How Oregon Health Authority Systems Could Integrate with a Universal Health Plan

2026 Report

Contents

Introduction 3

Universal health plan design components 5

- Governance 5
- Administration 7
- Eligibility 12
- Enrollment 14
- Covered Services 16
- Provider Roles and Rules 18
- Provider Payment 22
- Private Health Insurance 23
- Current Public Programs* 25
- Cost Containment 28
- Financing 31
- Health Equity 34

Implementation considerations 37

Conclusion 38

Resources 40

Introduction

While a record 97% of people in Oregon had health insurance in 2024, growing health care costs, workforce constraints, and other issues prevent many people in Oregon from getting the health care they need and deserve. One potential solution to this pressing problem is to create a universal health plan that would provide universal health benefits to everyone living in Oregon without requiring patients to pay out-of-pocket for co-pays, deductibles, coinsurance, and other expenses. For the purposes of this report, the term "the Plan" refers to a universal health plan that is currently being considered in Oregon.

Oregon Senate Bill 1089 (2023) established the Universal Health Plan Governance Board (Board) within the Oregon Department of Consumer and Business Services (DCBS) and directed the Board to create a plan to finance and administer a universal health plan [Section 2(2)]. The bill also directed the Board to assess key health care and public institutions' readiness to integrate with the universal health plan, and specifically directed the Board "to collaborate with state agencies, including the Oregon Health Authority (OHA)… to determine how the agencies' existing systems will integrate with the Universal Health Plan [Section 2(3)(c)]."

To support the Board in meeting its legislative directive, OHA developed this analysis to examine its existing systems and assess the agency's readiness to integrate with a universal health plan (UHP) if it were directed by the legislature to do so in the future. The 2022 *Joint Task Force on Universal Health Care Final Report and Recommendations* served as the foundation for this analysis, providing a preliminary model of how a universal health system in Oregon could be structured and administered. [1] OHA used this design as a starting point to evaluate its operational capacity, governance structures, and resource needs under a potential UHP.

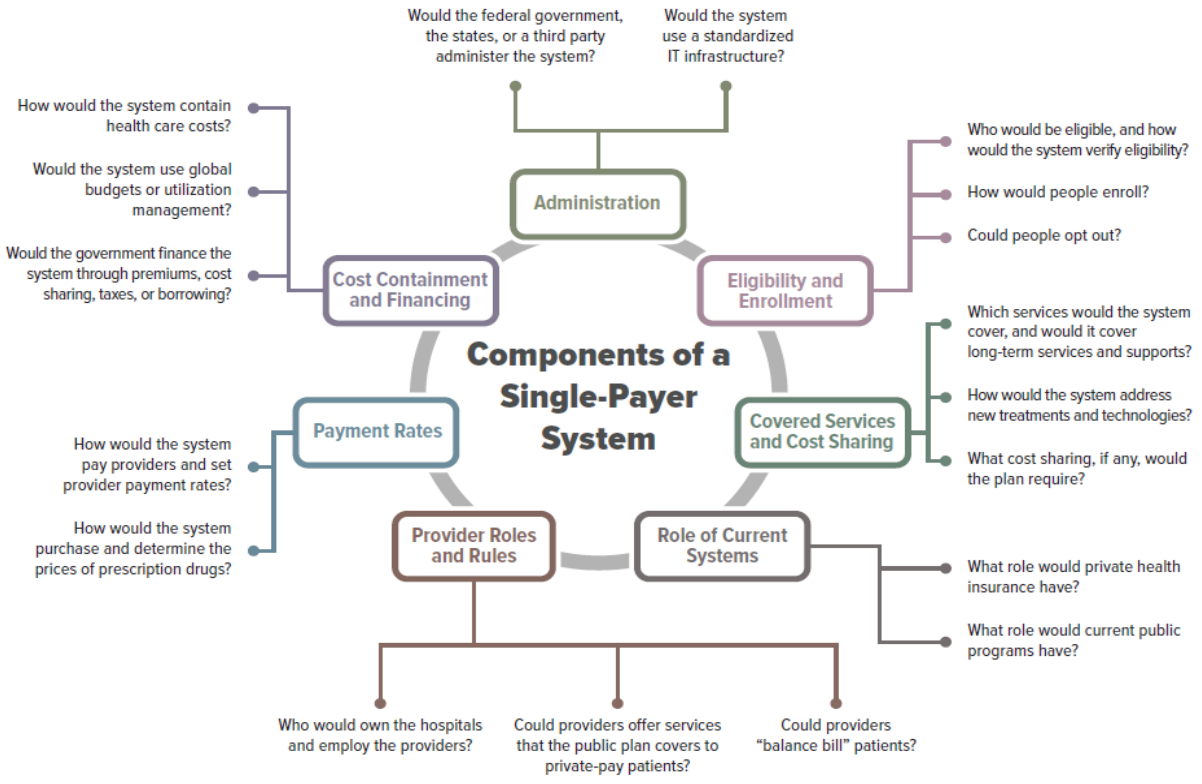
To organize this analysis, OHA drew on a 2019 U.S. Congressional Budget Office (CBO) report about the major components needed to establish a single-payer or universal health system.[2] It provides a logical framework for examining OHA's existing systems and readiness. *See Figure 1.* OHA adapted the CBO's components—adding components such as governance and equity—to better mirror the Joint Task Force model and Oregon's specific context and priorities. The following report is organized by these components, with descriptions of OHA's current functions, their alignment with the envisioned UHP, and the staff and system resources needed to support large-scale health system transformation.

The key components of a Universal Health Plan (UHP), adapted from the CBO framework to fit the Oregon context, include:

1. **Governance**: How will the plan be governed and overseen?
2. **Administration**: How would the state administer the plan?
3. **Eligibility**: Who would be eligible for the plan?
4. **Enrollment**: How would individuals be enrolled?
5. **Covered services**: Which services would the system cover?
6. **Provider roles and rules**: Which providers would be allowed to participate, and who would own the hospitals and employ the providers?
7. **Provider payment**: How would the single-payer system set provider payment rates and purchase prescription drugs?
8. **Role of private insurance**: What role, if any, would private insurance have?
9. **Role of current public programs**: What role would existing public programs have?
10. **Cost containment**: What strategies will be used to contain the growth of spending?
11. **Financing**: How would the system be financed?
12. **Equity**: How will the UHP address or impact historically marginalized groups, work toward eliminating barriers, and engage community partners?

Figure 1.

Designing a Single-Payer Health Care System



Source: Congressional Budget Office.

IT = information technology.

For each component, this report provides:

1. **A definition** of the component within the context of single-payer and universal health systems.
2. **Recommendations** from the Joint Task Force, where available.
3. **Relevant parameters** from SB 1089, if addressed in statute.
4. **A description** of current OHA systems and functions corresponding to that component.
5. **Resources** needed for OHA to adapt its current infrastructure, operations, and expertise to integrate with a UHP, organized into staff (skilled personnel and expertise) and systems (supporting infrastructure, policies, and governance mechanisms).

By mapping OHA's current systems to these core components of a UHP, this report aims to provide the Governance Board and the Legislature with a clearer picture of OHA's operational readiness to implement a UHP, and the areas that could require future investment and structural change.

Universal health plan design components

Governance 

Definition

The framework for oversight, accountability, policy-setting, and strategic direction for the universal health plan (UHP). The governance structure defines who sets goals, how decisions are made, and how performance and compliance are monitored at the system level.

Joint Task Force recommendation

- The Plan will be governed by a nonprofit public corporation subject to Oregon's transparency laws (public meetings, public records, ethics, and administrative procedures). (p. 32)
- A board will govern the Plan, potentially independent from other state agencies or administratively housed within a state agency, with members representing a broad set of health care professionals and community voices. (p. 32)

- The board shall report to the Legislative Assembly and the Governor and be advised by regional groups to respond to the unique needs of the diverse communities across Oregon. (p. 32)

SB 1089 parameters

None

Current OHA systems

Policy development and strategic planning: Under direction of the Governor's Office, OHA develops health policy recommendations, strategic plans, and programmatic frameworks. These efforts guide benefit design for the Oregon Health Plan (OHP), the Public Employees' and Oregon Educators Benefit Boards (PEBB/OEBB), and Marketplace coverage. They also establish eligibility criteria within federal and state parameters, provider payment rate methodologies, and delivery system transformation initiatives like the Coordinated Care Organization (CCO) model.[3] While the Legislature retains ultimate decision-making authority on major policy directions and budget allocations, OHA provides the technical expertise, data analysis, and operational insights that inform these legislative decisions.

Health policy governance structures: OHA currently operates under the oversight of the Oregon Health Policy Board (OHPB), a nine-member citizen board that serves as the policymaking and oversight body for the agency.[4] OHPB sets strategic direction, establishes priorities, and oversees health system transformation initiatives. OHA staff support OHPB functions including meeting coordination, policy analysis, public testimony processes, and implementation of OHPB decisions. Current legislation directs the OHA Ombuds program to make recommendations to the OHPB for improvement for publicly funded benefits.

