

Reduction Target: 25% of Current Service Level

Current Service Level Budget - OHA 2,758,636,321 1,411,200,970 5,456,418,737 9,626,256,028 3,931 3,873.88  
 25% Target 689,659,080 (Limited OF only - does not include non-ItD OF of \$3.17 Billion)

Item #	Division Rank	DIVISION	Title (in bold) and Public Reduction Description	Reduction Description	Current Service Level Budget - OHA					# of Employees Affected	Employee FTE Affected	Budget POS	Budget FTE	Impact of Reduction on Services and Outcomes	Effective Date
					GF&LF	OF	TTX	FF	TF						
1	1	DMAP		The Oregon Health Authority will continue the Non-program/Administrative cost reduction measures that have been implemented during the 2009-11 biennium and prior. These measures include targeted reductions of all Service & Supply expenditure budgets.	(1,166,525)			(1,166,525)	(2,333,050)	(7)	(5.31)		The division would have to manage its personal services and supplies budget by reducing costs in such areas as training, travel, office supplies, and contracted professional services. The division would be challenged to timely and effectively meet of its responsibilities.	7/1/2011	
2	New	PHD		The Oregon Health Authority will continue the Non-program/Administrative cost reduction measures that have been implemented during the 2009-11 biennium and prior. These measures include targeted reductions of all Service & Supply expenditure budgets.	(1,024,519)				(1,024,519)	(17)	(16.94)		Leaves all contractors with no cost of living adjustments and programs with flat funding for all services and supplies including medical S&S which historically has increased double-digit.	7/1/2011	
3	2	AMH - Program Support		The Oregon Health Authority will continue the Non-program/Administrative cost reduction measures that have been implemented during the 2009-11 biennium and prior. These measures include targeted reductions of all Service & Supply expenditure budgets.	(1,806,774)	(253,668)		(886,578)	(2,947,020)				The continued reduction of travel and training will hinder the department's ability to keep our community partners informed about policy, rule changes and federal and state mandates. In addition reduce our ability to provide training and technical assistance in selection and implementation of appropriate evidence-based practices.	7/1/2011	
4	9	AMH - BMRC		The Oregon Health Authority will continue the Non-program/Administrative cost reduction measures that have been implemented during the 2009-11 biennium and prior. These measures include targeted reductions of all Service & Supply expenditure budgets.	(994,859)	(175,256)			(1,170,115)				Blue Mountain Recovery Center (BMRC) implemented cost savings measures in 2009-11 biennium that will continue into 2011-13. These reductions will have minimal affect on services as they have been in place all of 2009-11, but this will limit any margin for unexpected costs.	7/1/2011	
5		OHA - Admin		The Oregon Health Authority will continue the Non-program/Administrative cost reduction measures that have been implemented during the 2009-11 biennium and prior. These measures include a department wide hiring freeze, and targeted reductions of all Service & Supply expenditure budgets.	(500,000)			(125,000)	(625,000)				This reduction will affect available resources to provide technical expertise for the Oregon Health Policy Board and its committees and the Oregon Health Authority in the development and implementation of health reform policy that would address the cost and quality of health services provided in state programs and in preparing the implementation of federal health reform.	7/1/2011	
6		Health Plan Outreach		The Oregon Health Authority will continue the Non-program/Administrative cost reduction measures that have been implemented during the 2009-11 biennium and prior. These measures include a department wide hiring freeze, and targeted reductions of all Service & Supply expenditure budgets.	(1,500,000)			(2,447,368)	(3,947,368)				This reduction will affect the available funding for Health Plan outreach efforts and may result in delays in achieving the 2011-13 goals for enrollment.	7/1/2011	
7		OHPR - Admin		The Oregon Health Authority will continue the Non-program/Administrative cost reduction measures that have been implemented during the 2009-11 biennium and prior. These measures include a department wide hiring freeze, and targeted reductions of all Service & Supply expenditure budgets.	(500,000)			(500,000)	(1,000,000)				This reduction will affect available funding for contracted professional services and other service and supply resources planned for the successful planning and implementation of health reform by the Oregon Health Policy Board and the Oregon Health Authority	7/1/2011	
8	9	DMAP		Program integrity continuous improvement initiatives. Initiatives focus on: 1) Targeted medical program case reviews with information used to provide caseworker feedback, to identify branch office training needs and to report statewide eligibility accuracy data; 2) Increased review of medical claims, using algorithms to target individual providers or classes of providers for review; 3) Increased recoveries from the work of federal Medicaid integrity contractors; and, 4) Recoveries resulting from federal health care reform mandated use of Recovery Audit Contractors (RACs) paid on a contingency basis.  In order to achieve the identified net savings, the following investments must be made: 1) \$878,870 GF, supporting 9 positions in DHS Children Adults & Families Division related to client case reviews; 2) \$208,750 GF supporting 2 positions in the DHS Office of Payment Accuracy and Recovery; and 3) Contingency payments to one or more RACs equal to 15-20 percent of the state share of recoveries resulting from their work.	(2,615,948)			(3,038,861)	(5,654,809)				Increasing program integrity efforts will reduce the number of ineligible clients on the Oregon Health Plan caseload. Program integrity initiative focused on medical providers will help address provider fraud, abuse and compliance with program rules.	1/1/2011	
9	1	PHD		PHD - Eliminate Cost of Living Increases in the Current Service Level budget for those areas that OHA has discretion over COLAs, such as program service contracted program dollars.	(911,895)			-	(911,895)				Cost of living adjustments (COLAs) for all providers would be eliminated. Service providers for Public Health are primarily Local Health Departments and medical services and supplies providers. Current contractual rates would remain in effect for another 2 years, however, the LHDs would still see reduction in capacity because most contract awards are distributed on a per-capita basis, as the population increases and the base amount remains flat, the per capita reimbursement drops. Medical services and supplies (including medications for (HIV/STD/TB) generally experience double-digit inflation. This will also weaken PHD ability to leverage purchasing these items for LHDs.	07/01/11	
10		OHA - Shared Admin Services		The Oregon Health Authority will continue the Non-program/Administrative cost reduction measures that have been implemented during the 2009-11 biennium and prior. These measures include a department wide hiring freeze, and targeted reductions of all Service & Supply expenditure budgets for a 4% Shared Services Administration budget reduction.	(3,500,000)	(600,000)		(2,400,000)	(6,500,000)	(14)	(13.82)		OHA Shared Administrative services will reduce it's budgeted personal services and supplies budget by reducing costs in such areas as personal services through continuation of the hiring freeze in place for the 2009-11 biennium, and continuing the cost reductions measures in place for training, travel, office supplies, and contracted professional services. This may pose a challenge to timely and effectively meeting the shared administrative service responsibilities for OHA.		

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11	4	DMAP		<b>Additional savings from Third Party Liability (TPL) initiative beyond CSL amount of \$33 million TF.</b> The department would build upon the current efforts to identify sources of third party liability to generate additional savings beyond the \$33 million (Total Funds) TPL savings included in the Continuing Service Level (CSL) budget. This reduction option is a continuation of an item on the division's 2009-2011 allotment reduction list.	(2,585,800)			(4,414,200)	(7,000,000)					No impact on client services. The department would identify more sources of health insurance and code it on the computer system more quickly thereby cost avoiding the payment of medical claims that need be paid by other coverage.	7/1/2011
12	8	DMAP		<b>Do not pay for health care acquired conditions.</b> The department will implement changes consistent with federal law to prevent the payment of health care acquired conditions, also known as never events. These are conditions that would have been reasonably avoided through the application of evidence-based practices. Under national health care reform, this initiative becomes a mandate for state Medicaid programs. This reduction option is a continuation of an item on the division's 2009-2011 allotment reduction list.	(37,502)	(6,318)		(168,814)	(212,634)					By not paying for health care acquired conditions, it is anticipated that providers will focus on preventing such conditions and increasing health care quality. Providers cannot bill clients for these costs.	7/1/2011
13	10	DMAP		<b>Streamline prior authorization (PA) process and expand use for effective management of services.</b> Streamlining activities include reduced paper processes and additional centralization of PA functions. Expanded use of PA includes using decision support software for authorization decisions related to imaging, increasing the number of evidence-based practice guidelines and utilizing PA to ensure appropriate use, and using PA to avoid payment for certain drugs administered in physician offices that are for non-covered conditions.	(1,953,761)			(3,640,211)	(5,593,972)	3	2.88	3	2.88	Rather than receive notification of PA decisions by mail, caseworkers would have access to the information online if they receive questions from clients or providers. Providers who currently seek PA from a contractor (Accumentra) for specific surgical, inpatient rehabilitation and imaging services would direct requests to the division (where the majority of PAs currently occur). Expanding a PA requirement to MRI and CT scan services would create an additional administrative step for health care professionals; however, use of decision support software will help ensure the division only pays for needed imaging services. Increasing the number of evidence-based practice guidelines and adherence to the guidelines should improve health outcomes for clients, although health care professionals would have an additional administrative step. Physician offices would be required to obtain PA before providing certain drugs to their OHP patients to ensure these drugs are for covered conditions under the Oregon Health Plan.	7/1/2011
14	13	DMAP		<b>Eliminate discretionary fee-for-service (FFS) cost of living adjustments (COLAs).</b> The division's 2011-2013 Current Service Level (CSL) budget includes inflation for medical services. Fee-for-service rates that are not tied to specific reimbursement policies (e.g., Medicare) and that the department has the discretion to change would receive COLA rate increases effective Jan. 1, 2012, and Jan. 1, 2013. This reduction would eliminate those budgeted increases.	(3,964,672)	-		(6,930,499)	(10,895,171)					Cost-of-living adjustments (COLAs) for certain fee-for-service (FFS) providers would be eliminated. These adjustments would otherwise be effective January 1, 2012, and January 1, 2013. The current reimbursement level for providers would remain the same. Affected providers received their last COLA in January 2009 of 3.5%. Without COLAs, clients will experience increasing access problems because providers may not be willing to accept low Medicaid reimbursement rates.	1/1/2012 & 1/1/2013
15	2	AMH		<b>AMH - Eliminate Cost of Living Increases in the Current Service Level budget for those areas that OHA has discretion over COLAs such, as program service contracts.</b>	(9,399,357)	(504,198)		(7,093,482)	(16,997,037)					This would be the second biennium that providers were not given an increase for providing services. As actual costs do increase, this means there would be less ability to provide the same level of service to clients in the community programs. There would likely be reductions in workforce in community providers and the loss of some smaller providers due to the inability to secure funding through other sources.	
16	2	DMAP		<b>Implement Medicare correct coding initiative.</b> The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative to promote accurate coding and payment of claims submitted for Medicare services. By implementing this initiative, the department avoids paying for claims rejected by Medicare because of inaccurate coding and similarly avoids paying for such claims for all Medicaid clients. Under national health care reform, this initiative becomes a mandate for state Medicaid programs. This reduction option is a continuation of an item on the division's 2009-2011 allotment reduction list.	(383,159)			(573,841)	(957,000)					The Medicare correct coding initiative will enhance program integrity by increasing the accuracy of billing practices for both Medicare and Medicaid claims. Providers who inappropriately bill for a procedure using both a comprehensive code and component codes will only be paid for the comprehensive procedure, but not the component code. Also, providers who bill mutually exclusive codes will only be paid for the least costly code. Mutually exclusive codes are for procedures that cannot reasonably be performed together.	7/1/2011
17	3	DMAP		<b>Net savings attributable to national health care reform drug rebate changes.</b> National health reform law changes drug rebate policies to increase rebate revenue for the federal government. Physician administered drugs are also included in this reduction. The policy changes affecting fee-for-service drugs will cause the department to lose drug rebate revenue. The policy changes affecting drugs provided under managed care will cause the department to gain drug rebate revenue. The net impact will be more revenue to the state. This reduction option is a continuation of a 2009-2011 reduction taken by the Emergency Board in July 2010.	(1,860,663)	6,264,514		7,305,653	11,709,504					Under national health care reform, managed care organizations (MCOs) will no longer benefit from drug rebate revenue, however, capitation rates will be adjusted to reflect their lost revenue. To capture and report rebates on physician administered drugs, providers will be required to submit claims with national drug code (NDC) numbers.	7/1/2011
18	9.5	DMAP		<b>Electronic transaction initiative.</b> The division would encourage fee-for-service providers to submit medical claims electronically, which provides more timely and accurate payments, by introducing a disincentive. The disincentive would be a 20-day delay between the date a fee-for-service claim is submitted by paper and date of payment. A 20-day delay would create a one-time savings for the biennium. The division would also eliminate the use of paper checks and use Electronic Funds Transfer to pay medical providers.	(668,093)		(39,039)	(1,347,568)	(2,054,700)	1	0.50	1	0.50	Providers submitting paper claims would experience a delay in their payments. To receive payment, providers would work with the department to establish electronic funds transfer capability.	7/1/2011
19	9.6	DMAP		<b>Administrative budget reduction as part of the Electronic transaction initiative.</b>	(53,160)			(53,160)	(106,320)						
20	1	AMH-SDSRTF		<b>Eliminate the budget for two State Delivered Secure Residential Treatment Facilities that were not opened as planned.</b>	(5,149,024)				(5,149,024)	(63)	(63.00)	(54)	(54.00)	These reductions will result in fewer patients being discharged from the Oregon State hospital to secure treatment facilities in community settings. 32 fewer secured residential treatment beds will be available than planned in the 2009-11 budget. This may increase Oregon's risk of a lawsuit related to the Olmstead Supreme Court decision.	7/1/2011

