The Oregon Health Authority and its Equity and Inclusion Division are leading the state’s effort to accomplish the largest and most ambitious transformations in health care and health delivery in the nation. The equity work charged and led by the OHA Equity and Inclusion Division has wide-scope and national impact and scope. Both OHA and especially the Equity and Inclusion Division, due to their standing in this work as best practice, national thought leaders and community partners, are recognized as national leaders in delivering equitable outcomes and improving health and health care delivery agencies, as well as federal entities for technical assistance, guidance and consultation. While the Equity and Inclusion Division has led and will continue to lead this work, all divisions of the agency will play a critical role in supporting equity work. It is critical to the success of this work that the agency hire additional subject matter experts in the discipline of equity and inclusion and anti-racism.

As an important step towards achieving agency goals, OSH recognizes, supports, and promotes initiatives that contribute to the advancement of equity and inclusion by active collaboration with the Office of Equity and Inclusion in creating policies, processes, procedures and developing or implementing strategies that will advance agency mission, vision, values, and transformation goals. Transformation change and progress cannot be achieved with one FTE to support the largest workforce in OHA and the people that are cared for at OSH. This POP provides investment and redirection of resources to build a successful and sustainable infrastructure necessary to continue efforts to advance the shared goal of health equity for all Oregonians.

Everyone in Oregon deserves uninterrupted access to needed supports and to the income they earn at work. More than one million Oregonians count on the state’s current mainframe platform to receive their benefits and provider payments. The COBOL programming code on the mainframe system dates to the 1970s and is increasingly unsupported. Mainframe programs are sucking in number and hard to replace, resulting in a variety of service and payment bottlenecks. If these problems are not resolved, there is a significant cost to the agency that will be unable to make timely payments to Oregonians, potentially for an extended period. Oregon Department of Human Services and the Oregon Health Authority are therefore jointly requesting the necessary funds to upgrade the mainframe platform and ensure continuity of payments and benefits for the people we serve. It is critical that we migrate all current mainframe functions to modern, more reliable cloud-based solutions. Doing so will help avoid the risk of service breakdowns caused by old software, bring OHA and OHA technology into alignment with peer agencies, improve the delivery of services and strengthen the Information Security and Privacy Office (ISPO)’s ability to protect the confidentiality of information to the communities whom we serve.

The Information Security and Privacy Office (ISPO) supports both the Oregon Health Authority and Oregon Department of Human Services program and business resources and provide assurance in the protection of agency risk and the confidentiality of information to the communities whom we serve. ISPO is responsible for implementing and enforcing the standards, procedures, and guidelines of the Oregon Health Authority that are necessary to prevent unauthorized access to, alteration of, and dissemination of information and information systems, and allow Oregon to achieve full benefit from its investments in the ONE eligibility system. This investment proposes a strategy to plan for and implement a new payment system, moving all remaining benefits currently determined on the mainframe to the ONE system, and develop a plan to decommission or archive remaining mainframe programs and data.

Since 2013, the Oregon Health Authority has been on a path to fundamentally shift its practice to ensure essential public health protections are in place for all Oregonians through equitable, outcomes-driven and accountable services. The groundwork laid through initial investments in public health modernization have been critical to management of the COVID-19 pandemic. However, the COVID-19 response has highlighted continued fragmentation in public health and social services, in health equity and outcomes and equity at every level of public health practice. This POP supports continued implementation of the key public health priorities selected by the Oregon Public Health Advisory Board (HPAB) for the 2023-25 biennium and beyond. The HPAB has directed OHA to move toward statewide representation to address health inequities more meaningfully, especially for communities of color.

In alignment with OHA’s 2030 strategic goal to eliminate health inequities, hindering the elimination of health inequities, and at worst, causing further harm. Transformational change and progress cannot be achieved with one FTE to support the largest workforce in OHA and the people that are cared for at OSH. This POP provides investment and redirection of resources to build a successful and sustainable infrastructure necessary to continue efforts to advance the shared goal of health equity for all Oregonians.