Rulemaking authority: OHA interprets legislative directives through formal rulemaking processes under the Oregon Administrative Procedures (APA) Act, developing proposed rules, conducting public hearings, hosting rules advisory committees (RACs) and comment periods, responding to community feedback, and submitting final rules to the Secretary of State for codification in the Oregon Administrative Rules (OAR).[5] This process governs operations of major programs including Oregon Health Plan benefits, CCO contracts,[6] and provider standards, demonstrating OHA's capacity to translate statutory authority into operational policy at scale.[7]

Resources needed for OHA systems to integrate with a universal health plan

Staff

Expanded governance and policy staff: Additional staff could support the Universal Health Plan Governance Board's responsibilities, including legal counsel, policy analysts, data experts, and regional liaison staff to engage diverse community advisory groups aligned with the Board's mandate. As the Ombuds Program currently advises the OHPB, it may be important to ensure staffing for similar data reporting and casework under a universal health plan (UHP).

Systems

Inter-agency coordination: For a successful integration process, OHA would likely need ongoing legal support from the Department of Justice to ensure statutory compliance throughout the process. This may entail consultation before, during, and after integration with a UHP. The public corporation that will govern the UHP will interact with other agencies, including the Department of Revenue for financing operations, the Department of Consumer and Business Services, and the Oregon Department of Human Services; as such, OHA and these agencies could need a dedicated system of communication, collaboration, or decision-making.

Administration



Definition

The day-to-day functions of operating a universal health plan (UHP), including provider enrollment, claims processing, eligibility determinations, operation of information technology systems, and program implementation.

Joint Task Force recommendation

- A Universal Health Plan entity will administer and operate the UHP. It will establish a global budget for each region, manage benefits, and process claims and reimbursements. (p. 35)
- State agencies will work with the Universal Health Plan entity and the Governance Board to support implementation of the plan and its ongoing operations. (p. 35)

SB 1089 parameters

None

Current OHA systems

Claims processing operations: OHA currently operates the Medicaid Management Information System (MMIS), a third-party platform which processes millions of claims annually for Oregon Health Plan beneficiaries.[8] The system handles claims adjudication, payment processing, provider reimbursement, and reconciliation functions. Staff perform claims reviews, process adjustments and corrections, manage payment cycles, and respond to provider inquiries about claim status and payment issues.

Provider enrollment and credentialing: OHA maintains operational systems for enrolling and credentialing Oregon Health Plan providers, including application processing, credential verification, background checks, network management, and ongoing monitoring of provider compliance.[9] The agency manages provider databases, issues provider identification numbers, and engages with coordinated care organizations (CCOs) to ensure they have providers in their networks to meet network adequacy requirements. Currently there is some system duplication because providers must also become credentialed by each individual CCO with which they wish to contract.

Program oversight and monitoring operations: OHA conducts day-to-day oversight of CCOs, PEBB/OEBB health plans, and Marketplace insurers. This includes monitoring contract compliance, reviewing encounter data submissions, tracking quality metrics, processing financial reports, conducting site visits, and managing corrective action processes when operational issues arise. In addition, the OHA Ombuds Program has enabling legislation to independently monitor OHP member access to care and quality of care and make recommendations for improvement.

Information technology operations: OHA relies on a robust IT infrastructure that supports program administration, including MMIS, enrollment databases, data warehouses, reporting platforms, and public-facing websites. OHA does not maintain and operate all of its own IT systems; for example, MMIS is a federal system that is administered by states. Operations staff within each of OHA's divisions coordinate with the Office of Information Services (OIS), a shared service with the Oregon Department of Human Services (ODHS) that manages system maintenance, security patches, user support, system interfaces, data backups, and disaster recovery. The agency coordinates with federal systems for data exchanges and federal fund claiming. OHA also engages in contractual relationships to maintain third-party platforms, like the ONE Eligibility system and the State-Based Marketplace, the latter of which is expected to launch in fall 2026. These relationships provide helpful access to contractors' expertise, but competing priorities among different programs and agencies can impose limitations on contractors' capabilities.

Partner, provider, and community engagement and support: OHA has established mechanisms for partner input and community voice, including CCO Community Advisory Councils (CACs), the Lived Experience Advisory Panel (LEAP) for Open Card, regional health equity coalitions (RHECs), and various advisory committees.[10] OHA's Feedback Team conducts comprehensive tracking of community and provider input to help guide decision-making and improve OHA's operations and policies. OHA works closely with other state agencies including the Department of Revenue, Department of Consumer and Business Services, and Department of Administrative Services to coordinate health care administration, monitoring, data sharing, eligibility, and program oversight.

Member and provider support: The agency operates the Client Services Unit (CSU) call center for OHP members who are on Open Card, or fee-for-service, to answer general questions about benefits. However, each CCO operates its own customer service line to answer specific questions. Open card does not currently have an appeal process for benefits, and members' issues with benefits proceed directly to hearings. There is a small team in CSU that processes formal grievances and complaints. For providers, OHA operates a provider call center to support all provider enrollment and fee-for-service billing questions and claims.[11] OHA's Office of Community Health and Engagement (OCHE) plays a critical role in providing education and enrollment assistance for OHP members and community partners; capacity building for grant-funded and volunteer assisters, many of whom are based in community settings (that use over 69 different languages); and also navigation to services. OCHE's grant-funded community partners play a key role in making sure those who have access to health care services know how to use those services appropriately.

Resources needed for OHA systems to integrate with a universal health plan

Staff

Additional provider enrollment and credentialing staff: To support a universal health plan (UHP), OHA may need expanded staff to process provider applications, verify credentials, conduct background checks, manage provider databases, and monitor ongoing compliance for all providers serving people who live in Oregon. The volume of providers requiring enrollment and credentialing, as well as the scope of work, could increase across all specialties and settings. Due to existing duplication of credentialing that leads to administrative burden for all entities in the system, the UHP could streamline the process so that no additional credentials are required. This could help ensure that regional entities, health care institutions, and individual providers could engage with the UHP more easily than they do with the current system, making the transition more feasible and appealing.

Additional eligibility and enrollment operations staff: OHA could need additional staff to process eligibility determinations and ensure smooth interaction with Medicaid and other federal funding sources.

Additional claims processing and adjudication staff: OHA could need significantly more claims examiners, payment specialists, and quality assurance staff to process claims for all people living in Oregon. Current Oregon Health Plan operations process millions of claims annually. A UHP could increase this significantly, requiring additional staff for claims review, payment processing, adjustments and corrections, audit functions, and fraud detection.

Additional data analytics and monitoring teams: OHA could need additional staff to process and analyze claims data, encounter data, and financial reports from all payers and providers to monitor system functions and comply with federal requirements.

Additional technical and IT operations staff: OHA could need substantially expanded IT staff to maintain and operate enlarged systems, including systems administrators, database managers, network engineers, IT security specialists, help desk support staff, application developers, and project managers. The scale and complexity of processing data for a UHP could require IT staff teams several times larger than current operations.

Additional customer service and support: OHA could need significantly expanded customer service capacity to support members and providers transitioning from multiple payer contracts to single-payer arrangements, address billing questions, explain new payment methodologies, and troubleshoot system issues. Staff would also be needed to support new types of consumer needs, similar to what CCOs currently provide for their members.

Additional program monitoring and compliance staff: OHA could need expanded staff to monitor regional entities receiving global budgets, review financial reports, track quality metrics, conduct site visits, manage corrective actions, and ensure compliance with program requirements.

Additional rate development and regulatory oversight capacity: OHA could need expanded staff and vendor support to develop actuarially sound rates under the new model, strengthen financial monitoring, and ensure compliance with evolving insurance regulations.

Additional communications staff: OHA could need additional communications staff to ensure clear, consistent, and accessible communications statewide, including webinars and town halls in alignment with OHA's best practices.

Additional OHA Ombuds Program staff: OHA could need additional Ombuds staff members to comply with legislation requiring OHA to provide Ombuds services to individuals receiving public health benefits.

Systems

Expanded payment processing systems: OHA could need more robust claims processing and payment systems capable of handling diverse payment methodologies—including global budgets, capitation, episode-based payments, and fee-for-service where retained—with reconciliation, budget tracking, and provider payment functions. Federal certification requirements for Medicaid systems would likely still apply, potentially requiring specific functionality and interfaces.

Enhanced provider enrollment and credentialing systems: OHA could need enhanced provider management systems capable of processing applications, verifying credentials, conducting background checks, managing provider databases, tracking compliance, and supporting network adequacy monitoring for all Oregon providers.

Rescaled eligibility and enrollment systems for patients: OHA uses several eligibility and enrollment systems, including the ONE Eligibility system, the PEBB/OEBB system, and the Marketplace system. OHA could need dedicated resources to rescale these systems, assuming all three will not continue to operate at their current capacities under a UHP. Whether eligibility systems are reduced or expanded, resources are required to minimize interruptions in patients' care.

Scaled administrative and HR management systems: Existing systems like HR management, procurement systems, financial management systems, and time tracking systems integrated with the Department of Administrative Services (DAS) and other state agencies could need to be scaled to support a workforce substantially larger than current OHA staffing.

Amplified quality assurance and performance monitoring: OHA could need broader systems for monitoring operational performance, tracking key metrics, and identifying areas requiring improvement.

Increased communication infrastructure: OHA could need enhanced technology for webinars, virtual town halls, online training modules, and digital communication platforms such as public-facing websites and data dashboards to engage and inform partners and support system-wide implementation.

Additional equipment: OHA could need expanded equipment, including computers and other technology, to support an expanded staff.

Eligibility

Definition

The policies and systems that determine which specific population groups qualify for universal health plan (UHP) benefits,[12] including rules about who is eligible (such as residency and federal program criteria) and the processes and infrastructure used to verify and maintain eligibility status.