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21	5	AMH-CMH	<b>Eliminate the Personal Care 20 program (on list to be in sync with SPD)</b>	(1,465,764)			(2,477,641)	(3,943,405)				Without the personal care program, the nearly 800 clients may lose the ability to function and no longer be maintained in the community. As a result, the clients may have to move to a more expensive form of care including hospitalization or facility based care. In addition, more than 70 care givers will lose their jobs.	9/1/2011	
22	6	AMH-CMH	<b>Continue select Mental Health program reductions from 2009-11.</b>	(8,701,985)				(8,701,985)				This reduction will significantly affect 2,983 Oregonians with mental illness. Access to crisis services, acute psychiatric treatment (in a hospital setting), medications and case management services will be reduced by this reduction. This will likely result in people becoming more ill, doing poorly in school, experiencing strained family relationships and in some instances people will become homeless or may be jailed. There will be increased demands on the crowded state hospital. These reductions could jeopardize the Maintenance of Effort requirements for the Mental Health Block Grant.	7/1/2011	
23	10.5	DMAP	<b>New reimbursement methodology to pharmacies.</b> The department is in the process of changing reimbursement methodologies to pharmacies. Currently, reimbursement for prescription drugs is based on average wholesale price (AWP). The department is evaluating other reimbursement methodologies that more accurately reflect the cost of the drugs and the cost for dispensing the drugs. This reduction option is a continuation of an item from the division's 2009-2011 allotment reduction list.	(2,445,656)	(264,265)		(4,626,085)	(7,336,006)				The department is in the process of changing the reimbursement methodologies to pharmacies. This change would not likely affect services to clients or health outcomes. Pharmacies may benefit from the new methodology to the extent it provides more stable and predictable reimbursement. Some pharmacies, however, may no longer serve OHP clients if they don't think they will benefit from the new methodology. If pharmacies leave the program, some Oregon Health Plan clients may have difficulty obtaining needed prescription drugs timely, increasing their risks for adverse health outcomes.	7/1/2011	
24	14	DMAP	<b>Implement Oregon Health Plan (OHP) Plus co-payments for client enrolled in managed care.</b> The department would implement co-payments for clients receiving the OHP Plus benefit package and enrolled in managed care. The co-payments would mirror those currently imposed under the fee-for-service delivery system. This reduction option is a continuation of an item from the division's 2009-2011 allotment reduction list.	(1,111,739)			(1,897,841)	(3,009,580)				Oregon Health Plan clients who receive the OHP Plus benefit package would have to pay co-payments. The same exemptions that exist for OHP Plus fee-for-service co-payments would apply. To the extent that plans and their providers are unable to collect co-pays, they will have less money available to pay for medical or dental services. Some managed care organizations may have to spend reserves to maintain access or health outcomes for OHP clients will suffer.	7/1/2011	
25	3	PHD	<b>Targeted Program Support reductions - eliminates two positions and related funding within the Emergency Medical Services Mobile Training program.</b> These two units are staffed by paramedical trainers to bring training equipment and required continuing education courses to Emergency Medical Technicians and First Responder, including volunteers, in rural and frontier areas.	(350,000)				(350,000)	(2)	(2.00)	(2)	(2.00)	Elimination of the Mobile Training Unit Program would result in reduced staffing for some ambulance agencies, particularly in rural and frontier areas that rely on volunteer emergency responders. It also greatly diminishes the EMS Programs ability to conduct certification examinations and evaluate EMS training programs.	Positions 7/1/2011
26	3	AMH - Program Support	<b>Targeted reduction of Personal Services Contracts that support both Mental Health and Alcohol and Drug programs.</b>	(264,535)				(264,535)				This action reduces four direct-service personal services contracts and eliminates another. The result would be reduced services for both mental health and alcohol and drug clients. In addition, reviews for children's mental health intensive treatment services would be reduced.	7/1/2011	
27	23	DMAP	<b>Limit increases to payments to managed care organizations (MCOs).</b> The department would adopt MCO capitation rates at the lower range of actuarial soundness. The 2011-2013 Current Service Level (CSL) budget includes 13% inflation for MCO rates from the 200 2011 biennium. The pay-for-performance initiative would assume that rates would increase 12.5%, instead of 13%, with 0.5% withheld for future performance bonus payments. This reduction assumes rates would increase by 11%, instead of 12.5%, with 1.5% the calculated savings.	(17,544,603)	(5,450,027)		(41,750,118)	(64,744,748)				Limiting increases to capitation payments may create access problems for Oregon Health Plan (OHP) clients if MCOs have difficulty contracting with providers within the funds received through their rates. Some MCOs may have to spend reserves to maintain appropriate capacity levels. Without adequate access to care, health outcomes for OHP clients would suffer. Before implementing new capitation rates, the department would need to obtain approvals from the Centers for Medicare and Medicaid Services.	1/1/2012 1/1/2013	
28	7	DMAP	<b>Medicare claim denials for dually eligible clients</b> For clients dually eligible for Medicaid and Medicare, the department would review claims denied by Medicare to determine if Medicaid should also deny the claim. In general, Medicaid currently pays these claims without determining whether Medicare's reason for denial could be justification for Medicaid to deny. If Medicare denies a claim because it did not meet medical appropriateness criteria, for example, the division would deny the claim and the provider would be required to appeal to Medicare for payment.	(221,615)			(425,966)	(647,581)	1	0.75	1	0.75	To the extent that the division reviews and denies claims that Medicare denied, providers would have to pursue reconsideration of those claims with Medicare.	1/1/2012
29	8	AMH -OSH	<b>Targeted 4% reduction of Services and Supplies budget items at Oregon State Hospital.</b>	(2,240,164)	(43,147)		(23,996)	(2,307,307)				Continued reductions in this area may hamper efforts to meet the treatment, information, and policy actions necessary to address the remedial remedies addressed in the Civil Rights of Institutionalized Persons Act (CRIPA) report.	7/1/2011	
30	18	DMAP	<b>Add diabetic supplies to the preferred drug list (PDL) and allow pharmacists to dispense to fee-for-service (FFS) clients.</b> The department would add diabetic supplies (e.g., blood glucose/reagent strips and blood glucose monitors) to the PDL and allow pharmacists to dispense the supplies to FFS clients. By adding the supplies to the PDL, the department gains additional revenue from the supplemental rebate program. By allowing pharmacists to dispense diabetic supplies, clients are able to obtain medications and related diabetic supplies at the same time.	(292,765)	(498,595)			(791,360)				Allowing pharmacists to dispense diabetic supplies would mean that Oregon Health Plan clients would only have to go to one place to get both their insulin and diabetic supplies. Currently, OHP clients must go to pharmacies to get their insulin and then to durable medical equipment providers for their diabetic supplies.	7/1/2011	