This policy package requests resources and funds to address requirements of House Bill 4312 and House Bill 2159 to better collect Race, Ethnicity, Language (REALSO) and Sexual Orientation, Gender identity (SOGI) data from providers and insurers. REALSO & SOGI data is OHA’s best tool to track health equity and to respond to racial equity, disability, lack of language access, sexual and gender identity, racial and ethnic minority impact individual and community health. It also allows OHA’s best tool to close the gaps in the data health inequities experienced by populations that remain invisible and undermine the ability of OHA to evaluate effectiveness of patient and person-centered care. The current lack of REALSO & SOGI data contributes to more expensive and less effective services, particularly for people of color, those with disabilities, and the LGBTQIA+ community. Solutions must be culturally appropriate and protect citizens’ data privacy and security while providing flexibility. OHA can achieve the call to action by communities impacted most by health inequity and with legislation with sufficient resources, staffing, professional supports, and tools.

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The Oregon Health Authority and its Equity and Inclusion Division are leading the state’s effort to accomplish the largest and most ambitious transformations in health care and health delivery in the nation. The equity work charged and led by the OHA Equity and Inclusion Division has wide-scope and national impact and scope. Both OHA and especially the Equity and Inclusion Division, due to their standing in this work as best practice, national thought leaders and community partners, are recognized as national leaders in delivering equitable outcomes and improving health and health care delivery agencies, as well as federal entities for technical assistance, guidance and consultation. While the Equity and Inclusion Division has led and will continue to lead this work, all divisions of the agency will play a critical role in supporting equity work. It is critical to the success of this work that the agency hire additional subject matter experts in the discipline of equity and inclusion and anti-racism.

This policy package would enable the Oregon Health Authority (OHA) to execute and implement the policy and program changes outlined in 115:5 Medical delegation waiver and approved by the Center for Medicaid and Medicare Services (CMS) (B247) and declared a state of emergency for Oregon’s struggling Behavioral Health Crisis System. Directive includes enhancement of existing services and expansion of the current system of care to better serve those in crisis. This request for funding is specific to (1) ensuring the sustainability and creating capacity necessary to continue to meet the federal standards for Behavioral Health Care Crisis System (BHCSS); (2) the design and implementation of Crisis Stabilization Centers specific to 21st century core of care framework through infrastructure and transplant. The required investment to address Oregon’s struggling Behavioral Health Crisis System is critical to the health and well-being of Oregonians and meeting federal standards for BHCSS.

In alignment with OHA’s 2030 strategic goal to eliminate health inequities, hindering the elimination of health inequities, and at worst, causing further harm. Transformational change and progress cannot be achieved with one FTE to support the largest workforce in OHA and the people that are cared for at OSH. This POP provides investment and redirection of resources to build a successful and sustainable infrastructure necessary to continue efforts to advance the shared goal of health equity for all Oregonians.
414 No Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

This POP is in response to strong community feedback that Oregon is lagging behind states in early vision and hearing identification, prevention, and treatment for children. Legislation is needed to increase EPSDT funding for vision and hearing services for all relatively low-income children. The provision is not intended to be implemented until 2025. This POP seeks to improve early identification and intervention for children with disabilities. The POP would increase funding for the EPSDT program and provide for the early identification and intervention of children with disabilities.

415 No Adult Intensive Services & Diversion

This POP would improve mental health services through the strategic funding of mental health diversion programs and jail diversion. This policy seeks to decrease mental illness and work for more equitable outcomes. Jail diversion and civil commitment center our focus on individuals who live in rural or frontier areas and people of color. Without these services individuals may otherwise enter the justice system which would result in continued growth of the Oregon State Hospital population.

416 LC 471 Marketplace Transition from SMB-FF to SMB-PPM

This policy package furthers OHA's mission of improving access to quality, affordable health care for Oregonians and its goal to eliminate health inequities by 2030. This package funds the initial stage of Oregon's transition away from the federally facilitated marketplace (FFM) to a state-based eligibility and enrollment platform and call center operation for administration of Oregon's health insurance exchange. Oregon is seeking a platform that:

-interfaces with Oregon's Medicaid systems to keep people covered during transitions and address chasm.

-optimizes the needed health plan (FFP) shopping and customer service experience for Oregonians.

-adopts a new pathway for Oregon from the federal marketplace to a more streamlined, state-based approach.

417 No Environmental Justice Mapping

This policy package would improve mental health services through the strategic funding of mental health diversion programs and jail diversion. This policy seeks to decrease mental illness and work for more equitable outcomes. Jail diversion and civil commitment center our focus on individuals who live in rural or frontier areas and people of color. Without these services individuals may otherwise enter the justice system which would result in continued growth of the Oregon State Hospital population.