Joint Task Force recommendation

- All Oregon residents qualify for the Universal Health Plan regardless of job, income, immigration status, or Tribal membership. (p. 17)
- Eligibility is residency-based with no income/asset tests; it is possible that the same information and processes may still be needed for individuals who qualify for federal programs such as Medicare or Medicaid to enable coordination of federal funding. (p. 17)
- Immigration status will not be a condition of eligibility. (p. 17)
- People who are eligible to receive care through Indian Health Care Providers or Indian Health Service facilities will have the ability to seek care through the Plan or through the Indian Health Service and Tribal health systems. (p. 17)

SB 1089 parameters

Ensure that the proposed plan will include all Oregon residents equitably. [Section 2(3)(m)]

Current OHA systems

Oregon Health Plan eligibility policy, verification, and core data infrastructure: The Oregon Department of Human Services (ODHS) conducts eligibility determinations for the Oregon Health Plan (OHP), including Medicaid, the Children's Health Insurance Program (CHIP), OHP Bridge, and Healthier Oregon using the Oregon Eligibility (ONE) system.[13] This includes verification of household information, program criteria, and ongoing redeterminations. OHA collaborates with ODHS to ensure eligibility determination logic is compliant with state and federal policy. The ONE eligibility system used by both agencies is a third-party platform that is shared across many programs, all of which compete for system changes using the same pool of operational resources. Additionally, system changes become more complex as the complexity of this system grows. OHA maintains technical infrastructure connecting ONE and downstream systems, including the Medicaid Management Information System (MMIS), which stores eligibility and enrollment data and allows providers to access real-time data through the Oregon Medicaid Provider Portal;[14] and the Health Analytics Library (HAL), which produces monthly enrollment reporting.[15]

OHA also oversees interfaces that securely move eligibility data between systems such as provider portals, Coordinated Care Organizations (CCOs) and federal data hubs, enabling real-time eligibility verification at the point of service.

Eligibility for public employees, Marketplace plans, and specialized populations: For the Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB), OHA supports eligibility policy related to employment status, hours worked, and dependent eligibility and convenes the boards that hold statutory authority over eligibility and benefits; this includes an ongoing transition to a unified platform for both PEBB and OEBB benefits with updated eligibility rules.[16] For Marketplace plans, core eligibility determinations—including income, household size, citizenship, and calculations of subsidies like Advance Premium Tax Credits and Cost-Sharing Reductions (APTC/CSR)—are currently run through the federal HealthCare.gov Marketplace platform. However, beginning on November 1, 2026, Oregon will launch its own State-Based Marketplace and OHA will also begin conducting eligibility determinations for the state's Marketplace enrollees.[17] OHA also manages eligibility-related data for specialized populations, including people who are eligible to receive care through Indian Health Care Providers, including the Indian Health Service,[18] and individuals who are eligible for hospital financial assistance or charity care,[19] among others.

Resources needed for OHA systems to integrate with a universal health plan

Staff

Additional eligibility policy and determinations staff: OHA could need additional staff to design and implement new state-driven, residency-based eligibility requirements for the entire state, as well as ensure compliance with current federally driven eligibility requirements for Medicaid and other federal programs.

Expanded information technology and data systems staff: Additional systems developers, IT specialists, and support staff could be required to develop, launch, and troubleshoot a universal health plan (UHP) eligibility system, including support for all public and private entities in accessing, sharing, and securing eligibility data.

Expanded Tribal and interagency liaison staff: New capacity could be needed for Tribal-State government-to-government formal consultation, hospital systems coordination, and cross-agency collaboration to adapt specialized eligibility processes to UHP data flows and billing requirements.

Systems

New residency-based, point-of contact eligibility verification system: To handle statewide eligibility verification, including real-time residency verification, OHA would need to develop a new eligibility management system to ensure the state has the

technological capacity to implement necessary changes, or substantially reinforce existing platforms it currently relies on. Existing systems include: the ONE system, a third-party platform for OHP eligibility determinations; Oregon's state-based marketplace system, which will be launched in 2026; and the PEBB/OEBB system that manages eligibility for state employees and other public workers.

Enrollment 

Definition

The systems and processes by which eligible people join a universal health plan (UHP), including tracking enrollment changes, issuing insurance cards, and enabling provider confirmation of active enrollment.

Joint Task Force recommendation

- A "no wrong door" policy (meaning patients can enroll in the Plan in any health care setting at any time) will enable automatic enrollment for all eligible Oregon residents, with easy point-of-care confirmation to eliminate access barriers. (p. 17)
- "Opting out" of coverage will not be possible, but residents can choose to pay out of pocket if they do not wish to accept universal benefits. (p. 17)

SB 1089 parameters

None

Current OHA systems

Oregon Health Plan enrollment: OHA automatically enrolls eligible individuals in a coordinated care organization (CCO) within three business days of eligibility determination,[20] with exemptions for those who are dually eligible for Medicare, children with special health care needs, and people who are eligible to receive care through Indian Health Care Providers or Indian Health Service facilities. OHA tracks, publishes, and reports enrollment data through the Medicaid Management Information System (MMIS) that stores enrollment data—which can be accessed through platforms like the Decision Support and Surveillance Utilization Review System (DSSURS) and Health Analytics Library (HAL)—and data interfaces with provider systems and the federal government.[21] Generally speaking, both DSSURS and HAL are simply different ways to store and access the data that originate in MMIS.

Public employees and Marketplace enrollment: OHA manages self-enrollment for public employees, at which point the agency transmits the employee's data to their

selected medical and dental insurers and administrators of flexible spending accounts.[22] Employees must confirm their enrollment choices or make desired updates thereafter during annual open enrollment periods. OHA tracks and publishes enrollment data for public employees and manages the underlying benefits systems, which are to be consolidated into a unified system in November 2026. OHA also operates a Marketplace program but uses the federal HealthCare.gov IT platform for eligibility and enrollment functions. OHA Marketplace staff maintain responsibility for plan certification, outreach and education, and coordination with partners such as insurance agents, community partners, and insurance carriers. OHA is preparing to transition to its own State-Based Marketplace (SBM) enrollment system on November 1, 2026, after which all exchange functions will be conducted by OHA.

Resources needed for OHA systems to integrate with a universal health plan

Staff

Additional enrollment operations and transition staff: OHA could need additional staff capacity to design and implement the automatic "no wrong door" enrollment policy (meaning patients can enroll in the Plan in any health care setting at any time) at a universal scale, including training for partners and providers during the transition.

Expanded IT and data coordination teams: OHA could require additional developers, analysts, and support staff to build and launch a universal health plan (UHP) enrollment system with real-time tracking and interfaces to federal systems.

Increased Tribal, partner, and contractor liaison staff: Increased resources could be needed for Tribal consultations, contractor management, and cross-system coordination to integrate enrollment data without disruption to IHS or Indian Health Care Providers.

Systems

Universal automatic enrollment platform: A new system or major expansion of an existing platform will be required —such as the third-party administered ONE system, State-Based Marketplace system, or public employee infrastructure—with additional capacity for statewide "no wrong door" enrollment, real-time provider confirmation, and seamless data transmission from carriers.

Federal reconciliation infrastructure: Given that the Task Force intended to integrate existing Medicaid funds and Marketplace subsidies into a UHP, the UHP enrollment system would need mechanisms for integrating or reconciling with federal financing systems, such as Medicaid and Marketplace systems. Medicaid and Marketplace enrollment tracking and reporting systems must continue to function to comply with the federal Centers for Medicare and Medicaid Services (CMS) requirements and continue to draw down federal funding as the Task Force envisioned.

Covered Services 

Definition

Services that are paid for by a universal health plan (UHP), including doctors' services, inpatient and outpatient hospital care, prescription drug coverage, primary, specialty and behavioral health care and more;[23] covered services also include processes for evaluating changes in covered services as needed.

Joint Task Force recommendation

The Universal Health Plan is based on the benefits public employees received through the Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB) in 2022. The Plan will cover services offered in 2022 to people on Medicaid, Medicare, or Affordable Care Act plans. (p. 18)

SB 1089 parameters

- Focusing on coverage of evidence-based health care and services. [Section 2(2)(j)]
- The plan shall cover health care services and goods from birth to death, based on evidence-informed decisions as determined by the board. [Section 2(3)(b)(D)]

Current OHA systems

Oregon Health Plan (OHP) benefit design: OHA provides essential staff support and operational infrastructure to the independent Health Evidence Review Commission (HERC), which maintains Oregon's Prioritized List of Health Services—which ranks 650+ condition and treatment pairs for Oregon Health Plan Medicaid coverage.[24] OHA's dedicated team includes analysts who review clinical effectiveness research and prepare coverage recommendations for HERC public meetings; operations staff who coordinate monthly meetings, draft guidelines based on HERC votes, and publish the Prioritized List; and program staff who implement HERC decisions across Coordinated Care Organization (CCO) contracts and track utilization impacts. Additional covered services, like gender-affirming care and reproductive health services, are not federally funded, yet are included in the OHP benefit based on state legislation.[25, 26]

- Note: Per the CMS letter of approval for Oregon's 2022-2027 waiver, the waiver that authorizes the Prioritized List will end Dec. 1, 2026.[27] By Jan. 1, 2027, the HERC's task will be to maintain a medical necessity policy for services in the OHP benefit package. [28]

Non-prioritized list coverage: OHA directly mandates and oversees several programs that ensure coverage of all medically necessary and medically appropriate care, regardless of placement on the Prioritized List. These are codified through federal mandates and Oregon's 1115 waiver, and include Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for Oregon Health Plan members under 21 years old (and young adults with special health care needs up to age 26); and for Health-Related Social Needs (HRSN), including rent assistance, medically tailored meals, and transportation. OHA approves HRSN implementation plans and monitors outcomes.[29, 30] OHA also provides directed payments — such as hospital directed payments and other wrap-around payments—to Federally Qualified Health Centers (FQHCs) on behalf of Medicaid members.