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31	19	DMAP		<b>Bulk purchasing for hearing aids.</b> The department would enter into bulk purchasing agreements with manufacturers to obtain reduced pricing.	(5,899)			(8,438)	(14,337)					Bulk purchasing agreements would limit the product choice for providers and Oregon Health Plan clients needing hearing aids, however, the impact would likely be minimal. Bulk purchasing agreements in place in other states include most major manufacturers.	4/1/2012
32	20	DMAP		<b>Sole-source contracts for 3 or 4 durable medical equipment (DME) supplies.</b> The department would solicit bids from suppliers and attempt to contract for three or four DME items or supplies. The division would choose the items for sole sourcing based on quality, cost and access, with quality for the client being the most important component. The division anticipates a saving of 10 percent on those items. As an alternative, the division will work with the industry to achieve the savings through other DME reduction options.	(407,099)			(694,955)	(1,102,054)					Sole source contracts for specific durable medical equipment (DME) items would restrict the purchase and payment for those items. Sole source contracts would negatively impact DME providers currently enrolled with the department. Sole source contracts could potentially affect client access by restricting choice.	4/1/2012
33	10	AMH-A & D Treatment		<b>Parent Child Interaction Therapy (PCIT) reduction.</b> This reduction cuts nearly \$2 million under service element A&D 60 for special projects.	(1,787,086)				(1,787,086)					Without this project, there will be a loss of infrastructure for Parent Child Interaction Therapy, an EBP addressing disruptive behavior disorders in young children. Adverse effects would be experienced by communities poised to train clinicians and implement PCIT. Families whose children exhibit these disorders would not be served. This will result in the need for child welfare services relating to permanency, increase in school failure, out-of-home placement, crime, special education, and K-12 grade repetition. This reduction will jeopardize the Maintenance of Effort (MOE) requirement of the Substance Abuse Prevention and Treatment (SAPT) block grant.	7/1/2011
34	11	AMH - OSH		<b>Reduce the transition program for a leaner staff to patient ratio.</b> The transition program is designed to help patients of the Oregon State Hospital prepare to move from hospital-level care to community settings. These patients are under the supervision of the Psychiatric Security Review Board, and the transitional housing is a way of demonstrating these patients are ready to make the transition to community treatment facilities. This action is a 20% reduction in personal services and an additional 5% reduction in services and supplies.	(1,744,954)	(33,609)		(18,691)	(1,797,254)	(20)	(15.00)			Continued reductions in this area without a corresponding increase in staff may result in possible legal action by the U.S. Department of Justice due to OSH inability to meet the standards of 20 hours active treatment per patient per week and 5.50 nursing hours per patient per day and may impact the quality of patient care. The Transition Units were established to address the issues in the Civil Rights of Institutionalized Persons Act report for transition to community services and providing skills to the patients for that transition. The implementation of the phase-out for this reduction will begin September 2011 and conclude August 2012.	7/1/2011
35	24	DMAP		<b>Make the mental health preferred drug list (PDL) enforceable.</b> Prescribers of mental health medications would be required to adhere to the PDL. Exceptions to the PDL would be administered by prior authorization. An enforceable PDL for mental health medications would increase usage of preferred drugs. There would be no limitation on access to prescriptions under this reduction. Before being placed on the PDL, drugs are subjected to rigorous evidence review.	(5,614,420)	(1,557,811)		(12,578,998)	(19,751,229)					Many mental health organizations, including the National Alliance of Mental Illness (NAMI), strongly oppose putting mental health drugs on an enforceable PDL stating that many drugs have little research or outcome data to be evaluated properly and that a generic replacement may be catastrophic for a patient, causing far reaching health care issues.	1/1/2012
36	25	DMAP		<b>Implement more restrictive selection criteria for medications on the preferred drug list (PDL).</b> The department would require that to get on the PDL, medications would have to be among the 25 percent least expensive in their class, as opposed to being among the 50 percent least expensive in their class.	(55,125)	(27,737)		(146,483)	(229,345)					Many new clients and their providers will have to change their current prescriptions to drugs making the list based on the new criteria. Clients may experience negative impacts to the extent that the policy interferes with the ability of the prescriber and patient to pursue the desired course of treatment.	4/1/2012
37	26	DMAP		<b>Limit utilization of non-preferred drugs.</b> This reduction requires the elimination of the statutory provision allowing a prescriber to order a non-preferred medication and have it paid for by the Oregon Health Plan when a preferred medication for the treatment is on the Preferred Drug List (PDL).	(1,429,239)	(414,095)		(3,221,785)	(5,065,119)					Little or no impact on clients as they would continue to be able to receive the drugs their doctor felt was appropriate but the doctor will have to seek permission from DMAP if the drug is not on the evidence-based Preferred Drug List.	1/1/2012
38	6	PHD		<b>OFH - Eliminates GF support to Women, Infants, and Children (WIC) and Seniors Farm Direct Nutrition Program.</b> The Oregon WIC program currently administers the WIC and Seniors Farm Direct Nutrition Program (FDNP) which allows low-income seniors and current WIC participants to purchase fresh fruits and vegetables. These dollars are used by the program to provide \$20 in coupons for eligible WIC families and \$32 in coupons for low-income seniors to spend at local farmers' markets and farm stands from June to October of each year.	(264,000)			(762,426)	(1,026,426)					Eliminates 100% of the state funded support for current Farm Direct Nutrition Program (FDNP) WIC participants and low-income seniors. FDNP participants purchase fresh, locally grown fruits and vegetables directly from authorized farmers. For the 11-13 biennium, these state funds provided \$264,000 in fresh fruits and vegetables for 5489 clients each year. Elimination of GF will also affect other United States Department of Agriculture (USDA) match requirements. Oregon will lose the WIC Farmer's Market grant award (FY 2010 \$381,213) and Senior Farmers' Market Nutrition Program funding (currently \$853,078).	6/1/2011
39	29	DMAP		<b>Change managed care reimbursement for inpatient services provided by Diagnostic-Related Group (DRG) hospitals to the Medicare payment methodology.</b> The department would change the method for determining the amount paid in capitation payments to managed care organizations for hospital inpatient services provided by DRG hospitals (those with 50 beds or more). The method would switch from a cost-based calculation to one based on the Medicare payment system for DRG hospital inpatient services.	(5,003,181)	(1,672,619)		(11,577,380)	(18,253,180)					Reduced reimbursement to hospitals could cause more costs to be shifted to other payers. If access to services is limited, health outcomes for OHP clients will suffer.	1/1/2012
40	13	AMH - OSH		<b>Reduce Portland Campus of Oregon State Hospital.</b> This cut reduces 20 beds from the long term psychiatric treatment ward for adults who have been civilly committed to DHS for treatment of Mental illness.	(4,160,355)	(883,887)			(5,044,242)	(32)	(28.00)			The loss of 20 beds from this ward means that approximately 41 people per year will not be treated, possibly without community alternatives. These are people who require extended treatment to stabilize and then recover from the episode of mental illness. The implementation of the phase-out for this reduction will begin September 2011 and conclude August 2012.	7/1/2011
41	14	AMH - Program Support		<b>Additional targeted reduction of Personal Services Contracts that support both Mental Health and Alcohol and Drug programs.</b>	(395,133)				(395,133)					This action takes additional reductions in four direct-service personal services contracts and eliminates another. The result would be further reduced services for both mental health and alcohol and drug clients. In addition, reviews for children's mental health intensive treatment services would be reduced.	7/1/2011

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 25% Target 689,659,080 (Limited OF only - does not include non-ItD OF of \$3.17 Billion)

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42	27	DMAP		<b>Restructure administration component of managed care rates.</b> The department would restructure the administrative component of managed care rates to be calculated on a per-member-per-month (PMPM) basis rather than as a percent of the overall capitation rate to which medical inflation is applied.	(4,164,803)	(785,382)		(8,740,544)	(13,690,729)					The administrative component of the capitation rates would no longer grow at the rate of medical inflation. This would have the effect of reducing the amount paid to managed care organizations (MCOs) for administrative costs.	1/1/2012
43	30	DMAP		<b>Change fee-for-service (FFS) reimbursement for outpatient services provided by Diagnostic-Related Group (DRG) hospitals.</b> The department would change outpatient reimbursement to DRG hospitals (those with 50 beds or more) in FFS delivery system. Reimbursement for outpatient services would switch from a cost-based calculation to a yet to be determined payment methodology that creates savings. Any related systems reprogramming cost, including MMIS, have been netted in this reduction.	(1,302,949)	(404,475)		(3,053,402)	(4,760,826)					Reduced reimbursement to hospitals will cause more costs to be shifted to other payers. If access to services is limited, health outcomes for OHP clients will suffer.	4/1/2012
44	16	AMH-A & D Treatment		<b>Eliminate SE 60 Tx Enhancement.</b> This reduction cuts \$1.4 million (38%) of the 10% total reduction of funding for alcohol and drug treatment services for Special Projects.	(1,453,918)				(1,453,918)					Activities and services provided through special projects would be eliminated that include outreach, screening and assessment, substance use treatment, family-based therapy and intensive case management. This reduction would decrease youth and family access to outreach, screening and assessment, treatment and support for recovery, services and supports to find and keep employment in collaboration with TANF JOBS program, further penetration into the criminal justice system, higher high school drop out rates and more parents losing custody of their children. This reduction would impact 6,922 individuals for the biennium. Would eliminate Special Projects that provide holistic approaches for Latino youth and their families who are disproportionate underserved already. This reduction will jeopardize the Maintenance of Effort (MOE) requirement of the SAPT Block Grant. In addition, this reduction may jeopardize the TANF MOE.	7/1/2011
45	17	AMH - A & D Treatment		<b>Reduce SE 66 Continuum of Care.</b> This reduction cuts \$615,407 (16%) of the 10% total reduction of funding for alcohol and drug treatment services for 400 people who are not eligible for Medicaid.	(615,407)				(615,407)					This reduction would eliminate critical A&D services for 400 people per biennium. Without treatment for substance use disorders these people will continue to abuse alcohol and drugs, be at increased risk for infectious diseases, commit crimes, endanger their children and be at risk of losing custody to the state, lose their jobs, and endanger other people. This will increase health costs, child welfare caseloads and reduce the ability of TANF clients to become employable. This cut will result in the layoff of highly skilled counselors who may never return to serving these clients. This reduction jeopardizes the MOE requirement of the SAPT Block Grant.	7/1/2011
46	18	AMH - BMRC		<b>Targeted 10% reduction from a combination of vacancies and position elimination.</b> Employee positions will be reduced and client care and treatment will be negatively impacted. Reduction would be met through vacancy savings and the lay off of 12 employees. Client census would not change.	(1,039,917)				(1,039,917)	(12)	(10.50)			At the 10% level, BMRC will need to lay off 12 employees; 8 of these are responsible for the direct care of clients and one is a psychiatric social worker. The loss of direct care employees has the potential to negatively impact client care. Currently, the length of stay for most clients at BMRC is 99 days (excluding forensic clients). With the loss of a psychiatric social worker, the length of stay for clients at BMRC will increase, resulting in increased costs of hospitalization and limiting BMRC's ability to admit clients from acute care hospitals. Layoffs would be completed by October 1, 2011.	7/1/2011
47	31	DMAP		<b>Reduce the Diagnostic-Related Group (DRG) hospital component of the capitation rates from 80% to 72% of cost.</b> The department would reduce capitation payments to managed care plans for inpatient and outpatient services by lowering the DRG hospital component of the rates by eight percentage points.	(27,961,119)	(5,361,670)		(58,657,123)	(91,979,912)					Diagnostic Related Group (DRG) hospitals and managed care organizations (MCOs) would continue to receive less reimbursement than their cost of services. MCOs would likely be pressured by hospital to pay more than MCOs are paid in the capitation rates for those services. If MCOs pay more, this means less reimbursement (less than cost) for other providers, such as physicians. As a result, MCOs may have difficulty providing clients optimal access to medical services. If access is limited, health outcomes for OHP clients would suffer.	1/1/2012
48	28b	DMAP		<b>Eliminate the indirect medical education (IME) component of the graduate medical education (GME) program.</b> The department would eliminate Medicaid payments to 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.	(10,236,882)	(3,738,175)		(24,807,347)	(38,782,404)					This reduction would mean that hospitals would have less incentive to train new physicians. The impact on the provider workforce may limit access to quality health care for all Oregonians. National health care reform, however, did create a national health care workforce commission tasked with reviewing health care workforce and projected workforce needs. In addition, grant opportunities were created for states to complete comprehensive assessment and planning for health care workforce development. Oregon has submitted a grant application.	10/1/2011
49	2	OPHP		<b>Reduce General Fund expenditures in the Family Health Insurance Assistance Program by 30%.</b>	(6,682,344)	6,682,344			-					The FHIAP caseload is projected to be approximately 11,000 members in July of 2011, and it is expected to drop to approximately 5,500 by June of 2013 through natural attrition. The biennial average for FHIAP in the 11-13 biennium is expected to be 8,000 members. This GF reduction has the potential to be mitigated by use of Insurer's Tax.	7/1/2011

