. Over the years, the systems have become more and more complex, resulting in an increased likelihood for security vulnerabilities, further reliance on contracted developers who are familiar with these specific systems, and increasing costs for ongoing operations and maintenance.

An analysis of the two systems and a resulting "Technical Assessment Report of the Benefit Management System" was produced in early 2015. The report notes that both systems are supported with obsolete technologies lacking significant historical documentation, and candidates for transitioning to a more modern and stable solution. The continued reliance upon the older base code and architecture of these systems further constrains OEBB/PEBB to dependence on Perspecta for technical expertise, while remaining responsible for managing the tendency for accruing technical debt inherent to a custom solution. 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.

To ensure system support stability and enable OEBB/PEBB to focus on planning for the necessary and eventual replacement of their systems, OHA has extended its existing contracts with DXC for 3.5 years until 2021, which will also end the special procurement period granted by DAS. In the 2017 legislative session, Senate Bill 1067[2] directed OEBB and PEBB to merge administrative functions and operations of the programs. The "pebb.benefits" and "MyOEBB" legacy Benefit Management Systems (BMS) are

[2] See Appendix B – Enrolled SB 1067

becoming increasingly costly and challenging to support, additional gains in efficiency which would be supported through technology automation would be difficult at best to realize. The primary goals of this business case and supporting Policy Option Package are the same: provide a modernized, centralized, standardized, supportable, and scalable solution to replace both benefit management systems for educators and public employees, with the ability to accommodate the administrative and organizational changes subsequent to SB 1067, while implementing and maintaining more rigorous security best practices.

The near and longer-term plans set forth in this Business Case align 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 expand 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 more modern solutions

Problem or Opportunity Definition

Problems

Several issues currently exist with the OEBB and PEBB BMS solutions:

Technology and Integration Issues

- Dated software code and architecture lacking proper documentation
- Lack of integration of business functions, such as financial management and dependent eligibility verification, into a single system has resulted in multiple one-off systems; this has resulted in maintaining sensitive data across multiple systems
- Contact Management System in BMS doesn't link with all OEBB and PEBB processes
- Lack of user notification capabilities

- Communications based on exports from criteria in BMS, then OEBB / PEBB staff send to OHA communications for printing and mailing (e.g. 12-month wait letters, Health Assessment reminders, etc.)
- Maintenance and enhancements performed on BMS' often result in new bugs or errors
- Applications developed using older, more difficult to support coding language

Vendor Issues

- Lack of complete, current system and technical documentation
- High rate of turnover for vendor developers and technical staff, as well as project management and account staff due to frequent organizational changes
- No provisions or enforcement mechanisms in existing vendor contracts to enforce regulations, standards, best practices, or methodologies
- Service Level Obligations do not specify penalties for vendor's failure to perform
- Business continuity and disaster recovery services not included in current contracts

Processes done outside of both OEBB and PEBB BMS

- Financial management including invoicing to entity-customers, individual subscribers, Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits administrators, and other third parties, which then OEBB and PEBB must reconcile back to carrier payments (currently handled in Microsoft Access)
- COBRA is managed by a 3rd party vendor (currently Benefit Help Solutions for OEBB and PEBB)
- Open Enrollment Plan comparisons, training and reference pricing handled in other tools
- Notifications (e.g. COBRA, reminders for those who haven't enrolled during open enrollment, and other required notices)
- Dependent eligibility verifications (e.g. birth certificates, marriage certificates, etc.); validation of eligibility currently documented in Microsoft Access
- Wellness programs owned and managed by carriers (e.g. Health Assessments, Tobacco, Diabetes, Weight Watchers, etc.)
- Appeals Process (managed using Word, Excel, Outlook, faxes, and shared drive)
- Manual entry of plans / carriers (2 OEBB), Qualified Status Changes (QSCs), rates (5 OEBB), member changes, and corrections (700+ plans entered for OEBB in 2016; PEBB 3-4 staff perform manual data entry)
- Reporting is currently performed using Business Objects which uses Crystal Reports, which must be maintained separately

Opportunities

OEBB and PEBB share the goal of implementing a centralized, standardized, supportable, and scalable solution to replace both OEBB and PEBB's systems, 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. Additionally, this presents the opportunity to accommodate the administrative and organizational changes subsequent to SB 1067, while implementing and maintaining more rigorous security best practices. The Manadatory and Value Added solution requirements identified in the Alternatives Analysis section below further detail potential gains anticipated through implementing a replacement solution.

The objective of this initial phase will be to outline a plan for system replacement including:

- Conduct preliminary market research to identify potential Benefits Management Solutions options
- Identify HP&As strategy for procuring a unified system supporting OEBB and PEBB
- Determine funding options and procurement approaches
- Issuance of an RFP to procure a replacement solution, and if needed, secure the services of a systems integrator
- Develop a written Transition Plan through partnership between OEBB/PEBB, OHA's Office of Information Services (OIS), ETS, and Perspecta

Alternatives Analysis

OEBB, PEBB, and OIS are committed to moving forward with the initiation and planning process for a new system, including prioritizing resources, documenting detailed requirements, and performing a full alternatives analysis. As the replacement of the OEBB and PEBB BMS solutions will require significant OIS and business resources, the estimates provided herein 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, OIS intends to aid OEBB and PEBB at this point of the project's concept origination phase with fully identifying functional and non-functional requirements, and detailing a comparative analysis of the alternatives. This effort will include the development of a high-level business case (this document), preliminary risk assessment, an overall project plan, and potentially initiating a Request For Information (RFI) process to support both internal and external (DAS OSCIO) approval.

Assumptions

- OEBB and PEBB resources will be dedicated for requirements gathering, initiation, and planning phases
- Funding will be available to cover the cost of continued vendor support of the systems
- OHA and DAS agree that aggressively pursuing transition to a new, sustainable replacement benefits management solution is preferable to continued reliance on the existing solutions with the current system vendor, or transitioning the maintenance and support work to a new vendor

Solution Requirements

Viable solutions should include, but are not limited to the following requirements:

Mandatory

- 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 / 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

Value Added

- Single sign-on for members to access carrier accounts
- COBRA managed as part of the integrated solution for OEBB and PEBB instead of in a third-party vendor's solution
- Wellness programs managed in integrated solution for OEBB and PEBB (e.g. Health Assessments, Tobacco, Diabetes, Weight Watchers, etc.)
- 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)

Alternatives

For this high-level business case, a detailed view of alternative solutions has not been prepared. During the planning phase, the RFI and/or RFP will uncover requirements, as well as performing a formal alternatives analysis, and initiation/planning preparations for commencing with a major project initiative.

Note: Analysis, planning, and initiation will require dedicated OEBB and PEBB staff time to aid with documenting and validating requirements.

Cost

OIS estimates a duration of 8 to 12 months to adequately cover this initial phase of project preparation prior to vendor solicitation, solution identification, implementation and transition. Detailed estimates will need to be developed to forecast the time and budget required for project execution, solution implementation, close out, and transitioning to operations & maintenance. The following high-level cost estimates have been gathered for Phase 1 Planning:

OEBB / PEBB Positions	**Duration**	**Cost**
Operations & Policy Analyst 3 position "Program Business Analyst"	12 months	$140,028
Operations & Policy Analyst 4 position "Program Project Manager"	12 months	$173,465
Estimate:		$313,493
OHA OIS Positions		
Information Services Specialist 8 "Technical Project Manager"	12 months	$157,533
Information Services Specialist 7 "Business Systems Analyst"	12 months	$147,679
Estimate:		$305,212
Professional Services		
"IT Strategic Advisor"	12 months	$375,000
Total 1st year package estimate (4 FTE + 1 Contracted Resource)		**$993,705**

This information is identified in a Policy Option Package, currently under development[3]. Funding would be through Other Funds category, provided by OEBB and PEBB Administrative Fees attached to plan premiums.

Benefits

OEBB and PEBB will 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 will also reduce duplication between programs and the use of "one-off" systems. Soliciting for a new, consolidated system will 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.

As stated in the Background section above, this initiative also aligns with the following DHS / OHA Strategic Technology Plan (STP) Initiatives:

- Business Automation
- Dynamic Needs Supported by Seamless Technology Services
- Enable Connectivity Anytime, Anywhere, in Multiple Ways
- Trusted Source for Health & Human Service Data

Risk

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 and account management 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.

[3] See anticipated costs in Appendix A (POP overview)

Though it has undergone a series of acquisitions and mergers, OEBB and PEBB have continued contracting 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, high degree of customization, and complexity of the systems, without sufficient technical or architectural documentation. It is also cumbersome and costly to transition to a new vendor to support its maintenance and operations. Special procurement authority for the current contract ends in 2021.

Conclusions and Recommendations

Conclusions

Once DAS approval is achieved, OIS resources will work in partnership with OEBB/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 will establish the foundation for a Request for Proposals (RFP) to solicit potential solution providers. Project management resources will also be identified and assigned in this timeframe, as well as other necessary project team members to support initiation.

Recommendations

The project to replace OEBB and PEBB's BMS is expected to exceed $1 million. As a result, the initiation and planning processes need to begin as soon as possible. OEBB and PEBB need prioritization of OIS resources to support the effort required for commencing with a major project initiative. Additionally, OEBB, PEBB, and OIS will continue supporting development of the POP for consideration by the 2019 legislature, which will authorize additional funding of positions to support planning, coordination, project management, and implementation.

Consequences of Failure to Act

Not prioritizing the necessary resources supporting a replacement effort means OEBB and PEBB will continue using technology that is fragmented, non-standard, difficult to support, and is not scalable. OEBB and PEBB members would be at risk for benefits interruption if a replacement system is not implemented prior to existing vendor support expiration in 2021. OEBB and PEBB's BMS are not meeting all current business needs, which have grown since their original implementations in 2008 and 2003 respectively. OEBB and PEBB both seek to have more processes integrated into a new solution that improves communication and care for all member and user experiences.

OSCIO IT Investment Form

IT Investment Name:	OEBB-PEBB BMS Replacement System	Date:	07/03/2019
Agency:	Oregon Health Authority	Division:	Health Policy & Analytics, OEBB/PEBB
Agency Contact:	Jay Torres, Sr. Project Manager, OHA/OIS	Phone Number:	503-378-2798
Approving Business Owner:	Damian Brayko, OEBB/PEBB Deputy Director	Phone Number:	503-373-0800
Approving Technology Mgr.:	Kristen Duus, Chief Information Officer, DHS/OHA	Phone Number:	503-947-5378

Approving Business Owner — Date: 8/27/19

Approving Technology Manager — Date: 8/27/2019

Information Technology Investment Type(s):

☒ New Investment ☐ Renew/Life Cycle Replacement ☐ Other:

Information Technology Investment Description (What is being proposed and why):

Background:

OEBB and PEBB are the divisions of OHA charged with providing certain employee benefits to educators, state, and local government employees, and handle benefits administration for these members through separate benefits management solutions. Over 283,000 Oregonians annually use the OEBB and PEBB Benefit Management Systems (BMS) to access benefit selections and enroll in benefits during their respective open enrollment periods. Members also use the BMSs throughout the year to select benefit plans and coverage levels upon hire, or update selections in response to qualifying events.

OEBB and PEBB's current BMS were developed ten (10) and fifteen (15) years ago respectively, and have undergone continuous development and enhancements, with almost all of the software code custom tailored for each program's customer-based needs. Consequently, the systems have become increasingly complex, resulting in an increased likelihood for security vulnerabilities, further reliance on contracted developers who are familiar with these specific systems, and increasing costs for ongoing operations and maintenance.

Systems maintenance and operational support, as well as annual updates to support benefit enrollment, are currently being provided by Perspecta (formerly DXC) under an existing Maintenance and Operation (M&O)/enhancements contract now extended through June 30, 2021.

A technical assessment conducted in 2015 notes both systems are supported with obsolete technologies, lack significant historical documentation (some of which was addressed in the subsequent 2018 study requested by OSCIO) and are therefore candidates for transitioning to a more

modern and stable solution. The continued reliance upon the older base code and architecture of these systems further constrains OEBB/PEBB to dependence on Perspecta for technical expertise, while remaining responsible for managing the tendency for accruing technical debt inherent to a custom solution.

Finally, State of Oregon procurement standards require all vendors to periodically re-bid their services in order to ensure the best possible support and pricing. Given the current system technologies and business processes are outdated/unsupported, thereby restricting the addition of new, desirable functions and processes, this opportunity to better serve our fellow Oregonians comes well timed.

Problem Identification:

Several significant issues exist with the current OEBB and PEBB BMS solutions:

Technology and Integration Issues

- Dated software code and architecture lacking proper documentation.
- Lack of integration of business functions into a single system has resulted in maintaining sensitive data across multiple one-off systems.
- Contact Management System in BMS does not link with all OEBB and PEBB processes and also lacks user notification capabilities.
- OEBB/PEBB BMS staff must first manually create and export communications material before sending it to OHA communications for printing and mailing (e.g. 12-month wait letters, Health Assessment reminders, etc.)
- Maintenance and enhancements performed on BMS' often result in new bugs or errors.
- Applications developed using older, more difficult to support coding language.

Vendor Issues

- High rate of turnover for vendor developers and technical staff, as well as project management and account staff, due to frequent organizational changes.
- Existing vendor contracts have no provisions or mechanisms to enforce regulations, standards, best practices, or methodologies.
- Service Level Agreement Obligations do not specify penalties for vendor's failure to perform.
- Current contracts do not include business continuity and disaster recovery services.

Processes done outside of both OEBB and PEBB BMS

- Financial management including invoicing to entity-customers, individual subscribers, Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits administrators, and other third parties, which then OEBB and PEBB must reconcile back to carrier payments (currently handled in Microsoft Access)
- COBRA is managed by a 3rd party vendor (currently Benefit Help Solutions for OEBB and PEBB)
- Open Enrollment Plan comparisons, training and reference pricing handled in other tools.
- Notifications (e.g. COBRA, reminders for those who haven't enrolled during open enrollment, and other required notices).
- Dependent eligibility verifications (e.g. birth certificates, marriage certificates, etc.); validation of eligibility currently documented in Microsoft Access.

- Wellness programs owned and managed by carriers (e.g. Health Assessments, Tobacco, Diabetes, Weight Watchers, etc.)
- Appeals Process (managed using Word, Excel, Outlook, faxes, and shared drive)
- Manual entry of plans / carriers (2 OEBB), Qualified Status Changes (QSCs), rates (5 OEBB), member changes, and corrections (700+ plans entered for OEBB in 2016; PEBB 3-4 staff perform manual data entry)
- Reporting (both customer-based and regulatory – i.e. ACA, IRS, etc.) is currently performed using Business Objects which uses Crystal Reports, which must be maintained separately

High-Level Business Opportunity:

OEBB and PEBB share the goal of implementing a centralized, standardized, supportable, and scalable solution to replace both OEBB and PEBB's systems. It is anticipated this shall 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. Additionally, this presents the opportunity to accommodate the administrative and organizational changes subsequent to SB 1067, while implementing and maintaining more rigorous security best practices.

Alternatives to be considered:

The assessment and recommendation of a solution will be based on current and projected operational requirements, business and technical process management, long-term support, and security, with a focus on customer services, commonality of functions, communications, training, security and overall product sustainability.

At this still early point of the project a detailed analysis of alternative solutions has not been developed. An initial baseline analysis of the present system will be conducted to properly identify areas which may lend themselves to improvement or replacement including, but not necessarily limited to, the following replacement alternatives:

- Upgrade/enhance current OEBB/PEBB systems (including consolidation of core processes and reporting methods) by current support vendor.
- Incorporation of BMS reporting and management into the current WorkDay HR platform.
- Outsourcing of operations and support to a third-party entity (e.g., IaaS, SaaS, Business Processes as a Service (BPaaS), External Service Provider/Integrator (ESP, ESI).
- Internal custom development and support of a state-funded, self-maintained software package and hardware platform (an "in-house" product).
- Development and release of a Request for Proposal (RFP) for competitive bidding by third party entities able to fulfill business, technical and sustainability requirements of the State.
- Transfer/leverage solution already being used by another public sector organization in Oregon or another state

OSCIO IT Investment Form

	Yes	No
1) Is the investment a project?	☒	☐
2) Will the investment have a Project Manager?	☒	☐
3) Will the investment include other agencies?	☒	☐
4) Will the investment include Information Asset Classification Level 3 or 4 data? (see DAS Policy 107-004-050)	☒	☐
5) Will the investment be for Cloud Services (as defined in Policy #107-004-150)	☒	☐

IT Investment Estimated Cost Summary

Hardware:	**$0**	**Software:**	**$6,300,000**
Services/Maintenance (projected over five years):	**$14,500,000**	**Personnel (Project) Adjusted for five years:**	**$4,500,000**
Source of Funding:	Other Funds	**Deadline for fund use:**	07/2021
Anticipated Start Date:	07/2019	**Anticipated End Date:**	07/2024
		TOTAL:	**$25,300,000**

NOTES:

1 - The initially approved POP amount of $1,993,396 by the legislature allows for work to be completed through the project planning phase. An added POP request will be made in CY2020 to obtain funding for the 21-23 biennium to enable final delivery.

2 – Personnel costs are based on 5 FTE project resources (2 each Project Managers and Business Analysts) from OIS and the business) plus a Strategic Advisor. Additionally, another 7 SMEs will be assigned as project resources with 10% each of their work time allocated to the project.

3 - Maintenance costs reflect anticipated 20% reduced expenses for the five-year period following implementation and delivery of the new system, on the assumption that the new system will replace some manual processes, newer technology is less expensive to maintain, and one system is cheaper to maintain than two. (Cost estimates based on costs for O&M related activity for the current systems).

Provider Time Capture (PTC)
Project Reboot
Business Case

DHS/OHA
APD and HSD

Date: 7/22/19
Version: v1.3
Author: Shannan Chaney

Authorizing Signatures

PROPOSAL NAME AND DOCUMENT VERSION #			
AGENCY		DATE	
DIVISION		DAS CONTROL #	
AGENCY CONTACT		PHONE NUMBER	

The persons signing below are attesting to reviewing and approving the business case as proposed.

This table to be completed by the submitting agency Agency Head or Designee	
Ashley Carson-Cottingham	Date
Signature	
Agency Executive Sponsor	
Mike McCormick	Date
Signature	
Project Director	
Brandon Crews	Date
Signature	
CIO for OHA/DHS	
Kristen Duus	Date
Signature	

This Section to be completed by DAS Chief Information Office (CIO) IT Investment and Planning Section DAS CIO Analyst	
Shelly Lofgren	Date
Signature	
State CIO	
Terrence Woods	Date
Signature	

Table of Contents

Purpose

The primary need for the Provider Time Capture (PTC) Project is to meet the Electronic Visit Verification (EVV) requirements of the 21st Century CURES Act. The CURES act was designed to improve the quality of care provided to individuals through furthered research, enhanced quality control, and strengthened mental health parity. The following data elements are required to be captured electronically at the time of service: Date of Service, Person Providing the Service, Person Receiving the Service, Time the Service Begins and Ends, Location of Service, and Type of Service Performed.

This document will help establish the scope of the project and contains an analysis of available options including the associated benefits and risks to identify a viable solution for a successful outcome. In addition, the solution will ensure continuity of care for critical community services provided to individuals and their families by Homecare Workers (HCWs) and Personal Support Workers (PSWs).

***See Appendix A for Acronym List.*

Background

The Department of Human Services (DHS) and the Oregon Health Authority (OHA) programs utilize approximately 24,000 HCWs and PSWs to provide in-home care for approximately 19,000 individuals across Oregon. DHS and OHA have documentation requirements which apply to HCWs/PSWs who provide personal care assistance to older adults and people with disabilities. As of October 2013, the Fair Labor Standards Act (FLSA) required the records to include certain identifying information about the HCW/PSW and data about the hours worked. The law requires individuals and service providers attest services rendered are accurate. Due to the compliance deadline of January 2016 set by the Department of Labor (DOL), the State completed the implementation of a short-term solution to pay providers for time worked for Aging and People with Disabilities (APD) and Health Systems Division (HSD) in the Client Employed Provider (CEP) system using a paper process for services beginning October 2015. The Office of Developmental Disabilities Services (ODDS) instituted upgrades to their current Express Payroll Reporting System (eXPRS) platform to meet their needs. The State then completed the cross-system payroll components (overtime and travel time) by the end of October 2016.

For APD and HSD, these records are being captured through manual processes. Paper timesheets are completed by HCWs/PSWs, and the data is entered manually into State systems by employees at State field offices and Type A and Type B Area Agency on Aging (AAA) offices. These manual processes are time intensive. In June 2015, the PTC Project was authorized to continue with the Request for Proposal (RFP) process for the long-term solution for APD, ODDS, and HSD. In November 2015, the RFP was posted for responses due by January 2016. Public Partnerships, LLC (PPL) was selected as the solution vendor for the project. In November 2016, stakeholders from across DHS and OHA gathered with PPL to discuss the possibility of combining the Financial Management Agent Services (FMAS) component with time capture. It was thought at the time the work to align the programs and modernize the approach taken would be more readily achievable. In conjunction with this, ODDS began using PPL for their FMAS needs in January 2017. The RFP outlined the desire for a provider payment option as an added value to the State. This was a direct need identified as a component of moving the State forward in the maturity models as defined by Centers for Medicare and Medicaid Services (CMS). The goal is to provide data that is timely, accurate, usable, and easily accessible to support analysis and decision making for healthcare management and program administration.

In mid-2017, ODDS officially withdrew participation in the design efforts of the PTC Project and have begun work on an enhancement for eXPRS to meet the EVV requirements. One of the key drivers for ODDS joining the project initially was the mobile application offered by PPL. Over time as the required system, policy, and

resourcing concerns were uncovered, using the same solution proved to be too significant a hurdle for ODDS. In November 2017, Stage Gate 3 was rescinded due to significant scope change and the continued struggles with PPL. Amendment 2 was executed in June 2018, to bring the State and PPL to an agreement to move forward based on the changes to the project scope from November 2017.

Due to delays, previously allocated technical resources from the Office of Information Services Solution Development and Delivery (OIS SDD) had been reassigned to the higher-priority Integrated Eligibility (IE) Project. In February 2018, OIS management notified Mike McCormick, the PTC Project Sponsor, that technical resources would not be available to the PTC Project until April 2019. This timing was contingent on the IE Project remaining on schedule, which has been extended by multiple months. The lack of dedicated technical resources caused a delay in progress on development tasks. This caused an additional complication with PTC Project scope, cost, and schedule.

The PTC Project reached a stage in which a re-evaluation of the project scope was necessary. The PTC Project Team worked closely with APD and HSD business and leadership, as well as OIS Project Solutions and OIS SDD, to create options to continue work on the project. Many options were considered, and it was decided to pursue an expanded scope to include FMAS with PPL in April 2018.

As the FMAS option was explored, PPL was presented with updated requirements to review for a cost proposal. PPL's cost proposal to include FMAS amounted to a 236% increase in the five-year cost. The PPL leadership changes and PPL's lack of knowledge of the out of box solution made it difficult for the PTC Project to understand configuration verses customization, which increased the risk in continuing the contract further. In January 2019, it was determined the cost increase was not in alignment with our responsibility around fiscal stewardship and it was decided to expire the contract via Amendment 3 with PPL and explore other options. As the Project continues to explore other options as it relates to EVV, Mike McCormick remains the PTC Project Sponsor supporting APD and HSD programs.

Estimated Project Expenditures

In the third quarter of 2016, the PTC Project began contracted work with the Design, Development, and Implementation (DDI) vendor. As of the Advanced Planning Document Update (APDU) in October 2018, the total CMS approved budget for the PTC Project was $9,569,050. As of May 2019, the cumulative budget spent for the PTC Project was $7,048,075. This included $3,407,622 for State staffing costs plus $3,640,453 for IT Vendor Services, which includes PPL and NTT DATA State Health Consulting, LLC (formerly Cognosante Consulting, LLC). Below are the breakdown tables for reference.

The below projections were compiled by federal fiscal year, based on a SaaS solution, and a completion date of September 30, 2021.

Project Expenditures	Total FFY19*	Total FFY20	Total FFY21	Total
State Staffing / Personal Services 90/10	226,909	1,755,101	2,894,015	**4,876,025**
Cost Allocation on Personal Services 90/10	6,123	263,265	421,862	**691,250**
IT Contractors - Professional Services 90/10	57,475	3,449,061	3,449,064	**6,955,600**
HW/SW Initial Purchase 90/10	0	548,208	548,208	**1,096,416**
Projected Yearly Spend	**290,507**	**6,015,635**	**7,313,149**	**13,619,291**

*This accounts for the remainder of FFY 2019, June – September

The total projected cost for Operations and Maintenance staffing and licensing for three years is $4,684,349. The breakdown of these costs is located in the Alternative Analysis section, under Option 6 – SaaS.
Below is the table for the total projected project expenditures:

Total Cost of Ownership for Five Years	
Cumulative Budget Spent to Date	$ 7,048,075.00
Budget Forecast through September 2021	$ 13,619,291.00
Three Year Operations and Maintenance Costs	$ 4,684,349.00
Total	**$ 25,351,715.00**

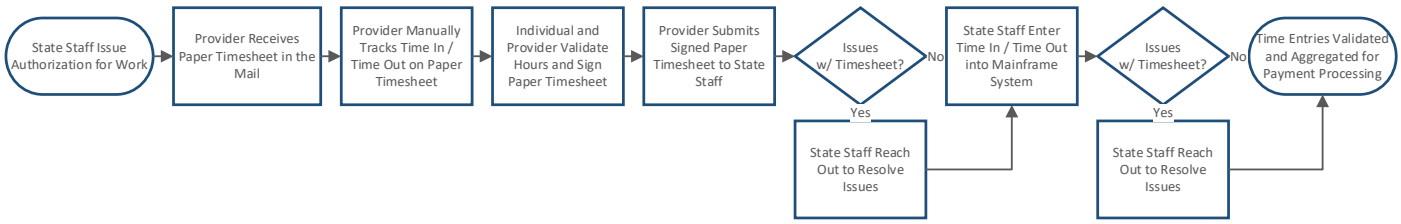
CMS has advised only one EVV solution will be funded per state, which has potential cost impacts and requires an inclusive solution. The Project is aware the APDU will need to go to CMS for review and approval for any updated costs. CMS will also be required to review any RFP or DDI contract.