Long-term services and supports (LTSS): Currently, long-term services and supports (LTSS) for OHP enrollees are jointly administered by OHA and the Oregon Department of Human Services (ODHS).[31] OHA leads clinical and quality oversight for LTSS within CCO contracts (Schedule A, Section 5), setting service standards, reimbursement methodologies, and performance metrics.[32] An evaluation of LTSS systems and their ability to integrate with a universal health plan (UHP) should include engagement with ODHS.[33]

Public employee benefit negotiation: OHA serves as the administrative and operational backbone for PEBB and OEBB negotiations with insurers and third-party administrators, acting as a group purchaser.[34] Additional negotiations occur between public employers and employees regarding premium sharing and benefits, in which PEBB and OEBB staff at OHA do not participate. OHA has dedicated teams that handle policy development, which includes drafting benefit frameworks and analyzing carrier proposals against state mandates; contract management, which includes structuring agreements with insurers and vendors, managing legal and compliance reviews, and tracking performance; member support, which includes designing communications for explanation of benefit changes, managing help desks during open enrollment, and processing appeals and grievances; and IT and data analytics.[35]

Marketplace plans: The Oregon Health Insurance Marketplace (OHIM) moved from the Department of Consumer and Business Services (DCBS) to OHA in 2021. While the Affordable Care Act (ACA) dictates the details of each metal-tier plan that can be offered on state Marketplaces (bronze, silver, gold), including benefits and actuarial value of plans, states must certify plans to ensure compliance with federal policies for their own Marketplaces.[36] OHA certifies Qualified Health Plans (QHPs) that cover required services and enters into contracts with insurance carriers that offer QHPs.[37] Additionally, OHA and DCBS work together to design standard bronze, silver, and gold plans, which are offered by every Marketplace carrier.

Resources needed for OHA systems to integrate with a universal health plan

Staff

New benefit integration specialists: New staff could be needed to support current PEBB/OEBB and Oregon Health Plan staff in harmonizing PEBB/OEBB's comprehensive benefit categories with Oregon Health Plan benefits, creating aligned universal health plan (UHP) coverage standards for everyone in Oregon. Additionally, to allow Marketplace subsidies to go towards the UHP, specialists could be needed to prove that the UHP includes essential health benefits.

Systems

Unified benefits platform: A UHP could require a single digital platform merging PEBB/OEBB coverage systems, Health Equity Review Commission (HERC) Prioritized List database (and/or the system that replaces the HERC), and CCO benefit administration tools for real-time UHP coverage determinations. This could replace the current fragmented system and allow for universal service lookup, as well as auto-adjudicating of statutory entitlements such as EPSDT, HRSN, gender affirming care and certain reproductive health services.

Provider Roles and Rules 

Definition

The policies and processes that determine which clinicians, facilities, and group practices may participate in the universal health plan (UHP), what services they may provide to beneficiaries, and how they may bill the plan, private insurers, or private-pay patients.

Joint Task Force recommendation

- "Participating providers" includes any individual, group practice, or institutional provider (including hospitals and health systems) that are licensed or authorized to practice in Oregon, in good standing, and provide services covered by the Plan. (p. 24)
- Because employers may choose to continue offering health benefits, participating providers may also serve people covered by self-funded plans. Providers would not be allowed to charge any other payers higher rates than those established by the Universal Health Plan. (p. 25)
- The state will be responsible for implementing necessary systems and processes, including provider credentialing. (p. 98)

SB 1089 parameters

- A participant in the Universal Health Plan may choose any individual provider who is licensed, certified or registered in this state or may choose any group practice [Section 2(3)(b)(A)]
- The plan may not discriminate against any individual health care provider who is licensed, certified or registered in this state to provide services covered by the plan and who is acting within the provider's scope of practice [Section 2(3)(b)(B)]
- A participant in the plan and the participant's health care provider shall determine, within the scope of services covered within each category of care and within the plan's parameters for standards of care and requirements for prior authorization, whether a service or good is medically necessary or medically appropriate for the participant. [Section 2(3)(b)(C)]

Current OHA systems

Provider enrollment and screening: Oregon requires any billing or rendering provider who is seeking to be reimbursed for services under an Oregon Health Plan (OHP) benefit to enroll with OHA and obtain a Medicaid identification number.[38] OHA is responsible for screening all OHP providers and sanctioning or excluding providers from reimbursement in the case of violations.[39] These policies apply to ordering, referring, prescribing, and attending providers, and contractors receiving public funds. OHA also includes provider roles and rules in Coordinated Care Organization (CCO) contract negotiations, including certain types of providers and services which CCOs must make available to their enrollees, like traditional health workers and birth doulas.

Network adequacy monitoring: OHA enforces statewide standards across OHP, the Public Employees' and Oregon Educators Benefit Boards (PEBB/OEBB), and public programs, tracking carrier compliance, maintaining centralized directories, and using All Payer All Claims (APAC) data—which includes claims and enrollment data from commercial insurers, Oregon Health Plan CCOs, Medicare Advantage plans and other payers—to analyze network composition.

Provider licensing and enforcement: Different offices within OHA perform licensing and enforcement functions for several types of facilities, individual health care professionals, providers, institutions and programs. Within OHA's Public Health Division, both the Health Care Regulation and Quality Improvement (HCRQI) Program and the Health Licensing Office (HLO) oversee different types of licenses and certifications. The HCRQI Program licenses acute and continuing care health facilities and community-based agencies; develops and regulates emergency medical services (EMS) and trauma systems; and administers the Certificate of Need (CN) program to encourage health care investment in

areas currently lacking sufficient facilities.[40] The HCRQI oversees hospitals, ambulatory surgical centers, outpatient dialysis facilities, home health agencies, hospice and in-home care. The HLO is a consumer protection office that oversees licensing, certification, and regulatory standards and administers 20 boards, councils, and programs for health-related professions, including: Art Therapy; Athletic Trainers; Certified Advanced Estheticians; Direct-Entry Midwives, Dieticians, and Sign-Language Interpreters, among others.[41] The HLO also conducts inspections of licensed facilities, responds to and investigates consumer complaints, and disciplines practitioners found in violation of state law or administrative rule. Altogether, the HLO regulates 6,100 facilities and 80,000 licensees. Within OHA's Behavioral Health Division, licensing and certification functions pertain to residential and outpatient behavioral health facilities and programs.[42] The Division oversees institutions and programs like adult foster homes, child and adolescent programs, and sobering facilities; it also certifies some individual providers including qualified mental health associates (QMHAs), qualified mental health professionals (QMHPs), addictions counselors and recovery mentors. This is not an exhaustive list of OHA's responsibilities, but it illustrates some of the agency's primary functions related to provider licensing, certification, and enforcement.

Provider engagement and technical assistance: OHA works with some providers across the state through advisory groups, technical assistance, and policy development on practice standards (e.g. culturally responsive care, behavioral health integration), informing how providers operate under state health systems in addition to contracts outside of OHA. However, these engagements are not comprehensive or coordinated for all providers in the state. OHA works with some providers and other community partners such as community health workers (CHWs), OHP assisters, and social services leaders through grants and volunteered time. Many of these systems experience frequent changes, and dedicated funding is an important way to ensure that best practices can be developed in a timely manner for a wide range of partners.

Audits for program integrity: The Program Integrity Audit Unit (PIAU) supports the responsible stewardship of Medicaid funds in three ways: auditing Oregon Medicaid providers and contractors for compliance; educating providers about Medicaid program integrity requirements; and oversight of Oregon's Medicaid operations. The Office of Program Integrity (OPI) has the authority to recover overpayments and discover possible instances of fraud, waste, and abuse in Oregon's Medicaid program.[43] These functions help prevent fraud, waste, and abuse so that funds are used as intended.

Resources needed for OHA systems to integrate with a universal health plan

Staff

New provider credentialing and contracting staff: If OHA were directed to implement the Task Force's recommendation of a state-operated provider credentialing process for a universal health plan (UHP), the agency could require significant credentialing and contracting staff. While OHA has explored common credentialing, the past program was repealed in 2021 and the agency no longer has staff dedicated to a centralized credentialing initiative.[44]

Expanded network policy and adequacy staff: Additional staff could be needed to design, enforce, and enhance standards for enrollment, screening, licensing, and assisting diverse provider types covered by the UHP and to monitor network adequacy statewide.

Additional rate development and regulatory oversight capacity: OHA could need expanded staff and vendor support to develop actuarially sound rates under the new model, strengthen financial monitoring, and ensure compliance.

Additional compliance, licensing, and grievance staff: OHA could need additional staff, perhaps expanding the scope and capacity of OHA's Health Licensing Office, to ensure all providers and provider types continue to abide by all relevant state and federal laws, are sanctioned if needed, and allow patients a process to report issues with providers.

Systems

Compliance monitoring systems: To work towards the Task Force's vision of unrestricted provider choice, the state would likely need to develop some type of compliance monitoring or nondiscrimination oversight process to monitor individual and clinic provider behavior regarding accepting new enrollees and equitable distribution of resources.