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50	10	PHD		<b>OSPHD- Reduces the State Support to Local Health Departments (per capita payments)</b> These state funds are to operate their Communicable Disease control program which includes: epidemiological investigations that report, monitor, and control Communicable Disease; diagnostic and consultative Communicable Disease service; early detection, education, and prevention activities to reduce the morbidity and mortality of reportable Communicable Diseases; appropriate immunization for human and animal target populations to control and reduce the incidence of Communicable Disease; and collection and analysis of Communicable Disease and other health hazard data for program planning and management.	(500,000)				(500,000)					This reduction would reduce the state general funds provided to Local County Public Health Departments (LPHD) to meet Program Element 1 requirements. Distributed on a per capita basis, this funding would reduce from \$1.12 per capita, to \$1.05. These state funds are to operate their Communicable Disease control program which includes: epidemiological investigations that report, monitor, and control Communicable Disease; diagnostic and consultative Communicable Disease service; early detection, education, and prevention activities to reduce the morbidity and mortality of reportable Communicable Diseases; appropriate immunization for human and animal target populations to control and reduce the incidence of Communicable Disease; and collection and analysis of Communicable Disease and other health hazard data for program planning and management. Reducing these funds will impair LPHD ability to provide this program. In addition, these state dollars are used to provide the required match of several federal funding sources including the Public Health Preparedness Program.		
51	36	DMAP		<b>Reduce discretionary fee-for-service (FFS) rates by 5 percent.</b> The department would reduce by 5 percent FFS rates that are not tied to specific reimbursement policies (e.g., Medicare) and the department has the discretion to change. Hospital provider tax (Other Fund) savings associated with DRG hospital services would be re-purposed creating additional General Fund savings.	(675,181)			(1,173,499)	(1,848,680)					This may reduce access to services. Clients may have to travel further to find participating providers. Reducing ambulance transportation rates may cause some ambulance companies to fail, affecting entire communities. Response times and the quality of service may suffer. Reducing DME will impact the ability of seniors and people with disabilities to live independently. Reducing vision rates may affect the financial viability of the qualified rehabilitation facility vendor that the division contracts with for many services.	1/1/2012	
52	8	PHD		<b>OFH- School Based Health Centers (SBHCs)- Reduces amounts available for current base awards;</b> this reduction would result in a 39% reduction in the base funding for existing SBHC program and may result in some SBHC closures. In 2009-10, 54 certified SBHCs were operating in 20 counties with 14 planning sites completing their first year of planning following the continued investment by legislature for the 2009-2011 biennium. SBHCs are an access model reducing traditional barriers to care and are part of the safety net system where 47% of clients in the 2008-2009 service year were uninsured. SBHCs focus on age and developmentally appropriate care including preventive care visits, diagnosing and treating acute and chronic illness or disease, providing screenings and health education, immunizations, reproductive health services, mental or emotional conditions and are found in elementary, middle and high school settings.	(2,300,000)				(2,300,000)						In 2008-2009, SBHCs provided access to 47,511 youth ages 5-19 and provided 24,995 unduplicated clients with 72,080 primary care, preventive health and mental health visits, 47% of those clients were uninsured. SBHCs are an important part of the safety net system with 70% of all clients reporting they would have otherwise been unlikely to receive care. It's estimated that 10,000 school-aged youth would not receive services based on a "proportional" reduction of services in respect to funds (39%). However, because the current funding model is based on GF dollars that leverage \$4-5 at the local level some centers would likely close and a larger number of school-aged youth will not have access to a center or receive services resulting in a significant systems-level impact. Client level impact will result in increases in foregone care including reductions in preventive care visits & screenings, treatment for acute and chronic illness or disease, immunizations, reproductive health services, mental or emotional conditions, delayed care that then requires more complex/expensive treatment.	7/1/2011
53	12 a	AMH -CMH		<b>13% reduction in Adult Outpatient Mental Health</b>	(4,551,493)				(4,551,493)					This is a 13% reduction of the funding for essential community-based services such as case management, assistance in obtaining benefits, finding and keeping affordable housing, medication management, supports to divert people from jail and therapy. It would require a focus on services for those most at risk of danger to themselves or others and eliminate services to individuals in need of early intervention. Without services these 1,695 adults will become more ill and will be at risk of eviction from affordable housing, be more likely to end up in jail for minor crimes, may be civilly committed to treatment in acute psychiatric hospitals or the state hospitals, and ultimately may die because of lack of treatment. This jeopardizes the MOE requirement of the MH Block Grant; will result in the layoff of experienced and skilled mental health professionals, including nurses and doctors; jeopardizes the success of the new state recovery and treatment facility that will replace OSH; and increases the risk of a federal lawsuit against the state under the Olmstead Supreme Court decision.	7/1/2011	
54	12 b	AMH -CMH		<b>10% reduction in Child Outpatient Mental Health</b>	(1,037,767)				(1,037,767)					This reduction is 10% of the funding for essential community-based services such as in home supports, case management, in school supports, assistance accessing the appropriate level of care to meet the child and family's needs. Because these children are not Medicaid eligible and are without other means to pay for services, the children will be removed from their classrooms, have problems with their families, do poorly in school, commit crimes and have problems with the juvenile justice system. Approximately 220 children per year will not receive services that are essential to keep the child at home, in school and out of trouble. Without these services many of these children will require institutional level of care outside of their school, home and community.	7/1/2011	
55	12 c	AMH -CMH		<b>10% reduction in Regional Acute Psychiatric Inpatient services</b>	(3,473,327)				(3,473,327)					This reduction is 10% of the funding for services for 584 adults who are so ill that they are a danger to themselves or others and require treatment for their mental illness in an acute care hospital psychiatric unit. Without this level of care the individual may harm him/herself or others. Once the person in this condition is in a hospital emergency room, the hospital is required to provide treatment. Hospitals cannot afford to provide expensive psychiatric inpatient services at lower rates or without compensation and if the reduction is made hospitals may consider closing their psychiatric units. This would ultimately have the effect of requiring the state to provide this level of care since those individuals who are civilly committed are committed to the state for care and custody. This cut jeopardizes the success of the new state recovery and treatment facility that will replace OSH. The new facility size and design assume a strong community mental health system. These cuts will increase admission pressure to have the state deliver acute care in state hospitals.	7/1/2011	

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<b>56</b>	12	AMH -CMH		8% reduction in Mental Health Crisis Services	(2,135,967)				(2,135,967)					This reduction cuts 8% of the funding for crisis mental health. Without this funding face-to-face crisis services would be reduced or eliminated. Law enforcement will be the default crisis system. This will result in increased harm to others and the person in crisis. Increased deaths related to mental health crises will occur. Law enforcement interventions will result in increased incarceration of individuals with a mental illness. More individuals will seek crisis services in the hospital emergency department placing increased strain on the emergency department and psychiatric acute care system. Counties would not be able to fully meet their statutory obligations to investigate civil commitments. Therefore, individuals meeting civil commitment criteria would need to be released. This reduction affects an estimated 1,259 individuals annually.	7/1/2011
<b>57</b>	22	AMH - Program Support		Additional reduction of the Program Support workforce related to reductions in community-based programs.	(687,511)			(338,092)	(1,025,603)	(5)	(4.37)			This action would reduce the workforce in Addictions and Mental Health administration. With the reductions taken in the community programs, a reduction in program support would also be taken. These reductions would result in loss of the ability to work proactively with communities where structured residential treatment facilities are to be located, as well as to establish cooperative relationships with local law enforcement relative to people with mental illness who commit crimes.	7/1/2011
<b>58</b>	35	DMAP		Reduce fee-for-service (FFS) durable medical equipment (DME) rates for codes that Medicare reduced effective January 1, 2009. Medicare reduced reimbursement on specific DME codes effective January 1, 2009. The department would reduce its FFS DME rates to match Medicare's rate reduction.	(290,969)			(496,790)	(787,759)					A reduction in rates may cause some DME providers to stop participating in the program, creating access problems for clients in areas with few providers. Access problems will cause longer hospital stays increasing costs for inpatient services. Clients who need complex wheelchairs may be dramatically affected. It will be very difficult for them to obtain wheelchairs to meet their needs for mobility, functioning and living in the least restrictive setting.	1/1/2012
<b>59</b>	37	DMAP		Eliminate advanced restorative dental. The department would eliminate advanced restorative dental services currently included in OHP benefit packages. OHP clients would no longer have coverage for basic crowns.	(109,629)			(187,146)	(296,775)					The department would eliminate advanced restorative dental services currently included in OHP benefit packages. OHP clients (including pregnant adults and children) would no longer have coverage for basic crowns.	7/1/2011
<b>60</b>	33	DMAP		Implement changes to the managed care delivery system: Implement changes to the managed care delivery system through such actions as soliciting managed care organizations to provide physical medicine health services for larger areas of the state. This would involve a competitive bidding process that considers costs and quality. In addition, integrate physical and behavioral health care that focuses on coordinating care through patient-centered health homes.	(29,000,000)	(8,000,000)	-	(66,000,000)	(103,000,000)					In the short term, this may cause a disruption of services for clients, such as having to learn new administrative processes if needing to switch plans or possibly doctors. Disruptions also may occur in the health care delivery system for providers with major changes to the current structure of managed care organizations. However, integrating physical and behavioral health care can provide benefits in improving the quality of care while lowering the cost of care.	7/1/2012
<b>61</b>	38	DMAP		Eliminate Oregon Health Plan (OHP) Plus non-pregnant adult therapies. The department would eliminate physical therapy, occupational therapy, and speech therapy from the OHP Plus benefit package for non-pregnant adults.	(564,629)			(956,872)	(1,521,501)					Non-pregnant adult Oregon Health Plan clients needing these services would experience prolonged health care issues affecting their ability to become self-sufficient. Hospital stays and recovery from orthopedic surgery would increase.	1/1/2012
<b>62</b>		DMAP		Administrative budget reduction as part of the elimination of OHP non-pregnant adult therapy services.	(21,688)			(64,032)	(85,720)	(1)	(0.50)		(0.50)		
<b>63</b>	39	DMAP		Eliminate Oregon Health Plan (OHP) Plus non-pregnant adult prosthetic devices, hearing aids, chiropractic services and podiatry services. The department would eliminate coverage for prosthetic devices, hearing aids, chiropractic services, and podiatry services from the OHP Plus benefit package for non-pregnant adults.	(981,350)			(1,663,086)	(2,644,436)					Health care needs for a significant number of non-pregnant adult Oregon Health Plan clients, especially seniors and people with disabilities would go unmet. For example, individuals would live without prosthetic devices for amputated limbs; individuals with hearing impairments would go without necessary aids; and, individuals with diabetic or neuropathic conditions would go without foot care treatment. In some instances, other agency programs would have to fund these services.	1/1/2012
<b>64</b>	41	DMAP		Cover fewer lines on prioritized list. Oregon Health Plan (OHP) coverage is based on the prioritized list of health services. The department would seek federal approval to cover nine fewer lines (503 through 511) on the proposed 2012 prioritized list for both OHP Plus and OHP Standard benefit packages.	(4,606,763)	(586,678)		(8,865,683)	(14,059,124)					This reduction would eliminate coverage for nine fewer lines (503 through 511) on the proposed 2012 prioritized list of OHP health care services. Conditions that would no longer be covered would include: treatment for rectal conditions; otosclerosis (hearing loss); removal of foreign body in ear and nose; treatment of vertebral fractures; treatment of benign breast cysts; treatment of some gynecologic conditions; treatment of conduct disorders; and, certain childhood mental health conditions.	7/1/2012
<b>65</b>		PHD		Office of Family Health (OFH) - Reduces general fund (GF) support in the State Immunization Program: Eliminates Immunization awards to the local county Public Health Departments. These state funded dollars leverage a match with Title XIX at a rate of 2:1. The State Immunization Program provides state funding awards to meet program Element 43 requirements to provide infrastructure, primarily salaries, to local county health partners. Funds are then used to offer on-going immunization clinics in each county, report data to the ALERT Registry, provide case-management services to Perinatal Hepatitis B cases, tracking and recall, WIC/Immunization integration, surveillance and outbreak control for vaccine preventable diseases, ensure reporting for adverse events following immunizations, maintaining School Immunization Law, and meeting key performance measures.	(1,200,000)			(1,200,000)	(2,400,000)					Eliminates state general fund Immunization awards to the Local County Public Health Departments (LPHD) to meet Program Element 43 requirements. These state funded dollars leverage a match with Title XIX at a rate of 2:1. Reductions will result in layoffs of county staff, closing of immunization clinics, and would force counties to revert responsibilities required by state statute or rule, such as the School Immunization Law requirement, to the state for maintenance. Elimination of these requirements under Program Element 43 puts the State at risk for not meeting grant requirements and loss of federal funding from the Centers for Disease Control under the Immunization Vaccine for Children Grant, which stipulates that these functions and grant requirements must occur. An additional risk associated with this reduction is that the Public Health Division may need to revise projected savings to reflect offsetting costs to the State by the increase in workload transferred from counties to the State for the maintenance of these requirements.	8/1/2011