**See Appendix B for the May 2019 Budget Update for more detailed information.

Current State Process

Currently, State Staff issue an authorization for the Provider to work for a specified Individual. HCWs/PSWs are then mailed a paper timesheet for a two-week service period. As they work, they are required to physically write the date, their time in, and their time out for each shift on the timesheet. A signature from the Individual or their representative is necessary when work has been completed to validate services were performed for the two-week period. The signed timesheet is then submitted to State Staff for additional verification to identify any issues i.e., start and end dates are filled out and legible, the timesheet is signed by the HCW and individual, etc. If there are no issues identified, State Staff enter the date, the time in, and the time out into the mainframe system for each shift the Provider reports. If State Staff identify any issues, they contact the Case Manager, Individual, or Provider to resolve the issues prior to entering the data. The time entries entered into the mainframe are run through additional system validations and aggregated for payment processing. If any issues are identified with the additional system validations, State Staff resolve these issues prior to the system aggregating the data for payment processing. The mainframe captures the Date of Service, Person Providing the Service, Person Receiving the Service, Time the Service Begins and Ends, and Type of Service Performed, but doesn't capture the Location of the Service. The mainframe system currently does not have the ability to capture these data elements in a real-time manner which is required for EVV.

See below for high-level current state process flow:

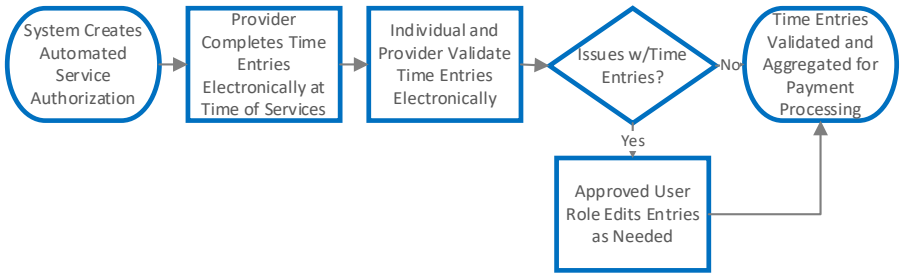


**See Appendix C for comprehensive Current State Process Flows.*

Future State Process

In the ideal future state, HCWs/PSWs will complete the enrollment process to receive an automated service authorization. HCWs/PSWs will electronically capture the required EVV data elements at time of service (Date of Service, Person Providing the Service, Person Receiving the Service, Time the Service Begins and Ends, Location of Service, and Type of Service Performed). If HCWs/PSWs are traveling directly from one individual to another to perform applicable services, departure and arrival time between individuals will be captured electronically. HCWs/PSWs will validate time entries and fix any issues they identify. The Individual or their representative will then validate entries to ensure services were performed as indicated on the timesheet. Specific user roles will have the ability to edit time entries as needed. Once time entries are validated, they will be aggregated for payment processing.

See below for high-level future state process flow:



***See Appendix D for comprehensive Future State Process Flow.*

EVV Solutions in Other States

After researching other state solutions, it was determined the most commonly used solution is Santrax by Sandata. According to the available data, 19 states are still in process of determining the solution or the information was unavailable. Based on the data compiled, most states with solutions identified have selected single vendor solutions. With many states already EVV compliant and more states in the implementation phase, the State has a lot of accessible information to draw from to make our solution work for our stakeholders.

***See Appendix E for detailed information on Alternative Analysis Out of State Solutions.*

Problem Examples

The implementation of the short-term solution to meet the FLSA requirements created a workload which was not accounted for in any workload model by DHS. The current manual process of State Staff keying information into the system from a paper timesheet is very time intensive and causes replication of existing data. Timesheets are stored locally, often in paper and electronic format, as well as being stored in the mainframe system. Additionally, this increases the risk of data entry errors which can result in inaccurate payments to providers. State Staff spend a significant amount of time communicating back and forth with providers due to timesheets being filled out incorrectly or time entries not being legible. This can potentially delay payments to providers. An estimated 70 full-time employees (FTEs) spend their time dedicated to manually entering provider time in and time out from a paper timesheet submitted by the HCWs/PSWs.

FMAS has been a topic throughout the life of the project and reflects the long-term vision of APD and HSD. The decision was made not to include FMAS in the initial phase of the project. With the exclusion of FMAS in the initial phase, there will still be a need to process payroll and claims through legacy systems. The Office of Financial Services (OFS) recommends claims processing stay in legacy systems to interface with Accounting Interface (AI) and State Financial Management Application (SFMA) for funding and reporting to CMS.

Opportunity Examples

Section 1903(l)(5)(A) of the 21st Century CURES Act provides that the system must be able to electronically verify, with respect to visits conducted as part of personal care services, the following:

1) the type of service performed;
2) the individual receiving the service;
3) the date of the service;
4) the location of service delivery;
5) the individual providing the service; and
6) the time the service begins and ends

Section 1903(l)(2) also requires states to provide a stakeholder process to allow input into the state's implementation of the EVV requirement from providers of Personal Care Services (PCS) and home health services, beneficiaries, family caregivers, and other stakeholders.

An EVV solution must be in place for personal care services starting January 1, 2020. If a state demonstrates to the Secretary that: (1) that the state has made a good faith effort to comply with the EVV requirements (including taking steps to adopt the technology used for an electronic visit verification system); and (2) that the state, in implementing such a system, has encountered unavoidable system delays, then the FMAP reductions shall not apply for calendar quarters in 2020 (for personal care services).

Compliance with the 21st Century CURES Act within the required implementation timeline will allow the State to avoid penalties. The good faith effort exception will allow for a January 1, 2021 implementation due date. The resulting penalties for non-compliance include a reduction of Federal Medical Assistance Percentages (FMAP) for Consumer-Based Care and In-Home Care expenditures beginning with a 0.25% on January 1, 2021. The percentage will increase to 0.50% by 2022, 0.75% by 2023, and 1% from 2024 going forward. See *'Option 10 - Cost of Doing Nothing'* in the *'Alternative Analysis'* section for cost estimates.

Being compliant with the 21st Century CURES act gives the State the opportunity to remove a significant burden from Providers, Field Staff, and System Teams. The savings in staff time will allow those staff to take on other responsibilities and allow case managers more time for person-centered planning and engagement.
It will also help improve the safety and security of vulnerable Oregonians by ensuring services are actually provided to the individual through monitoring location and real-time activity. By moving away from a manual process, it will save staff time and decrease the risk of data entry errors and erroneous payments to providers.

Lessons Learned Evaluation

The State requested the Quality Assurance (QA) vendor, Cognosante, prepare a Lessons Learned report to document project successes, challenges, and recommendations through collaborative information gathering sessions. This information will be used to identify areas of reinforcement and areas where mitigations are needed as the project reboots. The results of these sessions are comprehensive of the early stages of the project until the contract was expired with PPL.

***See Appendix F for Lessons Learned Report with mitigations added addressing recommendations.*

Goals, Objectives, and Measurements

Below is the list of Goals, Objectives, and Measurements (GOM) for the PTC Project, formulated utilizing the PTC Project Guiding Principles. The PTC Project Guiding Principles were drafted collaboratively and approved by APD and HSD program leadership, OIS management, and other impacted stakeholders.

Goals	Objectives	Baseline Measurements	Post Go-Live Measurement	Means and Frequency of Measurement (Report, Survey, Time Study, Process Mapping)
Goal #1: Comply with Federal requirements, including 21st Century Cures Act.	1.1 **Objective:** Establish use of Electronic Visit Verification (EVV) compliant recording mechanism(s).	N/A	Percentage of provider compliance.	Report – 30- and 90-days post pilot and statewide.
	1.2 **Objective:** Establish electronic approval of time entries by individuals.	N/A	Percentage of electronic approvals.	Report – 30- and 90-days post pilot and statewide.
	1.3 **Objective:** Capture the six required data elements for Electronic Visit Verification (EVV).	N/A	Percentage of data elements captured electronically.	Report – 30- and 90-days post pilot and statewide.
Goal #2: Improve program integrity.	2.1 **Objective:** Decrease number of time entry/reporting errors.	Total number of adjustments to paid claims both positive and negative 30 days prior to pilot for two pay cycles.	Compare total number of adjustments in the adjustments queue for reduction in errors.	Report – 30 days prior to pilot, and 45 days post pilot and statewide (adjustment reason codes used in post go-live reports).
	2.2 **Objective:** Decrease number of over/under payments.	Total number of over/under payments reported 30 days prior to pilot for two pay cycles.	Total number of timesheet adjustments in the adjustments queue that result in a change in pay.	Report – 30 days prior to pilot, and 45 days post pilot and statewide out of legacy system.

Goals	Objectives	Baseline Measurements	Post Go-Live Measurement	Means and Frequency of Measurement (Report, Survey, Time Study, Process Mapping)
	2.3 **Objective:** Decrease number of incidents of potential fraud.	Total number of potential incidents of fraud reported 30 days prior to pilot for the previous 6 months.	Total number of potential incidents of fraud reported post pilot and statewide.	Report – via Fraud Unit every 30 days prior and post pilot, through 90 days post statewide.
	2.4 **Objective:** Decrease number of errors in reporting travel time.	Total number of adjustments to paid claims positive or negative 30 days prior to pilot for two pay cycles.	Total number of adjustments in the adjustments queue post pilot and statewide.	Report – 30 days prior to pilot, and 45 days post pilot and statewide (adjustment reason codes used in post go-live reports).
	2.5 **Objective:** Increase reporting traceability processes and capabilities.	Record time between process steps pre-pilot.	Record time between process steps post-pilot.	Process Mapping – compare baseline durations with those 30 days post pilot.
Goal #3: Decrease workload on identified impacted groups.	3.1 **Objective:** Decrease workload for Voucher Clerks (Field Offices) and Provider Relations Unit (PRU) (Central Office) in voucher issuance and reprint processes.	Determine current workload for Voucher Clerks (Survey), and for PRU Staff (Time Study).	Establish workload for Voucher Clerks and PRU Staff 90 days post pilot and statewide.	Survey – send 90 days prior to pilot with 60-day deadline. Time Study – conduct visits 60 days prior to pilot, and 90 days post pilot and statewide.
	3.2 **Objective:** Decrease workload for Travel Time Clerks (Field Offices) and PRU staff in processing travel time.	Determine current workload for Travel Time Clerks (Survey), and for PRU Staff (Time Study).	Establish workload for Travel Time Clerks and PRU Staff 90 days post pilot and statewide.	Survey – send 90 days prior to pilot with 60-day deadline. Time Study – conduct visits 60 days prior to pilot, and 90 days post pilot and statewide.

Goals	Objectives	Baseline Measurements	Post Go-Live Measurement	Means and Frequency of Measurement (Report, Survey, Time Study, Process Mapping)
	3.3 **Objective:** Decrease workload for field staff in time entry and correction processes (time entry corrections and over/under adjustments).	Determine current workload for Field Staff (Survey), and PRU Staff (Time Study).	Establish workload for Field and PRU Staff post pilot and statewide.	Survey – send 90 days prior to pilot with 60-day deadline. Time Study – conduct visits 60 days prior to pilot, and 90 days post pilot and statewide.
	3.4 **Objective:** Decrease workload for staff in the payment correction processes (adjustments, exceptions, and corrections). (PRU and ITBS)	Determine current workload for staff to process all payment corrections via baseline from Objectives 2.1, 2.2, and 2.4.	Establish workload for staff post pilot and statewide via measurement from Objectives 2.1, 2.2, and 2.4.	Report – 30 days prior to pilot, and 45 days post pilot and statewide. Survey – send 90 days prior to pilot with 60-day deadline. Time Study – conduct visits 60 days prior to pilot, and 90 days post pilot and statewide.
	3.5 **Objective:** Decrease workload for providers in submitting time worked.	Determine current workload for providers.	Establish workload for providers post pilot.	Survey – send 90 days prior to pilot with 60-day deadline, and 30 days post pilot.
	3.6 **Objective:** Decrease workload for individuals in approving time entries.	Determine current workload for individuals.	Establish workload for individuals post pilot.	Survey – send 90 days prior to pilot with 60-day deadline, and 30 days post pilot.

Goals	Objectives	Baseline Measurements	Post Go-Live Measurement	Means and Frequency of Measurement (Report, Survey, Time Study, Process Mapping)
	*3.7 **Objective:** Decrease workload for staff in collecting, updating, and issuing payroll related documentation (W-2, W-4, DD, etc.).	Determine current workload for State Staff.	Establish workload for State Staff post pilot.	Time Study – conduct visits 60 days prior to pilot, and 90 days post pilot and statewide.
	*3.8 **Objective:** Decrease workload for staff in garnishment and recoupment processes.	Determine current workload for State Staff.	Establish workload for State Staff post pilot.	Time Study – conduct visits 60 days prior to pilot, and 90 days post pilot and statewide.
Goal #4: Decrease processes within legacy systems functions and/or data.	4.1 **Objective:** Decrease number of functions performed by the existing state systems in the time entry, calculation, and payment processes.	Determine current workload 30 days prior to pilot.	Establish workload post pilot.	Survey – send 90 days prior to pilot with 60-day deadline, and 30 days post pilot.
	4.2 **Objective:** Decrease number of validations performed by the existing state systems in the time entry, calculation, and payment processes.	Determine current workload 30 days prior to pilot.	Determine workload post pilot.	Survey – send 90 days prior to pilot with 60-day deadline, and 30 days post pilot.
	4.3 **Objective:** Decrease number of business processes that require legacy systems.	Determine current workload 30 days prior to pilot.	Determine workload post pilot.	Survey – send 90 days prior to pilot with 60-day deadline, and 30 days post pilot.
Goal #5: Reduce costs associated with manual processes.	5.1 **Objective:** Decrease paper voucher storage costs and physical location needs.	Determine storage costs and location needs at pre-determined go-live locations 30 days prior to pilot.	Establish storage costs and location needs at pre-determined go-live locations 30 post pilot.	Survey – send 90 days prior to pilot with 60-day deadline, and 30 days post pilot.

Goals	Objectives	Baseline Measurements	Post Go-Live Measurement	Means and Frequency of Measurement (Report, Survey, Time Study, Process Mapping)
	5.2 **Objective:** Decrease number of time entry claims that are paid solely out of the General Fund.	Determine provider payments that are paid out of General Fund 30 days prior to pilot for 90 days data timeframes.	Establish provider payments that are paid out of the general fund post pilot.	Report – 30 days prior to pilot, and 90 days post pilot and statewide (determine average for 90-day data timeframes).
	5.3 **Objective:** Decrease printing and mailing costs for printed paper vouchers.	Determine printing and mailing costs for vouchers 30 days prior to pilot.	Establish printing and mailing costs for vouchers post pilot.	Report – 30 days prior to pilot, and 90 days post statewide (compare previous voucher costs and mailing of Welcome packets and paper timesheets).
	5.4 **Objective:** Decrease Mainframe processing and storage costs.	Determine processing and storage costs.	Establish processing and storage costs post pilot.	Report – 30 days prior to pilot, and 90 days post pilot and statewide.
Goal #6: Maximize user adoption through identified, organized, and prioritized change management, communications, and trainings.	6.1 **Objective:** Decrease stakeholder barriers to adoption.	Gather barriers as well as communication or training needs to tailor outreach efforts to best meet the stakeholders' needs.	User experience survey results.	Survey – Collect barriers to adoption 90 days prior to pilot; satisfaction survey 90 days post pilot and statewide.
	6.2 **Objective:** Increased accessibility for successful time entry and approval.	N/A	User experience survey results.	Survey – send 90 days prior to pilot with 60-day deadline, and 30 days post pilot.
	6.3 **Objective:** Ensure stakeholders rely on appropriate resources for project information updates.	N/A	User experience survey results.	Survey – send 90 days prior to pilot with 60-day deadline, and 30 days post pilot.

Goals	Objectives	Baseline Measurements	Post Go-Live Measurement	Means and Frequency of Measurement (Report, Survey, Time Study, Process Mapping)
	6.4 **Objective:** Increase user satisfaction for all impacted groups.	N/A	User experience survey results.	Survey – send 90 days prior to pilot with 60-day deadline, and 30 days post pilot.
Goal #7: Ensure system and processes are clear and understandable for identified impact groups (Individuals, Providers, and Staff)	7.1 **Objective:** Increase number of readily accessible training materials and online documentation.	Determine current training materials available.	User experience survey results.	Survey – send 90 days prior to pilot with 60-day deadline, and 30 days post pilot.
	7.2 **Objective:** Decrease time for staff in describing/explaining the time entry and approval processes.	Determine time needs for staff in describing /explaining the time entry and approval process.	Establish time needs for staff in describing /explaining the time entry and approval process.	Survey – send 90 days prior to pilot with 60-day deadline, and 30 days post pilot.

**These objectives are related to payroll and may be considered in the future projects.*

Functional Alignment and Scope Information

The Project conducted research to determine what would be involved for functional alignment, as some of the programs have the same need to meet EVV requirements. The aging technology systems and the business processes they support have been siloed and customized within programs and counties, limiting access to and preventing the sharing of key data. Processes have evolved from exclusively paper-based processes to a mix of paper and technology, enhanced occasionally as technology changes have been available and policy requirements have dictated. Research included the solutions APD in-home agencies are utilizing for EVV requirements and whether they are meeting the requirements. The results of this research are outlined below.

1. **Functional Alignment -** The Project met with APD, HSD, ODDS, SSP, and OHA to see where there could be alignment between all the programs for appropriate Medicaid populations.

    a. APD In-Home Agencies are required to become EVV compliant by January 1, 2020. The Project did research and determined that 61% of in-home agencies in Oregon reported being EVV compliant, with the most commonly applied solutions to meet requirements being ClearCare and Generations (which support the needs of larger agencies). Both ClearCare and Generations have EVV compliant options via a mobile application and telephony system, with extensive training, self-help features, and tutorials available on their website. End users have reported positive experiences and the systems include nice to have features like care notes and real-time messages and notifications to users. Needs of in-home agencies may be different than the needs of the State but the State has a responsibility to aggregate this data for reporting.

***See Appendix G for more detailed In-Home Agency EVV Information.*

b. Office of Developmental Disabilities Services (ODDS) is currently planning a redesign of eXPRS with their stakeholder groups to align with their strategic vision. ODDS provides services to the developmental disabilities population and shares the same needs as APD and HSD for meeting EVV requirements. Currently ODDS issues yearly authorizations for the individuals/authorized representatives to manage the hours the providers can work. ODDS serves approximately 12,000 individuals (which includes both children and adults) in their homes with PSWs providing the care. The PSWs are enrolled in the eXPRS system. They also enter their time in and time out in the eXPRS system and once time is entered for the pay period, they print the timesheet and the individuals sign for approval. ODDS issues hours and rate to an FMAS vendor for payment and tax calculations for their PSWs. APD, HSD, and ODDS programs are not in alignment for policy/program and ODDS is in the process of separating out Oregon Administrative Rules (OAR) which could potentially divide the programs even more. In the early planning of the project, the goal was to align policy/program between the programs, but it was determined this was not achievable due differing policies/programs.

c. Self Sufficiency Program (SSP) may have time capture needs for their Temporary Assistance for Needy Families (TANF) and Employment-Related Day Care (ERDC) programs. The Project gathered information on the SSP population to identify if these programs have time capture needs. The SSP programs TANF and ERDC may be interested in integrating with an EVV solution in the long-term. TANF is interested in tracking the attendance of participants in the Job Opportunity and Basic Skills (JOBS) program receiving funding through the TANF block grant. SSP is interested in the tracking of day care recipients paid by SSP on behalf of the Individual enrolled in the ERDC program. SSP is working on the IE Project and will be maintaining legacy systems upon the completion of IE to support these populations.

   ERDC previously attempted a project called Child Care Billing and Attendance Tracking (CCBAT) which was designed around capturing attendance and authorizations. This project did not successfully roll out, and SSP may be interested in rolling the EVV project into this. In 2017, ERDC funding was reduced by $9.3 million due to a reduction in federal funds while serving 16,323 children across 8,658 cases. As of October 2017, there were 1,691 licensed child care providers actively providing child care across the state for DHS families.

   TANF works with recipients to identify a path to self-reliance. TANF has tools that may need to be integrated into the system, including a data tracking tool used to track family progression. TANF, combined with Pre-Supplemental Security Income (Pre-SSI) and Social Security Disability Insurance (SSDI) programs, served 21,664 families, including 38,821 children and 18,571 adults in 2018. Most parents/caretakers in TANF are required to participate in the JOBS program, which requires them to attend education and training opportunities. Currently, there are no active efforts to automate the attendance on either the TANF, JOBS, or ERDC programs.

d. OHA 1915i and Home Health Services (HHS) programs are currently outside of scope for PTC. OHA is interested in integrating into an EVV solution with APD and HSD. Currently, the 1915i program serves 400 individuals and the providers that serve these individuals are a variety of mental health and peer support specialists. They are currently enrolled and managed in the

Medicaid Management Information System (MMIS). Billing is through Prior Authorizations (PA) and has a set rate per hourly unit authorized. The providers submit units through MMIS for reimbursement. There are validations in place that check all eligibility and won't allow billing over the PA. These providers are 1099 contractors.

There are 40 provider agencies (nursing, physical therapy, occupational therapy, medical supplies, durable medical equipment, etc.) for Home Health Services (HHS). These providers are prior authorized through plan of care (fee-for-service). They bill at an agency level through revenue codes. The revenue codes used to bill home health services can be found at the following link: https://www.oregon.gov/oha/HSD/OHP/Tools/Home%20Health%20Rates%20-%20January%201,%202019.pdf. Time in and time out is captured by the agencies but not provided to OHA. The location is assumed as the Individual's home but is not actively captured.

e. IE (Deloitte) was in review for a potential EVV solution. There was consideration and research done into the option of either pursuing integration/enhancement to IE or utilizing the master services agreement with Deloitte. Deloitte does offer a module for time capture, but it was determined to be out of scope of the special procurement for IE. Department of Administrative Services (DAS) Procurement Services advised the type and level of work required to complete the project was not supported under the master services agreement. At this time, any procurement that might benefit the State to align with existing technologies and vendors would have to be managed through a separate procurement process.

f. Workday has experienced ongoing delays with the implementation including work on phase two. Workday is continuing to clarify what will be in/out of scope for the time capture and payroll solution and how/what options exist for differing needs. Based on the information received, planning efforts are still being researched for the scope, and the goal is to do the State payroll system before involving other partners.

g. MMIS Modularity Project is in the process of hiring a planning vendor to assist with modularization of MMIS. This may suggest any EVV related module would be later in the 10-year plan of modularization of MMIS.

2. **COTS Basic + COTS Plus Customization (Galaxux) -** There is not a COTS specific solution for scoring. The Project has updated the COTS information from Galaxux.

   ***See Appendix H for more detailed information on COTS Basic + COTS Plus Customization.*

Solution Requirements

The solution requirements are organized into the following categories:

- **Business Rules** - Describes the specifics about each rule for validating time entries, authorizations (service matrix), and relationships for Individual/Provider.

- **Data Management** - Describes EVV components such as how time and location are captured including travel time.

- **Data Processing** - Describes the specifics about how time entries and adjustments are processed (what triggers are for adjustments) and determines what will happen with failed validations.

- **Security and Privacy** – Describes user role-based security (detail on each role and what access they have), user profiles, and any privacy rules.

- **User Experience** - Describes what users (Individuals, Providers, State Staff, etc.) will see and related functionality. Also, describes performance, languages, accessibility, etc.

- **Reporting** - Describes basic and detailed reporting functionality including custom reports.

- ****Payroll** - Describes the payroll process i.e., taxes, union dues, garnishments, quarterly and yearly reporting, etc. Also describes the rules and flow for calculating overtime.

The requirements are prioritized by Critical, High, Medium, and Low. The goal of the critical requirements is to set the minimally viable product for initial release. High, medium, and low requirements will be used for planning future releases depending on the status of the project. Please see below for the definitions.

- **Critical** - "Shall"- Critical Impact - required to achieve strategic outcomes.
- **High** - "Should"- Considerable Impact - highly recommended but not required.
- **Medium** - "Could"- Some Impact - preferred but not required.
- **Low**- "Would" - Low Impact - considered for future enhancement.

***See Appendix I for comprehensive Project Requirements.*

***See Appendix J for Payroll Requirements (for reference for future projects)*

Project Assumptions

The following are project assumptions:

- The agreed upon option will continue to support the final rule set forth by DOL in the FSLA to Domestic Service, 78 FR 60454 (Oct. 1, 2013).
- The agreed upon option will ensure compliance with the 21st Century CURES Act.
- Federal and State funding will be made available as needed for the life of the project.
- Key project members will possess the skills needed to complete project tasks as assigned.
- Planning activities will be based on the availability of expected resources (Technical, Business, SME's and Stakeholders)
- There will be an increase in required resources for security administration and management for internal and external users.
- The level of risk between alternatives is not equal, but an average risk score was the most objective way to compare alternatives.
- Through real-time tracking, it will help improve the safety and security of vulnerable individuals by ensuring services are being provided and give the State a better understanding of individuals who may be at risk of not receiving their services.
- Claims processing will remain in existing legacy system to ensure correct funding allocation.
- Through the life of the project there will continue to be IE related policy and code freeze processes the project will need to accommodate in schedule planning.

- The IE Project will continue to be the priority project above PTC.

Alternative Analysis Options

Below are the alternative options the Project Team researched for mobile application and web functionality to determine which would be viable options for the project to move forward. See below for high level summary of each option:

1. **In-House Build**
    - A front end to CEP for time capture capability meeting EVV requirements.

2. **eXPRS Time Entry option**
    - APD and HSD to transition to eXPRS for all time capture related needs and pass the information to the mainframe for processing.

3. **All in-eXPRS Mobile-EVV with Mainframe**
    - APD and HSD to transition to eXPRS for all time capture related needs as well as inclusion of FMAS.