Unified provider enrollment and management platform: A statewide system for provider enrollment, credentialing verification, and network adequacy monitoring across the state could be needed. Elements and expertise from the discontinued common credentialing program and the Health Licensing Office could be leveraged to support the UHP.

Enhanced provider engagement and support tools: To continue and expand engagement and support for providers, OHA could need new technical assistance platforms and infrastructure to communicate UHP standards and mandates.

Provider Payment 

Definition

The rate-setting processes, billing and data infrastructure, and payment methods (such as fee-for-service, value-based payment, and global budgets) that determine how providers are paid for services and performance under the universal health plan (UHP).

Joint Task Force recommendation

- The Plan will pay providers directly. (p. 25)
- Global budgets, where providers are paid in advance to care for patients, and other alternative payment arrangements will be used to improve outcomes and value over time. (p. 25)
- Rates of pay will be set by region to account for different health care needs throughout the state. (p. 24)

SB 1089 parameters

None

Current OHA systems

Oregon Health Plan capitation payments, value-based payment, and rate-setting infrastructure: OHA negotiates coordinated care organization (CCO) contracts with capitated, per-member per-month rates set via federal Centers for Medicare and Medicaid Services (CMS)-approved processes. This rate development relies on historical encounter and cost data, risk adjustment, regional cost factors, and non-duplication rules. Non-duplication rules are intended to prevent double-counting costs for services and diagnoses for individuals in overlapping coverage populations, such as the Oregon Health Plan and Medicare. All of this ensures rates are adequate for required benefits and comply with federal standards.[45] OHA updates rates annually, incorporates policy changes (such as new covered services or benefits), and maintains parallel fee-for-service schedules for members who are not enrolled in CCOs. Additionally, OHA requires CCOs to shift a growing share of provider payments into advanced alternative payment models like shared savings, bundled payments, and pay-for-performance.[46]

Billing, claims, and contract-based payment rules: OHA's Medicaid managed care contracts and associated rules specify the minimum standards for providers to bill CCOs for covered services, including Medicaid enrollment, claims submission timelines, and dispute and appeal processes. They also specify the circumstances under which the methods and amounts paid to providers are at the discretion of CCOs or directed by contract or rule. The contracts also establish quality incentive pools that reward CCOs

based on performance on state-defined metrics, indirectly shaping how CCOs structure downstream payments and incentives to contracted providers. OHA also administers fee-for-service Oregon Health Plan (OHP) benefits for members not enrolled in CCOs, which requires its own claims processing rules and provider payment policies.

Data and analytics to support payment policy: OHA uses data systems such as the All Payer All Claims (APAC) database (which collects claims and enrollment data from commercial insurers, OHP CCOs, Medicare Advantage plans, and other payers),internal Medicaid data warehouses, and external actuarial analyses to evaluate spending trends, service utilization, and the distribution of payments across provider types and regions. These analytics support decisions on CCO rate updates, targeted directed payments, and refinement of VBP models, and they help assess how payment policies affect equity, access, and quality across different communities.

Resources needed for OHA systems to integrate with a universal health plan

Staff

Value-based payment policy and implementation specialists: Additional staff could be needed to design statewide provider payment models (shared savings, bundled payments, pay-for-performance) in partnership with communities, and monitor compliance with regional targets.

Regional rate-setting and actuarial experts: While OHA's experience with capitated per-member per-month rates could inform a regional global budget approach as recommended by the Task Force, additional actuaries and analysts could be needed to switch to and support ongoing implementation of a statewide global budget model.

Systems

Scaled rate and payment administration platform: Upgraded infrastructure to administer regional global budget payments and make annual rate updates could be needed.

VBP analytics: OHA's existing VBP infrastructure, including VBP requirements and technical guides, could provide a foundation for defining, implementing, and monitoring complex payment models that could be scaled or adapted under a UHP.

Private Health Insurance 

Definition

The policies and arrangements that determine how private health insurance relates to, integrates with, or remains separate from the universal health plan (UHP), including which

populations and benefits are included in the UHP and which continue under private payers.

Joint Task Force recommendation

- The Task Force envisions private insurers playing a more limited role than in the current system, offering supplemental ("wraparound") coverage for benefits and services that are not included in the Universal Health Plan, rather than serving as the primary source of major medical coverage. (p. 27)
- The Task Force expects the UHP to become the main coverage vehicle for everyone living in Oregon, with any remaining private coverage designed to supplement, rather than complement, the Plan. (p. 28)

SB 1089 parameters

None

Current OHA Systems

PEBB/OEBB contract negotiation: OHA negotiates contracts with private insurers and third-party administrators (TPAs), including performance incentive programs, to deliver services to public employees.[47] Oregon instituted a hospital price cap policy in 2019 for the Oregon Educators Benefit Board (OEBB) and in 2020 for the Public Employees' Benefit Board (PEBB), mandating that these plans not pay more than 200% of Medicare rates for hospital services.[48] The boards that govern PEBB and OEBB also work to include performance guarantees in the contracts with each program provider so that if performance targets are missed, the program provider returns a portion of the fees paid back to PEBB/OEBB. PEBB plans are 80% self-funded (administered under third-party contracts) and 20% fully insured (administered by insurers), while OEBB plans are all fully insured.[49]

Marketplace certification: OHA does not have authority to directly regulate payment arrangements for private insurers who participate in the Marketplace; however, OHA certifies Qualified Health Plans (QHPs) that are sold through the Oregon Health Insurance Marketplace by issuing requests for applications and evaluating whether plans meet federal and state certification criteria for metal tiers (gold, silver, and bronze).[50] The enforcement of Marketplace plan regulations generally lies with the state Department of Consumer and Business Services (DCBS), and OHA collaborates with DCBS in this function.[51]

All Payer All Claims data collection and analysis: OHA operates the All Payer All Claims (APAC) program, which collects claims and enrollment data from commercial insurers, Oregon Health Plan CCOs, Medicare Advantage plans, and other payers; this

infrastructure enables OHA to monitor private market trends, understand coordination of benefits for individuals covered by multiple insurance plans, and compare cost and utilization trends for private insurance with public insurance plans and could be critical for tracking the role of private insurance under a UHP.[52] APAC also collects value-based payment information at the payer level, which enables OHA to understand trends in capitation and other non-claims payment arrangements.

Resources needed for OHA systems to integrate with a universal health plan

Staff

Rescale or redistribute private market staff: Although the universal health plan (UHP) is expected to significantly shrink the role of private insurers, OHA, or any entity supporting the UHP, would need to maintain dedicated staff with private insurance regulatory expertise to coordinate with any remaining private insurers. This could mean a reduced workload for OHA. Most of this capacity currently resides with DCBS.

Additional rate development and regulatory oversight capacity: OHA could need expanded staff and vendor support to develop actuarially sound rates under the new model, strengthen financial monitoring, and ensure compliance with evolving insurance regulation.

Systems

Market monitoring and equity analytics: Expanded APAC and analytics capabilities, such as collecting claims-level capitation payment data, could be needed to track private insurance utilization happening alongside the UHP and to monitor equity across optional/excluded populations. While the program currently collects value-based payment information at the payer level, it is unable to align that data with individual claims. APAC has statutory authority to collect this data but would need to engage partners, conduct rulemaking, and flesh out a complex implementation plan for a UHP.

Current Public Programs* 

**Medicaid, CHIP, Medicare, and ACA Marketplace subsidies are assumed to be primary federal funding sources and are discussed in detail in the Financing component; this section focuses on smaller and/or parallel programs.*

Definition

The policies and arrangements that determine how existing public coverage programs relate to, integrate with, or remain separate from the universal health plan (UHP), including

which populations and benefits are included in the UHP and which continue under other programs.

Joint Task Force recommendation

Programs that remain fully or largely separate, with optional or no UHP enrollment:

- Veterans Affairs and TRICARE will remain fully operational and independent of the UHP; the Task Force assumes that veterans and active-duty military personnel will continue to receive their benefits through these federal systems and uses the term "excluded" to describe their status with respect to UHP enrollment. (p. 69)
- Indian Health Service and Tribal health systems are expected to remain independent, but individuals who are eligible to receive care through Indian Health Care Providers, including IHS and Tribal health programs, would have the option to enroll in the UHP if they choose, consistent with Tribal sovereignty. (p. 32)

Programs that remain separate but must be intentionally aligned:

- Long-term services and supports (LTSS): People who qualify for Medicaid or Medicare long-term care will continue to receive LTSS benefits and services through Medicaid and the Oregon Department of Human Services, while the UHP would cover some skilled nursing and home health care; the Task Force recommends that the UHP governance board work with ODHS to study how long-term care might be further integrated over time. (p. 19)
- Community behavioral health: The Task Force emphasizes the need to align UHP design with Certified Community Behavioral Health providers and other community behavioral health safety-net services so that universal coverage does not destabilize behavioral health infrastructure. (p. 26)

SB 1089 parameters

None

Current OHA systems

Supports to Tribes and Indian Health Care Providers: OHA maintains government-to -government relationships with the Nine Federally Recognized Tribes of Oregon, manages unique Medicaid billing and payment arrangements for Indian Health Care Providers, and provides a variety of technical assistance and support to Tribes and their health care infrastructure.[53]

Long-term services and supports (LTSS): In partnership with the Oregon Department of Human Services (ODHS) and local Aging and People with Disabilities (APD) / Area Agency on Aging (AAA) offices, OHA ensures that Coordinated Care Organizations (CCO) coordinate and align their medical and behavioral health services with Medicaid-funded

long-term services and supports (LTSS). LTSS remains outside CCO budgets.[54] Specifically, ODHS APD administers LTSS for physical disability with the Community First Choice option, and OHA administers LTSS for mental health disability with the Home and Community Based Services benefit, both of which are covered under Section 1915 of the Social Security Act.[55]

Behavioral health systems: OHA oversees a broad behavioral health portfolio, including Community Mental Health Programs (CMHPs),[56] substance use disorder treatment programs, mental health crisis services, residential treatment, and the Oregon State Hospital.[57] Many of these services are financed through a mix of Medicaid, federal block grants, and state funds and operate alongside or outside CCO contracts, giving OHA substantial experience managing multi-payer safety--net- services that would need to align with UHP coverage and payment policies.[58]

Safety-net- provider support: OHA supports Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Certified Community Behavioral Health Clinics (CCBHCs) that serve as key safety-net providers for populations that are underserved and earn low incomes-, including by administering prospective payment systems, monitoring- access and quality, and coordinating with CCOs on network participation.[59] These relationships and payment structures could be important to preserve and adapt under a UHP.