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66	20	OSH		<b>Close Portland Campus of Oregon State Hospital</b> This cut eliminates the remaining 72 long term psychiatric treatment beds for adults who have been civilly committed to DHS for treatment of mental illness, possibly without community alternatives.	(17,259,128)	(3,666,784)			(20,925,912)	(192)	(111.38)			The loss of the entire 92 beds from P1A, P1B, P5A, P6A and supporting programs means that approximately 250 people per year that, without community alternatives, will not be treated. These are people who require extended treatment to stabilize and then recover from the episode of mental illness. Without services these people will languish in acute psychiatric units, may be jailed and may die. Program cuts of this magnitude may require suspension of the mental health civil commitment statutes found in ORS 426.000 through 429.320. The implementation of the phase-out for this reduction will begin September 2011 and conclude August 2012.	9/1/2011
67	7	AMH - OSH		<b>Additional reduction in Overtime and Medical Services and Supplies.</b> The 2009-11 budget included the addition of 527 positions. As a result, a reduction in overtime and nurse contracts was taken. This action would reduce those costs even further.	(5,976,694)	(115,114)		(64,021)	(6,155,829)					Continued reductions in this area without a corresponding increase in staff may result in possible legal action by the U.S. Department of Justice due to OSH inability to meet the standards of 20 hours active treatment per patient per week, and 5.50 nursing hours per patient per day and may impact the quality of patient care.	7/1/2011
68		OHA - Shared Admin Services		<b>The Oregon Health Authority will continue the Non-program/Administrative cost reduction measures that have been implemented during the 2009-11 biennium and prior. These measures include a department wide hiring freeze, and targeted reductions of all Service &amp; Supply expenditure budgets for an additional 4% Shared Services Administration budget reduction (total of 8%).</b>	(3,500,000)	(600,000)		(2,400,000)	(6,500,000)	(14)	(13.82)			OHA Shared Administrative services will further reduce its budgeted personal services and supplies budget by targeted reduction actions in both personal services and service & supply categories such as training travel, office supplies, and contracted professional services. This will increase the challenge to timely and effectively meeting the shared administrative service responsibilities for OHA, such as processing of payments, budget development and analysis, contract processing, federal reporting, response to inquiries, etc..	7/1/2011
69	4	PHD		<b>Targeted reduction of General Funds in the Human Immunodeficiency Virus/Sexually Transmitted Disease/Tuberculosis(HIV/STD/TB) Program.</b> The HIV/STD/TB Program analyzes and reports epidemiologic data on HIV, STD and TB infections; with a variety of partners (e.g. local health departments, community-based organizations, other state agencies) develops, implements and evaluates evidence-driven population-based prevention programs; educates Oregonians about the impact of HIV, STD and TB infections; assists in the development of local and national public policy related to the prevention and care of these infections; coordinates with and informs other agencies of the services available to persons affected by these diseases; and assists people living with HIV/AIDS in accessing HIV medical care and treatment.	(524,656)				(524,656)					Reduces Human Immunodeficiency Virus (HIV) testing at counseling and testing centers statewide, which would mean approximately 1038 clients would not be counseled or tested for HIV; reduction in distributed to counties for HIV case management and support services; 131 clients would not receive case-management services and 64 clients will not receive support services. Could delay care, leading to disease progression and additional unnecessary transmission of HIV to others. Reduces state support for tuberculosis (TB) investigation, case management and medications. Failed treatment of TB, development of antibiotic resistance and additional transmission of TB would be the likely consequence in approximately 12 new cases. Reduces state purchase and distribution of medications to treat sexually transmitted disease (STDs) in Oregon and in client follow-up and contact tracing services for STDs. 5216 patients would not receive medication, and approximately 313 clients with STD would not be interviewed or notified of potential exposure. Reductions in all of these program areas would likely contribute to job	8/1/2011
70	24	AMH - Program Support		<b>Additional targeted reduction of direct-service Professional Service Contracts by 50%.</b>	(684,398)				(684,398)					This action further reduces and/or eliminates direct-service personal services contracts. The result would be reduced services for both mental health and alcohol and drug clients, including: <ul style="list-style-type: none"> <li>- Oregon Nurses Foundation: The contractor will need to eliminate staff positions. Reduction of services will continue to decrease for providing training and technical assistance for employers regarding drug free workplace policies; reduced support of a technical advisory committee to guide implementation of effective services, and maintenance of an up-to-date website that serves counties, tribes, and coalitions.</li> <li>- Recovery Association Project: A reduction in this contract will impact the contractor's ability to open additional housing for people who need safe, stable alcohol and drug free housing.</li> <li>- Dual Diagnosis: This contract provides funding for establishing Dual Diagnosis Anonymous (DDA) meeting groups, ongoing education, technical assistance, and support to all these groups established in the community.</li> </ul>	7/1/2011
71	23	AMH - CMH		<b>Eliminate development and operational costs associated with a portion of mandated civil caseload. Operate at less capacity.</b>	(8,574,203)				(8,574,203)					The mandated caseload for 2011-13 includes costs for development of residential capacity to meet the growing demand. The plan includes development of capacity for 25 young adults in transition, 10 residential beds for men and 5 beds for polydipsia. This reduction would eliminate the development and operation costs of this capacity. The young adults in transition population is the most underserved in the current system. If specialized services aren't developed for young adults, their current path to higher, more costly levels of care, return hospital visits and increased incarceration will continue. Developing specialized services will break the cycle of institutionalization many young adults face. In addition, patients remain in the state hospital after they no longer need a hospital level of care because there are not enough all-male facilities available in communities. Failure to develop these 10 beds will further exacerbate the situation and prevent patients from integrating back into the community. Finally, the specialized needs of patients with polydipsia would not be met in a community setting and they will remain in the hos	7/1/2011

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				GF&LF	OF	TTX	FF	TF							
72	7	PHD	<b>Office Community Health &amp; Health Planning (OCHHP) - Eliminates all funding to the Oregon Trauma System Program and state general fund support for the EMS for Children Program.</b> Elimination of the Oregon Trauma System Program will do away with the regulation and technical assistance of Oregon's 45 trauma hospitals that provide systematized care to trauma patients. It would also eliminate site surveys that verify compliance with standards of care per Oregon statute and administrative rule. It will also eliminate the Oregon Trauma Registry which provides a mechanism for robust Quality Improvement and assurance activities. Elimination of the state program may decrease the number of participating trauma hospitals and will reduce or limit access to quality trauma care. The current Oregon Trauma System has demonstrated that a system-based trauma care reduces morbidity and mortality associated with traumatic injuries.  The proposed cuts would also eliminate state support for the EMS for Children Program. These funds are used to provide education for prehospital and hospital medical providers and could result in a decrease	(368,272)					(368,272)				This reduction eliminates the Oregon Trauma System. Without this system in place, the protected practice of bypassing the closest hospital and utilizing a hospital that is appropriately staff and equipped to provide trauma care will erode. The trauma system relies on the state's ability to assure and regulate compliance with the national trauma standards. The protections provided for quality improvement reviews and the implementation of standards for care and equipment would deteriorate without the regulatory oversight of the Program. Without the current general funds support, the EMS for Children Program will eliminate specialized prehospital and hospital staff training. The majority of this training targets rural Oregon. The Program will be unable to provide specialized equipment for emergency medical services agencies and hospital emergency departments that is necessary to provide care for injured pediatric patients.		
73	New	PHD	<b>Elimination of all General Fund budget for Program Support within the Oregon Trauma System Program and the EMS for Children Program.</b>	(738,728)					(738,728)	(4)	(4.00)	(4)	(4.00)	Coupled with the other reductions above in the Mobile Training Unit, and the Trauma Registry, this will eliminate the EMS Trauma Program staff, which provide the necessary support to the State level oversight of a Trauma system, to assure and regulate compliance with the national trauma standards. The protections provided for quality improvement reviews and the implementation of standards for care and equipment would deteriorate without the regulatory oversight of the Program. It will eliminate specialized prehospital and hospital staff training for pediatric trauma which generally targets rural Oregon. Specialized equipment for emergency medical services agencies and hospital emergency departments that is necessary to provide care for injured pediatric patients will not be provided. Because pediatric patients represent a very small percentage of patients who are critically ill or injured, the lack of appropriate education and equipment will negatively impact the care of the pediatric patient.	
74	42	DMAP	<b>Reduce Oregon Health Plan (OHP) Plus non-pregnant adult dental coverage to OHP Standard level.</b> The department would reduce non-pregnant adult dental coverage for the OHP Plus benefit package to be the same as that in the OHP Standard benefit package.	(16,028,806)			(27,147,564)		(43,176,370)				Non-pregnant adults who receive the OHP Plus benefit package would receive the same limited dental package as provided to OHP Standard clients. OHP Standard benefits are limited to services requiring immediate treatment and are not intended to restore teeth. Services provided include treatment for the following: acute infection; acute abscesses; severe tooth pain; tooth re-implantation when clinically appropriate; and extraction of teeth, limited to those teeth that are symptomatic.	1/1/2012	
75	19 a	AMH - CMH	<b>Additional reduction of Child Outpatient Mental Health</b>	(297,381)					(297,381)				This reduction cuts and additional 3% of the funding for essential community-based services such as in home supports, case management, in school supports, assistance accessing the appropriate level of care to meet the child and family's needs. Because these children are not Medicaid eligible and are without other means to pay for services, the children will be removed from their classrooms, have problems with their families, do poorly in school, commit crimes and have problems with the juvenile justice system. Approximately an additional 64 children per year will not receive services that are essential to keep the child at home, in school and out of trouble. Without these services many of these children will require institutional level of care outside of their school, home and community.	7/1/2011	
76	19 b	AMH - CMH	<b>Additional reduction of Adult Outpatient Mental Health</b>	(1,304,267)					(1,304,267)				This is an additional 3.6% reduction of the funding for essential community-based services such as case management, assistance in obtaining benefits, finding and keeping affordable housing, medication management, supports to divert people from jail and therapy. The community mental health programs would focus services on those most at risk of danger to themselves or others and eliminate services to individuals in need of early intervention. Ultimately without services an additional 486 adults will become more ill and will be at risk of eviction from affordable housing, be more likely to end up in jail for minor crime and may be civilly committed to treatment in acute psychiatric hospitals or the state hospitals. Ultimately some individuals may die because of lack of treatment. This cut jeopardizes the maintenance of effort requirement of the MH Block Grant. The cut will result in the layoff of experienced and skilled mental health professionals including nurses and doctors who will never return to the public mental health system with its uncertain funding.	7/1/2011	
77	19 c	AMH - CMH	<b>Additional reduction of Regional Acute Psychiatric Inpatient services</b>	(995,310)					(995,310)				This reduction cuts an additional 2.8% of the funding for services for 167 adults who are so ill that they are a danger to themselves or others and require treatment for their mental illness in an acute care hospital psychiatric unit. Without this level of care the individual may harm him/herself or others. Once the person in this condition is in a hospital emergency room, the hospital is required to provide treatment. Hospitals cannot afford to provide expensive psychiatric inpatient services at lower rates or without compensation and if the reduction is made hospitals may consider closing their psychiatric units. This would ultimately have the effect of requiring the state to provide this level of care since those individuals who are civilly committed are committed to the state for care and custody. This cut jeopardizes the success of the new state recovery and treatment facility that will replace OSH. The new facility size and design assume a strong community mental health system. These cuts will increase admission pressure to have the state deliver acute care in state hospitals.	7/1/2011	