418 No Integrated Care - Project Expansion

In the past 20 years, the United States has seen a fourfold increase in the prevalence of mental illness among children. Substance use during pregnancy is associated with infant health outcomes. A policy seeking to incorporate case management and supports for children with severe behavioral health needs will improve health outcomes. Federal funds will be used to support integrated care for children and families.

419 No MMIS Infrastructure Replacement

Support continued availability of the mission critical Medicaid Management Information System (MMIS) that processes over $5 billion annually in capitation payments to CCNs and supports the operations for over 1.4 million Oregonians. The majority of this request focuses on replacement of end-of-life servers.

420 No Pandemic Response Information System

This POP will fund the planning and phased development of a robust data system for collection, safe storage, data exchange, and use of collected data over the course of a reportable disease investigation. Federal funds will be used to support this initiative.

421 LC 439 Fee For Service Transformation

This POP would provide funding for the transformation of Medicaid's Fee For Service (FFS) program to a new payment model that incentivizes health care providers to ensure high-quality care at lower costs. This policy seeks to reduce health care costs, improve health outcomes, and create a more sustainable health care system.

422 No Regional Health Resource for Disaster Response

In rural or state-wide emergencies the state healthcare system is capacity to hospitals and Emergency Medical Services (EMS) have limited liability to efficiently coordinate patient distribution beyond normal operations or normal seasonal hospital seasons. With temporary federal grants, OHA and partners built upon existing Health Care Coordinated Regional Health Resource Centers and established Regional Resource Response System (R2S) to resource distribution and resource sharing capacity. OHA also worked with the Oregon Medical Commission Center to ensure appropriate care no matter where you live in Oregon. These efforts support better and equitable access to all levels of health care during major health system surges. Oregon needs a sustained and robust operational system of communication and clinical coordination for current and future emergencies and disasters that isn't dependent on temporary federal COVID-19 related grant funding.

423 LC 486 100% FMAP Tribal Savings and Reinvestment Program

This POP seeks improvements for the 100 percent FMAP Tribal Savings and Reinforcement Program, which OHA has operated at the request of Oregon's Federally-recognized Tribes since 2018. Federal funds will be used to support this initiative.

424 LC 436 Oral Health Workforce Dental Pilot Project

Oral health is essential to overall health. In Oregon oral health inequities exist for children, adolescents and adults based on race, ethnicity, geographic residence, household income, etc. The Oregon Health Authority (OHA) operates the Dental Pilot Project that accepts pilot projects that are designed to test innovative oral health workflow models that eliminate health inequities and increase access to oral health care, but it is scheduled to sunset on January 2, 2025. This POP seeks to expand the oral health workforce to address immediate and long-term gaps in dental care.

425 No Universally offered Home Visiting

The policy package will continue to provide the services required to implement and scale up the next phase of universally offered home visiting (UHV) in Oregon with the early adopter communities and the next cohort. It also focuses on building the public and community engagement, and, if needed, federal demonstration grant funding programs. This policy seeks to improve health outcomes for children and families by providing early intervention services to support their healthy development.

426 No Child and Family Behavioral Health Continuum of Care

This policy package seeks to address gaps identified by youth and families to strategically expand the continuum of services available to children, youth and families experiencing behavioral health challenges. Oregon could use federal funding for this effort to improve access to quality and cost-effective services. This POP would support the expansion of services and capacity for children and families experiencing behavioral health challenges.

427 No Medicaid Enterprise System Modularity

To mitigate health inequities and identify areas targeting for equitable healthcare delivery changes to legacy Agency systems are needed. Lack of investment in infrastructure greatly increases the risk of cascading system failure. Even in the absence of system failure, the age of the current FFS system likely results in increased costs to benefit Medicaid recipients and recipients of other services who face delays in access to care. Federal funds will be used to modernize the existing Medicaid Enterprise System that includes systems that reside outside of Medicaid boundaries and Medicaid Connect.

428 No PPE & Medical Supply Management

During the COVID-19 pandemic, OHA learned many lessons related to health security, preparedness, and response. One vital lesson learned is that Oregon needs a robust and operational stockpile and inventory management system that can efficiently provide medical supplies to effectively respond to pandemic, natural disasters, and other threats. The stockpile and management systems should always be operational to be effective for saving as many lives as possible in emergency response.
This policy package uses existing Marketplace funds to further OHA's goals of 98 percent coverage by 2024 and elimination of health inequities by 2030. Priority populations face significant barriers to access to enroll in benefits, utilize benefit tools and wellness programs, and make informed benefit choices. Not prioritizing and supporting a replacement effort for the current system will result in the canceling of contract signed with new vendor, discontinued implementation efforts, and continued use of end-of-lifecycle technology that is fragmented, non-standard, difficult to support, and is not scalable. Approximately 300 covered lives would be at risk for benefit interruptions if a replacement system is not identified and procured prior to the expiration of current vendor support in 2022.