OHP Bridge: Oregon has established a state-administered Basic Health Program (BHP) under section 1331 of the Affordable Care Act. The program is called OHP Bridge and began operating in July 2024. OHP Bridge was first established to maximize the number of individuals who were able to maintain the Medicaid coverage they gained under the COVID-19 public health emergency. It then began enrolling individuals within the 133-200% FPL income range – a group that often "churns" between Medicaid and private insurance due to income fluctuations.

Healthier Oregon: OHA administers the Healthier Oregon program, which extends coverage to individuals who would otherwise be eligible for Medicaid if not for their immigration status.[60]

Reproductive health programs: OHA administers reproductive health programs including Reproductive Health Equity Act (RHEA) coverage,[61] Title X family planning, and breast and cervical cancer screening.[62] These programs provide essential services to populations that may continue to experience barriers despite having universal coverage and may require deliberate alignment with UHP benefits and financing.

Resources needed for OHA systems to integrate with a universal health plan

Staff

Expand intergovernmental and Tribal liaison staff: OHA could need expanded staff for government-to-government consultation with Tribes, coordination with federal agencies

(VA, TRICARE, IHS), and cross-agency work with DHS to align LTSS, behavioral health, and safety-net programs with UHP operations.

Systems

Enhanced data integration and cross-program tracking tools: OHA may need systems upgrades for real-time data exchange between UHP eligibility/claims platforms and separate systems for safety net clinics, LTSS, and Tribal health to prevent gaps or overlaps.

Cost Containment 

Definition

Strategies used to contain the growth of the universal health plan (UHP) spending and total health care cost in Oregon while maintaining or improving quality of benefits, services and care provided. Examples include:

- Value-based payment methodologies, including global budgets and capitation rates.
- Utilization management, including cost-sharing, prior authorization and care coordination.
- Sustainable health care cost growth targets and health care market oversight.

Joint Task Force recommendation

- The Plan will use global budgets and other alternative payment arrangements to improve outcomes and value over time. (p. 25)
- The Plan seeks to build on Oregon's experience with advanced forms of value-based payment, but with an expanded notion of "value;" different types of payment arrangements, including capitation, global budgets, prospective episode-based payment, and budget-based models will be considered. (p. 27)
- The Plan will not require any cost-sharing from patients. (p. 20)

SB 1089 parameters

Institutional providers are paid with global budgets that separate capital budgets, established through regional planning, and operational budgets. [Section 2(1)(b)]

Current OHA systems

Annual budget setting and rate development: OHA sets annual budgets for Coordinated Care Organizations (CCO) through annual capitation rate development processes that include both capitated and non-capitated payment components. [63] For capitated

payments, OHA collects detailed CCO encounter data showing member utilization, diagnoses, and service costs, which is then used to develop per-member-per-month capitation rates that reflect each CCO's expected costs. These rates are certified as actuarially sound and submitted to the federal Centers for Medicare and Medicaid Services (CMS) for approval. For non-capitated components, OHA administers quality incentive programs including the Quality Pool, which distributes bonus payments to CCOs based on performance across multiple quality metrics. OHA also manages directed payment programs, including hospital assessments and provider rate increases tied to specific performance requirements. The agency coordinates rate development timelines, issues rates-related communications, publishes rate certifications, and monitors CCO financial performance throughout the contract year.

Value-based payment infrastructure: OHA has significant infrastructure and policy expertise in value-based payment (VBP) implementation and oversight. This includes CCO contracts, which set progressive annual targets requiring CCOs to shift payments from traditional fee-for-service to value-based arrangements.[64] Through its All Payer All Claims (APAC) Reporting Program, OHA gathers and analyzes CCO, commercial, PEBB/OEBB, and Medicare Advantage VBP data. Other resources beyond the Oregon Health Plan include the VBP Compact, jointly developed by OHA and the Oregon Health Leadership Council, which is a voluntary commitment by payers and providers across the state to increase the use of VBP to lower the rate of cost growth, improve quality and outcomes, and foster health equity.[65]

Health care cost growth target and market oversight: OHA has established comprehensive infrastructure for monitoring health care cost growth across the state, creating system-wide accountability for cost containment, and working toward a statewide goal of containing health care cost growth across all markets, health plans, and provider organizations. The statewide cost growth target was 3.4% for 2021-2025 and has been set at 3.75% for 2026-2030.[66] To measure cost growth performance, OHA has built robust data collection and analytics capabilities, including the All Payer All Claims database, which aggregates claims from commercial insurers, CCOs, Medicare Advantage plans and public employee benefit plans. Analysts and actuaries calculate total per-person spending growth annually, produce public reports disaggregated by payer type and market segment, and analyze cost drivers including hospital spending, prescription drug costs, and utilization patterns.

Additionally, OHA has developed a formal regulatory infrastructure for reviewing and monitoring health care business transactions. Proposed health care business deals that are subject to review must receive OHA approval to move forward. The Health Care Market Oversight (HCMO) program collects detailed information from transacting parties; analyzes potential impacts on costs, competition, access to care, workforce, and health

equity; may conduct public hearings to gather community input; and issues public reports with findings and recommendations.[67] OHA coordinates market oversight reviews with other state agencies and OHA programs that also conduct regulatory review, including DCBS' commercial insurance Form A review, OHA's certificate of need process, and the state Attorney General's office, which has authority to challenge anticompetitive transactions under antitrust law.

Resources needed for OHA systems to integrate with a universal health plan

Staff

Additional actuarial, financial, and rate-setting staff: OHA could substantially expand its actuarial, financial analytics, and rate-setting staff to develop and administer global budgets for all regional entities serving Oregon's entire population. OHA could also expand its analytic capacity to analyze and report on cost growth trends and cost growth drivers within the universal health plan.

Additional negotiation and contract management staff: Current CCO contract staff could evolve and expand to negotiate and oversee global budget agreements with significantly more entities—including hospitals, health systems, specialty providers, and potentially multi-state health systems operating in Oregon. Staff with expertise in complex contract negotiations, legal compliance, and alternative payment model design could be essential.

Additional health care market oversight staff: HCMO program staff could expand to handle increased transaction review volume as the market adjusts to single-payer implementation, including potential consolidation attempts or market exits. HCMO does not currently review market exits.

Systems

Enhanced quality assurance and accountability frameworks: OHA could expand its current quality incentive and monitoring systems to ensure that VBPs, regional global budgets and other cost containment techniques support quality care in the UHP. This could include building on its experience monitoring CCO quality metrics and adapting the CCO Quality Pool methodology to regional entities receiving global budgets.

Expanded transaction review and market monitoring systems: OHA could expand the HCMO infrastructure to address single-payer-specific market dynamics, including monitoring whether providers attempt consolidation to gain leverage in global budget negotiations with regional entities, analyzing how elimination of payer competition affects provider market power, tracking whether hospital systems or large provider groups gain dominant positions that could threaten budget sustainability, and reviewing transactions

where providers might seek to exit markets or reduce services under single-payer payment rates.

Financing 

Definition

The mechanisms and sources through which money is raised or collected to pay for health care services in a universal health plan (UHP). Examples include:

- Taxes (income, payroll, provider)
- Insurance premiums
- Premiums and cost sharing (deductibles, copayments, coinsurance)
- Employer contributions
- Government appropriations, including funding for government programs including Medicaid, Medicare, and Marketplace funds.