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78	19 d	AMH - CMH		Additional reduction of Mental Health Crisis Services	(612,079)				(612,079)					This reduction cuts an additional 2.3% of the funding for crisis mental health. Without this funding face-to-face crisis services would be reduced or eliminated. Law enforcement will be the default crisis system. This will result in increased harm to others and the person in crisis. Increased deaths related to mental health crises will occur. Law enforcement interventions will result in increased incarceration of individuals with a mental illness. More individuals will seek crisis services in the hospital emergency department placing increased strain on the emergency department and psychiatric acute care system. Counties would not be able to fully meet their statutory obligations to investigate civil commitments. Therefore, individuals meeting civil commitment criteria would need to be released. This reduction affects an estimated 361 individuals annually.	7/1/2011	
79	43	DMAP		Eliminate Oregon Health Plan (OHP) Plus non-pregnant adult and OHP Standard dental coverage. The department would eliminate the remaining non-pregnant adult dental coverage for the OHP Plus and OHP Standard benefit packages. Hospital provider tax (Other Fund) revenue would be re-purposed creating General Fund savings.	(9,329,458)			(15,810,552)	(25,140,010)					The lack of a dental benefit for non-pregnant adults on the Oregon Health Plan (OHP) would cause adverse effects on their physical health such diabetes and cardiovascular disease. Emergency room visits would increase. The OHP dental care organization infrastructure would be threatened with the loss of the adult population.	1/1/2012	
80	25	AMH - CMH		Reduce residential rates by 6%	(4,161,285)			(4,358,955)	(8,520,240)					This reduction would result in the layoff of experienced and skilled mental health professionals and would reduce community residential capacity. This would hinder efforts to move people from the state hospital into community settings and could result in lawsuits.	7/1/2011	
81	26	AMH - A & D Treatment		This reduction cuts \$3.5 million (34%) 25% of the total reduction of the funding for alcohol and drug treatment services for 2,200 youth and adults who are not eligible for Medicaid. Without treatment people will continue to abuse alcohol & drugs, be at greater risk for infectious diseases and other chronic health problems, commit crimes, endanger their children, and lose their jobs. This will increase child welfare caseloads and reduce the ability of TANF clients to become employable. This cut will result in the layoff of highly skilled counselors who may never return to serving these clients at a time the system should be maintaining or growing capacity to prepare for the implementation of federal health reform initiatives. This reduction jeopardizes the MOE requirements of the SAPT Block Grant.	(3,447,912)				(3,447,912)					This reduction would eliminate critical A&D services for 2,200 people per biennium. The system is already only able to meet about 25% of the need based on the population of people in Oregon with a substance use disorder, according to the National Survey on Drug Use and Health. Without treatment for substance use disorders, people will continue to abuse alcohol and drugs, be at increased risk for acquiring infectious diseases and other chronic health conditions, commit crimes, endanger their children and be at risk of losing custody to the state, lose their jobs and endanger other people.  This reduction will increase the cost of untreated substance abuse in Oregon, already estimated to be \$5.9 billion per year, according to a report published by ECONorthwest in 2008, and jeopardizes the maintenance of effort requirement of the SAPT Block Grant - a significant funding source that comprises roughly 30% of the alcohol and drug services budget. The reduction will result in the layoff of numerous experienced and skilled alcohol and drug counselors.	7/1/2011	
82	27	AMH - A & D Treatment		This General Fund reduction cuts \$4.8 million of funding from the Intensive Treatment and Recovery Services (ITRS) program. This program provides outpatient A&D treatment and wraparound services for parents with children under the age of 18 who are not eligible for Medicaid. 1379 parents will be without treatment, at risk for continued use of alcohol and other drugs, and their children are at risk of entering or remaining in family foster care at a cost of \$1,900.00 a month per child. These cuts will increase child welfare caseloads. Highly skilled counselors will be laid off and they may never return to serving these parents. This reduction jeopardizes the Maintenance of Effort (MOE) requirements of the SAPT Block Grant, the TANF MOE requirements and reverses the investments and gains made by implementing the ITRS initiative during the 2007-2009 and 2009-2011 biennia.	(4,829,389)				(4,829,389)					This reduction will eliminate critical A&D services for 1,379 parents per biennium. Without treatment for substance use disorders parents are likely to continue to abuse alcohol and drugs, become involved in the child welfare system, be at risk of losing custody to the state, and for those already in the system their children will remain in foster care. This cut will reverse investments for treating addicted child welfare parents and the gains they have made working toward reunification with their children.  The magnitude of this cut will jeopardize the ability of counties and/or nonprofit providers to continue to provide alcohol and drug treatment in their communities. This cut will result in the layoff of numerous experienced and skilled alcohol and drug counselors. During the 2003-2005 reductions, 1,000 experienced and skilled alcohol and drug counselors lost their jobs.	7/1/2011	
83	5	PHD		ODPE - Further Reduces GF support in the Human Immunodeficiency Virus/Sexually Transmitted Disease/Tuberculosis (HIV/STD/TB) Program areas. The HIV/STD/TB Program analyzes and reports epidemiologic data on HIV, STD and TB infections; with a variety of partners (e.g. local health departments, community-based organizations, other state agencies) develops, implements and evaluates evidence-driven population-based prevention programs; educates Oregonians about the impact of HIV, STD and TB infections; assists in the development of local and national public policy related to the prevention and care of these infections; coordinates with and informs other agencies of the services available to persons affected by these diseases; and assists people living with HIV/AIDS in accessing HIV medical care and treatment.	(1,400,000)				(1,400,000)						In addition to description of the Human Immunodeficiency Virus/Sexually Transmitted Disease/Tuberculosis (HST) reduction above, this reduction would reduce state support for AIDS Drug Assistance Program (ADAP) by 33%, which could mean a waiting list for what is a safety net program for persons with HIV and AIDS and an increase in co-pays for some HIV infected persons. Persons whose drug therapy is interrupted have a significant increased risk of developing viral strains that are resistant to existing therapies and would result in an increased progression of disease which could result in an additional 35 deaths (est.) in Oregon. HIV infected persons who are not on drug therapy are more likely to cause new infections in the community and individuals have the ability to pass drug resistant strains as new infections. We can not expect these Oregonians to shift to other local or state social programs because, in most cases, the CAREAssist Program is the payor of last resort and has been the safety net for these clients. The combination of both HST cuts could result in a match shortfall for Ryan White program.	8/1/2011

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84	10	PHD	<b>OSPHD- Further reduction of the State Support to Local Health Departments (per capita payments)</b> These state funds are to operate their Communicable Disease control program which includes: epidemiological investigations that report, monitor, and control Communicable Disease; diagnostic and consultative Communicable Disease service; early detection, education, and prevention activities to reduce the morbidity and mortality of reportable Communicable Diseases; appropriate immunization for human and animal target populations to control and reduce the incidence of Communicable Disease; and collection and analysis of Communicable Disease and other health hazard data for program planning and management.	(500,000)					(500,000)					This reduction would reduce the state general funds provided to Local County Public Health Departments (LPHD) to meet Program Element 1 requirements. Distributed on a per capita basis, this funding would reduce from \$1.05 per capita, to \$.99. These state funds are to operate their Communicable Disease control program which includes: epidemiological investigations that report, monitor, and control Communicable Disease; diagnostic and consultative Communicable Disease service; early detection, education, and prevention activities to reduce the morbidity and mortality of reportable Communicable Diseases; appropriate immunization for human and animal target populations to control and reduce the incidence of Communicable Disease; and collection and analysis of Communicable Disease and other health hazard data for program planning and management. Reducing these funds will impair LPHD ability to provide this program. In addition, these state dollars are used to provide the required match of several federal funding sources including the Public Health Preparedness Program.	
85	28a	DMAP	<b>Eliminate the direct medical education (DME) component of the graduate medical education (GME) program.</b> The department would eliminate Medicaid payments to 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.	(2,721,197)	(993,692)			(6,594,358)	(10,309,247)					This reduction would mean that hospitals would have less incentive to train new physicians. The impact on the provider workforce may limit access to quality health care for all Oregonians. National health care reform, however, did create a national health care workforce commission tasked with reviewing health care workforce and projected workforce needs. In addition, grant opportunities were created for states to complete comprehensive assessment and planning for health care workforce development. Oregon has submitted a grant application.	10/1/2011
86	52	DMAP	<b>Cover fewer lines on prioritized list.</b> Oregon Health Plan (OHP) coverage is based on the prioritized list of health services. The department would seek federal approval to cover an additional 55 fewer lines (Lines 448 through 502) on the proposed 2012 prioritized list for OHP Plus, Standard and CHIP benefit packages.	(100,555,993)	(19,000,000)			(204,350,000)	(323,905,993)					This action would have a dramatic impact on health care services that are covered for all OHP clients, including pregnant women, children, and other groups. Treatment of serious conditions such as cancer of the gall bladder and non-union of fractures would be deleted, as well as treatment of many common conditions, including acute bronchitis, menopause, and osteoarthritis. Conditions causing significant functional disability would no longer be covered, including urinary incontinence and several types of hearing loss. The most common mental health conditions would no longer be covered, which would likely result in broader family and community impacts. In addition, coverage of many common dental treatments, such as root canal therapy, crowns, and dentures, would be eliminated for all eligibility groups. Elimination of coverage of this magnitude would make it very difficult for physical, dental, and mental health providers to deliver high quality, comprehensive care. This proposal would significantly increase administrative burden for providers and for the department.	07/01/12
87	50	DMAP	<b>Eliminate Oregon Health Plan (OHP) Standard adult prescription drugs &amp; re-purpose tax revenue.</b> The department would eliminate prescription drug coverage from the OHP Standard benefit package. Hospital provider tax (Other Fund) revenue would be re-purposed creating General Fund savings.	(25,343,716)	(6,113,970)			(53,701,182)	(85,158,868)					Non-pregnant adults who receive the OHP Standard benefit package would lose coverage for the drugs, including mental health drugs, they need to maintain their health. As health problems worsen, the use of emergency departments and hospitalizations would increase. It would become more difficult to help families become self-sufficient. Prior to implementation the department would work with the pharmacy industry and other organizations to identify any other means for clients to obtain their medications.	4/1/2012
88	50.1	DMAP	<b>Additional targeted reduction of Administrative Services &amp; Supplies budget.</b>	(500,000)				(500,000)	(1,000,000)					This reduction would prevent the division from contracting for certain services related to health care quality, and Oregon Health Plan managed care disenrollment and monitoring. In addition, the division would not be able to contract for any professional service needs the Oregon Health Authority administration identifies between now and the end of the biennium. Potential needs, such as those related to the planning and implementation of national health reform, could no longer be addressed through contracting.	7/1/2011
89		OHA - Shared Admin Services	<b>The Oregon Health Authority will continue the Non-program/Administrative cost reduction measures that have been implemented during the 2009-11 biennium and prior. These measures include a department wide hiring freeze, and targeted reductions of all Service &amp; Supply expenditure budgets for an additional 4% Shared Services Administration budget reduction (total of 12%).</b>	(3,750,000)	(600,000)			(2,400,000)	(6,750,000)	(14)	(13.82)			OHA Shared Administrative services will further reduce its budgeted personal services and supplies budget by targeted reduction actions in both personal services and service & supply categories such as training, travel, office supplies, and contracted professional services. This will effect the ability to meet the shared administrative service responsibilities to OHA and will add risk of delays and errors.	
90	28	AMH - BMRC	<b>Additional targeted position reductions</b> Reduction would be met through vacancy savings, continued cost saving measures, the lay off of 29 employees and decreasing client census by 25% (45 clients). One residential unit would be used only for a maximum of clients who are identified as "Ready to Place" (ready to discharge to a lower level of care). This unit would be staffed minimally as allowed by licensure	(2,080,468)					(2,080,468)	(29)	(21.75)			At the 25% level, 29 employees would be laid off; 23 of these employees work directly with clients every day. At this level, client individual and group therapies will be greatly reduced and hospital lengths of stay will increase. BMRC currently admits and discharges 145 - 150 people each year and is the primary state hospital resource for Eastern Oregon. A census reduction will mean that 38 - 40 people every year that need state hospital level of care will either not receive services or spend much longer in acute care before they are admitted to the Portland/Salem campuses of OSH. This action would be phased-out by January 1, 2012.	7/1/2011