4. **All in-eXPRS Mobile-EVV without Mainframe**
    - APD and HSD to transition to eXPRS for all (policy/rules/business process/system) needs.

5. **MMIS Current Contract**
    - Utilizing the current MMIS vendor and contract to support an EVV solution.

6. **SaaS**
    - Utilizing SaaS would eliminate the need to install new servers and software at the State Data Center and data would be stored with the vendor solution.

7. **Other Agency Solutions-Oregon Department of Transportation (ODOT)**
    - Integrating into the State instance of KRONOS, a time keeping software being piloted by ODOT.

8. **Free and Open Source Software (FOSS)**
    - FOSS that may be utilized for EVV with our current systems.

9. **Salesforce**
    - A cloud-based platform solution that would require a separate procurement for system integration services.
    - Given the State's licensing contract for Salesforce, the State could independently develop on the Salesforce platform.

10. **Cost of Doing Nothing**
    - The cost the Agency would incur if an EVV option is not implemented.

Alternative Analysis

Below are the alternatives the Project analyzed which describe the option with the associated benefits, risks, and estimated cost for each alternative. For more information regarding the methodology used to calculate "Staffing Costs/Professional Services Costs" for each of the alternatives, see the 'Selection Criteria and Ranking' section.

Option 1 – In-House Build

This option proposes a mobile application and a web front-end user interface that allows HCWs and PSWs to enter time electronically. HCWs and PSWs will use the online web interface and mobile application to record their service time and mileage entries. The scope of work for this option will only include the system modifications to the Mainframe systems, new development for a web front-end UI (user interface), and new development for a mobile application. Ongoing maintenance and enhancement work will remain in house.

Benefits to implementing In-House Build:

- Providers have access to both mobile application (with offline capability) and online functionality
- Individuals and their Authorized Representatives (AREPs) have access to electronic approval of time entries
- Least impact to mainframe applications and mainframe development resources by utilizing existing mainframe functionality for authorizations and payments
- Real-time provider eligibility validation
- Real-time individual eligibility validation
- Individual and provider demographic information is accurate/up to date
- Continue to allow last day worked and emergency payments/off cycles processing
- EVV compliant

Risks or negative outcomes associated with implementing In-House Build:

- Resourcing issues may still be a risk with prioritization of OIS resources
- Additional resourcing needed for ongoing Operations and Maintenance for the online/web application

Estimated Cost:

In-House Approach – 12-18 Months	**Total**
State Data Center Costs	$158,270
Software Costs	$0
Hardware Costs	$0
State Staffing Costs / Professional Services Cost	$3,803,800
Implementation Total	**$3,962,070**
Ongoing Maintenance Costs	
Post Implementation adjustments – for 12 months: 1 OPA2 at FTE ($109,670) 1 OPA3 at FTE ($120,397) 2 0.5 ISS7s FTE ($142,123)	$372,190

Software Licensing, Hosting or User/Transaction Based Fees	$0
State Data Center	$324,870
Maintenance Total	**$697,060**
TOTAL	**$4,659,130**

Option 2 – eXPRS – Providers enter time via eXPRS System

This option will utilize the existing technology, with eXPRS desktop and eXPRS Mobile-EVV, for time entry currently done by ODDS PSWs. This option will require modifications to both eXPRS and Mainframe to allow HCWs and PSWs to log into eXPRS and enter time entries via an online web interface. This will allow for a consolidated environment across all applications, individual populations, and provider populations. Time entries will be sent to CEP to process payroll. Ongoing maintenance and enhancement work will remain in house.

Benefits to implementing eXPRS - Providers enter time via eXPRS System:

- eXPRS can access the authorization information in real-time
- Basic time entry validations exist in eXPRS
- eXPRS, in the upcoming release, will have the ability to capture last day worked and emergency payments/off-cycles in an automated manner (manual functionality is currently available)
- Pended time entries: Queue already exists in eXPRS to work pends (by Field Office and Central Office – depending on the reason for the pend)
- Real-time provider eligibility validations
- Real-time individual eligibility validations
- Would allow for individual notifications to be sent
- Individual and provider demographic information is accurate/up to date

Risks or negative outcomes associated with implementing eXPRS - Providers enter time via eXPRS System:

- Estimated number of OIS hours would likely exceed 3,000 actual effort hours (could be more during design sessions) (OIS performs estimation based on the combination of size/risk/complexity along with the expert judgement of their system developers.)
- Expected risk of change to existing legacy application would be medium to high
- Policy and business processes are not in alignment
- Potentially not EVV compliant due to limited current CMS guidance (lack of offline functionality would be non-compliant) (Offline functionality is being pursued by ODDS)
- Resourcing issues may still be a risk for ODDS and APD with prioritization of OIS resources.
- Limitations to include OHA Home Health program
- Limitations to include OHA 1915i program

Estimated Cost:

eXPRS Time Entry End Approach – 18-24 Months	**Total**
State Data Center Costs	$158,270
Software Costs	$0

Hardware Costs	$0
State Staffing Costs / Professional Services Cost	$6,738,959
Implementation Total	**$6,897,229**
Ongoing Maintenance Costs	
Post Implementation adjustments – for 12 months: 1 OPA2 at FTE ($109,670) 1 OPA3 at FTE ($120,397) 2 0.5 ISS7s FTE ($142,123)	$372,190
Software Licensing, Hosting or User/Transaction Based Fees	$0
State Data Center	$324,870
Maintenance Total	**$697,060**
TOTAL	**$7,594,289**

Option 3 – All in-eXPRS Mobile-EVV with Mainframe – Provider Time Capture and FMAS in eXPRS

This option will utilize the existing technology with eXPRS desktop and eXPRS Mobile-EVV for time entry currently done by ODDS PSWs, including FMAS for payroll processing. This option will require modifications to both eXPRS and Mainframe to allow HCWs and PSWs to log into eXPRS and enter time entries via an online web interface. This will allow for a consolidated environment across all applications, individual populations, and provider populations. This option would require some policy and business process alignment. Ongoing maintenance and enhancement work will remain in house.

Benefits to implementing All in-eXPRS Mobile-EVV with Mainframe:

- Basic time entry validations already exist in eXPRS
- Would have the ability to capture last day worked and emergency payments/off cycles in an automated manner
- Pend queue already exists in eXPRS to work pends (by Field Office and Central Office depending on the reason for the pend)
- Real-time provider eligibility validations
- Real-time individual eligibility validations
- Individual and provider demographic information is accurate/up to date
- OT and Travel time would be calculated accurately with cross program providers in the same solution (same payment system for programs)
- Would allow for individual notifications to be sent
- Single source payment system

Risks or negative outcomes associated with implementing the All in-eXPRS Mobile-EVV with Mainframe:

- Expected risk of change to existing legacy application would be medium to high
- Additional development on the mainframe for claim financing for funding sources
- Policy and business processes are not in alignment
- Pay cycles are not in alignment

- Resourcing issues may still be a risk for ODDS and APD with prioritization of OIS resources
- Updating/changing coding could cause some unforeseen system issues
- Potentially not EVV compliant due to limited current CMS guidance (lack of offline functionality would be non-compliant) (Offline functionality is being pursued by ODDS)
- Limitations to include OHA Home Health program
- Limitations to include OHA 1915i program

Estimated Cost:

eXPRS All-in w/MF Approach – 24 Months	**Total**
State Data Center Costs	$158,270
Software Costs	$0
Hardware Costs	$0
State Staffing Costs / Professional Services Cost	$7,701,667
Implementation Total	**$7,859,937**
Ongoing Maintenance Costs	
Post Implementation adjustments – for 12 months: 1 OPA2 at FTE ($109,670) 1 OPA3 at FTE ($120,397) 2 0.5 ISS7s FTE ($142,123)	$372,190
Software Licensing, Hosting or User/Transaction Based Fees (This includes payroll services through existing contract held by ODDS)	$47,684,712
State Data Center	$324,870
Maintenance Total	**$48,381,772**
TOTAL	**$56,241,709**

Option 4 - All in eXPRS Mobile-EVV without Mainframe

This option will utilize the existing technology and bring APD, HSD, and ODDS into alignment for rules/policy/business process/system. This option will require modifications to eXPRS to allow HCWs and PSWs to log into eXPRS and enter time entries via an online web interface. This will allow for a consolidated system application across individual and provider populations. Ongoing maintenance and enhancement work will remain in house.

Benefits to implementing All in eXPRS Mobile-EVV without Mainframe:

- Utilization of existing technology
- Basic time entry validations already exist in eXPRS
- Would have the ability to capture last day worked and emergency payments/off cycles in an automated manner
- Pend queue already exists in eXPRS to work pends (by Field Office and Central Office depending on the reason for the pend)
- Real-time provider eligibility validations
- Real-time individual eligibility validations

- Individual and provider demographic information is accurate/up to date
- OT and Travel time would be calculated accurately with cross program providers in the same solution (same payment system for programs)
- Would allow for individual notifications to be sent
- Single source payment system

Risks or negative outcomes associated with implementing the All in eXPRS Mobile-EVV without Mainframe:

- Expected risk of change to existing legacy application would be high
- Policy and business processes are not in alignment
- Pay cycles are not in alignment
- Resourcing issues may still be a risk for ODDS and APD with prioritization of OIS resources
- By updating/changing coding could cause some unforeseen system issues
- Potentially not EVV compliant due to limited current CMS guidance (lack of offline functionality would be non-compliant) (Offline functionality is being pursued by ODDS)
- Additional resources may be needed for Operations and Maintenance
- MMIS resourcing needs for modifications to the eligibility interface with eXPRS to include APD and HSD eligibility
    - *Note: Oregon Project Independence (OPI) and Extended Waiver Eligible (EWE) individuals are not in MMIS and/or Oregon ACCESS*
- Limitations to include OHA Home Health program
- Limitations to include OHA 1915i program

Estimated Cost:

eXPRS All-in w/out MF Approach – 24 Months	**Total**
State Data Center Costs	$158,270
Software Costs	$0
Hardware Costs	$0
State Staffing Costs / Professional Services Cost	$7,701,667
Implementation Total	**$7,859,937**
Ongoing Maintenance Costs	
Post Implementation adjustments – for 12 months: 1 OPA2 at FTE ($109,670) 1 OPA3 at FTE ($120,397) 2 0.5 ISS7s FTE ($142,123)	$372,190
Software Licensing, Hosting or User/Transaction Based Fees (This includes payroll services through existing contract held by ODDS)	$47,684,712
State Data Center	$324,870
Maintenance Total	**$**48,381,772
TOTAL	**$56,241,709**

Option 5 – MMIS Current Contract

This option would entail using current MMIS vendor and contract to support an EVV solution. If the timeline for modularity is far enough in the future, it would be equivalent to the "Do Nothing" option.

Benefits to implementing MMIS Current Contract:

- Potential to coordinate efforts with OHA and utilization of existing resources, contract and technology
- DXC is aware EVV compliance requirements and is the vendor for MMIS for Oregon
- Some staff are already familiar with using the MMIS system
- In-Home Agency and Home Health providers currently use the system for the MMIS Web portal
- HSD providers are currently stored and maintained in MMIS system
- Alignment on enterprise solution for MMIS

Risks or negative outcomes associated with implementing MMIS Current Contract:

- Potential risk if need to change legacy/mainframe
- Prioritization of other MMIS work including IE interfacing
- System and/or vendor limitations that prevented CEP inclusion in initial MMIS implementation
- Cross program travel time hours/OT hours calculation
- Movement of information into MMIS could have downstream impacts to other systems
- New mainframe interface needed for non-financial eligible OPI and EWE not stored in MMIS and IE ONE
- MMIS does not always apply Service Eligibility date ranges (segments) in Recipient module
- Long-term Operations and Maintenance are unclear past the 2-year contract extension option
- Sub-contracting with Sandata via MMIS would add an additional vendor to the project
- An amendment for the special procurement would be required due to added cost
- Sub-contracting could also mean a separate license agreement could be required when transitioning away from DXC
- If we include PTC in the MMIS scope, DAS Procurement Services would have to be involved at some level and it's possible there is risk of losing delegation for MMIS in trying to force this body of work under the MMIS RFP from 2004
- CMS will only pay for one EVV solution for the State
- Additional resources may be needed for Operations and Maintenance

Estimated Cost:

- For cost comparison purposes the Montana modularity pricing for a provider module is claims based and includes some degree of provider management. The cost is around $50 million total. DDI is $13 million and Operations and Maintenance is $37 million for 4 years.

Below is the estimated cost breakdown:

MMIS Approach – 18-24 Months	**Total**
State Data Center Costs	$0
Software Costs	$662,450
Hardware Costs	$0
State Staffing Costs / Professional Services Cost	$5,843,514
Implementation Total	**$6,505,964**
Ongoing Maintenance Costs	
Post Implementation adjustments – for 12 months: 1 OPA2 at FTE ($109,670) 1 OPA3 at FTE ($120,397) 2 0.5 ISS7s FTE ($142,123)	$372,190
Software Licensing, Hosting or User/Transaction Based Fees	$7,000,000
State Data Center	$0
Maintenance Total	**$7,372,190**
TOTAL	**$13,878,154**

Option 6 – SaaS

The SaaS approach involves implementing new software but does not require installing new servers and software at the State Data Center. Data for this approach is stored by the solution vendor in an environment that meets the agency security and privacy requirements.

Benefits to implementing a SaaS solution:

- With multiple EVV solutions having been implemented, the market place for vendor solutions is much larger than previously identified
- Since SaaS solution vendors have implemented solutions in other States for EVV, they are familiar with the EVV requirements
- Offers robust functionality with automated workflows, a variety of time capture methods, and electronic or telephonic notifications
- Several vendors in this space have deep experience providing time capture solutions to Direct Care Workers under the Medicaid program
- Most of the desired functionality is already existing; project efforts to implement are focused on configuration, integration, and training
- Requires fewer technical resources from the state
- Shorter implementation timeframe
- No hardware/software to install/maintain
- Provides necessary output to solve the business problem
- Many SaaS solutions are extensible to meet future business goals, such as payroll
- Most of the responses to the original PTC RFI proposed a SaaS solution, which is consistent with the direction of the software industry and market research into time capture solutions

- No dependency on State Data Center
- The solution will automate the time capture process and eliminate or greatly reduce manual processes associated with time capture

Risks or negative outcomes associated with implementing a SaaS solution:

- Lack of direct access to State owned data can result in the inability to analyze and report on the data and may preclude ad-hoc queries
- May be limited in the ability to incorporate agency requirements into a Service Level Agreement with the solution vendor, therefore changes in business process, policy, and potential workarounds will need to be considered.
- Agency specific customizations may be difficult or unattainable depending on the solution
- Solution may consist of technology involving unique hardware that must be in place at all service locations (Fixed Visit Verification/Electronic Visit Verification devices)
- Not all SaaS solutions can scale into additional case management and provider payment (payroll) functions that are envisioned in the long-term future state
- Additional resources may be needed for Operations and Maintenance

Estimated Cost:

This approach assumes an 18-24-month DDI period with the commencement of licensing or fees after implementation. It is assumed that the solution and all data is hosted by the SaaS vendor. Some vendors may require an up-front payment of a portion of the implementation and integration services.

SaaS Approach – 18-24 Months	**Total**
State Data Center Costs	$0
System Integration/Software Costs**	$7,542,540
Hardware Costs	$18,375
State Staffing Costs / Professional Services Cost	$5,026,884
Implementation Total	**$12,587,799**
Ongoing Maintenance Costs	
Post Implementation adjustments – for 12 months: 1 OPA2 at FTE ($109,670) 1 OPA3 at FTE ($120,397) 2 0.5 ISS7s FTE ($142,123)	$372,190
Software Licensing, Hosting or User/Transaction Based Fees	$4,312,159
State Data Center	$0
Maintenance Total	**$4,684,349**
TOTAL	**$17,272,148**

** All associated cost Information is provided as captured in the Galaxux Alternative Analysis document, compiled in 2015, with updates made to account for inflation and an extended implementation timeline. Inflation costs were calculated at 2% for software licensing and impacted costs per Galaxux, and staffing costs were calculated at ~6% per COLA (2016 – 1.48%, 2017 – 2.75%, 2018 – 1.85%, 2019 – 0).*

**System Integration/Software Cost Breakdown:

System integration costs were calculated by compiling five current/recently executed State of Oregon SaaS solutions similar in size, scope, and complexity, and averaging the associated contracted system integration costs. Project information has been deidentified for confidentiality. See below for individual costs used for calculations.

Project A	$ 9,000,000.00
Project B	$ 6,543,300.00
Project C	$ 4,196,300.00
Project D	$ 6,286,900.00
Project E	$ 6,296,000.00
Average (System Integration)	**$ 6,464,500.00**

Software costs were calculated as 25% of the licensing costs (per Galaxux). See below for calculations.

$4,312,159 (Software Licensing) *25% = **$1,078,040 Software Costs**

These costs were then added together for a comprehensive system integration/software cost estimation.

$6,464,500 (System Integration)
+$1,078,040 (Software Costs)
= **$7,542,540 System Integration/Software Costs**

Note: These costs are for estimation purposes only - actual costs may vary.

Option 7 - Other Agency Solutions – ODOT

This option would require collaboration with DAS to integrate into the State instance of Kronos, a time keeping software currently in the process of being rolled out to replace multiple time and attendance systems. The key limitation is the completed implementation for currently prioritized agencies before expansion can occur. The Workday implementation delays have pushed back implementation dates for ODOT.

Benefits to implementing Kronos:

- Kronos is a highly-regarded and well-proven system for the tracking of time and attendance
- APD utilizing the ODOT contract could potentially lower the overall cost of integration
- Since ODOT's project is in the pilot phase, there are experienced state resources

Risks or negative outcomes associated with implementing Kronos:

- The Workday implementation delays have pushed back implementation dates for ODOT
- Would need to identify an additional component for cross program travel time and OT calculations

- Would need to identify an additional component for integration of data for reporting and payroll
- Additional conversations with the vendor to confirm EVV compliance scenarios
- Additional resources may be needed for Operations and Maintenance

Estimated Cost:

ODOT provided the Project with a fee schedule which outlines the annual fees and hosting costs plus per employee per month (PEPM) costs. With 24,000 providers, a rough estimate puts costs at $1.2 million per year. This number does not include costs for professional services, training, or hardware. Professional services and training are estimated to cost roughly $1.5 million for ODOT's project. Hardware costs could be optional.

The estimated cost breakdown below does not account for the optional hardware:

Kronos Approach – 18-24 Months	**Total**
State Data Center Costs	$0
Software Costs	$0
Hardware Costs	$0
State Staffing Costs / Professional Services Cost	$5,446,884
Implementation Total	**$5,446,884**
Ongoing Maintenance Costs	
Post Implementation adjustments – for 12 months: 1 OPA2 at FTE ($109,670) 1 OPA3 at FTE ($120,397) 2 0.5 ISS7s FTE ($142,123)	$372,190
Software Licensing, Hosting or User/Transaction Based Fees	$6,000,000
State Data Center	$0
Maintenance Total	**$6,372,190**
TOTAL	**11,819,074**

Option 8 – FOSS

This option would allow us to meet the minimum requirements for EVV Compliance, with less of a financial burden than procuring a vendor solution. The selection of open source software would provide the State with the opportunity to improve functionality and adapt the software to fit our needs. If this solution is chosen, an RFP will be required if the license fees exceed $150,000.

There are several FOSS solutions available to help meet the EVV data collection items. The solutions that were explored for the sake of this analysis are as follows:

- Axxess
- Alora
- AlayaCare
- MyGeoTracking – Solution offers Geofence Based visit verification, mobile time clock apps, and phone call and text-based visit recording

- Vesta EVV – Mainly used in Texas, currently serving Aetna, Accenture, Anthem, Blue Cross Blue Shield, Cigna-Healthspring, and United HealthGroup

Benefits to implementing FOSS:

- Decreased or free software costs
- Agency would have full control of using and customizing source code (also facilitates in discovering and fixing security/privacy vulnerabilities proactively)
- Agency could test against the OSS without committing to the solution
- No contracts required to secure the solution
- There are many FOSS vendors that the state could explore as options

Risks or negative outcomes associated with implementing FOSS:

- There is less guarantee of development with free software systems
- Support services generally rely on communities of other users as opposed to vendor support
- If vendor support exists, we will be limited to their support hours which are likely not 24/7
- Shifting project priorities may require OIS resource re-allocation that would be needed for this solution
- With open source code, potential security vulnerabilities are quantifiable and accessible for remediation vs closed source solutions where you have no tangible way to verify if the security meets our need

Estimated Cost:

Alora – Cost is based on either unlimited users or unlimited individuals. Pricing is tiered by size of Agency (tier details are not included). Medium sized agencies pay between $600-$1,200 a month, while large agencies may range from $1,200 to $6,000 per month. More specific pricing is available upon request.

AlayaCare – Cost is determined by the number of modules selected and the total number of service hours each month. More specific pricing is available upon request.

MyGeoTracking – Cost is based on modules selected per user/per month. At a non-enterprise level, Tracking costs $5/month/user, Manual Time Clock with GPS or IVR/SMS Time Clock costs $5/month/user, and Automatic Time clock with Geofencing costs $10/month/user. Field Data also starts at $5/month/user for mobile forms and includes notes/pictures and electronic signature. Each module includes add-ons for a fee.

State of Oregon Estimates:

Vendor	Number of Users (Role)	Cost / Provider	Total / Month	Total / Year	Total / 5 Year
Alora	N/A	N/A (flat rate)	$1,200 - $6,000	$14,400 - $72,000	$72,000 - $360,000
MyGeoTracking	24,000 (Provider) 1,000 (State Staff)	$5.00/month - $10.00/month $5.00/month	$120,000 - $240,000 $5,000	$1,440,000 - $2,880,000 $60,000	$7,200,000 - $14,400,000 $300,000 **Combined Total** $7,500,000 - $14,700,000

FOSS Approach – 12-18 Months	Total
State Data Center Costs	$158,270
Software Costs	$0
Hardware Costs	$0
State Staffing Costs / Professional Services Cost	$3,232,172
Implementation Total	**$3,390,442**
Ongoing Maintenance Costs	
Post Implementation adjustments – for 12 months: 1 OPA2 at FTE ($109,670) 1 OPA3 at FTE ($120,397) 2 0.5 ISS7s FTE ($142,123)	$372,190
Software Licensing, Hosting or User/Transaction Based Fees	$14,700,000
State Data Center	$324,870
Maintenance Total	**$15,397,060**
TOTAL	**$18,787,502**

Option 9 – Salesforce

This option is a cloud-based Customer Relationship Management (CRM) system - data for this approach is stored by Salesforce in an environment that meets the agency security and privacy requirements. *Note: Because the State will need to hire a system integrator to perform the work, an RFP will be required along with additional DDI costs, as the State lacks skilled Salesforce developers.*

Benefits to implementing Salesforce:

- Confirmed ability to work with Carahsoft to purchase licenses (without seeking competitive quotes for other CRM tools)

- Offers robust functionality with automated workflows, a variety of time capture methods, and automated notifications
- Most of the desired functionality is already existing; project efforts to implement are focused on configuration, integration, and training (faster deployment)
- Solution may allow State to utilize the Deliverables from PTC 1.0
- Requires fewer technical resources from the state
- Shorter implementation timeframe
- No hardware/software to install/maintain (automatic updates)
- Provides necessary output to solve the business problem
- Flexible and scalable to meet potential future needs
- Most of the responses to the original PTC RFI proposed a SaaS solution, which is consistent with the direction of the software industry and market research into time capture solutions
- Cloud-based system - no dependency on State Data Center
- Centralized data that is instantly accessible, including customized dashboards and notifications

Risks or negative outcomes associated with implementing Salesforce:

- May be limited in the ability to incorporate agency requirements into a Service Level Agreement (SLA) with Salesforce
- Agency specific customizations may be difficult or unattainable
- Additional resources will be needed for Operations and Maintenance

Estimated Cost:

Salesforce Approach – 12-18 Months	**Total**
State Data Center Costs	$0
System Integration*	$6,464,500
Software/Hardware Costs	$0
State Staffing Costs / Professional Services Cost	$3,639,658
Implementation Total	**$10,104,158**
Ongoing Maintenance Costs	
Post Implementation adjustments – for 12 months: 1 OPA2 at FTE ($109,670) 1 OPA3 at FTE ($120,397) 2 0.5 ISS7s FTE ($142,123)	$372,190
Software Licensing, Hosting or User/Transaction Based Fees**	$21,663,450
State Data Center	$0
Maintenance Total	**$22,035,640**
TOTAL	**$32,139,798**

*System Integration/Software Cost Breakdown:

System integration costs were calculated by compiling five current/recently executed State of Oregon SaaS solutions similar in size, scope, and complexity, and averaging the associated contracted system integration costs. Project information has been deidentified for confidentiality.

Project A	$ 9,000,000.00
Project B	$ 6,543,300.00
Project C	$ 4,196,300.00
Project D	$ 6,286,900.00
Project E	$ 6,296,000.00
Average	**$ 6,464,500.00**

Note: this cost is for estimation purposes only - actual cost may vary.

**License Cost Breakdown:

State Staff/Provider Licenses:

25,500 licenses (24,000 Providers + 1,500 State Staff users) x $125* = $3,187,500

**Actual current cost is $125 per year per license (this cost could be reduced based on volume)*

Individual Licenses:

20k logins a year for $60 x 365 = $21,900**

***Calculated using community licenses (No access to mobile app – access to website for approvals, etc.)*

*$3,187,500 + $21,900 = $3,209,400 x 1.35*** = 4,332,690 a year for licenses x 5 years =* ***$21,663,450***

****This number represents the associated support costs as quoted by Salesforce.*

Option 10 - Cost of Doing Nothing

This option would continue current process.