Joint Task Force recommendation

- Combine federal and state revenues along with contributions from employers and households. (p. 39)
- Oregon will continue to receive premium subsidies available for eligible individuals who receive premium subsidies to purchase coverage from the Oregon Health Insurance Marketplace. (p. 98)
- There shall not be premiums nor out-of-pocket costs, including co-pays or deductibles. Instead, people will pay new taxes based on their ability to pay. (p. 20)
- Revenue should be collected through existing systems to optimize efficiency and reduce administrative costs. (p. 20)
- Both OHA and the governing Board are referred to as entities with the authority to work with the federal Centers for Medicare and Medicaid Services (CMS) to administer federal health care funds. (p. 34, p. 37)

SB 1089 parameters

- Include a plan to create a Universal Health Plan Trust Fund in the State Treasury, separate and distinct from the General Fund, consisting of moneys from all sources, public and private, that are allocated to or deposited to the Universal Health Plan Trust Fund for the purpose of financing the planning for and the administration and operation of the Universal Health Plan. [Section 2(3)(k)]

- Establish a revenue system in which employers would contribute to the cost of health care for all Oregonians while retaining the flexibility to offer self-funded health plans to employees. [Section 2(3)(f)]

Current OHA systems

Federal funding infrastructure and waiver management: OHA is the designated state agency that partners with the federal government to draw down funding from federal health programs.[68] The agency draws down federal funds through the advanced planning document (APD) process. States submit APDs to receive enhanced federal funding to support their Medicaid Management Information Systems (MMIS)[69] which process claims and store operation data. The APD also allows Oregon to receive federal funding for its eligibility and enrollment system and the Transformed Medicaid Statistical Information System (T-MSIS)[70] through which OHA submits data to CMS for federal reporting. OHA staff have significant expertise in federal Medicaid regulations, securing and managing 1115 demonstration waivers, developing state plan amendments, and maintaining compliance with federal requirements necessary to maximize federal funding.

State funding coordination and appropriations management: OHA receives and manages state General Fund appropriations for Medicaid match requirements, public employee health benefits, fee-for-service carve outs, and various grant programs through established budget development, allocation, and monitoring processes.[71] The agency coordinates closely with the Department of Administrative Services, the Legislative Fiscal Office, and the Governor's budget office through biennial budget cycles, tracking state funding by program, biennium, and funding source through integrated financial management systems. OHA also administers dedicated revenue streams, including provider taxes (hospital assessments and insurer taxes that support Medicaid financing and leverage federal matching funds) and various fees. The agency has experience proposing financing mechanisms to the Legislature, conducting fiscal impact analyses, and managing complex fund accounting across General Fund, Federal Funds, Other Funds, and dedicated revenue sources.

Premium collection and employer contribution systems: OHA operates premium collection and employer contribution systems to support the Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB), which collect funds from participating employers and covered employees to finance health benefits for over 300,000 public employees, educators, retirees, and their families.[72] The boards manage premium rate-setting but do not determine employer and employee share; coordinate with the Employment Department and individual employers on payroll deduction systems; processes premium payments from multiple sources (state agencies, school districts, local governments, employees), reconcile premium collections with enrollment records,

and track employer contributions and employee cost-sharing. When employers and employees negotiate their share of premiums, OEBB and PEBB apply those decisions to premium collection systems.

Resources needed for OHA systems to integrate with a universal health plan

The following section assumes OHA will remain the designated entity with the authority to work with the Centers for Medicare and Medicaid Services (CMS) to administer federal health care funds.

Staff

Additional forecasting, actuarial, and fund management staff: OHA would likely need to expand actuarial and financial modeling capacity to design and regularly update a comprehensive UHP financing model that integrates existing federal and state funding streams into a single trust fund. Managing a UHP Trust Fund that pools all public and private health funding for Oregon residents would likely require additional staff for fund accounting, cash-flow management, audit and compliance, and financial reporting at a scale beyond current program-level operations.

Additional federal authority compliance, negotiation, and strategy staff: New staff could be needed to develop and implement a complicated multi-waiver and federal authority strategy, and to secure and maintain federal approvals needed to route Medicaid, Medicare, and Marketplace funds into the UHP and to navigate complex regulatory and reconciliation requirements.

Additional rate development and regulatory oversight capacity: OHA could need expanded staff and vendor support to develop actuarially sound rates under the new model, strengthen financial monitoring, and ensure compliance with evolving insurance regulation.

Systems

Enhanced trust-fund management systems: OHA would likely need to adapt or build financial systems capable of receiving, pooling, and tracking multiple revenue streams (federal program funds, state appropriations, and dedicated taxes) into a unified trust fund, while maintaining the ability to report to CMS at the appropriate person-level detail to maintain compliance for Medicaid and other federal programs.

Integrated revenue collection and reconciliation systems: To align with the goal of using existing collection mechanisms, OHA could need systems that interface effectively with tax and payroll collection infrastructure (e.g., Department of Revenue and employer payroll systems) while reconciling those inflows with UHP enrollment.

Enhanced MMIS and payment systems: The existing Medicaid Management Information System would likely need substantial upgrades or replacement to handle processing

claims for all Oregon residents rather than just Oregon Health Plan beneficiaries. This could include expanded processing capacity, integration with new data sources, and enhanced reconciliation capabilities.

Health Equity 

Definition

Designing and operating a universal health plan (UHP) that addresses historically marginalized groups, works toward eliminating barriers, and engages community partners so that all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. This includes equitable distribution or redistribution of resources and power; and recognizing, reconciling, and rectifying historical and contemporary injustices.

Task Force recommendations

- Equity should be centered across universal health plan design and implementation, including eligibility (p. 17), benefits (p. 18), and provider payment recommendations (p. 20).
- The universal health plan should seek to address social determinants of health (SDOH) (p. 31).

SB 1089 parameters

Senate Bill 1089 mentions equity several times, in reference to access [Section 2(2)(d)], public service [Section 2(3)(a)(A)], financing and delivery [Section 2(3)(g)], and eligibility [Section 2(3)(n)].

Current OHA systems

Leadership in equity initiatives, training, and policy development: OHA's Equity and Inclusion Division leads statewide efforts to embed equity across all agency programs and operations. The division develops comprehensive policies, delivers training programs for staff and partners, and establishes key performance metrics to measure progress toward eliminating health disparities.[73]

Equity-focused community engagement: OHA has robust systems for ongoing community engagement, including the Office of Community Health and Engagement

(OCHE), which supports Oregon Health Plan (OHP) applicants and members by coordinating a statewide network of community partners that provide culturally and linguistically responsive outreach, enrollment assistance, and system navigation support;[74] the Ombuds Program, which advocates for people eligible for or enrolled in OHP and other publicly funded health services by helping resolve complaints and barriers related to access, quality, and member rights;[75] and Regional Health Equity Coalitions, which are autonomous, community-led, cross-sector groups that bring together grassroots leaders and culturally specific organizations to identify the most pressing health equity issues in their regions and propose policy, systems, and environmental solutions;[76] among others. Other OHA-convened boards and committees, some required by statute and others convened by agency policies, help drive and direct the agency's work toward eliminating health inequities.

Social determinants of health: Under OHA's Medicaid 1115 Demonstration waiver, Oregon received authority to provide health-related social needs (HRSN) benefits through September 2027.[77] These benefits address basic needs that influence health outcomes, such as housing stability and food insecurity, among other factors. HRSN services — including rent assistance, medically tailored meals and nutritional education, and home changes for safety such as ramps and remediations— improve health outcomes for OHP members with complex health conditions. The majority of HRSN services are covered by OHP CCOs through a non-risk arrangement, meaning they are reimbursed directly for services. HRSN Home Changes for Health, which help members stay healthy during extreme weather by delivering air conditioners, heaters, and more, are an exception because CCOs accept some of the risk for covering these services. They are covered under the capitated arrangement with CCOs.

Collaboration with community-based organizations: Strategic partnerships with Community Doula Programs,[78] traditional health workers,[79] and community-based organizations deliver tangible benefits by expanding access to trusted, culturally congruent care for underserved populations.[80] These collaborations reduce barriers for communities facing language access issues, geographic isolation, or historical mistrust of health systems, leading to higher engagement rates and better health outcomes. By embedding community-led expertise into service delivery, OHA enhances overall equity without relying solely on traditional clinical models.

Equity in data: OHA leverages data tools to conduct analyses of health disparities, including the All Payer All Claims (APAC)[81] database, which collects claims and enrollment data from commercial insurers, Oregon Health Plan CCOs, Medicare Advantage plans, and other payers. APAC data is limited, however. Demographic data for individuals with commercial insurance is especially sparse. APAC is planning to incorporate area-level demographic information from U.S. Census' American Community

Survey and other sources. OHA also uses the Health Analytics Library (HAL), which is a data warehouse that the agency uses to store, access, and analyze data in the Medicaid Management Information System (MMIS).[82] These systems give OHA some limited ability to track outcomes. OHA is committed to protecting people's privacy as a key part of public health and community safety, and prioritizes this commitment when considering data collection and sharing requirements.

Tribal Affairs and Tribal liaisons: OHA's Office of Tribal Affairs maintains a network of dedicated Tribal Liaisons throughout the agency to support the work of the Office of Tribal Affairs and honor the government-to-government relationships with the Nine Federally Recognized Tribes of Oregon. The Tribal Team ensures the Tribes and Urban Indian Health Program (UIHP) are notified early of any work by OHA that might impact the Tribes/UIHP, and support formal tribal consultation when requested, to ensure that the Tribes' requests and needs are proactively integrated into policy and program design.[83]

Resources needed for OHA systems to integrate with a universal health plan

Staff

Expanded equity policy staff: Additional equity policy staff could be required to design, implement, and monitor comprehensive equity policy frameworks tailored to universal health plan (UHP) operations at statewide scale.

Expanded data equity analysts: Expanded teams of data analysts could be essential to monitoring UHP performance metrics with a focus on equity, build more robust data infrastructure for statewide monitoring, and conduct analyses of any emerging inequities, throughout implementation and beyond.

Additional community engagement capacity: Additional roles focused on supporting advisory boards, committees, and other community-based entities could help facilitate meaningful consultations and create formal mechanisms for incorporating lived experience into UHP design and implementation, particularly during the transition.