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91	29	AMH - OSH	<b>Closure of 3 Non-Medicaid Geropsychiatric Wards at OSH.</b> Three wards at OSH that serve older clients with psychiatric and behavioral symptoms and younger brain injured adults with similar symptoms will be closed without community alternatives. It is unknown at this time who might be eligible for SPD services.	(17,447,436)	(1,078,192)				(18,525,628)	(113)	(113.00)		This reduction closes 3 wards in the Geropsychiatric Hospital Program that serve clients who themselves or whose services are not eligible for Medicaid reimbursement. The hospital would lose 86 beds serving 150 people per year. Patients formerly served will be discharged into existing community programs that were unable to meet their complex medical, behavioral and mental health needs in the first place. This cut will destabilize the planning for the replacement of OSH which assumed a growth in the population. Program cuts of this magnitude may require suspension of the mental health civil commitment statutes found in OR 426.005 through 429.320. The implementation of the phase-out for this reduction will begin September 2011 and conclude August 2012. This action could lead to increased costs in community settings for both Community Mental Health and Seniors and People with Disabilities.	7/1/2011
92	30	AMH - OSH	<b>Remove the remaining cost for the Forensic Psychiatric Treatment Cottage Transition program.</b> The clients served have psychiatric disabilities and skill deficits that impede their placement in the community. The goal is to teach them social and community survival skills that will enhance their life satisfaction and decrease their risk of re-offending or relapse.	(10,771,376)					(10,771,376)	(83)	(62.25)		The Cottage Transition patients are all under the Psychiatric Security Review Board. If the cottages closed we would lose 36 transitional beds and there would need to be appropriate resources in the community in order for them to continue to actively move toward conditional release and discharge. Continued reductions in the area may result in possible legal action by the U.S. Department of Justice as this program assists in addressing the issues in the CRIPA report for transition to community services and providing skills to the patients for that transition. The implementation of the phase-out for this reduction will begin September 2011 and conclude August 2012.	7/1/2011
93	46	DMAP	<b>Eliminate Oregon Health Plan (OHP) Standard mental health benefits &amp; re-purpose tax revenue.</b> The department would eliminate mental health coverage from the OHP Standard benefit package. Hospital provider tax (Other Fund) revenue would be re-purposed creating General Fund savings.	(5,468,098)			(9,348,153)		(14,816,251)				This reduction would eliminate mental health services and community-based rehabilitative service provided through the OHP Standard benefit package. While these services are optional, inpatient mental health services are not. Limited hospital services (emergent and urgent) would remain part of the OHP Standard benefit package.	4/1/2012
94	31	AMH - OSH	<b>Remove Ward 35A.</b> This unit serves forensic, PSRB clients who have psychiatric disabilities and skill deficits that impede their placement into the community. Our goal is to teach residents social and community survival skills that will enhance their life satisfaction and decrease their risk of re-offending.	(7,535,434)					(7,535,434)	(38)	(28.50)		Closing 35A means a loss of 30 beds that is currently serving 35 men and women who are under the Psychiatric Security Review Board. They have not reached the next level of stability to transfer to the cottages. This is a Transition Unit in which the clients would need appropriate resources in the community that would enable them to gain the skills to move forward in their treatment. 35A is a ward within the Forensic Psychiatric Services program which provides services for the Court ordered evaluation or services under the Psychiatric Security Review Board. Forensic Psychiatric Services provide evaluations for fitness to proceed (ORS 161.370) and criminal responsibility; treatment to restore capacity for trial (ORS 161.365) (i.e., aid and assist in a trial); and treatment for those found guilty except for insanity and placed under the jurisdiction of the Psychiatric Security Review Board (ORS 161.327). The implementation of the phase-out for this reduction will begin September 2011 and conclude August 2012.	7/1/2011
95	32	AMH - OSH	<b>Remove Ward 35C.</b> This unit serves forensic, PSRB clients who have psychiatric disabilities and skill deficits that impede their placement into the community. Our goal is to teach residents social and community survival skills that will enhance their life satisfaction and decrease their risk of re-offending.	(3,112,381)					(3,112,381)	(43)	(32.25)		In closing 35C OSH loses 35 beds serving co-ed patients who are also under the Psychiatric Security Review Board. Closure of this unit would involve placing the 13 patients who are not transition ready, into existing 50 building units which would increase the census for those areas. If closed, there would need to be appropriate resources in the community in order for them to continue to actively move toward conditional release and discharge. 35C is a ward within the Forensic Psychiatric Services program which provides services for the Court ordered evaluation or services under the Psychiatric Security Review Board. Forensic Psychiatric Services provide evaluations for fitness to proceed (ORS 161.370) and criminal responsibility; treatment to restore capacity for trial (ORS 161.365) (i.e., aid and assist in a trial); and treatment for those found guilty except for insanity and placed under the jurisdiction of the Psychiatric Security Review Board (ORS 161.327). The implementation of the phase-out for this reduction will begin September 2011 and conclude August 2012.	7/1/2011
96	33 a	AMH - CMH	<b>Additional reduction in Mental Health Crisis Services</b>	(7,068,004)					(7,068,004)				This reduction cuts an additional 26% of the funding for crisis mental health. Without this funding face-to-face crisis services would be reduced or eliminated. Law enforcement will be the default crisis system. This will result in increased harm to others and the person in crisis. Increased deaths related to mental health crises will occur. Law enforcement interventions will result in increased incarceration of individuals with a mental illness. More individuals will seek crisis services in the hospital emergency department placing increased strain on the emergency department and psychiatric acute care system. Counties would not be able to fully meet their statutory obligations to investigate civil commitments. Therefore, individuals meeting civil commitment criteria would need to be released. This reduction affects an estimated 4,100 individuals annually.	7/1/2011
97	47	DMAP	<b>Eliminate Oregon Health Plan (OHP) Plus non-pregnant adult mental health benefits.</b> The department would eliminate mental health coverage from the OHP Plus benefit package for non-pregnant adults.	(29,537,182)			(50,455,488)		(79,992,670)				This reduction would eliminate mental health services and community-based rehabilitative service provided to non-pregnant adults who receive the OHP Plus benefit package. While these services are optional, inpatient mental health services are not. Mental health drugs would remain part of the benefit package for OHP Plus non-pregnant adults.	4/1/2012

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98	48	DMAP		Eliminate Oregon Health Plan (OHP) Standard addiction services & re-purpose tax revenue. The department would eliminate addiction services from the OHP Standard benefit package. Hospital provider tax (Other Fund) revenue would be re-purposed creating General Fund savings.	(2,704,241)			(4,629,991)	(7,334,232)					This reduction would eliminate clinic and community-based assessment and treatment for substance use disorders from the OHP Standard benefit package. These services are covered in the Medicaid state plan under rehabilitative services and are optional. Hospital-based detoxification, screening and brief intervention by a physician would remain covered.	4/1/2012
99	33 b	AMH - CMH		Additional reduction in Child Outpatient Mental Health	(3,434,015)				(3,434,015)					This reduction cuts and additional 34.23% of the funding for essential community-based services such as in home supports, case management, in school supports, assistance accessing the appropriate level of care to meet the child and family's needs. Because these children are not Medicaid eligible and are without other means to pay for services, the children will be removed from their classrooms, have problems with their families, do poorly in school, commit crimes and have problems with the juvenile justice system. Approximately an additional 739 children per year will not receive services that are essential to keep the child at home, in school and out of trouble. Without these services many of these children will require institutional level of care outside of their school, home and community.	7/1/2011
100	49	DMAP		Eliminate Oregon Health Plan (OHP) Plus non-pregnant adult addiction services. The department would eliminate addiction services from the OHP Plus benefit package for non-pregnant adults.	(1,535,183)			(2,653,482)	(4,188,665)					This reduction would eliminate clinic and community-based assessment and treatment for substance use disorders for non-pregnant adults who receive the OHP Plus benefit package. These services are covered in the Medicaid state plan under rehabilitative services and are optional. Hospital-based detoxification, screening and brief intervention by a physician would remain covered.	4/1/2012
101	33 c	AMH - CMH		Additional reduction in Adult Outpatient Mental Health	(15,061,076)				(15,061,076)					This is an additional 42% reduction of the funding for essential community-based services for an additional 5,610 adults. Would further increase risks that clients will become more ill, be at risk of eviction from affordable housing, be more likely to end up in jail, and may be civilly committed to treatment in acute psychiatric hospitals or the state hospitals. Ultimately some may die because of lack of treatment. Jeopardizes the maintenance of effort requirement of the MH Block Grant. Will result in the layoff of experienced and skilled mental health professionals including nurses and doctors who will never return to the public mental health system with its uncertain funding. Jeopardizes the success of the new state recovery and treatment facility that will replace OSH as its design assumes a strong community mental health system. Will increase admission pressures on the facility and make it harder to discharge people from the facility when they have completed hospital level of treatment. Increases the risk of a federal lawsuit against the state under the Olmstead Court decision.	7/1/2011
102	33 d	AMH - CMH		Additional reduction in Regional Acute Psychiatric Inpatient services	(11,493,380)				(11,493,380)					This reduction cuts an additional 32.6% of the funding for services for 1,934 adults who are so ill that they are a danger to themselves or others and require treatment for their mental illness in an acute care hospital psychiatric unit. Without this level of care the individual may harm him/herself or others. Once the person in this condition is in a hospital emergency room, the hospital is required to provide treatment. Hospitals cannot afford to provide expensive psychiatric inpatient services at lower rates or without compensation and if the reduction is made hospitals may consider closing their psychiatric units. This would ultimately have the effect of requiring the state to provide this level of care since those individuals who are civilly committed are committed to the state for care and custody. This cut jeopardizes the success of the new state recovery and treatment facility that will replace OSH. The new facility size and design assume a strong community mental health system. These cuts will increase admission pressure to have the state deliver acute care in state hospitals.	7/1/2011
103	11	PHD		ODPE - Further Reduces GF support in the Human Immunodeficiency Virus/Sexually Transmitted Disease/Tuberculosis (HIV/STD/TB) Program areas. The HIV/STD/TB Program analyzes and reports epidemiologic data on HIV, STD and TB infections; with a variety of partners (e.g. local health departments, community-based organizations, other state agencies) develops, implements and evaluates evidence-driven population-based prevention programs; educates Oregonians about the impact of HIV, STD and TB infections; assists in the development of local and national public policy related to the prevention and care of these infections; coordinates with and informs other agencies of the services available to persons affected by these diseases; and assists people living with HIV/AIDS in accessing HIV medical care and treatment.	(1,500,000)				(1,500,000)					In addition to description of the Human Immunodeficiency Virus/Sexually Transmitted Disease/Tuberculosis (HST) reductions above, this reduction would further reduce state support for AIDS Drug Assistance Program (ADAP), which would amount to a 69% combined total reduction to this program. This would mean the establishment of a waiting list for what is a safety net program for persons with HIV and AIDS and an increase in co-pays for some HIV-infected persons; persons whose drug therapy is interrupted have a significant increased risk of developing viral strains that are resistant to existing therapies and would result in an increased progression of disease which could result in an additional 70 deaths (est.) in Oregon; HIV infected persons who are not on drug therapy are more likely to cause new infections in the community because HIV is not suppressed by prescription drug therapy or individuals have the ability to pass drug resistant strains as new infections. We can not expect these Oregonians to shift to other local state social programs because, in most cases, the CAREassist Program	8/1/2011