Benefits to Doing Nothing:

- The team would be dissolved, and no additional money or time would be invested in the project
- No time or money would be spent on procuring a product nor a vendor for the project

Risks or negative outcomes associated with Doing Nothing:

- Failure to comply with federal regulations will result in a loss of funds matched by the federal government
- Continued reliance upon an outdated computer system (Mainframe) means limited resources could be a problem further down the line

Estimated Cost:

- If the state fails to incorporate an EVV solution, it is subject to incremental reduction in Federal Medical Assistance Percentages (FMAP) up to 1%. The penalties enforced on the State and APD for non-compliance for the first year alone amounts to $874,314. When penalties reach 1%, penalties are to be nearly $6.7 million annually.
- This lack of a solution means the state continues to pay an estimated 70 Full-Time employees at APD offices to enter time (typical classification for this role is an Office Specialist 2), at an estimated current annual cost of $4.2 million. This annual cost is likely to increase over time.
- Doing nothing will also mean that the state continues with printing vouchers, a cost which annually is nearly $1.4 million. This number is likely to grow with the population.
- Total costs are shown below and assume the unlikely scenario that employment and printing/postage costs will stay stagnant. It is very likely these numbers will increase over time; however, it is not possible to accurately depict those numbers.

Fiscal Year	Penalties	Employment	Printing / Postage	Total
2020	$874,314	$4,200,000	$1,387,815	$6,462,129
2021	$3,202,812	$4,284,000	$1,415,571	$8,902,383
2022	$5,007,680	$4,369,680	$1,443,883	$10,821,243
2023	$6,676,906	$4,457,074	$1,472,760	$12,606,740
2024	$6,676,906	$4,546,215	$1,502,216	$12,725,337
5-year total	$22,438,618	$21,856,969	$7,222,245	$51,517,832

Alternative Scoring Guide

Each alternative was scored using the below criteria. Note: The percentage next to the ranking criteria represents the weighted score for each category totaling 100%.

Alternative Scoring Guide		
Ranking Criteria (100%)	**Definitions**	**Scoring Key (1 – 5)**
Requirements (30%)	The estimated requirements met by the solution.	1- 0-92% Requirement Alignment 2- 93-94% Requirement Alignment 3- 95-96% Requirement Alignment 4- 97-98% Requirement Alignment 5- 99-100% Requirement Alignment
Estimated Cost* (25%)	Comparative estimated cost for the solution.	1- Comparative High Cost 2- Comparative Middle-High Cost 3- Comparative Middle Cost 4- Comparative Low-Middle Cost 5- Comparative Lowest Cost
Resources (15%)	Estimated amount of resources identified to implement the solution on schedule.	1- 41+ FTE 2- 31-40 FTE 3- 21-30 FTE 4- 11-20 FTE 5- 0-10 FTE

Schedule (10%)	Estimated implementation timeline for the solution.	1- > 2 years 2- 1 ½ years – 2 years 3- 1 year – 1 ½ years 4- 6 months – 1 year 5- < 6 months
Risk (10%)	Likelihood and impact of associated risks.	1- Overall Risk Score = 4.1- 5 2- Overall Risk Score = 3.1- 4 3- Overall Risk Score = 2.1- 3 4- Overall Risk Score = 1.1- 2 5- Overall Risk Score = 0-1
Mission (5%)	Alignment with State and APD goals and objectives.	1- 0-19% Mission Alignment 2- 20-39% Mission Alignment 3- 40-59% Mission Alignment 4- 60-79% Mission Alignment 5- 80-100% Mission Alignment
Reusable Artifacts (5%)	Previous documentation utilization.	1- 0-19% Reusable Content 2- 20-39% Reusable Content 3- 40-59% Reusable Content 4- 60-79% Reusable Content 5- 80-100% Reusable Content

* These criteria will be a comparison with the other options, as opposed to evaluating as stand-alone elements.

Selection Criteria and Alternatives Ranking

The following criteria for scoring identify quantitative and qualitative project areas to evaluate the most viable alternatives. The criteria were selected based on prior project analysis and research into industry standards evaluating alternatives for the implementation of the best solution. See *'Alternative Scoring Guide'* section for scoring key.

Requirements: Requirements the solution must support are in the Hewlett Packard Application Lifecycle Management (HP ALM) requirements documentation. The Project Team recently reviewed, revised, and vetted the requirements with impacted stakeholders. The requirements were then prioritized as Critical, High, Medium, and Low and were evaluated to ensure the solution meets the critical business needs.

Out of the total number of business requirements scored (42), 31 were identified as Critical, six were identified as High, and five were identified as Medium. For the purposes of scoring, all business requirements determined to be Low were not included as they are all low impact and considered "nice to have" features. In addition, functional requirements were not scored as they directly support the identified business requirements. The selection of critical requirements will be essential for the viable product for the initial release. High and Medium will be considered during the RFP process for scoring purposes. Low requirements will be used for future planning.

Each requirement was scored for alignment individually against each alternative using the key below:

KEY	
0	**Does NOT Meet Requirement**
0.5	**Partially Meets Requirement**
1	**Meets Requirement**

These scores were then totaled for each alternative option, for a total percentage of alignment by priority. This alignment percentage was then used to calculate the weighted percentages as follows (for a total of 100% requirement alignment): Critical – 60%; High – 30%; Medium – 10%; Low – 0%

Below is a summary table outlining requirement alignment scoring results based on the weighted percentages. An overall score was assigned using the alignment criteria for the Total Percentage as defined in the '*Alternative Scoring Guide*.'

Alternative Options	Critical	High	Medium	Total Percentage	Overall Requirements Score
In-House Build	60%	30%	10%	100%	5.00
eXPRS Time Entry	57%	30%	10%	97%	5.00
eXPRS with Mainframe	57%	30%	10%	97%	5.00
eXPRS w/o Mainframe	57%	30%	10%	97%	5.00
MMIS	56%	30%	10%	96%	5.00
SaaS	60%	30%	10%	100%	5.00
Kronos	55%	30%	9%	94%	5.00
FOSS	58%	30%	10%	98%	5.00
Salesforce	58%	30%	10%	98%	5.00
Do Nothing	47%	25%	0%	72%	4.00

***See Appendix K for the Project Requirements Detailed Scoring*

Estimated Cost: An estimated cost has been collected in the Alternative Analysis, when available. The full life-cycle costs including Design, Development, Testing, Training, Migration, Implementation, and Operations and Maintenance (total and by fiscal year) will be used for comparison; see example below:

**Given the following estimated costs: $10 MM, $15 MM, $8 MM, $12 MM, $20 MM, $4 MM, $13 MM, $22 MM, $6 MM, $25 MM, $30 MM, $7 MM

The alternatives would be ranked in order of high to low: 4, 6, 7, 8, 10, 12, 13, 15, 20, 22, 25, 30
The median value would be determined (High-Low/2=Average): (30-4)/2=**13** – this value would be assigned a ranking of 3.

The median value of the high-middle would be determined [(High-Middle)/2] + Middle]: (30-13)/2=8.5 + 13 = **21.5** – this value would be assigned a ranking of 4.

The median value of the low-middle would be determined [(Middle-Low)/2] + Low]: (13-4)/2=4.5 + 4 = **8.5** – this value would be assigned a value of 2.

Once this is complete, the values would be assigned a ranking: 1 (4), 2 (8.5), 3 (13), 4 (21.5), 5 (30)
The example above would be ranked as follows: **1**- (4, 6), **2**- (7, 8, 10), **3**- (12, 13, 15), **4**- (20, 22), **5**- (25, 30)

Below is a summary table outlining the estimated cost scoring results.

Alternative Options	Total Estimated Cost	Overall Estimated Cost Score
In-House Build	$4,659,130	5.00
eXPRS - Time Entry	$7,594,289	4.75
eXPRS - All-in with MF	$56,241,709	1.00
eXPRS - All-in without MF	$56,241,709	1.00
MMIS	$13,878,154	4.25
SaaS	$17,272,148	4.00
Kronos	$11,819,074	4.50
FOSS	$18,787,502	4.00
Salesforce	$32,139,798	3.00
Do Nothing	$51,517,832	1.50

***See Appendix L Alternative Analysis Cost Comparison*

Mission: The mission includes an evaluation of qualitative factors important to the selection of a path forward. Factors include but are not limited to: project goals including the effects on business processes and functions; the effects on the organization such as culture and end user benefits; and other non-quantifiable aspects of the business environment.

The following elements were extracted directly from the APD Strategic Plan:

DHS Mission: To help Oregonians in their own communities achieve wellbeing and independence through opportunities that protect, empower, respect choice and preserve dignity.

APD Vision: Oregon's older adults, people with disabilities and their families experience person-centered services, supports and early interventions that are innovative and help maintain independence, promote safety, well-being, honor choice, respect cultural preferences and uphold dignity.

The following APD Goals will be assessed for alignment with each alternative:

- **Accessibility**: Oregonians can readily and consistently access services and supports to meet their needs.

  Actions - Design improvements to increase individual knowledge of access to services and case management. Continue developing platforms (such as Aging and Disability Resource Centers (ADRC) and IE platforms) and best practices for individuals who are technologically savvy, such as web sites, hotlines, and other self-serve mechanisms where individuals can access information and services while retaining the option for individuals to get information in one-on-one, in person contact with staff. Implement ongoing, sustainable supports for the direct care workforce in partnership with stakeholders.

- **Quality outcomes**: Oregonians engage in services and supports that are preventive, evidence-informed, and lead to quality outcomes.

  Actions - Continue modernizing data and information technology systems (CAM, IE, ADRC) to develop greater capacity for data collection and analysis. Work with DHS and other agencies to develop strategic data sharing agreements for policy planning in the areas of health, housing, transportation, and other services under other state agencies' purview, as well as potential partnerships with universities and community colleges.

Each identified element was scored for alignment individually against each alternative using the key below:

KEY	
0	**Does Not Align with Mission**
0.5	**Partially Aligns with Mission**
1	**Fully Aligns with Mission**

These scores were then totaled for each alternative option, for a total percentage of alignment.

Below is a summary table outlining the mission scoring results. An overall score was assigned using the alignment criteria for the Total Percentage as defined in the '*Alternative Scoring Guide*.' Please note: These overall mission scores are based on qualitative measures and are subjective. The team evaluated each option and assigned an overall score of how well it aligned to the Agency's mission, vision, and goals.

Alternative Options	Total Mission Alignment	Overall Mission Score
In-House Build	91%	5.00
eXPRS - Time Entry	82%	5.00
eXPRS - All-in with MF	73%	4.00
eXPRS - All-in without MF	77%	4.00
MMIS	86%	5.00
SaaS	95%	5.00
Kronos	86%	5.00
FOSS	95%	5.00
Salesforce	95%	5.00
Do Nothing	14%	1.00

See *'Goals, Objectives, and Measurements'* for more information on the project goals.

***See Appendix M for the Mission Detailed Scoring*

Estimated Schedule: An estimate for how long each option will take to implement was determined for each alternative based on the type of solution. Estimates were based on a combination of previously suggested timelines and expert judgement from experienced team members.

Below is a summary table outlining the estimated schedule scoring results In-house and eXPRS options were based on estimates from OIS as referenced in the *'Alternative Analysis'* section. The project team divided out what would be the longest effort and then broke it out into 6-month increments.

Alternative Options	5 (<6 mo)	4 (6 mo – 1 yr)	3 (1 yr – 1 ½ yrs)	2 (1 ½ yrs - 2 yrs)	1 (>2 yrs)	Overall Estimated Schedule Score
In-House Build			X			3.00
eXPRS Time Entry				X		2.00
eXPRS with Mainframe					X	1.00
eXPRS without Mainframe					X	1.00

MMIS				X		2.00
SaaS				X		2.00
Kronos				X		2.00
FOSS			X			3.00
Salesforce			X			3.00
Do Nothing	X					5.00

Risk: Risk items were captured for each alternative utilizing the Probability and Impact Matrix (included in appendix O). The Project used the methodology and tools defined in the PMP. The overall risk assessment includes the following factors: capability of the agency to manage the investment, overall risk of investment failure, organizational and change management, technology, strategic plan, and project resources.

Below is a summary table outlining the risk scoring results.

Alternative Options	Total Average Risk Score	Overall Risk Score
In-House Build	4.1	2.00
eXPRS - Time Entry	2.9	3.00
eXPRS - All-in with MF	3.0	3.00
eXPRS - All-in without MF	3.1	3.00
MMIS	3.4	2.00
SaaS	2.0	4.00
Kronos	3.9	2.00
FOSS	3.8	2.00
Salesforce	2.7	3.00
Do Nothing	4.3	1.00

***See Appendix N for complete Alternative Analysis Risk Log for each alternative.*

***See Appendix O Project Risk Narrative for the definitions of probability and impact by objective.*

Resources: The solution needs to have the required resources to be successful. Each solution was compared to the estimated resources needed to implement each option.

Staffing costs were estimated using existing policy option package data for personnel costs. Total number of staff needed is based on the staffing model developed to support the project approach.

Below is a summary table outlining the resources scoring results.

Alternative Options	Project Director	Project Mgrs.	Tech. Resources	Business Analysts	Org. Change Mgmt.	Training	Total Resources	Overall Resources Score
In-House Build	1	2	3	6	6	6	24	3.00
eXPRS Time Entry	1	2	6	8	6	6	29	3.00
eXPRS with Mainframe	1	2	6	8	6	6	29	3.00

eXPRS w/o Mainframe	1	2	6	8	6	6	29	3.00
MMIS	1	3	3	8	6	6	27	3.00
SaaS	1	3	2	6	6	6	24	3.00
Kronos	1	3	3	6	6	6	25	3.00
FOSS	1	1	2	6	6	6	22	3.00
Salesforce	1	3	2	6	6	6	24	3.00
Do Nothing	0	0	0	0	0	0	0	5.00

***See Appendix L Alternative Analysis Cost Comparison*

Reusable Artifacts: The Project completed an assessment of project artifacts to determine how much existing documentation could be leveraged based on each alternative option. The Project scored each alternative against each deliverable and associated state supporting documentation to determine an estimated percentage of reusable content for the future effort. There were deliverables not used in the scoring such as the Project Management Plan, PMP Monthly Reports, Development Checkpoints, System Testing, Test Cases Part 2, Test Results, and Implementation Plan as these were relevant to PPL's core system and would not be applicable for any other solutions. The Project was able to use the Requirements Traceability Matrix (RTM) as an input for re-baselining the reboot of the project.

Below is the summary table with the estimated percentages of reusable documentation for each alternative option. Please note these percentages are based on qualitative measures and are subjective.

Alternative Options	Total Percentage	Overall Reusable Artifacts Score
In-House Build	34%	2.00
eXPRS - Time Entry	28%	2.00
eXPRS - All-in with MF	28%	2.00
eXPRS - All-in without MF	38%	2.00
MMIS	30%	2.00
SaaS	44%	3.00
Kronos	40%	3.00
FOSS	44%	3.00
Salesforce	44%	3.00
Do Nothing	0%	1.00

***See Appendix P Approved PPL Deliverables for more information regarding scoring details.*

Alternative Option Comparison

Below are the Alternative Option Comparison final scores based on the scoring criteria using the Scoring Guide.

Alternative Options	Final Score
In-House Build	**4.05**
eXPRS - Time Entry	**3.99**
SaaS	**3.95**
Kronos	**3.88**
FOSS	**3.85**
MMIS	**3.76**
Salesforce	**3.70**
Do Nothing	**3.03**
eXPRS - All-in without MF	**2.90**
eXPRS - All-in with MF	**2.90**

There are some important points to keep in mind when looking at this list where no clear way existed to include specific factors into the scoring model. Much of the impact to resource availability and schedule duration depend greatly on when project reinitiating occurs and how long it would take to obtain the appropriate resources (internal or external). Should the project receive immediate approval to move forward key resources from DHS and OHA remain committed to other projects (IE and CAM) and the schedule will be adjusted to reflect the constraints. This greatly decreases the feasibility of success of the options that would rely more heavily on internal development options (In-House Build, eXPRS- all options, & FOSS).

The scores do represent we have the most ability to control outcomes, cost, and delivery of items that are managed in-house.

These scores are not representative of both DHS and OHA's desires to move to more modern technologies and begin to reduce the support workload of existing resources that are already overburdened in supporting more and more systems. The team who developed this Business Case has also engaged repeatedly with the OIS leadership who are working on a variety of strategic initiatives to help move the Agencies forward from a technology perspective.

***See Appendix Q for full Alternative Analysis Scoring Matrix for comparison details.*

Conclusions & Recommendation

The PTC Project is intended to capture the following required data elements electronically at the time of service: Date of Service, Person Providing the Service, Person Receiving the Service, Time the Service Begins and Ends, Location of Service, and Type of Service Performed. This planned workflow involves the transition from a paper-based data gathering method to a more modern, electronic time capture solution.

As part of this new process, the Provider will record EVV data elements in real-time via a mobile app/web portal interface. The processing of the data will involve data-integrity validations to ensure accuracy of services performed, the date/time of service, and the location of the service delivered to the Individual.

The Software as a Service (SaaS) option is the most realistic available option that balances the needs of the organization in the short to medium term for compliance with the longer-term goals of more modular systems. Through the RFP process we can prioritize those vendors able to deliver a compliant solution through a phased delivery model to support quicker time to value with a projected estimated cost total of $25,351,715.

Because Salesforce, Kronos, MMIS (Sandata), FOSS would require outside support from an integrator and an RFP would be required there is no recommendation for a specific SaaS solution. Any selection during the RFP process will reflect the appropriate criteria for scoring between any proposers, which could include any of the above mentioned.

SaaS Option:
The recommended approach for the PTC Project is to utilize a SaaS solution for the following reasons:

- Ability for advanced configuration, integration with other applications, and possible customization
- Aligns with the direction the software industry is going
- Possibility to expand to other solutions in the future for FMAS, Case Management, Provider Management, etc.
- Fewer technical resources would be required from the State and there would be no dependency on the State Data center
- Possibility of faster implementation
- Workload reduction in the State field offices and Type A and Type B AAA offices
- Moves the Agency away from having sole responsibility for supporting an increasing number of systems
- Ability to access data for reporting
- Several vendors are now offering EVV solutions that are incorporated into their system

To best support incremental delivery of this effort the following prioritization are put forth in conjunction with the recommendation for a SaaS solution:

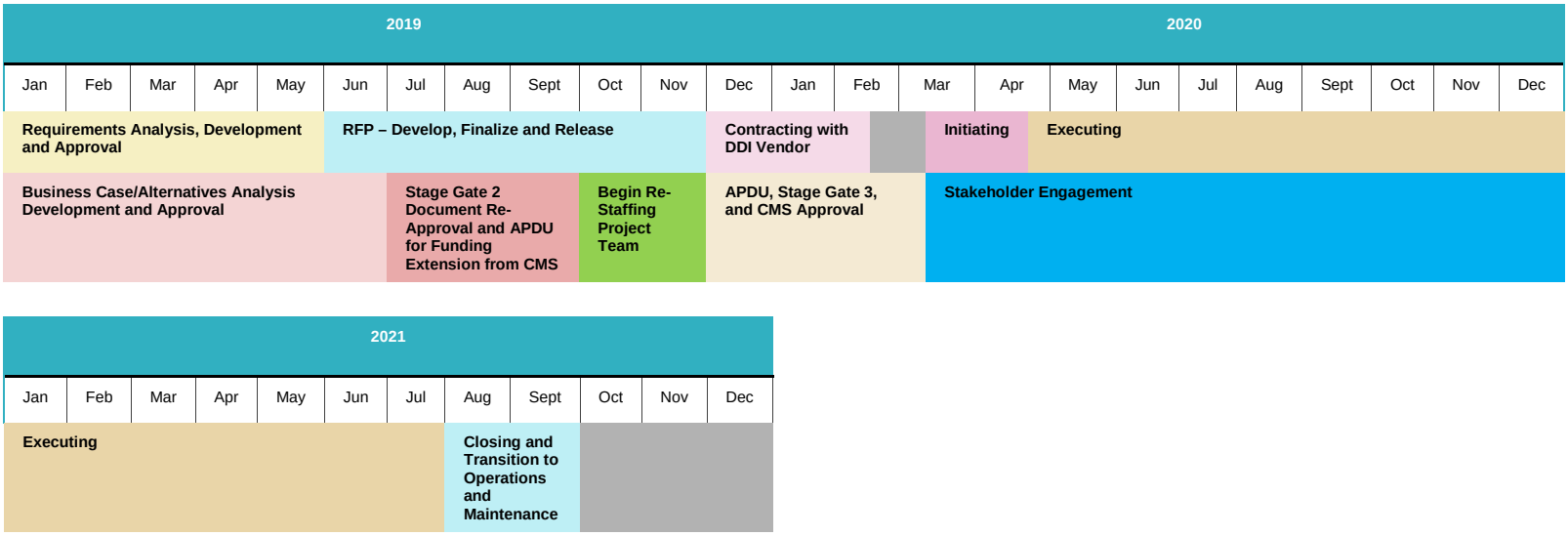
<u>Iterative Phases which would include ongoing Operations and Maintenance once implemented:</u>

1) Required data element capture through EVV compliant tool which may require manual entry of initial provider demographic information, individual demographic information, and service authorization details such as service period, authorized hours, type of service, etc.
2) Interfaces
    a) Implementation of inbound interfaces for provider demographic information, individual demographic information, and service authorization details such as service period, authorized hours, type of service, etc.;
    b) Implementation of outbound interface by extracting data from new solution to map to existing tables for payment processing via CEP.
3) OHA inclusion & Data Aggregation
    a) Phasing in other programs (OHA 1915i) over a longer timeframe
    b) Phasing in data aggregation as CMS delivers updated guidance

<u>Future Phases or Efforts:</u>

1) Payroll processing and interface with accounting and/or system
2) Potential opening to other program/agency participants

See below for a high-level proposed timeline for the solution implementation (Phases 1 minimally, Phase 2 potentially):



Appendixes and References

A. Acronym List
B. March 2019 Budget Update
C. Current State Process Flows
D. Future State Process Flow
E. Alternative Analysis Out of State Solutions (Spreadsheet)
F. Lessons Learned Report
G. In-Home Agency EVV Information (Spreadsheet)
H. COTS Basic + COTS Plus Customization (Galaxux)
I. Project Requirements
J. Payroll Requirements
K. Project Requirements Detailed Scoring
L. Alternative Analysis Cost Comparison
M. Mission Detailed Scoring
N. Alternative Analysis Risk Log
O. Project Risk Narrative
P. Approved PPL Deliverables (Reusable Project Artifacts)
Q. Alternative Analysis Scoring Matrix
R. Original Business Case

OSCIO IT Investment form

IT Investment Name:	Provider Time Capture (PTC) Project	Date:	08/20/2018
Agency:	Oregon Health Authority (OHA) & Department of Human Services (DHS)	Division:	Aging and People with Disabilities and Health Delivery Systems
Agency Contact:	Mike McCormick, APD Deputy Director	Phone Number:	503-945-6229
Approving Business Owner:	Mike McCormick, APD Deputy Director	Phone Number:	503-945-6229
Approving Technology Mgr:	Jon Debban	Phone Number:	503-947-5378

8/23/18

Approving Business Owner Date

Approving Technology Manager Date

Information Technology Investment Type(s):

☒ New Investment ☐ Renew/Life Cycle Replacement ☐ Other:

Information Technology Investment Description (What is being proposed and why):

In Oregon, the Department of Human Services (DHS) and Oregon Health Authority (OHA) are considered joint employers. Their Home Care Workers (HCW) /Personal Service Workers (PSW) programs must be modified to comply with the federal mandates under 21st Century CURES Act for an Electronic Visit Verification (EVV) system and U.S. Department of Labor's (U.S. DOL) Fair Labor Standards Act (FLSA). DHS and OHA must keep certain records for each HCW/PSW. The requirements apply to HCW/PSW's who provide personal and home care assistance to older adults and people with disabilities. Both federal mandates require that records include certain identifying information about the HCW/PSW and data about the hours worked. The law requires this information to be accurate and attested to by both clients and providers. DHS and OHA do not have shared technology in place necessary to meet the regulations.

In addition, Electronic Visit Verification (EVV) was created to help cut down on fraud and ensure that people receive the documented care they need. EVV was designed to help verify that services billed for home healthcare are for actual visits made.

A final component of this project is to enable payment services to the care workers through a Financial Management Agent Services (FMAS) option. The inclusion of a payment services option allows for an "end-to-end" process of capturing time and services through to payment.

An Information Technology (IT) solution will help minimize the long-term costs associated with increased workload, increased dependency on manual paper process and fraudulent reporting of services being provided to Medicaid recipients.

This project offers an opportunity for the State to develop and implement technology that will assist case managers in meeting the workload associated with HCW/PSW management. The solution should also assist

OSCIO IT Investment form

HCW/PSW and the consumers they serve in streamlining the service management portion of their relationship. The solution will do this with the following solution enhancements:

- Worker Portal – a secure web-based portal which allows Agency staff and partners to view and edit information pertaining to service planning and provider management.
- Provider Portal – a secure web-based portal which allows providers to enter time, view information about the service recipient(s) they serve, manage voucher/payment information, and update personal contact information.
- Service Recipient Portal – a web-based portal which allows service recipients (or their authorized representatives) to view necessary information about their cases and service plans. Service recipients will be able to validate reported hours and services, send requests, and update personal contact information through the portal.
- Database – a single, well-designed database to support all three portals listed above.
- Optimized Reporting – optimized reporting functionality providing access to current and historical service recipient and provider data in real time.
- Document Management – track, manage and store documents. The Solution will auto-populate and generate specified paper and electronic notices.
- System and Data Integration – ability to integrate and interface with a variety of systems real-time and batch including, but not limited to Medicaid Management Information Systems (MMIS).
- Role-based Security – the Solution will utilize role-based security allowing usage of internal and external partners as determined by the business.
- Multiple Access Channels - real time accessibility and data entry through web, and mobile technology. The Agency will be able to capture location using geospatial data accessible online or offline.
- Automated Workflow - automatic routing, processing, and integration between different functional software applications. Including validations, alerts, and notifications.
- Secure Payment Processing – ability to process provider payments directly through Financial Management Agent Services.