The Oregon newborn bloodspot screening (NBS), which is statutorily mandated for the Oregon Health Authority (OHA), is conducted by the Northwest Regional Newborn Bloodspot Screening (NBS) Program at the Oregon State Public Health Laboratory (OSPHL). The requested fee increase will allow the NBS Program to eliminate the gap between revenue and expenses once sufficient fees are collected. Additionally, because of the evolving landscape for NBS, the fee increase will allow the program to be self-sufficient in future years and remain agile, with ability to respond to the maturing needs of Oregon's newborns. This fee increase will not impact Oregon's infants in the same manner with federal funding. In 2014 employer requested Affordable Care Act (ACA) (reporting) was implemented to enable reporting of claims from this state. There is not a comprehensive list of fees associated with this request. The requested fee is a continuation of Kentucky's similar request. The decreases in ACA fees for the current year are due to a decrease in the cost of ACA verification. The ACA fees are a result of OHA processing approximately 100,000 ACA claims per year and each program is derived from authorization holders. Currently HLO has no way of knowing how many TSAs will apply for an authorization.

The Oregon Health Authority (OHA) has identified a goal to eliminate health inequities by 2030. Central to the pursuit of this goal, OHA has identified two areas related to operations of the Medicaid Management Information System (MMIS), which, without increased staffing, will significantly jeopardize the achievement of this goal. Transformed Medicaid Statistical Information System (TMIS) data reporting and IT support for OHA’s Medicaid Policy Program lends itself to a greater composition of historically under-resourced populations, gaps identified throughout these two areas are more likely to impact these communities and further inequities throughout Oregon.

The purchase of House Bill 2471 in Oregon during the 2021 session directs Oregon Health Authority to implement, expand and enhance Oregon’s 960 & Behavioral Health Crisis System (SHCS & BHCs) and declared a state of emergency for Oregon’s struggling Behavioral Health Crisis System. Directive includes enhancement of services and expansion of the current system to provide a ‘no wrong door’ approach to ensure all people with experience with the appropriate level of care. Oregon Health Authoritycreated White Glove Outreach Program, expanding made contact, creating Crisis Stabilization Centers (CSCs) within each county, and developing a seamless continuity of care through follow-up service referral and tracking. This request for funding is specific to addressing payer parity for behavioral health crisis services by commercial payors. This is because it is known that commercial payors will not be required to be accessible and be delivered to all Oregonians regardless of insurance type or status. Payor parity is essential for long term fiscal sustainability and attractive reimbursement for the workforce delivery of services.

The System of Care Advisory Council recommends additional staff to fulfill their vision of a future where young people from all backgrounds are healthy, safe, learning and thriving at home and in their communities. This proposal adds two positions to enable the Council to attend to the needs of youth and families.

The general fund collects data related to the importance of testing drinking water for use at public health and personal use. The report included data collected for 1470 water systems in Oregon. The annual report includes raw and tagged data to facilitate the comparison between available data sets. The request for the Oregon Water Watch Program (Groundwater) is intended to fund the Oregon Water Watch Program (Groundwater) project. This project funds public health interventions in LUBGWMA including outreach for domestic well screening and test where indicated.

This policy package uses existing Marketplace funds to further OHA's goals of 98 percent coverage by 2024 and elimination of health inequities by 2030. Priority populations face significant barriers to access to enroll in benefits, utilize benefit tools and wellness programs, and make informed benefit choices. Not prioritizing and supporting a replacement effort for the current system will result in the canceling of contract signed with new vendor, discontinued implementation efforts, and continued use of end-of-lifecycle technology that is fragmented, non-standard, difficult to support, and is not scalable. Approximately 300 covered lives would be at risk for benefit interruptions if a replacement system is not identified and procured prior to the expiration of current vendor support in 2022.

Additional staff for ACDP to help implement Oregon’s Strategic Plan.