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Item #	Division Rank	DIVISION	Title (in bold) and Public Reduction Description	Reduction Description	GF&LF	OF	TTX	FF	TF	# of Employees Affected	Employee FTE Affected	Budget POS	Budget FTE	Impact of Reduction on Services and Outcomes	Effective Date
104	34	AMH - OSH		<b>Remove Wards 50C &amp; D.</b> These units serve forensic, PSRB clients and provides psychiatric rehabilitation and treatment to mentally ill adult males in a medium security setting within the Forensic Psychiatric Services (FPS). The primary population consists of patients who have major mental illness and whose symptoms are in at least partial remission.	(12,141,706)				(12,141,706)	(79)	(59.25)			Closing 50C & D units removes 78 beds serving PSRB clients, and provides psychiatric rehabilitation and treatment to mentally ill adult males in a medium security setting within the Forensic Psychiatric Services (FPS). The primary population consists of patients who have a major mental illness and whose symptoms are in at least partial remission. If closed, there would need to be appropriate resources in the community in order for them to continue to actively move toward conditional release and discharge. 50C & D are wards within the FPS program which provides services for the Court ordered evaluation or services under the Psychiatric Security Review Board. Forensic Psychiatric Services provide evaluations for fitness to proceed (ORS 161.370) and criminal responsibility; treatment to restore capacity for trial (ORS 161.365); and treatment for those found guilty except for insanity and placed under the jurisdiction of the Psychiatric Security Review Board (ORS 161.327). The implementation of the phase-out for this reduction will begin September 2011 and conclude August 2012.	7/1/2011
105	5	DMAP		<b>Health insurers' tax revenue forecast.</b> The revenue projection for the one percent health insurers' tax is \$36.9 million greater than budgeted. These dollars would be used to cover a greater percentage of children health care.	(36,887,355)				(36,887,355)					No impact on client services or outcomes. This revenue could be used to mitigate other reductions.	7/1/2011
106	44	DMAP		<b>Eliminate enhanced reimbursement for hospital services &amp; re-purpose hospital tax revenue.</b> The department would eliminate enhanced reimbursement for hospital services in both managed care and fee-for-service delivery systems. Hospital provider tax (Other Fund revenue would be re-purposed creating General Fund savings.	(106,804,232)			(186,210,947)	(293,015,179)					Reimbursement rates for Diagnostic-Related Group (DRG) hospitals would decrease to base levels yet hospitals would still pay taxes on their net patient revenue. The combination of both a rate cut and continued tax could threatened the financial viability of some DRG hospitals, especially those with a higher percentage of Medicaid patients. This revenue could be used to mitigate other reductions.	1/1/2012
<b>Subtotals at 25%</b>					(689,659,080)	(50,482,506)	(39,039)	(854,519,566)	(1,594,700,191)	(777)	(615.33)	(55)	(56.37)		
<b>% Totals</b>					-25.0%	-3.6%		-15.7%	-16.6%	-19.8%	-15.9%				
<b>Additional Other Fund Reductions:</b>															
107	53	DMAP		<b>Reduce or eliminate leverage programs.</b> The division would reduce or eliminate those programs in which other government entities provide the state share dollars to claim Medicaid matching funds. Leveraging programs that would be subject to this reduction include: graduate medical education (GME) program with OHSU; disproportionate share hospital (DSH) program with OHSU; proportionate share hospital (Pro Share) with OHSU; University Medical Group (UMG) with OHSU; targeted case management (TCM) with counties and educational service districts (ESDs); Medicaid administrative claiming (MAC) with ESDs; Department of Education leverage program; and behavioral rehabilitation services (BRS) with ten county juvenile justice departments. The dollars listed for this reduction represent 90% of the total leverage program dollars in CSL.		(87,314,517)		(137,456,417)	(224,770,934)					The government entities providing the state funding and those benefiting from the services they provide would be directly affected by reducing or eliminating the division's leverage programs.	
108	1	OHA-OEBB		<b>OEBB Customer Service and Technical Support:</b> This reduction in OEBB staffing level will shift some member relations activities from OEBB to the educational entities. This action would severely limit OEBB's ability to support district staff in the administration of OEBB benefits by not providing sufficient oversight and proper application of internal control measures. This reduction places an additional administrative burden on the educational entities they are likely not equipped to handle. The resulting risk is that certain activities may not be performed according to rules governing the OEBB program, or misinterpretation of these rules and guidelines may be undertaken unnoticed. Abolishes one Operations and Policy Analyst 1 (X0870) position, and one Administrative Specialist 2 (X0108) position. (\$462,151 Other Funds Limited & 2.00 FTE permanent full-time positions)		(462,151)			(462,151)	(2)	(2.00)	(2)	(2.00)	The reductions will limit OEBB members' and entity benefit personnel's access to OEBB staff during key periods in the benefit administration process. Decisions and actions might be made without the necessary information and/or tools needed for well-informed decisions and/or appropriate actions, increasing the potential for bad decisions and/or errors. No one else can do the work. Components of this reduction option include services that would be purchased or contracted for on behalf of participating entities. Elimination of these functions will also significantly impact OEBB's ability to meet its vision which includes educating and communicating with educational entity personnel and members to provide the necessary tools and resources to make the best possible decisions regarding their healthcare options.	7/1/2011
109	2	OHA-OEBB		<b>OEBB Professional Services:</b> Reducing Professional Services down to a core service level impacts the OEBB plans in several ways. It eliminates the Health and Wellness and the Medical Management Process and related projects in those areas. This reduction would severely restrict the analysis and evaluation of OEBB experience focused on cost containment measures, prevention, market trending and the overall quality of plans. There would be missed opportunities for cost savings directly attributed to premiums.		(200,000)			(200,000)					The elimination of these functions will significantly impact OEBB's ability to continue its efforts in identifying, designing and implementing innovative ways to provide high-quality benefits and meet customer needs in the most effective and efficient manner possible.	7/1/2011
110	3	OHA-OEBB		<b>OEBB Customer Service-</b> Defer development of Customer Service Module that would automate and streamline open enrollment activities to create further efficiencies internally as well as to participating school district, ESD, and community college customers. Upgrading to a customer service telecommunications module programmed for OEBB's business needs, would better equip staff to handle the 24,000 calls it receives during the Open Enrollment month. The new module would allow more coordinated and efficient efforts, appropriate tracking and monitoring of calls, as well as reporting and task management. This deferral would correspondingly reduce the budget needed for data processing and storage.		(132,000)			(132,000)					OEBB would miss opportunities to transform healthcare and administration of benefits for Oregon's educational entities. Components of this reduction option represent examples of OEBB's commitment to providing the best customer service and the highest quality benefits at the lowest possible cost to districts, district employees and the taxpayers of Oregon.	7/1/2011

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111	4	OHA-OEBB		<b>OEBB Open Enrollment</b> – Specific areas impacted include the availability and distribution of open enrollment materials, travel to educational entity Insurance Committee meetings and Open Enrollment meetings to consult members and participating entities on OEBB benefits and plan changes, new legislation, rules and requirements, and new benefit offerings. System training to educational entities on OEBB enrollment and administration of OEBB plans would be limited. Severely constrains communication mediums to OEBB stakeholders. Savings mainly in printing, postage, and in-state travel.		(461,935)			(461,935)					OEBB could contract with a vendor or individuals to participate in insurance committee meetings, open enrollment sessions and benefit fairs. The cost for doing so could be significantly more than what it costs OEBB to be available. In addition, OEBB would need to spend a significant amount of staff resources training a vendor or individual to take on this responsibility.	7/1/2011
112	1	OHA-PEBB		<b>Eliminate Position: Project Manager 3</b> -This position works under the direction of the Board to collaborate with agencies, health plans and other benefit purchasers in the areas of evidence based medicine, patient centered medical homes, statewide quality		(333,845)			(333,845)	(1)	(0.50)	(1)	(0.50)	PEBB would be challenged to collaborate and partner with other stakeholders on initiatives that are currently accepted as key to changing the health care system.	7/1/2011
113	2	OHA-PEBB		<b>Eliminate Positions: Fiscal Analyst 1</b> -This position provides support of all accounting and budget functions for the internal operation of PEBB, the PEBB Stabilization Fund; and PEBB's self insured medical and dental plans on a daily basis. This position directly supports PEBB's ability to meet its fiduciary responsibility and to ensure the integrity of program benefit expenditures and costs.		(138,806)			(138,806)	(1)	(1.00)	(1)	(1.00)	Elimination of this position will result in the delay of processing payment and put the state at significant risk of meeting required payment timeframes and contract deliverables. This position also monitors and reconciles the newly adopted increase in P	7/1/2011
114	3	OHA-PEBB		<b>Eliminate Position: Exec Support Spec 2</b> This position supports PEBB 75% and OEBB 25%. Support for all Board functions would be shifted to remaining staff, and administrative support (Admin Specialist 1) would be required to provide full support functions for all PEBB staff, OEBB functions, the PEBB Board and PEBB Operations Subcommittee.		(155,056)			(155,056)	(1)	(1.00)	(1)	(1.00)		7/1/2011
115	4	OHA-PEBB		<b>Eliminate Position: Admin Specialist 2</b> Agencies will experience additional work load due to pebb benefits support being limited, and payroll and human resources staff will experience delays in making enrollment adjustments. Employee impact due to delays probable related to pay adjustments and benefits. Response time to answer call from state employees will be increased and customer service hours will need to be shortened. This is a 20% reduction in the number of client service staff.		(155,056)			(155,056)	(1)	(1.00)	(1)	(1.00)	Risk to program compliance with benefit regulations and Collective Bargaining Agreements. Customer service satisfaction at risk.	7/1/2011
116	5	OHA-PEBB		<b>Eliminate Position: Admin Specialist 1</b> -This eliminates the one clerical position that provides support to all of the internal operations staff, is the PEBB rules coordinator; maintains all contract documents; and maintains PEBB official records. The critical functions of this position will need to be absorbed by the executive support position for the PEBB/OEBB administrator, Board and Deputy Administrator to minimize the risk of untimely updates to administrative rules for compliance with federal and state statutory changes and for appropriate contract oversight. The number of Board meetings may be reduced to accommodate the increased workload.		(120,995)			(120,995)	(1)	(1.00)	(1)	(1.00)		7/1/2011
117	6	OHA-PEBB		<b>Eliminate Position: Admin Specialist 2</b> Agencies will experience additional work load due to pebb benefits support being limited, and payroll and human resources staff will experience delays in making enrollment adjustments. Employee impact due to delays probable related to pay adjustments and benefits. Response time to answer call from state employees will be increased and customer service hours will need to be shortened. This is a 40% reduction in the number of client service staff.		(129,739)			(129,739)	(1)	(1.00)	(1)	(1.00)	The Customer Service Team will continue to function at a significantly reduced level. Quality of service will be diminished and timeliness of responding to members and agencies would be reduced.	7/1/2011
118	7	OHA-PEBB		<b>Eliminate Positions: 2 Ops/Policy Analyst 2</b> Elimination of two OPA 2 positions is an ongoing reduction taken recently to balance the 2007-09 budget. PEBB is currently identifying services to be reduced to manage the workload with a 80% reduction in client service staff. Eliminating this position reduces the unit to one staff and will impact customer service to agencies and members. PEBB will modify timeline for appeals and staff response to member calls and emails and look at outsourcing for this work. Enrollment and eligibility errors will not be addressed timely which may result in temporary loss of coverage for members and dependents. Agencies may have additional workload to correct enrollment and eligibility errors currently handled by PEBB. PEBB must reduce the hours analysts are available to assist agencies and members with benefit issues. Customer service will decline and agencies are likely to be negatively impacted. Shift of workload from in-house to external carriers will increase administrative load in premium rates for 2012.		(712,519)			(712,519)	(2)	(2.00)	(2)	(2.00)		7/1/2011
119	8	OHA-PEBB		<b>Eliminate Position: Accountant 2</b> This position oversees all accounting for PEBB self insured medical and dental plans with premiums equivalent to \$650,000,000 annually. This position directly supports PEBB's ability to meet its fiduciary responsibility and to ensure the integrity of program benefit expenditures and costs. This reduction will result in delayed information to the Board, potentially creating drastic benefit changes because staff may be unable to adequately monitor funds and cost increases for self-insured plans along required general budgetary functions		(92,897)			(92,897)	(1)	(0.50)	(1)	(0.50)	PEBB has no capacity to perform the financial functions without this position. PEBB would be unable to continue current self-insurance and would be unable to consider self-insurance expansion.	7/1/2011

Reduction Target: 25% of Current Service Level

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120	9	OHA-PEBB		<b>Eliminate Position: Ops/Policy Analyst 3</b> This position is responsible for the ongoing development and execution of key compliance strategies that insure the internal and external integrity of PEBB and carrier operations, respectively. This position reviews current compliance reports and develops corrective action as needed. PEBB must maintain an aggressive compliance program to ensure that vendors are meeting performance expectations and that PEBB internal controls and vendor controls are appropriate and followed.		(228,079)			(228,079)	(1)	(1.00)	(1)	(1.00)	Loss of this position places PEBB at risk for poor performance outcomes and increased costs. PEBB has no capacity to absorb these functions on an ongoing basis.	7/1/2011
<b>Total - All Reductions</b>					(689,659,080)	(141,120,101)	(39,039)	(991,975,983)	(1,822,794,203)	(789)	(626.3)	(67)	(67.4)		
<b>% of 2011-13 CSL Budget</b>					-25%	-10.0%		-18.2%	-18.9%						