		Yes	***No***
1)	Is the investment a project?	☒	☐
2)	Will the investment have a Project Manager?	☒	☐
3)	Will the investment include other agencies?	☒	☐
4)	Will the investment include Information Asset Classification Level 3 or 4 data? (see DAS Policy 107-004-050)	☒	☐
5)	Will the investment be for Cloud Services (as defined in Policy #107-004-150)	☐	☒

IT Investment Estimated Cost Summary

Hardware:	N/A	**Software:**	N/A

OSCIO IT Investment form

Services/Maintenance (projected over five years):	$51,095,931	**Personnel (Project):**	$9,455,142
Source of Funding:	Federal Fund	**Deadline for fund use:**	dd/mm/yyyy
Anticipated Start Date:	10/06/2016	**Anticipated End Date:**	07/31/2021
		TOTAL:	**$60,551,073**

PROPOSED SUPERVISORY SPAN OF CONTROL REPORT

In accordance with the requirements of ORS 291.227, the Oregon Health Authority presents this report to the Joint Ways and Means Committee regarding the agency's Proposed Maximum Supervisory Ratio for the 2021-2023 biennium.

Supervisory Ratio for the last quarter of 2021-2023 biennium

The agency actual supervisory ratio as of December 17, 2020 is **1: 10.67** as published by DAS CHRO (see attached)

The Agency actual supervisory ratio is calculated using the following calculation:

1. **Total supervisors (i.e., vacant and filled supervisory positions) minus the Agency head position equals 451.**
2. **Total non-supervisors (i.e., vacant and filled non-supervisory positions) equals 4,813.**

The Oregon Health Authority has a current actual supervisory ratio of:

1:10.67	=	4,813	/	451
(Actual span of control)		(Total non - Supervisors)		(Total Supervisors)

When determining an agency maximum supervisory ratio all agencies shall begin of a baseline supervisory ratio of 1:11, and based upon some or all of the following factors may adjust the ratio up or down to fit the needs of the agency.

← Narrow Span		Wide Span →
High	**RISK TO PUBLIC/EMPLOYEE SAFETY**	Low
Dispersed	**GEOGRAPHIC LOCATION(s) OF SUBORDINATES**	Assembled
Complex	**COMPLEXITY OF DUTIES/MISSION**	Not complex
Low	**BEST PRACTICES/INDUSTRY STANDARDS**	High
Small	**AGENCY SIZE/HOURS OF OPERATION**	Large
Many	**NON AGENCY STAFF/TEMPORARY EMPLOYEES**	Few
High	**FINANCIAL RESPONSIBILITY**	Low
← More Supervisors		Fewer Supervisors →

Ratio Adjustment Factors

Is safety of the public or of State employees a factor to be considered in determining the agency maximum supervisory ratio? **Yes** ☒ **No** ☐

The safety and health of Oregonians is a major governmental priority and the reason the Oregon Health Authority was established. OHA's activities are indicative of these priorities, and include:

- Delivering integrated physical, behavioral, and oral health care services.
- Monitoring and addressing water quality.
- Strengthening the coordinated care model.
- Improving health outcomes health policy, and clinical improvement services.
- Administering health plans, group insurance policies and flexible spending accounts for state employees and their dependents.
- Administering medical, dental, vision and other benefits for Oregon's school districts community colleges, and education service districts.
- Addressing behavioral and social drivers of health by working to ensure that physical and social environments promote health.
- Reducing the need for costly health care services.
- Ensuring compliance with regulatory and health based standards.
- Protecting Oregonians from environmental health hazards.
- Preventing chronic disease, child developmental delays, and physical and behavioral problems.
- Ensuring emergency public health services in natural and human caused disasters.
- Helping people recover from their mental illness and return to life in their communities.

All of these Agency functions contribute to the safety, health, and the overall quality of life of all Oregonians and requires a narrow span of control to administer and provide oversight to this major governmental priority.

Is geographical location of the agency's employees a factor to be considered in determining the agency maximum supervisory ratio? **Yes** ☒ **No** ☐

The nature of the Agency's work has statewide impact and touches all Oregonians, spanning the four corners of the state. The Agency has presence in forty-five distinct facilities and in 18 cities, including rural and major metropolitan areas, ranging from St. Helens to Ontario; and from La Grande to Medford. Such broad dispersion requires a narrow span of control for effective oversight.

Is the complexity of the agency's duties a factor to be considered in determining the agency maximum supervisory ratio? **Yes** ☒ **No** ☐

The public's health is a major indicator of quality of life. OHA's mandate is a primary driver affecting quality of life of all Oregonians. Ensuring that the Agency's mandate is met requires a complex framework of activities and a narrow span of control in order to provide the appropriate oversight to staff. The complexity of the Agency's duties is further reflected through the knowledge, skills, and abilities that required by most Agency positions in order to perform their deliverables. To determine Agency complexity, the Agency has made a thoughtful exposition of the complexity of its programs and provided an objective framework to determine the complexity of individual Agency positions in addressing this complexity factor.

Are there industry best practices and standards that should be a factor when determining the agency maximum supervisory ratio? **Yes** ☐ **No** ☒

OHA, as an organization, is *sui generis*. The various components (e.g., OSH, HSD, PEBB, OEBB, etc.), which the State of Oregon has brought together under one umbrella, are discrete governmental functions-yet interrelated. However, in most states, these various functions are performed by distinct organizational entities. Given the multi-program nature of the Agency, and its multiple objective, it is not possible to obtain a span of control ratio, or schema that would reflect an industry best practice or standard, in relation to such a broad and varied mandate. Neither federal, nor state governmental entities that OHA is aware of, survey for span of control data on an industry-wide basis that would be an analogue to the varied functions OHA performs. There are private sector organizations that provide span of control research and other related benchmarking data, but they are limited to unrelated private sector industries (e.g. finance, insurance, technology, utilities, etc.). Furthermore, the data is restricted to a few companies and only provided these data to their members. Although some of these members may include public sector entities, the data does not have "industry wide" breadth, to establish relevant benchmarks for OHA's organizational needs, or establish a best practice.

Is size and hours of operation of the agency a factor to be considered in determining the agency maximum supervisory ratio? **Yes** ☒ **No** ☐

The Oregon State Hospital provides services 24/7. Agency FTE's allocated to the OSH program constitute a majority of OHA positions. In addition, the emergency support function (ESF-8), provided by the Agency, and requires the associated staff to be prepared, at a moment's notice, in the event an emergency situation arises.

Are there unique personnel needs of the agency, including the agency's use of volunteers or seasonal or temporary employees, or exercise of supervisory authority by agency supervisory employees over personnel who are not agency employees a factor to be considered in determining the agency maximum supervisory ratio? **Yes** ☒ **No** ☐

The Agency has classes of workers that are neither permanent nor limited duration. These workers include temporary workers (including GALT temporary workers), contractors, interns, student workers, and volunteers that in many instances work under the control of Agency supervisory positions. The duties performed by these workers range from audiologists to trauma managers. These classes of workers not only need to be on-boarded through the ad hoc personnel processes that have been established (e.g., background checks, system password issuance, computers, desks, etc.), but in some instance may require supervisory oversight to ensure the State's and Agency's codes of conduct are adhered to, and performance standards are met. These activities add to the managerial burden. Hence, these workers are within the span of control relationship of the organization.

Is the financial scope and responsibility of the agency a factor to be considered in determining the agency maximum supervisory ratio? **Yes** ☒ **No** ☐

The Oregon Health Authority seeks to protect and promote the health and safety of all Oregonians; and, reinforces the State's commitment to making the public's health a foundational pillar of the State's goal to enhance the quality of life of all Oregonians. Funding for OHA's mandate reflects the importance that both the Legislature and the Governor has placed on this priority. To provide for this mandate the legislature allocates the largest portion of the State's funds towards the goal of achieving the Agency's mission.

Based on the foregoing factors DAS CHRO has authorized an "Agency Maximum Supervisory" ratio of 1:8.6

as published by DAS CHRO (see attached)

Unions Requiring Notification_____

Date unions notified_____

Submitted by: _____ **Date:_____**

Signature Line _____ **Date _____**

Signature Line _____ **Date _____**

Signature Line _____ **Date _____**

Signature Line _____ **Date _____**

Oregon Health Authority
Audit Response Report

1. Oregon Department of Human Services (ODHS) and Oregon Health Authority (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 procedures that affected the fiscal year 2018 audit were updated and no additional errors were present in the fiscal year 2019 audit.

- 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.

  This audit finding was partially mitigated by OR-Kids JIRA# 25911 – as the system not allowing placement corrections on service types with age bracketed services. This system correction will now calculate the Placement Begin Date against the participant's DOB, allowing retroactive placement corrections for all age bracketed service types.

  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 to accurately report federal expenditures. The new report will be used for the reporting period ending June 30, 2020.

- *Questioned costs in this finding were repaid for both IV-E and Medicaid and reported March 31, 2019 as follows:*
- *IV-E amount of $92,487 was adjusted on the March 31, 2019 CB-496.*
- *Medicaid questioned costs were adjusted on the March 31, 2019 CMS-64 report in the amount of $45,339.*

- 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.

  The department has taken positive steps since the fall of 2016 to improve its business reporting capabilities for tracking and remediating untimely Medicaid redeterminations. The department expects that the technological advancements and improved functionality of the new Integrated Eligibility (IE) system will provide greater operational opportunities to strengthen its client eligibility controls specifically related to the timeliness of determinations, correct enrollment and the electronic retention of required eligibility data elements such as signed applications. In addition, the department is engaged in efforts to restructure existing caseworker training to support and align with the new Integrated Eligibility system, which will reduce the risk of administrative errors. Similarly, the department expects that the statewide implementation of the Centers for Medicare & Medicaid Services (CMS) approved electronic Asset Verification System (AVS) will provide client resource information in a more timely, robust and comprehensive manner. All unallowed costs have been repaid.

- 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) finalized the process of amending the contract with PPL, the Fiscal Intermediary, to validate the I9's prior to paying providers. In addition, questioned cost of $5,573 has been reimbursed as of September 30, 2018.

The Provider Enrollment unit has implemented the quarterly data pull for missed checks. Initially how the data was pulled from MMIS and the content of the data caused delays due to the volume and sorting through the provider file. Those issues are being worked through and as additional reports are pulled the process will become more streamlined. The next data pull is on track and scheduled for July 2019.

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.

2. 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.

  OHA has an established relationship with licensing boards and has collaborated to increase enrollment. Since there will always be new licensees moving into the state or obtaining a first-time license this collaboration will be on-going with annual lists being provided to licensing boards to allow for targeted outreach.

- Provide guidance, including examples, to prescribers on ways to integrate accessing the PDMP database into their daily workflow.

1. *OHA will review and update the PDMP website to ensure the broadest possible reach of these resources. In process, to be completed by June 1, 2019.*

   Clinical tools available to educate and support prescriber workflows for integrated PDMP:

   Oregon Public Health Prescription Drug Monitoring Program (PDMP) is committed to providing the right guidance and tools to support prescribers. Opioid Prescribing Guidelines Taskforce members, in collaboration with the Public Health PDMP, developed opioid prescribing guideline implementation tools in 2017, which include: example 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.

   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 materials are being made available on the PDMP page as of June 1, 2019. The PDMP program website (currently orpdmp.com) is migrating to a new platform to increase visibility and transparency. These tools will be part of the new PDMP page when live.

2. *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.*

   Training and technical assistance on PDMP use in clinical workflows:

   The Public Health Division's Prescription Drug Overdose prevention project supports training and in-person assistance on PDMP clinical use and workflows through contracts with members of the Pain Management Improvement Team. This team is 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. Clinics in need of assistance are identified in collaboration with the Oregon Medical Board. Prescribers, through this opportunity,

learn how to integrate into their workflows PDMP access and use. This work has been nationally recognized as a model for a team-based primary care approach to address the opioid epidemic.

3. *In response to this recommendation, this (PDMP Integration initiative) work will continue. Statewide PDMP Integration Initiative:*

   The PDMP Integration initiative enables prescriber and pharmacist to integrate health IT systems with the PDMP for improved access to the data at the point of care. This initiative launched in August 2018 by the Oregon Health Leadership Council, OHA, and other stakeholders under a public/private partnership called the HIT Commons. It 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. The initiative provides guidance on how prescribers can integrate PDMP into their health IT to enable one-click or instant access to the data within their workflow. As of March 30, 2019:

   - *100 entities, representing 6,040 prescribers, are LIVE with PDMP integrated in their electronic health record (EHR), Emergency Department Information Exchange (EDie), or health information exchange (HIE);*
   - *3 pharmacy chains (570 pharmacists) are LIVE with PDMP integrated into their pharmacy management systems;*
   - *19 entities, representing 6,727 prescribers are scheduling go-live dates; and*
   - *93 entities, representing 2,930 providers, have started applications.*

- Verify practitioner specialty information with the respective health licensing board and update the PDMP database with this information.

In October 2018, the PDMP team pulled a comprehensive list of all PDMP profiles with missing prescriber specialty. The list was then organized by licensing board and divided among 5 PDMP staff to manually look up each licensee on their respective licensing board databases and obtain missing information.

Between November 1, 2018 and December 31, 2018, the PDMP team added specialty of practice to all PDMP user profiles. Totaling approximately 1,350 updates. A final review was performed on January 3, 2019 to ensure no profiles were overlooked; after which this project was closed.

Specialty of practice is now listed for every PDMP profile and since the new PDMP platform requires that it be entered when creating an account, it is captured for all new users.

- 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.

  Provide best practices to legislators when requested to justify or deny sharing data between the PDMP and Medicaid for quality assurance and benefit of clients.

  The Oregon Health Authority leadership and Oregon Health Authority policy advisors have developed a close working relationship with the Oregon legislature and the many stakeholders invested in Oregon's response to the opioid epidemic. If requested the Oregon Health Authority is prepared to provide information and evidence to the legislature to support altering the Oregon law to allow Medicaid access to PDMP data.

- 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 the 2019 legislative session, OHA supported and collaborated on multiple legislative changes allowing for new drugs to be collected in the PDMP.

House bill 2257 is supported by OHA and would require gabapentin to be collected and displayed in the PDMP. OHA has collaborated to modify Senate bill 910 to include provisions that would allow OHA to determine which drugs to collect in the PDMP by administrative rule rather than through statute.

OHA has facilitated and participated on the Governor's Opioid Epidemic Task Force since 2017. The Task Force consists of medical experts, drug treatment specialists, and government officials. Their mission is to identify and implement efforts to address the growing opioid misuse and abuse across the state. This task force was instrumental in prioritizing legislative changes to effectively combat the epidemic, House Bill 2257 contains its recommended changes.

OHA is actively utilizing the appropriate channels to makes legislative changes to combat the opioid epidemic and recommend additional drugs be collected in the PDMP.

- 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.

  In December 2018, PDMP staff worked with SAMHSA and obtained a list of Oregon providers with x-DEA numbers. This list is not guaranteed to be comprehensive but did allow PDMP staff to update 800 provider PDMP profiles. SAMHSA will provide Oregon with supplementary lists periodically to allow PDMP staff to update profiles. The first of these supplementary lists was received in April 2019.

  Between December 2018 and April 2019, PDMP compliance staff reviewed data submitted by pharmacies where an x-DEA was listed to proactively identify discrepancies between pharmacy submitted X-DEA numbers and X-DEA numbers listed in PDMP user profiles. This allowed PDMP staff to identify providers not listed in the SAMHSA

provided list and add X-DEA numbers to an additional 400 providers. PDMP staff will routinely use pharmacy data to identify X-DEA numbers and add them to PDMP profiles on an ongoing basis.

Between December 2018 and April 2019 PDMP staff added approximately 1200 X-DEA numbers to user profiles. Identifying X-DEA numbers not captured in the SAMHSA lists will be an on-going project for PDMP staff to ensure providers are able to see all of the prescriptions written under their DEA and X-DEA numbers.

- 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

OHA has provided best practices to legislators when requested to justify or deny preparing and issuing unsolicited reports to licensing boards and law enforcement.

HB 4143 passed during the 2019 legislative session allowing for the PDMP Advisory Commission Subcommittee to evaluate Oregon providers prescribing history and determine who ought to receive a prescribing report card. Report cards were available to prescribers 2nd quarter 2020.

Providing unsolicited reports to licensing boards and law enforcement is not allowed under the Oregon statute governing use of PDMP data. The Oregon Health Authority leadership and Oregon Health Authority policy advisors have developed a close working relationship with the Oregon legislature and the many stakeholders invested in Oregon's response to the opioid epidemic. If requested, the Oregon Health Authority is prepared to provide information and evidence to the legislature to support altering the Oregon law to allow these groups access.

- 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 will provide best practices to legislators when requested to justify or deny stronger enforcement of mandate to register with the PDMP.

The Oregon Health Authority leadership and Oregon Health Authority policy advisors have developed a close working relationship with the Oregon legislature and the healthcare licensing boards. The OHA is invested in improving compliance with the existing statute requiring licensees to register with the PDMP and requiring pharmacies to submit corrected data. If requested the Oregon Health Authority is prepared to provide information and evidence to the legislature to support altering the Oregon law to improve enforcement.

OHA will continue to work with the legislature and advocate to increase participation in the PDMP for prescribers. Registration is mandated but not enforceable. Licensing boards are actively communicating with prescribers about the importance of registration and utilization.

- 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 Oregon Health Authority leadership and Oregon Health Authority policy advisors have developed a close working relationship with the Oregon legislature and the many stakeholders invested in Oregon's response to the opioid epidemic. If requested, the Oregon Health Authority is prepared to provide information and evidence to the legislature to support strengthening the authority of the subcommittee.

- Expand authority for other professional and state entities authorized access to PDMP information.

  The Oregon Health Authority leadership and Oregon Health Authority policy advisors have developed a close working relationship with the Oregon legislature and the many stakeholders invested in Oregon's response to the

opioid epidemic. If requested the Oregon Health Authority is prepared to provide information and evidence to the legislature to support altering the Oregon law to allow expanding access to addition professional and state entities.

- 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.

  The Oregon Health Authority leadership and Oregon Health Authority policy advisors have developed a close working relationship with the Oregon legislature and the many stakeholders invested in Oregon's response to the opioid epidemic. If requested the Oregon Health Authority is prepared to provide information and evidence to the legislature to support altering the Oregon law to require mandatory use of the PDMP under certain circumstances.

- 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 provided best practices to legislators when requested to justify or deny altering the statute governing the PDMP to allow for the above practices to be implemented.

HB 4143 passed during the 2019 legislative session requiring the pharmacy to report diagnosis code to the PDMP when provided, this began January 1st, 2020.

The Oregon Health Authority leadership and Oregon Health Authority policy advisors have developed a close working relationship with the Oregon legislature and the many stakeholders invested in Oregon's response to the opioid epidemic. If requested, the Oregon Health Authority is prepared to provide information and evidence to the legislature to support altering the Oregon law to require reporting of schedule V drugs, collection of prescriptions from other types of pharmacies, collections or veterinarian prescriptions, and collection of method of payment and lock-in contracts in the PDMP.

3. ODHS and OHA: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2018, audit #2019-14 (dated March 2019)

- Recommend management ensure year-end reporting methodologies reflect a complete understanding of transaction relationships as well as proper application of amounts provided by other entities.

  The year-end task list shows the annual meetings with each unit, including the Management Reporting Unit (MRU) of the Office of Financial Services, to provide information and inquire of changes. The fiscal year 2019 year-end list, Office of Financial Services MRU, is the actual agenda for items discussed with each unit. The MRU specific items include inquiring of new program revenues and expenditures.

- Recommend management implement monitoring processes to provide assurance over the accuracy of the MMIS claims edits and audits, as well as implement processes to understand the edits and audits controls and test their effectiveness and completeness. Additionally, management should continue to work with their service provider to maintain a comprehensive inventory of current MMIS edits and audits.

The claims edit and audit testing plan was reviewed internally and approved by both the MMIS Business Support Unit and the Office of Financial Services. The plan was put into effect on April 1, 2019 and two quarterly deliverables have been provided to demonstrate the testing that has occurred so far in 2019. The MMIS Claims Edits and Audits testing is being conducted by the MMIS contractor, DXC.

An MMIS Claims Edits and Audits Monitoring plan was developed and implemented on November 1, 2019. The monitoring plan involves the following approaches:

- *Utilize the weekly Flush Claims report*
- *Work with the Claims analysts in MMIS BSU to identify areas that need to be monitored*
- *Monitor new edits and audits to be certain they are functioning properly*
- *Research and monitor edits and audits when Provider Services identifies a provider whose claims are denying*
- *Research and monitor edits and audits when the HSD Claims unit identifies any anomaly with a claim edit issue*
- *Work with the MMIS BSU Financial team to do research on an edit they see as inconsistent with what they would normally see when fixing flushed claims*
- *Monitor edits and audits around issues identified by the Program Integrity Unit in OHA*
- *Monitor claims identified during the bi-weekly interaction with DXC*
- *Pulling of random edits and audits from the comprehensive list*
- *Monitor edits and audits through the MMIS User Acceptance Testing site when claims changes are being tested for promotion to the Production site.*

Two quarterly deliverables are being produced. One for testing activities and one for monitoring activities. OHA maintains a comprehensive electronic inventory of current MMIS edits and audits. The revised and updated list is provided quarterly by the MMIS contractor, DXC.

All new edits for MMIS are first tested and validated through the MMIS User Acceptance Testing site. They are tested by three different groups: DXC, MMIS BSU and an analyst from the Medicaid Policy team in Health Systems Division. Once all three have validated the accuracy of the edit or audit is correct, the change is promoted to the MMIS Production site. Those new edits and audits are then part of the ongoing monitoring plan.

Gainwell Technologies tests the top 20% of financial edits each year and a select number of edits are monitored by the MMIS BSU. HSD is in full compliance with the recommendations of this finding.

- Recommend management strengthen the review of contracts to ensure the correct funding sources are included and that contracts and the subsidiary system agree.

*The Contracts Unit of HSD is responsible for contracting the majority of the Behavioral Health Services. These services are identified by service element name and number; each service element describes a specific mental health or substance use disorder services to be provided. The funding associated with each service element is found in a contract's financial pages. All funding is classified under one of four primary sources: general funds, federal funds, other funds, and lottery funds. However, the financial pages provide line-item detail that includes the name and number of the fund, corresponding to the revenue source, from which payments are to be made. The Contracts Unit enters the detailed financial information for each contract into R*BASE, a financial system also used by Office of Financial Services (OFS) for contract payments.*

The Contracts Unit was notified of the audit finding regarding a discrepancy between the fund name and number identified in a contract's financial pages and the actual fund name and number from which OFS made payment. We discovered that the language in the County Financial Assistance Agreements (CFAA) limited payment by OFS to the

specific fund identified in the financial pages. The intent is to adhere to the funds and funding sources listed but there are times when funding is insufficient—a frequent occurrence—to cover payments due. Therefore, to make the payments, the Contracts Unit had to issue an amendment just to change the fund number so OFS could make the payment.

After meeting with OFS, it was agreed that transferring between funds within the same primary category (GF, FF, OF, LF) would allow OFS to meet its statutory requirement for prompt contractor payments when revenue was insufficient under another fund number. This would also eliminate the need to issue frequent amendments for simple administrative fund movements. It also reduced the cost to the contractor as a result of fewer amendments being required. The corrective action taken was to modify the terms in the CFAA, by adding a short disclaimer at the end of the fund number listing in the "Explanation of Financial Pages" exhibit.

During this process, an error was discovered in the "Explanation of Financial Pages" exhibit, errantly identifying fund "888 Gambling Treatment" as general funds. The correct identification should have been lottery funds. That was corrected, along with the language change mentioned above. The CFAA was amended once both issues were addressed.

This item is implemented due to action taken in the new contract language that went into effect on July 1, 2020.

- Recommend department management implement procedures to gain an understanding of controls over transactions processed by service organizations and follow established procedures to ensure all revenue due to the department is received.

  By implementing the items below the Program can more easily monitor claims activity and follow up quickly with our Pharmacy Benefit Manager (PBM) and contract pharmacies relating to contract compliance, when necessary. We include this analysis in our bi-weekly operational meetings with the PBM and it is reviewed at our monthly 340B Oversight Committee and Financial Review meetings. We can be confident that the revenue numbers reporting on

both federal grant and state fiscal year reports are reconciled to SFMA and to the PBM's external accounting system as well.

- ***Developing and updating policies and procedure documents pertaining to the collection, process and summarization and analysis of program income***

  Department management immediately implemented procedures for the receipt and reconciliation of pharmaceutical cost recoveries, known as "Program Income for Insurance Claims Reimbursements Revenue" (AOBJ 2653). Policy documents to formalize the newly refined processes are under review awaiting final approval.

- ***Creating an accounts receivable (AR) model in Excel to track amounts owed to the Program by the seven contract pharmacies for insurance claim reimbursements***

  The Program audited all program income transactions, both billing and payments, back to July 1, 2015. An excel tracking sheet was created to download and record contract pharmacy accounts receivable invoices directly from the Program's Pharmacy Benefits Manager's (PBM) database. Payment tracking is included on the accounts receivable tracking sheet to ensure reconciliation to PBM's portal as well as to OFS daily cash reports received from the state's receipting office in Salem.

  Enhancements to the tracking sheet were added to expand reporting periods for both federal and state fiscal years. This allows the Program to track amounts carried forward from year to year, as well as to generate predictives for budgeting and program income activity. This information supported requests for limitations reporting, and the Legislative Fiscal Officer to understand and learn about our program's activities. These predictives are actively used by program management to better understand and detect changes in program income activities by the PBM, acting as fiscal intermediary, as well as contract pharmacy transactions claims activity in general.

- ***Downloading all invoiced claims into a secured portal to add to the AR model***

  Program income insurance claims reimbursement invoices are generated by the PBM's accounting system and posted to their secure portal semi-monthly. The Program downloads the information and imports these directly into the program income/accounts receivable tracking sheet in excel format on the 1st and 16th of each month. The new entries are compared to the prior download to observe all changes to the PBM Portal since the last download.

- ***Evaluating amounts due from each PBM on a biweekly basis and following up using collection procedures for any that are past due***

  Program management reviews our program income's accounts receivable position and contract pharmacies' contract performance on a monthly basis at our 340B compliance committee meeting and follows up with contractors accordingly. At our request, our PBM is also including an accounts receivable summary semi-monthly to show the outstanding (unpaid) invoices currently owed to the program.