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**2023-25 Oregon Health Authority Policy Packages**

**445 No Electronic Health Record Replacement Planning**
The Oregon State Hospital's (OSH) current electronic health record (EHR) does not adequately support the clinical or business needs of the hospital. Since 2011, the current system has been in a continuous state of development, preventing OSH from fully eliminating the paper processes and tracking systems. OSH, as part of the state's strategy to eliminate health inequities, must integrate our EHR with community and regional health systems. Our current solution lacks the ability to share clinical information between OSH and other health systems. This lack of effective integration has adverse consequences for patient care when patients move between providers and treatment sites. Additionally, The Joint Commission explicitly cited the hospital in its 2021 survey due to the difficulty users have in finding necessary patient information in the current EHR. Again, this creates additional risk for adverse patient consequences. Finally, the system lacks a functional revenue cycle management element, which presents challenges for billing and reconciling claims and necessitates use of additional ancillary systems. This package requests funding to begin a multi-biennia process of replacing the current OSH EHR.

**446 No Youth and Adult Suicide Intervention & Prevention Plans**
Suicide remains a persistent, pervasive, and yet largely preventable cause of death. Oregon's suicide rates remain above the national average. Every death by suicide in Oregon carries a substantial and long-lasting ripple effect into our communities. The important work to prevent youth suicide (ages 5-24) remains a top priority for OHA. Now through intensive community engagement, Oregon has developed a plan for reducing adult suicide. The work of this POP includes initiatives as broad as creating connection and meaningful experiences and as specific as training providers to treat suicidal ideation confidently and effectively. This POP has equity, cultural responsiveness, and community voice woven throughout.

**447 No Life Span Respite**
The funding request is to hire the Behavioral Health Metrics Committee incentive a robust metrics system. The Behavioral Health Metrics and Committee support team is currently being built and supporting the design of metrics by the Behavioral Health Committee which HSD would list to institute in the next biennium.

**448 No Behavioral Health Metrics Incentive Fund**
Provides additional General Fund for implementation of the Oregon Psilocybin Services Act, M109, by addressing any immediate shortfalls while license applications are being accepted, reviewed, and issued by OHA. Without the additional funding, the sustainability of the work would be jeopardized. OHA would not have adequate resources to hire and retain staff to seek licenses in a timely manner. There would be insufficient staff to continue to implement the regulatory program, review license applications and conduct licensure inspections. Consequently, psilocybin businesses seeking licenses could experience financial hardship due to delays in obtaining licenses, an inability to provide services and to legally receive revenue. Additionally, community members seeking treatment could experience financial challenges or delays in obtaining care.

**449 No Oregon Psilocybin Services: Nation's First Regulatory Framework for Psilocybin**
The Salem campus of the Oregon State Hospital consists of 1.2 million square feet of buildings and interior court yards and 23 cottages with a Current Replacement Value (CRV) as reported to the Medicaid Advisory Board (CPAB) of $386,214,542. This makes the Oregon State Hospital among the highest replacement value of any single facility owned by the State. The Junction City campus is 229,816 sq. ft. with a current CRV of $140,646,437. The Pendleton Cottages facility consists of several older buildings with a total square footage of 21,700. The facility has a current replacement value of $7,846,216.

**450 No Deferred Maintenance**
The Oregon State Hospital's (OSH) current electronic health record (EHR) does not adequately support the clinical or business needs of the hospital. Since 2011, the current system has been in a continuous state of development, preventing OSH from fully eliminating the paper processes and tracking systems. OSH, as part of the state's strategy to eliminate health inequities, must integrate our EHR with community and regional health systems. Our current solution lacks the ability to share clinical information between OSH and other health systems. This lack of effective integration has adverse consequences for patient care when patients move between providers and treatment sites. Additionally, The Joint Commission explicitly cited the hospital in its 2021 survey due to the difficulty users have in finding necessary patient information in the current EHR. Again, this creates additional risk for adverse patient consequences. Finally, the system lacks a functional revenue cycle management element, which presents challenges for billing and reconciling claims and necessitates use of additional ancillary systems. This package requests funding to begin a multi-biennia process of replacing the current OSH EHR.

**451 No Family Care Settlement**
This POP seeks OHA's requirements for meeting the agreed upon settlement costs between OHA and FamilyCare.

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**Summary**

<table>
<thead>
<tr>
<th>POP #</th>
<th>Legislation</th>
<th>Summary</th>
<th>General Fund</th>
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<td>No Electronic Health Record Replacement Planning</td>
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<td>No Youth and Adult Suicide Intervention &amp; Prevention Plans</td>
<td>Suicide remains a persistent, pervasive, and yet largely preventable cause of death.</td>
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