- ***Posting payments daily into the AR mode***

  Daily, the Program posts cash receipts sent by the PBM, who directly receives contract pharmacies' insurance claim reimbursement billings payments as part of their fiscal intermediary services provided for in their contract. Each month, these cash receipts are recorded and compared to both the OFS Receipting Unit's monthly cash receipt report for both amount and AOBJ coding and then reconciled to SFMA accounting system.

- ***Evaluating, reconciling and summarizing revenue to determine budget versus actual on a weekly basis***

Program income invoices are recorded and summarized on a biweekly basis when PBM generates contract pharmacy billings. Payments are applied to the specific invoice numbers as they are received by the Program on a daily basis. Reports are generated from the excel model and reviewed by program management and the 340 Monitoring Committee. Contract pharmacy performance is discussed, including billing and payment practices.

- Recommend management implement monitoring processes to provide assurance over the accuracy of MMIS claims edits and audits, as well as implement processes to understand the edits and audits controls and test their effectiveness and completeness. Additionally, management should continue to work with their service provider to maintain a comprehensive inventory of current MMIS edits and audits.

  The plan around the response to this original audit is itself fully implemented, and annual reviews of the process will continue for an unspecified period by the SOS auditors. There was a verbal finding in 2019 determined by the SOS Auditor that has to do with the mitigation against an authorized user in MMIS, who is permitted to add edits and audits to the MMIS, from entering incorrect edits or audits, either by mistake or intentionally. There are only four users in MMIS who can add edits and audits to the system, but there is no objective process for monitoring the changes those four make in the system as an "upstream process." Downstream, the edits and audits will catch an error, but the idea is to mitigate against a potential error at the start of the edit and audit entry into MMIS. We are exploring options to have a process that would ensure we can monitor those changes more closely and put controls in place that would keep someone from entering an edit or an audit either incorrectly or without authorization. Along those lines, we have implemented annual manager reviews of employees to be certain that proper access is given to each MMIS user. Additionally, new reporting structures are currently being built into the Security tool where roles are granted. One of those reports will give us a "thumb print" of any user in MMIS as to where in the system they have been and actions taken by that individual.

  The entire process for getting a new edit or audit into MMIS is quite extensive and has a number of checks and balances within the change request process for MMIS. Regarding MMIS claims edits and audits, not only is the

detailed change request process used, but no edits or audits, after having been extensively tested, can be put into MMIS without three signatures. There is also extensive documentation around this process that has been previously provided to the SOS auditors.

With regard to the "actual" finding, the claims edits and audits testing and monitoring plans were implemented in 2019. The testing of the top 20% of edits and audits with the greatest financial impact started being tested by DXC in April 2019. In November 2019 the plan for monitoring of other edits and audits was started and quarterly deliverables are sent to the SOS Auditor's office, as well as the posting of deliverables on the Team Central site with an update.

The claims edit and audit testing plan was reviewed internally and approved by both the MMIS Business Support Unit and the Office of Financial Services and put into effect on April 1, 2019. Two quarterly deliverables have been provided to demonstrate the testing that has occurred so far in 2019. The MMIS Claims Edits and Audits testing is being conducted by the MMIS contractor, DXC. An MMIS Claims Edits and Audits Monitoring plan was developed and implemented on November 1, 2019. This activity will be conducted by the MMIS Business Support Unit. A quarterly deliverable will also be completed to represent this activity as well.

Two quarterly deliverables are being produced. One for testing activities and one for monitoring activities. OHA maintains a comprehensive inventory of current MMIS edits and audits, electronically. Both the Medicaid Policy Unit and the MMIS Business Support Unit maintain a current list. The revised and updated list is provided quarterly by the MMIS contractor, DXC.

- Recommend department management investigate and identify the extent to which client income was verified. Also recommend department management provide appropriate notification and training to staff to ensure that data is entered in a manner that would ensure the ONE system appropriately accesses the hub to verify income eligibility.

The department has provided additional guidance by way of an all-staff transmittal issued in March of 2019, has updated the staff eligibility manual in April 2019, and made an update to the ONE eligibility system on April 11, 2019 to default the question about verification to trigger the Federal Data Services Hub. This update was done to ensure the Hub is pinged, regardless of the avenue in which the application is entered, when no one on the case has income. After the system update, guidance regarding the update was put in an agency-wide newsletter in May of 2019 and an all-staff transmittal was sent in August 2019. Staff training was also held.

The department added an updated guide on the "No Income Verification Section" as a link to the staff eligibility manual. Per A-10-19-63645, the federal agency concurs with the corrective action and timeline.

- Recommend management strengthen controls to perform timely eligibility redeterminations and verification of client income, and ensure eligible clients are appropriately enrolled in both Medicare and Medicaid. Additionally**,** we recommend management provide periodic training to caseworkers to reduce the risk of administrative errors. We also recommend management correct all identified issues and reimburse the federal agency for unallowable costs.

  Approximately 90% of APD rule changes required for the implementation of the integrated ONE system on July 6, 2020 are complete and training materials have been updated to reflect these changes. The remaining 10% of rule changes will be effective on July 6, 2020. Cross program training, which covers, MAGI, OSIPM and Medicare Savings Programs, is in process and will be delivered prior to the new system's rollout in each area. This will ensure that staff across Aging and People with Disabilities and Self-Sufficiency programs are knowledgeable in all Medicaid programs, and that eligibility is determined timely, accurately, and with the required verifications.

  An adjustment for $35,153 FF (100% FF) was processed and reported on CMS-64 FFY20Q2.

- Recommend department and authority management strengthen controls to ensure documentation supporting a provider's eligibility determination is retained. We also recommend department management reimburse the federal agency for cost paid related to the ineligible provider.

  Questioned costs of $8,518 were adjusted through the JH system with document BTJHCQAP. The effective date of the adjustment is January 19, 2020.

  A missed data base verification has been added to the enrollment staff self-reporting spreadsheets. The state is reviewing a report to complete any missed required validations every three months.

  The automated solution is still a work in progress and will not begin to replace staff database checks until March 2020. We are also reviewing an automated missed check tool or a daily query to ensure missed checks are fixed within one business day.

- Recommend management ensure changes to the cost allocation process are included in its change log to ensure all changes are incorporated in subsequent plan submissions. Further, the department should ensure the discrepancies identified are corrected in the next plan submission.

  Our new procedure is to document all correspondence in a log with a number, brief description and which plan year it applies to. Additionally, with each update requested, the plans are being produced in their entirety where each version builds on the prior so that the most recent plan or update is always the most current and inclusive of all changes and or updates. Regarding the Random Moment Sampling, most of those activity codes required narrative updates only to ensure the description of the calculation was accurate.

  There were two activity codes that resulted in claiming differences:

  Activity Code 4.A.8 – Pre-Finalized Adoption Assistance Case Management – The penetration rate used in activity code 4.A.8 is based on IV-E Foster Care. This rate should have instead been based on IV-Adoptions. The funding

source charged for this activity, however, was in fact "TITLE IV-E ADOPTION ASSISTANCE". Because the Federal Funding source is correct, there is no adverse impact to reporting. Because the Foster Care penetration rate is lower (57.07%) than the Adoptions rate (86.24%), the resulting impact on claiming is that Oregon under-claimed to IV-E. Since the amount that is not funded by IV-E is charged to State Funds (GF), as such no correcting entry is necessary.

Activity Code 4.A.2 Transportation for Medical, Dental, And Mental Health Services – The penetration rate used in this activity is XIX Foster Care (XIX FC) eligible children. The rate should have instead been XIX weighted / blended (based on Foster Care and In-Home). The approximate difference in rates is 2.5% less when using a blended rate. As a result, the agency over-claimed to title XIX. Activity code 4.A.2 accounts for approximately 1.77% of Child Welfare Survey results. The overall impact to Child Welfare RMSS results is 0.043% (or a 2.5% XIX reduction in the 1.77% of survey responses in activity code 4.A.2), the Federal Fund impact and correcting entry is estimated at approximately $63,000.

The entry for 4.A.2 was made with document numbers BTCC2130 through BTCC2136. Total Federal Fund impact was $36,204. The initial estimate was based on averages versus a month by month calculation. This was reported on the CMS-64 FFY19Q4.

- Recommend management strengthen internal controls to ensure all costs entering the cost pools are allowed and for the correct amount. Further, the department should identify any additional mileage rate errors and correct all known issues.

  The agency has a regular process to review for duplicate payments; however, the questioned payment was missed. It was corrected October 30, 2018 on document AR075480 for $2,201.

  Also, the agency will be working with program staff to ensure they understand that submissions for court witness mileage reimbursements are paid a different IRS per diem rate. The agency reviewed court witness mileage reimbursements and found an additional 27 transactions paid at the inappropriate rate, resulting in $535.33 in

overpayments. This amount was adjusted March 15, 2019 on BTCL1177. The questioned cost of $18.20 was also adjusted March 13, 2019, on BTCL1176.

4. Oregon's Framework for Regulating Marijuana Should Be Strengthened to Better Mitigate Diversion Risk and Improve Laboratory Testing, audit #2019-04 (dated January 2019)

- Recommend OHA enforce existing data reporting requirements for medical marijuana growers.

OMMP created a plan to address non-compliance with reporting for growers and grow sites using the monthly Oregon Medical Marijuana Online System (OMMOS) as well as grow sites with 3 or more patients that were required to track using the Cannabis Tracking System (CTS).The program's enforcement priority was to target those registrants not complying with the CTS tracking requirements first as statute provided that OHA must revoke or not renew grow sites that did not comply with the law by July 1, 2018. At that time. there were 365 grow sites that were out of compliance with the law. Enforcing this tracking requirement was a time-consuming process and the program is still addressing many enforcement actions through appeals, hearing, settlement agreements and follow-up to ensure the settlement agreements are being adhered to.

Enforcement of non-reporting for those using OMMOS will begin with warning letters sent to all growers at grow sites who do not report for the month. They will have 15 days to report or be charged a civil penalty. Notices of Intent to Impose Civil Penalties will be sent to those who do not comply. For those who still do not comply OMMP will issue a Notice of Intent to Revoke, followed by issuing a Final Order of Revocation if a hearing is not requested.

It is important to note the volume of citations needed to address non-reporters will strain OMMP's staff resources and also impact the Department of Justice's resources to assist with thousands of potential contested administrative hearings.

- Recommend OHA establish inspection frequency goals and metrics and determine how many inspectors are needed to meet those goals.

  There were no changes made to the program's position authority from Oregon Legislature during the 2019 session. The Compliance Unit continues to be short staffed to handle a significant and time-consuming work- load. Currently, the unit has four permanent Compliance Specialist 3's (CS3) and one limited duration CS3. One of the four has been on a job rotation and the employee in a limited duration position is leaving the program in July. This will leave only three to manage the workload. The Compliance Unit also has a limited duration Compliance Manager position and limited duration Compliance Specialist 1 position that terminated on June 30, 2019 but have both been extended until the end of 2019 due to the workload.

  The work of the Compliance Specialist 3's consists of conducting inspections of grow sites, dispensaries, and processing sites, completing post inspection reports, investigating complaints, and issuing enforcement actions from OLCC medical marijuana grow site inspections. This work takes time and requires a lot of travel, follow up with OMMP registrants, OLCC, DOJ, and writing various enforcement actions and civil penalties.

  The program is working on completing a monthly report to measure our success. There have been substantial barriers in creating this report as information is stored in various locations and excel sheets. The program is working with OIS to revise our current database to help track inspections and enforcement actions. Initial indications show that the Compliance Unit is not meeting the goal of 4 grow site inspections a week per position. Without more positions, the program will continue to be challenged in meeting this goal. Management will continue to work with and coach staff, to improve the reporting features to have easily reliable data and continue to coordinate inspections and process improvements with OLCC.

  The Oregon Medical Marijuana Program (OMMP) tracked the workload of the Compliance Unit monthly, including inspection frequency, to help determine inspection goals and metrics.

The program struggled to balance inspections of OMMP registered locations with enforcement of violations referred from the Oregon Liquor Control Commission (OLCC). OLCC was given legislative authority in 2018 to conduct inspections of certain medical marijuana facilities. OMMP has delegated inspection responsibility to OLCC for all grow sites reporting into the Cannabis Tracking System (CTS), including all sites with 3+ patients designated. The enforcement for any violation conditions observed by OLCC inspectors remains the responsibility of OMMP inspectors to pursue. Such cases are referred to OMMP.

This case work represents a significant, time-consuming, and necessary function of the OMMP Compliance Unit, but which reduces the unit's ability to conduct grow site inspections. Efforts to conduct OMMP inspections were further complicated when the program lost two temporary compliance staff in the summer of 2019, leaving the team to just four permanent positions with no support staff compared to OLCC's staff of fifteen. Given the shortage of compliance staff, OMMP cannot adequately establish frequency of inspection goals and performing routine inspections will continue to be a challenge.

- Recommend OHA, under the guidance of the Governor's office and the Legislature, review the level of authority OMMP needs to improve its regulatory framework for security, product tracking, and bolster resources for inspections, or consider placing the medical marijuana compliance program within the existing Oregon Liquor Control Commission (OLCC) authority and control framework.

  In our Operations and Compliance Assessment, submitted to the Oregon Cannabis Commission in May 2018, we acknowledge the shortcomings OHA has in regulation and that policy makers are working towards determining which agency is and should be responsible for specific components of the law.

  OHA awaits direction from the Oregon legislature regarding this recommendation and will support decision making with data and evidence-based practice.

There were no changes made to OMMP's authority regarding regulatory framework during the 2019 Oregon legislative session.

- Recommend OHA evaluate the reasons behind high inspection staff turnover and implement management strategies to reduce turnover.

  The program had Cascade Center interview all employees in the Compliance Unit, as well as the Manager and Section Manager. It was recommended to hold a burnout training for staff which was conducted in November of 2018. Coaching session was provided to the manager in November and October of 2018.

  Management has also acknowledged staff morale and is beginning to address staff concerns. OMMP partnered with an Employee Assistance Program to provide employees an opportunity to bring forward their concerns and has implemented actions to address them. Management has taken classes and employees have received burnout prevention classes. Management is continuing to work with the staff to address their concerns and is implementing a performance system agency wide. Staff turnover is an important element of the performance measures.

- Recommend OHA perform a thorough study on the potential impacts and presence of microbiological and heavy metal contaminants in marijuana products, to make an informed decision on adding them to testing requirements, potentially in consultation with a reference lab.

  While OHA agrees with this recommendation, there are currently no resources to conduct such a study. Resources would need to be allocated for this study to occur. In the absence of dedicated resources to conduct a thorough study, OHA will reach out to other states with legalized marijuana to request their data related to testing for specific microbiological and heavy metal contaminants. OHA can also convene a rules advisory committee to seek guidance on testing for microbiological and heavy metal contaminants in marijuana products.

- In consultation with the Legislature, review options for medical marijuana testing and take action to better ensure product safety for medical marijuana patients. Potential actions could include:

    a. Implementing a public health campaign with assistance from other state agencies to educate medical growers and patients on ways to avoid, reduce, or eliminate marijuana product contamination;
    b. Requiring testing for all medical marijuana to ensure it is free of contaminants that may impact patient health.

  OHA acknowledges the importance of public safety and implementing a public health campaign would be important. While OHA agrees with this recommendation, there are no resources to conduct a campaign. Funds would need to be allocated for the campaign to occur.

  OHA awaits direction from the Oregon legislature regarding this recommendation and will support decision making with data and evidence-based practice.

  There was no input or discussion on this recommendation during the 2019 Oregon Legislative session. Funds and resources continue to be a barrier to implement this recommendation. OHA will continue to wait for direction from the Oregon legislature regarding this recommendation and will support decision making with data and evidence-based practice.

- Recommend OHA consider developing a reference lab focused on standards and methodology setting, additional compliance testing and random testing of marijuana products, and assessing the overall risk of marijuana product contamination.

  The need for a reference lab has been acknowledged in the report to the Oregon Cannabis Commission in May 2018 as a necessary component to ensure the safety of marijuana in the market and accuracy of cannabis testing labs. The Oregon Cannabis Commission included a recommendation to create a reference lab in the report to the interim

committees of the Legislative Assembly related to Health and Judiciary. Funds would need to be allocated for this to be implemented.

During the 2019 legislative session, the A-Engrossed version of House Bill 2098 included a State Cannabis Reference Lab, but that section was removed with the senate amendments. The bill did pass which directs OLCC to establish an advisory committee to advise OLCC, OHA, and ODA on establishing and maintaining standards for testing the potency of marijuana and marijuana items. Members of OHA will be on this advisory committee. This bill becomes operative January 1, 2020.

- Recommend OHA in consultation with OLCC perform random compliance testing, or shelf audits, to independently validate test results and assure product safety.

  OHA will work with OLCC to implement this recommendation. In the absence of a reference lab, OHA and OLCC will partner with the Department of Agriculture to conduct the audit tests. In order to accomplish this recommendation, additional staff resources and funding for the tests will be needed.

  There was no input or discussion on this recommendation during the 2019 Oregon Legislative session. Funds and resources continue to be a barrier to implement this recommendation. OHA will continue to wait for direction from the Oregon legislature regarding this recommendation and will support decision making with data and evidence-based practice.

- Recommend OHA-ORELAP continue transitioning alternate matrix solvent proficiency tests in Oregon to real matrix solvent proficiency tests.

  This requirement has been fulfilled as of March 11, 2019. As part of proficiency test (PT) Provider Phenova's contract agreement with ORELAP, the provider developed additional in-matrix samples to support the OHA lab accreditation

program. The PT sample for residual solvents now uses Hemp Oil as the base matrix and contains Total Butanes and Propane. Additionally, PT samples in cannabis matrix are now available for microbiology analytes and metals.

- Recommend OHA-ORELAP complete all provisional accreditation assessments to ensure that sampling procedures taken by labs are appropriate.

  Currently, ORELAP is working towards this goal in collaboration with OLCC. In November of 2018, ORELAP requested through OLCC video footage of a selected day and time of sampling events. These dates were selected based on the laboratory's sampling plans and chain of custody documents to evaluate and assess sampling protocols and practices from19 cannabis labs. As of January 23, 2019, ORELAP received confirmation of three video recordings. Based on the cannabis laboratories' failure to provide the requested video recordings, ORELAP is currently scheduling on-site assessments of the remaining ten laboratories with provisional sampling accreditation. Upon completion of the ten laboratories' observation assessments of sampling, there will be no provisional accreditation sampling thereafter.

  ORELAP completed the provisional accreditation assessments for sampling procedures on June 28, 2019. At this moment, only one laboratory out of the 21 Cannabis labs did not respond to ORELAP's call for the sampling onsite assessments and will be removed from the official ORELAP Cannabis list for this field of accreditation. ORELAP no longer offers provisional sampling accreditation.

- Recommend OHA-OIRELAP streamline the proficiency test tracking process for marijuana labs.

  Currently, ORELAP is working on this process in collaboration with the PT Provider and OHA IT specialists. ORELAP has developed a summary document to keep track of laboratory's participation in PT studies and PT performance. It is ORELAP's intent to transition the PT evaluation to ORELAP's database in order to streamline the proficiency test tracking process for cannabis labs. Additionally, we are working closely with Phenova PT provider in order to receive PT final reports in a timely manner to ensure appropriate corrective actions are addressed in accordance with the TNI standards.

- Recommend OHA-ORELAP review its level of authority to address lab issues related to upholding accreditation standards to determine what level is needed, and work with the Legislature to make necessary adjustments.

  OHA awaits direction from the Oregon legislature regarding implementation of this recommendation. ORELAP will support the recommendation with time capture data staff is currently compiling for evidence-based practice.

- Recommend OHA-ORELAP work with OLCC and the Legislature to ensure appropriate and sufficient staff coverage to better monitor lab practices and review test result data.

  OHA awaits direction from the Oregon legislature regarding implementation of this recommendation. ORELAP will support the recommendation with time capture data staff is currently compiling for evidence-based practice.

- Recommend OHA-ORELAP develop a strategy to meet established response timelines for addressing proficiency test failures and other lab accreditation deficiencies.

  PT reports have been evaluated for conformance to the TNI standard within 60 days of the receipt of the final report from the PT provider. ORELAP is currently tracking PT studies by using a spreadsheet-like user interface where relevant information is recorded in order to meet the 60-day requirement for the evaluation of PT studies. The document is used to record laboratory's PT receipt date, due dates, review dates, PT study information and PT report status.

  ORELAP is currently developing a summary document that contains historical information about the cannabis labs PT results to meet the established timeline for the evaluation of proficiency test failures and to address cannabis labs PT failures in a timely manner and according to ORELAP Program policies.

  The accreditation status is based on a laboratory maintaining a history of at least two successful performances out of the most recent three PT samples analyzed for the same accreditation FoPT. Upon any desk review, ORELAP sends a

letter requesting information regarding the unacceptable performances. The ORELAP manager will notify the laboratory's director by registered mail, return receipt, of suspension of accreditation. The notification shall include the beginning date of the suspension, which elements are suspended and the reasons for the suspension. If the cause of suspension has not been corrected within six months or the period of accreditation, whichever is shorter, the status of the affected fields of testing will change to revoked.

5. OHA: Integrated Eligibility Project Has Generally Followed Industry Standards to Help Ensure Data is Converted Completely and Accurately, Fiscal Year 2019, audit #2019-37 (dated October 2019)

- Recommend compare data extracts to legacy systems to ensure completeness and accuracy and document the results.

  After the audit, the Integrated Eligibility, Data Conversion team reached out to the Legacy extract team to better understand steps taken to ensure the mainframe extracts correctly represented the data from the online systems.

  Each Legacy team providing an extract (FSMIS, CM, CI, OA and AJ) was interviewed and design/test artifacts were reviewed.

  In summary, the team determined the following:

  1. The Legacy teams have varying processes to manage and track extract requests - some using ticketing systems that track and manage requests, while other teams manage requests via email

  2. In all cases, the Legacy teams were working from defined specifications, either uploaded to the ticketing system or managed via email

3. *In all cases, the Legacy teams confirmed the accuracy of the extract with the Legacy BA's, who confirmed against the online system.*

4. Test evidence/confirmation was exchanged via email, and either uploaded to the ticketing system or preserved in email.

Based on this follow-up review of the process, there is now sufficient evidence that the mainframe data extracts have been adequately tested against a defined design, and accurately represent that data in the mainframe.

- Recommend management develop a staffing plan that reflects the potential volume of work that will need to be completed after data conversion along with existing eligibility processing workloads and staff availability.

  The state has developed a plan to minimize the amount of impacts created for eligibility workers by data conversion. This plan includes creation of a team to perform duties necessary to align the data within the multiple systems and automating some of the functions necessary to align the data within the multiple systems. These two strategies will decrease the impact to eligibility workers and allow for better service to Oregonians. There is a workplan that has been developed for the cases that will continue in conversion mode after go-live. This plan includes appropriate necessary time for every point of contact. This time correlates to our current recertification timelines.

- Recommend management eliminate the use of shared accounts to transmit PII and PHI.

  The Audit Team observed server administrators using a shared account to manage file transfer of sensitive data. This practice was stopped upon notification to Project leadership and did not expose sensitive data outside of the system boundaries. Additionally, the server in question is being replaced and decommissioned.

- Recommend management improve monitoring of the transmission of PII and PHI.

While the Audit Team did not assess specific security risks for the IE system, there was recognition by the Project Team that controls were needed to address Project-identified risks related to the protection of PII and PHI during UAT. A team called the Security Controls Workgroup was formed to identify and put into place controls necessary to protect this data. This workgroup was made up of security professionals from the Project Team, SI, Enterprise Security Office (ESO), Enterprise Technology Services (ETS), Office of Information Services (OIS), Public Knowledge, and oversight agency representatives. These controls included:

- *Ensuring there was no mechanism to allow offshore resources to access the UAT environment.*
- *Ensuring processes were in place to validate no PII or PHI was copied into Team Foundation Server or other environments in which offshore personnel had access.*
- *Requiring all testers to use test ID's during testing.*
- *In the mainframe environment, specifically placing "deniers" into access scripts to ensure testers could not access production environments and, conversely, production users could not access the test environment.*
- *User profiles for testers were created to change the background color of screens such that it was easy for users to differentiate between production and test environments.*
- *Ensuring processes were in place to quickly provide testing credentials (authentication and access) to new testers.*

In addition to the above controls, security-related plans are followed and are regularly updated and reviewed by the ESO and federal partners. These plans include:

- *System Security Plan (SSP)*
- *Information Security Risk Assessment (ISRA)*
- *Privacy Impact Assessment (PIA)*
- *Plan of Action and Milestones (POAM)*

- Recommend management update existing Business Associate Agreements to include clauses required under HIPAA.

  According to a message from the Department of Justice (DOJ) dated November 14, 2019, the Business Associate Agreement (BAA) template used by OIS was found legally sufficient and is not out of compliance with federal requirements. No further action will be taken on this finding by the IE Project Team leadership.

6. ODHS and OHA: Using the U.S. Treasury's Do Not Pay System for Health and Human Services Program Will Save Taxpayers Money, audit #2020-05, (dated February 2020)

- Work with U.S. Treasury to gain access to Do Not Pay's worker portal to perform on-demand searches.

  The implementation date for ODHS/OHA to gain access to the DNP portal is contingent upon the execution of a data use agreement (DUA) and other data security measures needed per data source. The data sources cross both the ODHS and OHA, and data sources contain protected health information, personally identifiable information, and other protected information. The protection and security strategies for sharing each data source will need to be clarified, and separate DUA's for ODHS and OHA may need to be executed.

  Communications with U.S. Treasury are ongoing, and the initial questionnaire has been submitted to U.S. Treasury.

- Work with U.S. Treasury to develop annual death matching that covers all clients and all providers in the SNAP, TANF, ERDC, and Medicaid programs. Based on research of those matches, terminate ineligible clients and provides, and correct erroneous data in information systems.

  ODHS and OHA request this recommendation incorporate the rationale and goal of Recommendation 7, rather than having two separate timeframes for matching purposes. Monthly matches would be the most efficient and provide ODHS and OHA the opportunity to correct records in a timely manner.

- Develop internal policies and procedures for using Do Not Pay and taking the appropriate actions to close cases.

  Policies and procedures already exist for the current Date of Death work being conducted by OHA and ODHS. Once the DUA and other data security measures are executed, and portal access is approved, ODHS and OHA will know the specific aspects of the portal and data matching needing to be addressed in policy and procedures and will finalize prior to full utilization of DNP.

- Send letters to all clients and providers who are identified as potentially deceased, but whose records could not be independently verified by ODHS or OHA staff.

  ODHS and OHA staff will check all internal databases and perform internal research to verify the data that has been received by DNP. If DNP identifies someone as deceased, we are concerned that it would not be an effective approach to submit letters to clients and providers who, through the use of DNP, have been identified as deceased. We would clearly take the DNP data seriously and would do all necessary validation, but sending letters to potential surviving family members does not seem the most effective approach.

- Work with appropriate authorities to correct erroneous death reports found as a result of Do Not Pay data matching.

  Policies and procedures will be developed to address recommendations from this audit. ODHS and OHA will include in those policies and procedures methods and strategies for communicating with the data source of any potentially erroneous record.

- Work with U.S. Treasury to develop annual data analytics to identify potential data quality issues in information systems serving SNAP, TANF, ERDC, and Medicaid clients and providers.

ODHS and OHA will use the matching process to identify the source, structure and prevalence of the data issue. ODHS and OHA will use the findings to identify corrective actions within data sets over which ODHS and OHA have control.

- Work with U.S. Treasury's Do Not Pay services to develop monthly matches against required datasets for all providers. Based on research of those matches, terminate ineligible providers, and correct erroneous data in information systems.

  ODHS and OHA recommend incorporating this recommendation with another recommendation thereby streamlining the operational aspects of the two recommendations.

- After the Integrated Eligibility system is implemented, research cases that lack Social Security numbers and valid exemptions. Based on research of those cases, address any eligibility, compliance, and/or system issues.

  This recommendation will be addressed post implementation of the Integrated Eligibility System. It will be addressed per applicable federal regulation for each program utilizing the Integrated Eligibility system.

7. ODHS and OHA: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2019, audit #2020-14 (dated March 2020)

- Recommend management ensure year-end accrual methodologies are complete and include consideration of all relevant expenditures.

  The Office of Financial Services has updated its accrual methodology instructions to review all estimates to ensure they are calculated correctly and include consideration of all relevant expenditures. OFS will engage more closely with budget staff on projections of biennium-end expenditures to ensure alignment of expenditures and accrual estimates.

- Recommend authority management implement procedures to monitor user access and potential unauthorized changes to the application, as well as continue to implement processes to verify the effectiveness and completeness of the claims edits and audits function.

  At the initial review of which employees had the ability to modify claims edits and audits, it was difficult to determine how many and who exactly had the access to do such work. We were looking at the incorrect role and it appeared that more employees had that access than it was originally thought to be the case.

  A process was not in place to capture upstream whether unauthorized changes are being made in the adding of edits and audits into MMIS. There is a healthy downstream process through testing and validation that captures any anomaly regarding edits and audits after they are entered into MMIS. The addition of new claims edits and audits goes through a robust process for testing and validation, but that process does not mitigate against someone, either intentionally or accidentally making a change in MMIS outside of that robust testing process.

  It is true that the contractor had only tested 11 of the 116 edits and audits in MMIS as of June 30, 2019. The approved testing plan and contract did not go into effect until April 1, 2019, so it is not surprising that only 11 edits and audits had been tested. Deliverables received since then will show a greater number have been tested, but it is true that only 11 had been tested as of June 30, 2019.

  It is also true that an HSD monitoring of the remaining 80% of the edits and audits plan had not been delivered as of June 30, 2019. The HSD plan was implemented on October 1, 2019.

  A further review of the roles was conducted following the audit visit and it was determined that we were looking at an incorrect role. The role unique to that type of work in MMIS is, in fact, in place with only four employees able to modify claims edits and audits in MMIS. That has since been verified and confirmed that only four OHA employees can indeed modify claims edits and audits.

The testing of claims edits and audits continues both with the MMIS contractor and with the MMIS Business Support Unit and a quarterly deliverable is produced and sent to the Secretary of State Auditors office, along with a copy provided to HSD leadership for addition to the Team Central site.

We are exploring a way to have a "checks and balances" approach to the claims edits and audits modification process that would require any proposed new edit or audit be monitored by allowing only one person to set up the edit or audit and the another person be able to activate the edit and audit. We are working on a way to have a process that would capture upstream impact. No plan has yet been created, but we have worked on some scenarios to put a plan into place.

The claims edits and audits testing plans have been implemented as of April 1, 2019 and October 1, 2019 and are currently active with quarterly deliverables required both for the MMIS contractor and the MMIS Business Support Unit.

There still remain only four individuals who can actually add edits and audits to the system. Additionally, we are implementing a process that will involve three other managers in HSD who will review any proposed changes before we proceed. This will add a layer of review that will ensure edits and audits are being placed into the MMIS correctly. This group that will meet regularly to review edits and audits is an additional layer of practices already in effect, as outlined below in the last update. The additional process also allows for managers to know when edit and audit changes are going into MMIS so they be aware should there be an error in change that could cause claims to deny or flush. This would allow them to be prepared to help correct any issues that arise from an update to the MMIS. BSU continues to work with DXC on the testing of claims edits and audits and quarterly deliverables continue to be developed.

- Recommend authority management continue their analysis and correct all incorrect provider payments. It is also recommended that authority management ensure tables are updated timely and accurately when CMS provides updates.

It was discovered that an incorrect table put into MMIS that adjudicates claims and that table contained rates that did not agree with those established by CMS. This oversight, it was discovered, was due to HSD not being aware of a new table and rates that had been sent in one of CMS' regularly sent transmittals. This led to the incorrect table being in MMIS through 2019 and not allowing for the processing of certain claims containing a specific code at the appropriate rate.

Once the error was discovered by an analyst in the Medicaid Policy Unit, immediate action was taken to calculate the extent of the incorrect payment on those claims. The claims data was gathered and an assessment of the total amount of the inaccurate amounts is being calculated. Furthermore, the correct table was put into MMIS so that as of today, those claims are paying appropriately and at the correct rate. Furthermore, an effort is underway to reprocess the claims from 2019 to determine the amount of underpayment.

Additionally, we are determining the course of action that should happen to see what can be done in the future to mitigate against the incorrect rates being loaded into MMIS tables for claims processing. While a final plan awaits development and HSD leadership approval, one possibility is to be sure more individuals are receiving CMS transmittals where guidance is given, including changes to rates for certain claims coding.

A conversation was held with the Medicaid Policy Unit and it was agreed that it would be beneficial for the MMIS Business Support Unit to have someone who can receive the CMS Transmittals so that others can see when a change in guidance has occurred. There will be two analysts in the MMIS BSU who will be added to the transmittal email list.

The claims data is first being run through the MMIS User Acceptance Testing site to reprocess the claims to determine the amount still owed these providers. An analyst from the Medicaid Policy Unit and two analysts from the MMIS Business Support Unit have set up 6 System Mass Adjusted Process (SMAP's) segments and three of have been completed so far. Once the six SMAP's are completed the accurate amounts will be known and a

determination made to reprocess those claims to make the provider whole. The MMIS BSU worked the Medicaid Policy team to identify the number of claims and amounts and prepare them for reprocessing.

As of 11/16/2020, reprocessing has been completed for claims up through 3/31/2020. The remaining reprocessing of claims will be from 4/1/2020 - present or current.

- Recommend authority management strengthen controls to ensure documentation supporting a provider's eligibility determination is retained.

  During the 2019 Revalidation cycle the state began requiring updated Provider Enrollment Agreements (PEAs) for all revalidating organizations. Revalidation is required every 5 years for Medicaid providers. By the end of 2020, the state will require PEAs from all newly enrolling and revalidating organization and individual providers. By the end of 2020, full implementation, enrollment applications and revalidations without attached PEA's will no longer be accepted. These requirements will ensure all providers have a current PEA.

  Provider validations may be missed due to manual processes. In 2019, the state began pulling missed validation reports on a quarterly basis and completing a new set of validations for providers missing any validations. Beginning in February 2020, the state implemented to process to pull the missed validation reports no less frequently than monthly to ensure missed validations are corrected at the earliest opportunity. The state is currently exploring automated processes to ensure provider validations are completed at the time of enrollment, revalidation and reactivation. The state continues to check all providers against OIG, SAM and Death Master databases monthly as required.

- Recommend authority management comply with subrecipient monitoring requirements, develop and implement internal controls to ensure risk assessments are performed and documented for each subrecipient, and monitoring activities are completed and documented in conformance with risk assessment results.

The Health Systems Division will implement the use of a risk assessment tool for each subrecipient of federal grant funds for all future SAMHSA grants administered by HSD. HSD will also develop a tool to document post award monitoring for subrecipients based on their respective risk assessments.

Documents to be used as Risk Assessment tool and subrecipient Monitoring tool have been developed and will be used starting September 2020.

- Recommend authority management develop and implement controls to ensure performance progress report are complete and accurate prior to report submission.

The Health Systems Division (HSD) will develop a tool to track internal control processes to ensure progress reports are complete and accurate prior to submission for future SAMHSA grants. This tool will include each step for the internal control and will identify the responsible entity. A performance monitoring process has been identified along with a draft tool. This tool will be used starting in September 2020.

8. OHA: Efforts Have Helped Limit Some Employee Health Care Costs, but PEBB and OEBB Can Do More to Manage Costs and Optimize Benefits audit #2020-39 (dated November 2020)

- Recommend PEBB and OEBB regularly communicate to members further educational opportunities in addition to open enrollment for members to learn how to better understand the details of their insurance coverage and how to utilize their benefits to make optimal health and cost decisions.

PEBB staff are currently collaborating with Rise Partnership, SEIU, and DAS to develop training and materials for newly hired State employees. Rise Partnership and SEIU began piloting the training with DAS in October 2020.
In 2019, the PEBB Board directed our consultant, Mercer, to develop a comprehensive communications strategy.

- *Staff will begin work in Q1 2021 with Mercer, to develop and implement a dedicated new hire section for the PEBB website, with supporting materials. This section is aimed at guiding new employees through the benefits decision-making process.*

- *PEBB will also work with Mercer to create a monthly calendar for "Did you know?" emails, integrating carrier resources where possible. Calendar is targeted for Q4 2020 completion; implementation to begin Q1 2021.*

PEBB and OEBB, in collaboration with contracted insurance carriers will create educational resources including webinars, targeted videos, downloadable flyers and newsletters. The goal to create the same "on demand" experience we have during open enrollment. Open Enrollment focuses on choosing the right plan. This resource hub will be focused on how best to use your plan once chosen.

- Recommend PEBB and OEBB periodically communicate to employers, members, and stakeholders about the boar's ongoing administration of benefits, cost containment efforts, and the anticipated effects on affordability and accessibility of health care coverage to stakeholders, including employers and members.

  PEBB and OEBB already sponsor and lead employer focus groups. They are the PEBB Information Exchange (PIE) and OEBB Business Information Exchange (BIE) and were created to communicate and exchange information on emerging issues from board meetings, act as a conduit to the boards and place an emphasis on disseminating Board decision-making around benefits, cost-containment efforts, and making sure information is getting to the right places at the right time. These focus group meetings have been on hold during COVID-19 but will re-emerge on a more frequent basis with an expanded outreach to other stakeholders.

  PEBB and OEBB will include a more detailed breakdown of board discussions, the decision-making process, and take a more pro-active role in disseminating information. Examples would include adding a new section to the PEBB monthly "Did you know" and will expand PEBB and OEBB Board web pages to highlight board decisions.

- Recommend PEBB and OEBB consistently collect, analyze, and share results of employers' and members' experiences to better inform board decisions; for example, consistently track customer service calls to the programs, ask about benefit and claim experiences on the annual member survey, and obtain information from carriers on claims calls and appeals.

  OEBB currently has "benefit-experience" related questions on the annual member survey. Rather than expand the number of questions in the survey, staff will work with contracted insurance carriers to collect and synthesize information annually about: utilization of benefits, claims processing timeliness, member call resolution, overall satisfaction as well as information related to benefit appeals.

  PEBB currently performs a customer-service focused survey that does not contain benefit utilization questions. PEBB will seek to align with OEBB over the next year and request the carriers collect the same information.

- Recommend PEBB and OEBB promptly enhance clarity and oversight of consultant and carrier contracts, which should include:

  a) Ensuring consultant contracts have clearly defined deliverables that are of value and the related costs;
  b) Identifying deliverables in current contracts, and monitoring and enforcing deliverables be contract compliant;
  c) verifying invoices for mathematical accuracy and contract compliance by staff who have the pertinent training and knowledge of contract terms; and
  d) having a comprehensive program for identifying improper claim payments that is reflected in contracted services.

  a) We have implemented new processes and regular meetings with both consultants to better track assigned work and approve invoices, which have gone well and have been effective. We have also asked Mercer to provide

additional information as part of their invoice process, which has been helpful. We plan to build on all this going forward. In addition, we have decided to move to a raw dollar NTE, which will be amended into the consultant contracts for the upcoming terms. Furthermore, we are addressing these various needs through our development of an upcoming Consultant RFP. Currently, we have Contracts staff working with other department staff and leadership to identify what our exact consultant needs are going forward and how to best build that into the next procurement.

b) *Contracts staff worked with leadership to review and refine carrier contractual reporting requirements, scoping down what was not needed and being actively monitored. In the future, we will review each report and ensure it is assigned to specific staff with the requisite expertise to review.*

   Staff is developing several updated contract administration processes, including those tied to monitoring and enforcement. We are currently focusing on the annual contract renewal process. This updated process will be a full end to end process that actively incorporates contract deliverables and analysis into real time decision-making processes for the subsequent plan year renewals. We envision reporting certain information from contracts to consultants and the Boards at the very beginning of the annual renewal process and again before the end of the process after we have a more complete picture of the prior year (due to claims lag). We also envision asking consultants and certain staff to take a more active role in determining reporting needs and required performance measures during the renewal process itself and around the time we provide contract report information to the decision-makers. We anticipate partially standing up new processes in 2021 and then refining and adjusting them near the end of 2021 based on our experience.

c) *See comments in (a) regarding changes in how we review consultant work and invoices.*

d) *This will be partially addressed through the process work described above in b). Specifically, we will review the current claims-related contract to determine how that information together is best used to lead to Board renewal decisions.*

- Recommend PEBB develop a formal strategic plan that includes elements such as the appropriate amount to be maintained in reserve and steps to take when the reserve reaches higher or lower levels than targeted.

  The PEBB board maintains the Stabilization Fund (also known as "the reserve") in the state treasury. The board works with its consultant actuary each year to project an amount in the Stabilization Fund sufficient to meet both anticipated and unanticipated fluctuations in claims costs. The Board has used the fund to stabilize premiums, subsidize the employee premium share, and fund programs designed to reduce premium increases, but the board has no formal policy for how to manage funds in the event that reserves exceed the fully funded target level.

  When the PEBB Reserve exceeds the targeted fully funded reserve level, the legislature has in recent years legislated a "fund sweep" of those excess reserves that have resulted in an OMB Circular A87 Federal payback for an unallowable transfer. Over the next 12 months the PEBB board will consider developing a "Formal" reserve policy that includes direction for handling of excess funds in the reserve when they exceed the target. One item to note is that PEBB's legislatively adopted biennial budget is developed using a 3.4% annual increase. For the board to "buy-down" a higher than anticipated annual contract renewal beyond the 3.4%, it would likely need to secure additional budget limitation from the legislature in an Emergency Board rebalance request, or full legislative session. A formal reserve policy may inhibit future fund sweeps.

- Recommend OEBB clearly communicate the extent school districts participate in OEBB (e.g., when communicating externally to stakeholders such as in Legislature communications and on OEBB's website).

  Because a total penetration figure will be more meaningful than a raw number to most audiences, staff will add a statement to the OEBB website indicating the percentage of education-based entities covered by OEBB. Since local government entities can participate in OEBB but were never required to, staff will also add the raw number of local government entities who have chosen to participate in OEBB. Staff will use these figures in future communications to the Legislature, such as the Ways and Means presentation in January 2021.

- Recommend OEBB Clearly communicate the extent school districts participate in OEBB (e.g., when communicating externally to stakeholders such as in Legislature communications and on OEBB's website).

Because a total penetration figure will be more meaningful than a raw number to most audiences, staff will add a statement to the OEBB website indicating the percentage of education-based entities covered by OEBB. Since local government entities can participate in OEBB but were never required to, staff will also add the raw number of local government entities who have chosen to participate in OEBB. Staff will use these figures in future communications to the Legislature, such as the Ways and Means presentation in January 2021.

Secretary of State Audits
Current Status of Oregon Health Authority Audits
November 30, 2020

Ongoing Audits	Scope
SOS 2020 Single Statewide Audit -Financial	Audit of the State of Oregon's financial statements and related note disclosures included in the Comprehensive Annual Financial Report (CAFR) including report on internal control over financial reporting and compliance with laws, regulations and provisions of contract or grant agreements.
SOS 2020 Single Statewide Audit -Medicaid	Federal compliance audit for the Statewide Single Audit Report to determine if the federal program complied with the audit requirements of Title 2 U.S. Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance). Fieldwork in process. Entrance Conference held October 26, 2020.
SOS 2020 Single Statewide Audit -Women, Infants, Children, (WIC)	Federal compliance audit for the Statewide Single Audit Report to determine if the federal program complied with the audit requirements of Title 2 U.S. Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance). Fieldwork in process. Entrance Conference was held November 10, 2020.
SOS 2020 Single Statewide Audit -Childrens' Health Insurance Program (CHIP)	Federal compliance audit for the Statewide Single Audit Report to determine if the federal program complied with the audit requirements of Title 2 U.S. Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance). Fieldwork in process. Entrance Conference held December 14, 2020.
SOS 2020 Performance Audit: Medicaid	This topic was identified due to the importance Medicaid plays in Oregon government and the heightened enrollment to the program due to the COVID-19 pandemic. Audit will look for ways OHA can operate more efficiently and effectively to better achieve its missions.

PROGRAM PRIORITIZATION FOR 2021-23

Agency Name: Oregon Health Authority

2021-23 Biennium

Agency-Wide Priorities for 2021-23 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	1,604,661,429		3,799,247,290		14,357,259,301		19,761,168,020
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	328,087,338	13,422,925	235,378,943		98,901,156		675,790,362
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	30,081,136	-	33,181,051	40,000,000	98,427,838	101,929,051	303,619,076
4	Public Health Programs	State Public Health Director	No	Responsible for state emergency preparedness, planning, and response.		8, 10	52,610,842		649,352		267,765	-	53,527,959
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	3,662,903	-	21,825,062		33,277,402	-	58,765,367
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	3,157,243		1,279,138		3,125,908	-	7,562,289

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	617,152,994		38,093,539		25,775,258	-	681,021,791
8	Oregon State Hospital	State Delivered SRTF's	No	The state operated 16-bed facilities permit the safe movement of persons from the State Hospital(s) into the community that current providers choose not to serve.		12	7,819,769		227,677		2,617,612	-	10,665,058
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			2,295,178,751				2,295,178,751
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			1,857,421,546				1,857,421,546
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.							5,459,947		5,459,947
							2,647,233,654	13,422,925	8,282,482,349	40,000,000	14,625,112,187	101,929,051	$ 25,710,180,166

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:

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

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).

Oregon Health Authority: 10 Percent Reduction Options

The 2021-23 Governor's Budget for the Central Office and Shared Services includes removing inflation for select Services and Supplies accounts and a reduction of 3 percent in Personal Services from vacancy savings as well as eliminating 9 full-time positions.

Health Systems Division

Inflation increases for coordinated care organization (CCO) capitation rates and Oregon Health Plan (OHP) fee-for-service provider rates would be less than 3.4 percent annual inflation. ***The 2021-23 Governor's Budget includes the following reductions:***

- ***CCO capitation rates inflation decreased from 3.4 percent to 2.9 percent.***
- ***Hospital reimbursement rates for DRG hospitals reduced from 80 percent of Medicare to 76 percent of Medicare.***
- ***The CCO quality pool is reduced from 4.25 percent to 3.5 percent of 2021 and 2022 capitation rates.***
- ***Hospital tax funds used for a supplemental payment program are repurposed to support OHP.***
- ***Value-based payment savings of 1 percent for hospital spending in OHP.***

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 2021-23 Governor's Budget includes this reduction.***

Non-Medicaid inflation for substance use disorder treatment and community mental health programs would be eliminated. ***The 2021-23 Governor's Budget includes this reduction.***

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.

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. ***The 2021-23 Governor's Budget includes this reduction.***

Oregon Health Authority: 10 Percent Reduction Options

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.

The 2021-23 Governor's Budget for the Health Systems Division also includes reductions to recognize a delay in the construction of permanent supportive housing, savings from 1915i clients leaving residential treatment facilities, and savings in the Medicaid Graduate Medical Education program. It also includes removing inflation for select Services and Supplies accounts and eliminating 11 full-time positions.

Public Health

The budget for Oregon Contraceptive Care program payments would be reduced by 20 percent.

Farmers Market Food Voucher program for both Women Infants and Children (WIC) families and low-income seniors would be eliminated. ***The 2021-23 Governor's Budget includes the WIC families Farmers' Market Food Voucher program reduction.***

The 2021-23 Governor's Budget also includes the following reductions in the Public Health division:

- ***Reduces Services and Supplies budget for the Oregon Cannabis Commission.***
- ***Reduces HIV, STD, and TB administrative activities.***
- ***Reduces Communicable Disease modernization efforts and Services and Supplies budgets.***
- ***Removes inflation for select Services and Supplies accounts.***
- ***Increases vacancy savings to 3 percent.***

Oregon Health Authority: 10 Percent Reduction Options

Oregon State Hospital

Because of ongoing revenue and expenditure challenges at the hospital, OHA is not proposing any reductions to this budget. The Oregon State Hospital faces continued challenges in balancing the needs for individuals are referred to the hospital through a civil commitment and individuals ordered to the hospital by the courts for treatment that will help them to assist in their own defense. Because of the number of individuals requiring court-ordered treatment to assist in their own defense, there is a waiting list for hospital admission for individuals referred through a civil commitment.

The 2021-23 Governor's Budget for OSH includes the elimination of program coordination support staff, a reduction in nursing management and administrative positions, and restructures psychology program services, resulting in savings and a reduction in positions. It also removes inflation for select Services and Supplies accounts.

Health Policy & Analytics

OHA is not proposing any reductions to this budget. This division is critical to supporting the rest of the agency in addressing health disparities and health inequities.

The 2021-23 Governor's Budget includes removing inflation for select Services and Supplies accounts and a reduction of 3 percent in Personal Services from vacancy savings.

Oregon Health Authority
Reduction Options: 2021-2023 Governor's Budget

10% General Fund / 10% Other & Federal Fund Reduction Options for the 2021-2023 Biennium

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

Current Service Level Budget (OHA LEVEL)	3,537,333,170	7,977,281,471	14,614,326,326	26,128,940,967
10% Target	(353,733,317)	(797,728,147)	(1,461,432,633)	(2,612,894,097)

Accumulative % Reduction of CSL GF	Program Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc.)
~~-0.93%~~	~~1~~	~~Medicaid~~	~~Reduce Oregon Health Plan inflation for managed care and fee-for-service from 3.4% to 3.0% per year.~~	~~N~~	~~(32,800,000)~~	~~0~~	~~(78,300,000)~~	~~(111,100,000)~~			~~This reduction is removing inflation that was built into the CSL 2021-23 budget to meet the anticipated program growth. Removing this inflation would leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place, it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts, Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it would be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.~~
~~-1.20%~~	~~2~~	~~Medicaid~~	~~Eliminate the Indirect Medical Education (IME) component of the Graduate Medical Education (GME) program. The agency would eliminate Medicaid payments to teaching hospitals that help offset indirect costs associated with their GME programs. IME includes indirect costs that arise from the inexperience of residents such as extra medical tests and reduced productivity. CMS APPROVAL REQUIRED.~~	~~Y~~	~~(9,766,000)~~	~~0~~	~~(15,046,000)~~	~~(24,812,000)~~			~~Oregon's teaching hospitals depend on these payments to supplement their teaching programs. Discontinuing payments would be a hardship on ten teaching facilities and would de-incentivize hospitals from training new physicians. Discontinuing GME payment 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 healthcare.~~
~~-1.25%~~	~~3~~	~~Medicaid~~	~~Eliminate the Direct Medical Education (DME) component of the Graduate Medical Education (GME) program. The agency would eliminate Medicaid payments to teaching hospitals that help offset costs associated with their graduate medical education programs. GME includes costs associated with stipends or salaries for residents, payments to supervising physicians, and direct program administration costs. CMS APPROVAL REQUIRED.~~	~~Y~~	~~(1,805,000)~~	~~0~~	~~(2,782,000)~~	~~(4,587,000)~~			~~Oregon's teaching hospitals depend on these payments to supplement their teaching programs. Discontinuing payments would be a hardship on ten teaching facilities and would de-incentivize hospitals from training new physicians. Discontinuing GME payment 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 healthcare.~~
-1.27%	4	PHD/AGRH	Reduction in Oregon Contraceptive Care (CCare)	N	(500,000)	0	(4,500,000)	(5,000,000)			It is likely that this level of reduction could be covered by unspent funds for claims for clinical services, including vasectomy services which are typically underutilized. Additionally, program staff can continue efforts to support providers to reduce the number of ineligible claims (due to clients determined to be over the income threshold for CCare eligibility), thereby reducing the need to adjust ineligible claims to all General Fund instead of Federal Fund/General Fund.
~~-1.89%~~	~~5~~	~~Non-Medicaid~~	~~Remove inflation for Community Mental Health and Substance Use Disorder Programs.~~	~~N~~	~~(22,013,205)~~	~~0~~	~~(5,264,706)~~	~~(27,277,911)~~			~~Removal of inflation for the 2021-23 biennium would be devastating to the BH system. Programs reliant on OHP reimbursement for treating clients may have layoffs and smaller providers impacted by COVID may close. Cuts disproportionately hurt the most vulnerable including BIPOC, homeless and children. Oregon has one of the highest rates of mental illness and addiction in the USA, suicide is the leading cause of death for children. We would see an increase in costly services including EDs, inpatient care and pressure on a health system that doesn't have capacity to address the need. Oregon would be at increased risk for non-compliance with current lawsuits, audit findings and increase the risk of more judicial oversight.~~
~~-2.58%~~	~~6~~	~~Medicaid~~	~~Further reduce Medicaid inflation for managed care and fee-for-service from 3.0% to 2.7% per year.~~ ***~~The 2021-23 Governor's Budget reduces Medicaid inflation to 2.9% per year.~~***	~~N~~	~~(24,400,000)~~	~~0~~	~~(58,200,000)~~	~~(82,600,000)~~			~~This reduction is removing inflation that was built into the CSL 2021-23 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place, it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts, Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it would be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.~~

Accumulative % Reduction of CSL GF	Program Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc.)
-3.27%	7	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 2.7% to 2.4% per year.	N	(24,300,000)	0	(58,000,000)	(82,300,000)			This reduction is removing inflation that was built into the CSL 2021-23 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place, it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts, Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it would be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.
-3.62%	8	Medicaid	Eliminate coverage for specific dental services for adult Oregon Health Plan (OHP) clients. The agency would no longer cover the following dental services for adults (including pregnant adults) on OHP: Crowns, full and partial dentures; scaling & root planning. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions prohibit the state from reducing eligibility or benefits.	Y	(12,570,007)	0	(47,058,442)	(59,628,449)			Eliminate coverage for specific dental services for adult Oregon Health Plan (OHP) clients, no longer covering the following dental services for adults (including pregnant adults) including: crowns, full and partial dentures, scaling and root planning. CMS negotiation and approval are required. Dental benefit reductions would impact an individual's over-all health. Reductions would create a worsening of chronic diseases such as diabetes, poor pregnancy outcomes, and create a shift in treatment need. Patients not receiving needed dental care would experience need to go to the Emergency Department, possibly elevating need for opioids and/or requests for opioids and higher ED costs. People would lose teeth unnecessarily with no means to replace them. People will experience more difficulty in getting jobs due to poor oral appearance and experience missed days from work due to oral disease and pain. Dental benefit reductions would hinder populations affected by health inequities from achieving health equity or equitable health outcomes. Marginalized populations suffer the highest incidence or oral disease in all categories.
~~-3.77%~~	~~9~~	~~Non-Medicaid~~	~~Reduce Community Mental Health (CMH) Choice Funding by 50%.~~	~~N~~	~~(5,226,849)~~	~~0~~	~~0~~	~~(5,226,849)~~			~~This is a 50% reduction for Choice Model services which address care coordination needs and bridging services for adults with Serious and Persistent Mental Illness who are: 1) at risk of going to the Oregon State Hospital, 2) are at the Oregon State Hospital and needing discharge coordination into the community, and 3) utilization management of license residential care (residential treatment and adult foster homes).~~ ~~The need for these services is still highly critical. Choice contractors would still be responsible for addressing these needs but efficiency and timeliness would be severely reduced.~~ ~~There would be reduced bridging services which pay for services not covered by Medicaid or between authorizations in order to make transitions from one level of service to another more rapid. This would include: establishing guardianships and payees, funding certification training for peers, paying for placements before authorization or Medicaid is finalized, paying for temporary transitional housing through hotels, paying for off formulary medications and treatments, paying for therapeutic supports that help community integration, etc.~~ ~~The central program outcome is to discharge those who are identified at Oregon State Hospital as Ready To Transition. The goal is for 90% discharged within 20 days. This has been a challenging objective to reach (about 30% of providers are able to achieve this goal so far) but funding reduction will make this an exceptionally difficult goal to reach.~~
-4.76%	10	Medicaid	Eliminate dental coverage for Oregon Health Plan (OHP) non-pregnant adults. The agency would eliminate the remaining non-pregnant adult dental coverage for the OHP benefit package. LEGISLATIVE ACTION REQUIRED. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions prohibit the state from reducing eligibility or benefits.	Y	(35,157,011)	0	(140,760,276)	(175,917,287)			Eliminate dental coverage for OHP non-pregnant adults, which would eliminate all services for non-pregnant adult dental coverage for the OHP benefit package. Dental benefit reductions would impact an individual's over-all health. Reductions would create a worsening of chronic diseases such as diabetes, poor pregnancy outcomes, and create a shift in treatment need. Patients not receiving needed dental care would experience need to go to the Emergency Department, possibly elevating need for opioids and/or requests for opioids and higher ED costs. People would lose teeth unnecessarily with no means to replace them. People would experience more difficulty in getting jobs due to poor oral appearance and experience missed days from work due to oral disease and pain. Dental benefit reductions would hinder populations affected by health inequities from achieving health equity or equitable health outcomes. Marginalized populations suffer the highest incidence or oral disease in all categories.

Accumulative % Reduction of CSL GF	Program Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc.)
-4.76%	11	Medicaid	Eliminate all leverage.	Y	0	(110,236,762)	(175,444,192)	(285,680,954)			This reduction would eliminate all leveraged Medicaid funds from the following programs: Disproportionate Share (DSH) – Oregon Health Sciences University (OHSU); Graduate Medical Education (GME) - the leverage portion (OHSU), not GME supported by General Fun; University Medical Group (UMG) - OHSU; Poison Control - OHSU; Child Development and Rehabilitation Center (CDRC) – OHSU; School-Based Health Services (SBHS); Medicaid Administrative Claiming (MAC); Behavioral Rehabilitation Services (BRS); and, Targeted Case Management (TCM). These programs would likely cease to exist without being able to utilize Federal Funds (FF). These programs serve populations with the most disparate health outcomes, including: high-risk factor children, children with disabilities, the elderly, pregnant women, Tribes, and individuals experiencing substance abuse disorder and mental health disorders. Oregon's most at-risk populations would be negatively affected with the loss of this funding. Eliminating the Federal Funds contribution for the OHSU QDP would negatively impact Medicaid clients access to the high-quality specialty care and support activities provided by Oregon's only public academic health center.
-5.68%	12	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 2.4% to 2.0% per year.	N	(32,300,000)	0	(77,200,000)	(109,500,000)			This reduction is removing inflation that was built into the CSL 2021-23 budget to meet the anticipated program growth. Removing this inflation would leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts, Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it would be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.
-6.36%	13	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 2.0% to 1.7% per year.	N	(24,200,000)	0	(57,600,000)	(81,800,000)			This reduction is removing inflation that was built into the CSL 2021-23 budget to meet the anticipated program growth. Removing this inflation would leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts, Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it would be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.
-7.04%	14	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 1.7% to 1.4% per year.	N	(24,100,000)	0	(57,400,000)	(81,500,000)			This reduction is removing inflation that was built into the CSL 2021-23 budget to meet the anticipated program growth. Removing this inflation would leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts, Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it would be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.

Accumulative % Reduction of CSL GF	Program Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc.)
-7.95%	15	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 1.4% to 1.0% per year.	N	(32,000,000)	0	(76,400,000)	(108,400,000)			This reduction is removing inflation that was built into the CSL 2021-23 budget to meet the anticipated program growth. Removing this inflation would leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts, Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it would be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.
~~-7.96%~~	~~16~~	~~PHD/NHS~~	~~Elimination of the USDA/WIC Farmer's Market Food Voucher Program.~~	~~N~~	~~(268,075)~~	~~0~~	~~(1,327,003)~~	~~(1,595,078)~~			~~Provides vouchers to 25,300 low income WIC participants each summer to purchase locally grown fresh fruits and vegetables. Additionally, there would be reduced income to local farmers as over 90% of the dollars go directly to 500+ local Oregon farmers; and reduced access to healthy food choices for this vulnerable population. This program supports the SHIP priority: Slow the increase of obesity, Strategy 4: improve availability of affordable, healthy food and beverage choices for two identified target groups, 2-5 year olds and adults. USDA does require state fund administrative match requirement to participate in this grant.~~
-7.96%	17	PHD/NHS	Elimination of the USDA/Senior Farmer's Market Program	N	(6,169)	0	(1,639,748)	(1,645,917)			Provides vouchers to 43,000 low income seniors each summer to purchase fresh locally grown fruits and vegetables. Additionally, there would be reduced income to local farmers as over 90% of the dollars of directly to 500+ local farmers; biennium; and reduced access to healthy choices for this population at risk for inadequate intake of fruits and vegetables and food insecurity. This program supports the SHIP priority: Slow the increase of obesity, Strategy 4: improve availability of affordable, healthy food and beverage choices for adults, a primary target group.
-8.58%	18	Medicaid	Cover 25 fewer lines on Prioritized List of Health Services. Oregon Health Plan (OHP) coverage is based on the Prioritized List of Health Services, which ranks treatment and condition pairs in order of effectiveness. Starting July 1, 2021, OHP would cover lines 1 through 446. The agency would seek federal approval to no longer cover lines 447 through 471 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.	Y	(22,016,198)	0	(51,661,390)	(73,677,588)			This reduction would eliminate coverage of 25 lines on the Prioritized List representing important medical 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, 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. Children with vision problems would experience barriers to quality education. This reduction would result in a loss of revenue to hospitals, physicians, and mental health providers.
-9.26%	19	Medicaid	Reduce the covered lines on the Prioritized List of Health Services by an additional 15 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, 2021, OHP would cover lines 1 through 432. The agency would seek federal approval to no longer cover lines 433 through 446 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.	Y	(24,204,581)	0	(54,639,883)	(78,844,464)			This reduction would eliminate coverage of 15 lines on the Prioritized List (for a total of 40 when including 25 lines in a separate reduction package) representing important medical 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, 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. Children with hearing problems will experience barriers to quality education. These changes would result in a loss of revenue to hospitals, physicians, and mental health providers
-9.26%	20	PEBB	PEBB self-insured and fully insured plan reductions	N	0	(378,522,266)	0	(378,522,266)		-	PEBB contracts with insurance carriers for employee benefit plans. The operating budget for PEBB is 0.50%. The remaining 99.5% is program budget, which is dedicated funding for payment of self-insured and fully insured benefit plans. Taking reductions at any level may potentially default PEBB in its contractual obligations with carriers. Major plan design changes could possibly hit the reduction targets but it would take a major reduction in medical plan coverage and would jeopardize the stabilization of the statewide risk pool. A major shift in cost sharing between employee and employer could also potentially hit the reduction target but the reductions would have to be taken at the state agency budget level, as it passes employee benefit dedicated dollars through to PEBB.

Accumulative % Reduction of CSL GF	Program Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc.)
-9.26%	21	OEBB	OEBB plan reductions	N	0	(306,940,096)	0	(306,940,096)			OEBB contracts with insurance carriers for Entity and Self-Pay member benefit plans. The operating budget for OEBB is 0.5%. The remaining 99.5% are dedicated funds for payment of fully-insured benefit plans that OEBB is contractually obligated to pass-through to carriers. The pass-through premiums include other taxes and fees at the state and federal level. Taking reductions at any level may potentially default OEBB in its contractual obligations with carriers. Premium shifts to members will not change the pass-through budget dollars needed to meet contractual obligations with carriers.
-9.26%	22	OHA	Federal Funds reductions		0	0	(470,534,190)	(470,534,190)			OHA is eligible for and receives federal matching funds from a variety of programs, including Medicaid and Children's Health Insurance Program (CHIP). The agency also receives Federal Funds from many other grant opportunities for public health and behavioral health programs. This $470 million reduction in Federal Funds limitation is provided to meet the required 10% reduction target. No specific program cuts are identified.
			Total		**$ (327,633,095)**	**$ (795,699,124)**	**$ (1,355,457,830)**	**$ (2,557,090,049)**	**0**	**0.00**	

UPDATED **OTHER FUNDS ENDING BALANCES FOR THE 2019-21 & 2021-23 BIENNIA**

Agency: Oregon Health Authority
Contact Person (Name & Phone #): Janell Evans 503-385-7654

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
Other Fund Type	rogram Area (SC	Treasury Fund #/Name	Category/Description	Constitutional and/or Statutory reference	2019-21 Ending Balance In LAB	2019-21 Ending Balance Revised	2021-23 Ending Balance In CSL	2021-23 Ending Balance Revised	Comments
Limited	30-01	Fund 3400 - Grant 100000 - Medicaid Map	Grant Fund: Medicaid		0				
Limited	30-01	Fund 3400 - Grant 100001 - Medicaid Map	Grant Fund: Medicaid		0				
Limited	30-01	Fund 3400 - Grant 100100 - Medicaid Admin	Grant Fund: Medicaid		0				
Limited	30-01	Fund 3400 - Grant 400300 - HB2391 MCO Assessment	Grant Fund: Medicaid		0				
Limited	30-01	Fund 3400 - Grant 400350 - HowTo OHSU Provider Incentive Program	Grant Fund: Medicaid		0				
Limited	30-01	Fund 3400 - Grant 460201 - OHA Restitution Grant	Grant Fund: Medicaid		0				
Limited	30-01	Fund 3400 - Grant 462000 - OR Rev From A/R's	Grant Fund: Medicaid		0				
Limited	30-01	Fund 3448 - Treasury Fund 1385, Grant 426600 Hospital Assessment	Grant Fund: Medicaid	Section 2, Chapter 736m Oregon Laws 2003, as amended	0	0			
Limited	30-01	Fund 3400 - Grant 400190 - OHCS Housing Development Awards	Grant Fund: Non Medicaid		0				
Limited	30-01	Fund 3400 - Grant 411535 - HSD Settlement Community	Grant Fund: Non Medicaid		0				
Limited	30-01	Fund 3400 - Grant 421100 - AMH Beer & Wine (OLCC)	Grant Fund: Non Medicaid		0				
Limited	30-01	Fund 3400 - Grant 421200 HSD Marijuana	Grant Fund: Non Medicaid	ORS 475B.759	0				
Limited	30-01	Fund 3400 - Grant 460201 - OHA Restitution Grant	Grant Fund: Non Medicaid		0				
Limited	30-01	Fund 3402 - Grant 424000 Law Enforcement Medical	Grant Fund: Non Medicaid	414.85 Law Enforcement Medical Liability Account	0	1,278,000			HB 4304 Revenue sweep was approved during the special session 2020 (August 2020) for $2.1M
Limited	30-01	Fund 3405 - Grant 411504 - HSD Tobacco Settlement	Grant Fund: Non Medicaid		0				
Limited	30-01	Fund 3407 - Grant 411510 - A&D Outpatient	Grant Fund: Non Medicaid		0				
Limited	30-01	Fund 3418 - Grant 711000 - CMH Community Housing Fund	Grant Fund: Non Medicaid		0				
Limited	30-01	Fund 3420 - Grant 711000 - CMH Community Housing Fund	Grant Fund: Non Medicaid		0	5,726,586			Restricted R3. 2009 c.595 §431 S (3)(a) establishes a Community Housing Trust Account due to sale of state property, remains in perpetuity and nonspendable. Fund can expend earnings, such as interest, and applied to Fund 3418 3419.
Limited	30-01	Fund 3449 - Treasury Fund 1390, Grant 426000 Tobacco Tax	Grant Fund: Non Medicaid	Chapter 595 Oregon Laws 2009, Section 18	0				
Limited	30-01	Fund 3471 - Grant 411540 - Birth Certificates for Homeless	Grant Fund: Non Medicaid		0				
Limited	30-01	Fund 3400 - Grant 100100 - Medicaid Admin	Grant Fund: Program Support		0				
Limited	30-01	Fund 3400 - Grant 400011 - Synectic's Contracts	Grant Fund: Program Support		0				
Limited	30-01	Fund 3400 - Grant 400180 -Alcohol & Drug Policy Commission	Grant Fund: Program Support		0				
Limited	30-01	Fund 3400 - Grant 104311 - A&D Criminal Forfeiture	Grant Fund: Program Support		0				
Limited	30-01	Fund 3400 - Grant 426650 - 1.4% OCCF Admin Revenue	Grant Fund: Program Support		0				
Limited	30-01	Fund 3400 - Grant 460201 - OHA Restitution Grant	Grant Fund: Program Support		0				
Limited	30-01	Fund 3405 - Grant 411504 - HSD Tobacco Settlement	Grant Fund: Program Support		0				
Limited	030-02	1389 Prescription Drug Purchasing Fund	Operations	ORS 414.312	0	40,809	0	41,412	Oregon Prescription Drug Program. Three months of reserve to cover payroll.
Limited	030-02	1793 Healthcare Provider Incentive Fund	Other, Incentive Fund	ORS 676.450	0	17,118,736	0	17,118,736	These funds are awarded via loan repayment and other incentive agreements with providers and will be fully obligated.

UPDATED **OTHER FUNDS ENDING BALANCES FOR THE 2019-21 & 2021-23 BIENNIA**

Agency: Oregon Health Authority
Contact Person (Name & Phone #): Janell Evans 503-385-7654

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
Other Fund Type	rogram Area (SC	Treasury Fund #/Name	Category/Description	Constitutional and/or Statutory reference	2019-21 Ending Balance In LAB	2019-21 Ending Balance Revised	2021-23 Ending Balance In CSL	2021-23 Ending Balance Revised	Comments
Limited	030-02	0401 General	Operations	ORS 442.466	0	42,643	0	42,643	All Payers All Claims (APAC). 24 months of reserve to cover data contract.
Limited	030-02	0401 General	Operations	ORS 409.745	0	90,000	0	90,000	J-1 Conrad Physician Visa Waiver Program is funded by small application fees. These fees are spent in full for program operations costs. Eighteen months of reserves to cover payroll.
Limited	030-02	0401 General	Other, Donation	ORS 413.570	0	14,303	0	0	Pain Management Commission donations for supplemental meeting costs.
Limited	030-02	0401 General	Operations	ORS 676.410	0	474,752	0	474,752	Oregon Healthcare Workforce Database. 18 months reserve for payroll and data/research contracts.
Limited	030-02	0401 General	Operations	ORS 413.310	0	0	0	0	Common Credentialing program suspended in July 2018
Limited	030-02	0401 General	Operations	ORS 676.410	0	38,731	0	38,731	Ambulatory Surgery Data fees collected when the program was active resulted in a small amount of remaining revenue. HB 4020 (2018) re-establishes the need for a data contract and fees to be collected to cover those costs. GB reduction will delay startup to the 23-25 biennium with Extended Stay Center data.
Limited	030-03	0433 Operations	PEBB Operating	ORS 243.165	5,322,182	4,134,600	5,322,182	2,400,000	
Limited	030-03	1381 Flex Benefits	PEBB Flexible Spending Admin	ORS 243.165	305,000		305,939	305,939	
Limited	030-03	1384 Stabilization	PEBB Self-Insured, Stabilization	ORS 243.165	243,326,290	180,326,290	189,490,690	188,526,290	2019-21 ending balance reflects the $63million GF transfer
Limited	030-04	1387 Operations	Operating	Senate Bill 426, Section 12	550,000	550,000	550,000	550,000	
Limited	030-04	1388 Revolving	Revolving Fund (Stabilization)	Senate Bill 426, Section 12	9,700,000	17,316,000	9,150,000	20,816,000	
Limited	030-05	0401 General	Operations	ORS 441.020, 060, 442.315, 443.035, 315, 860, 682.126, 155, 157, 212, 216, 688.645, 682.047	1,264,000	1,322,407	1,264,000	1,200,000	HRCQI
Limited	030-05	0401 General	Operations	ORS 475.309, 797, 475B.785, 949, 950, 797, 810, 840, 858, 895	3,689,006	84,488	3,689,006	(900,000)	Oregon Medical Marijuana Program (OMMP)-Revenue estimates have decreased.
Limited	030-05	0401 General	Operations	ORS 448.131, 279, 450, 448	889,000	1,081,384	889,000	850,000	Drinking Water Services (DWS)
Limited	030-05	0401 General	Operations	ORS 453.757, 454.757	316,000	(47,300)	316,000	131,000	RPS-Costs are outpacing revenues
Limited	030-05	0401 General	Operations	ORS 431.29X, 92X, 446.321, 446.35X, 453.894, 624.02X, 624.57X, 431A.270	738,000	756,248	738,000	700,000	Environmental Public Health (EPH)
Limited	030-05	0401 General	Operations	ORS 675.405, 676.595, 605, 607, 615, 640, 800, 678.410, 680.525, 687.435, 688.728, 830, 834, 690.235, 385, 415, 550, 694.185, 700.080	3,288,000	2,371,654	3,288,000	2,000,000	Health Licensing Office (HLO)
Limited	030-05	0401 General	Operations	TURA	0	1,200,000	0	0	Tobacco Use Reduction Act (TURA)
Limited	030-05	0401 General	Other	Settlement/restricted fund	2,123,775	1,060,428	2,123,775	0	JP Morgan settlement account dedicated to TWIST to Web Implementation
Limited	030-05	0401 General	Operations	ORS 431A.855, 431A.880	650,000	281,000	650,000	281,000	Prescription Drug Monitoring Program (PDMP). 2019-21 OF ending balance increased from prior proejction of $91k due to receiving 3-year Harold Rogers grant (effective October 2020).
Limited	030-05	0401 General	Grant	Governed by Federal law/HRSA guidelines	43,975,727	54,900,000	43,975,727	41,578,000	Care Assist; restricted fund
Limited	030-05	0401 General	Other		700,000	700,000	700,000	700,000	Contributions dedicated to ALERT IIS. No new revenues coming in. Funding being held for ALERT system replacement. Project is in OIS queue, but program does not know when project will start.

UPDATED **OTHER FUNDS ENDING BALANCES FOR THE 2019-21 & 2021-23 BIENNIA**

Agency: Oregon Health Authority
Contact Person (Name & Phone #): Janell Evans 503-385-7654

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
Other Fund Type	rogram Area (SC	Treasury Fund #/Name	Category/Description	Constitutional and/or Statutory reference	2019-21 Ending Balance In LAB	2019-21 Ending Balance Revised	2021-23 Ending Balance In CSL	2021-23 Ending Balance Revised	Comments
Capital Improvement	030-06	Fund 3421 - Treasury Account 0401. Grant #400089 OSH Capital Improvement OF	Beginning Balance			225,000	0	0	OSH expects to carry ~$225K forward into AY23 for use on projects/improvements. We estimate that all available CI funding will be utilized in AY23.
Limited	030-06	0401	Forensic Evaluator Fees: OSH charges fees to forensic evaluators to certify them as forensic evaluators		20,750	0	22,341	0	Forensic Certification Program - Revenues received from the certification program for Forensic Evaluators. Anticipate no revenues to be carried forward at this time.
Limited	030-06		Electric Car Charging Stations: Percentage of fee vendor charges		6,095	0	12,425	0	All revenue is used to offset GF expenditures. Anticipate no revenues to be carried forward at this time.
Limited	030-06		Charges for Services		0	0	0	0	
Limited	030-06		Medical Record Copy Charges: Administrative Service Charges		16,540	0	28,378	0	All revenue is used to offset GF expenditures. Anticipate no revenues to be carried forward at this time.
Limited	030-06		Care of State Wards: Medicare Part A, Medicare Part B, Medicare Part D, Medicare HMO, 3rd Party Insurance, and Private Payments.		66,876,580	0	35,678,168	0	All revenue is used to offset GF expenditures. Anticipate no revenues to be carried forward at this time.
Limited	030-06		Fines and Forfeitures		0	0	0	0	
Limited	030-06		Rents and Royalties: Cottage Rental Fees		156,400	0	156,400	0	All revenue is used to offset GF expenditures. Anticipate no revenues to be carried forward at this time.
Limited	030-06		Sales Income: Canteen, Benchwork, Recycling, Café, Coffee Shop, and Meal Tickets		2,027,924	0	2,030,000	0	All revenue is used to offset GF expenditures. Anticipate no revenues to be carried forward at this time.
Limited	030-06	0401	Other Revenues: Safety Grant, Veteran Transportation, Miscellaneous		468,867	1,093,000	468,867	1,501,000	OSH carried forward $685k of Safety Grant from AY19 which is represented in the current actuals. Safety grant is volatile in both collections and expenditures, the projections below are a guess based on recent history. Safety grant expenditures are approved by a committee in charge of the grant. OSH works with the committee to attribute as many appropriate expenditures as possible to the safety grant. Through the first 17 months of AY21 OSH has collected an average of $27k/mo in Safety Grant Revenue and spent an average of $10k/mo. Using this 17 month history to project the remainder of the biennium, OSH will collect $408k more than it will spend in the safety grant. Adding $408k to the $685k carried forward from AY19, OSH expects to carry $1.09M forward into AY23." The same methodology was used to calculate AY23 ending balance estimates; estimates are subject to change based on revenue collected and expenditures approved by the Committee.
Capital Improvement	030-06		Transfer in Intrafund: Transfer of OF (3400) to OF CI (3410).		725,501	0	785,452	0	CSL amount used at current inflation; amounts transferred to OF CI to fund future capital improvement projects.
Limited	030-06		Transfer in from DHS AGY 100: OSH purchases seats in CPS Tier 2 trainings, SACU reimburses OSH for some of the seats		30,135	0	10,646	0	All revenue is used to offset GF expenditures. Anticipate no revenues to be carried forward at this time.
Limited	030-06		Transfer from General Fund: Recording of GF Expenditure into OF (3400).		0	0	0	0	

Objective: Provide updated Other Funds ending balance information for potential use in the development of the 2021-23 legislatively adopted budget.
Instructions:

UPDATED **OTHER FUNDS ENDING BALANCES FOR THE 2019-21 & 2021-23 BIENNIA**

Agency: Oregon Health Authority
Contact Person (Name & Phone #): Janell Evans 503-385-7654

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
Other Fund Type	rogram Area (SCI	Treasury Fund #/Name	Category/Description	Constitutional and/or Statutory reference	2019-21 Ending Balance In LAB	2019-21 Ending Balance Revised	2021-23 Ending Balance In CSL	2021-23 Ending Balance Revised	Comments

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 2019-21 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,
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 2019-21 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 2019-21 General Fund approved budget or otherwise
Column (j): **Please note any reasons for significant changes in balances previously reported during the 2019 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.