Systems

New educational and technical support trainings: In the transition to a UHP, the development of new, multilingual technical assistance infrastructure and platforms, educational trainings, and other systems of support will be necessary to help reduce barriers for patients, providers, employers, administrators, and UHP staff. To eliminate barriers statewide, trainings could build upon current OHA trainings grounded in cultural humility, bias reduction, and trauma-informed care practices.

Implementation considerations

Implementation of a universal health plan (UHP) would require not only detailed health plan and policy design, but also extensive legal, financial, political, and operational changes that would dramatically reshape how OHA and partner agencies function. This section highlights key prerequisites and constraints that could dictate the pace, sequencing, and feasibility of any transition.

- **Enabling legislation and rulemaking**: Legislation and Oregon Revised Statutes would need to explicitly direct OHA to conduct detailed readiness assessments and fiscal analyses, negotiate waivers and other federal authorities, and initiate system transitions in alignment with the final plan design. Oregon Administrative Rules outlining definitions, covered services, eligibility and enrollment, grievances and appeals, and administration would then need to be drafted, analyzed, and approved as part of program development.
- **Ballot measure for revenue authority**: A voter-approved ballot measure would likely be required to establish new revenue sources such as payroll or income taxes, as Oregon's constitution limits certain tax increases without public vote.
- **Federal authority cooperation and process**: Securing Section 1115 Medicaid waivers, Medicare demonstrations, and Section 1332 Marketplace waivers would be essential to redirecting federal dollars into the UHP as the Task Force envisions. These processes would involve multi-year analyses, ongoing negotiations, public comment periods, Tribal consultations, and detailed concept notes and applications. While OHA has the authority to pursue federal authorities without legislative direction, and has completed a detailed analysis of what federal authorities would likely be needed for UHP implementation, negotiations with the federal Centers for Medicare and Medicaid Services (CMS) of this scale would likely require enabling legislation. The current federal administration has discouraged state innovation efforts—see OHA's 2025 report on Federal Authorities Required for Universal Health Plan Implementation in Oregon.
- **Wind-down of existing programs**: A strategic, thoughtful wind-down of existing programs and systems would be essential to avoiding coverage gaps, loss of benefits, accessibility disruptions, loss of data and infrastructure, and setbacks in equity progress while centering Oregon residents and ensuring compliance with state and federal mandates.
- **H.R.1 immediate and longer-term impacts**: House Resolution 1 (H.R. 1, – the U.S. Congressional spending and reconciliation bill that became law in July 2025) created mandates that impact Medicaid, including six-month eligibility

determinations and work/community engagement verification requirements. These mandates are driving massive, immediate systems overhauls within OHA, including ONE system platform upgrades (which are challenging due to the many HR1 mandates affecting all medical and self-sufficiency programs that must be implemented on similar timelines), enhanced data matching with employment systems, and compliance reporting.[84] These demands will consume significant IT and operational capacity through the foreseeable future, limiting OHA's bandwidth and funding for additional system change work.

Conclusion

The Oregon Health Authority's existing systems align with many of the core functions required to operate a universal health plan (UHP)—from eligibility and enrollment to provider payment and cost containment. This analysis highlights that while OHA has substantial infrastructure, expertise, and statutory authorities in place, significant additional resources, coordination, and authority would be essential to implementing a fully integrated UHP at a statewide scale.

Implementing a UHP would require extensive legal, financial, and operational changes well beyond OHA's current capacity or statutory authority. It would depend on new enabling legislation, rulemaking, sustained fiscal and readiness analyses, voter-approved revenue mechanisms, and complex federal negotiations to align Medicaid, Medicare, and Marketplace funding through multiple waivers—each requiring multi-year processes and significant analytical and staffing resources. At the same time, Oregon would need to carefully plan the wind down of existing programs and systems to prevent coverage gaps and ensure continuity of care. These efforts would occur alongside other major agency modernization initiatives, such as system upgrades mandated under H.R.1, which already impose substantial demands on OHA's IT and operational capacity.

A transition to a UHP also presents exciting opportunities for OHA. Establishing universal health care in Oregon could enable OHA to expand and advance its current efforts to limit health care cost growth, improve health care quality, and achieve health equity. OHA is committed to expanding equitable access to quality health care for everyone in Oregon. The agency stands prepared to leverage its infrastructure and expertise and to collaborate with the Board, policy makers, and community partners in future legislatively directed steps toward establishing universal health care in Oregon.

Resources

[1] Joint Task Force on Universal Health Care. Final Report and Recommendations. Legislative Policy and Research Office, Oregon State Legislature. 2022 Sept. [cited 2026 Jan 13]. Available from: https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/257230.
[2] Congressional Budget Office. Key Design Components and Considerations for Establishing a Single-Payer Health Care System. Congress of the United States. 2019 May 3. [cited 2026 Jan 13]. Available from: https://www.cbo.gov/system/files/2019-05/55150-singlepayer.pdf.
[3] Oregon Health Authority. Office of Health Policy. Health Policy and Analytics. n.d. [cited 2026 Jan 16]. Available from: https://www.oregon.gov/oha/hpa/hp/pages/index.aspx.
[4] Oregon Health Authority. Oregon Health Policy Board. n.d. [cited 2026 Jan 9]. Available from: https://www.oregon.gov/oha/ohpb/pages/index.aspx.
[5] Oregon Health Authority. OHA Rulemaking. n.d. [cited 2026 Jan 16]. Available from: https://www.oregon.gov/oha/pages/oha-rulemaking.aspx.
[6] Oregon Secretary of State. OAR Chapter 410. 2025. [cited 23 Feb 2026]. Available from: https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87
[7] Oregon Health Authority. OHP Notices of Proposed Rulemaking. Health Systems Division. n.d. [cited 2026 Jan 16]. Available from: https://www.oregon.gov/oha/hsd/ohp/pages/rule-notices.aspx.
[8] Oregon Health Authority. Oregon Medicaid Provider Portal. Health Systems Division. n.d. [cited 2026 Jan 16]. Available from: https://www.oregon.gov/oha/hsd/ohp/pages/webportal.aspx.
[9] Oregon Secretary of State. Health Systems Division: Medical Assistance Programs - Chapter 410 Division 120, Oregon Administrative Rules. 2025. [cited 2026 Jan 16]. Available from: https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=310113.
[10] Oregon Health Authority. CCO Community Advisory Councils. Health Systems Division. n.d. [cited 2026 Jan 16]. Available from: https://www.oregon.gov/oha/hsd/ohp/pages/cco-community-advisory-councils.aspx.
[11] Oregon Health Authority. Oregon Health Plan (OHP) and Getting the Care You Need. Health Systems Division. n.d. [cited 2026 Jan 16]. Available from: https://www.oregon.gov/oha/hsd/ohp/pages/care-help.aspx.
[12] Medicaid and CHIP Payment and Access Commission. Eligibility. 2025. [cited 2025 Dec 15]. Available from: https://www.macpac.gov/topic/eligibility/.
[13] Oregon Department of Human Services. ONE Eligibility System. Oregon Eligibility Partnership. n.d. [cited 2026 Jan 8]. Available from: https://www.oregon.gov/odhs/agency/pages/oep-one-system.aspx.
[14] Oregon Health Authority. Oregon Medicaid Provider Portal. Oregon Health Plan. n.d. [cited 2026 Jan 8]. Available from: https://www.oregon.gov/oha/hsd/ohp/pages/webportal.aspx.
[15] Oregon Health Authority. Medicaid Management Information System: HPA Data Profile. Health Policy and Analytics. 2025 May. [cited 2026 Jan 8]. Available from: https://www.oregon.gov/oha/HPA/ANALYTICS/Documents/Dataprofile_MMIS.pdf.
[16] Legislative Fiscal Office. 2025-27 Budget Review, Oregon Health Authority (p. 47). Oregon Legislature. 2025. [cited 2026 Jan 16]. Available from: https://olis.oregonlegislature.gov/liz/2025R1/Downloads/CommitteeMeetingDocument/288990.
[17] Oregon Health Authority. State-Based Marketplace Project. Oregon Health Insurance Marketplace. n.d. [cited 2026 Jan 8]. Available from: https://healthcare.oregon.gov/marketplace/sbmtransition/pages/home.aspx.
[18] Oregon Health Authority, Health Systems Division: Medical Assistance Programs, American Indian/Alaska Native. Oregon Administrative Rules Chapter 410 Division 146. Oregon Secretary of State, 2025. [cited 2025 Dec 22]. Available from: https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1732.

[19] Oregon Health Authority, Health Policy and Analytics: Community Benefit Reporting. Oregon Administrative Rules Chapter 409 Division 23. Oregon Secretary of State, 2025. [cited 2025 Dec 22]. Available from: https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1656.
[20] Mandatory enrollment in coordinated care organization. Oregon Revised Statutes Chapter 414 Section 631, 2023 edition. [cited 2025 Dec 22]. Available from: https://oregon.public.law/statutes/ors_414.63.
[21] Oregon Health Authority. Medicaid Management Information System: HPA Data Profile. Health Policy and Analytics. 2025 May. [cited 2026 Jan 8]. Available from: https://www.oregon.gov/oha/HPA/ANALYTICS/Documents/Dataprofile_MMIS.pdf.
[22] Oregon Secretary of State. Oregon Health Authority, Public Employees' Benefit Board: Enrollment Rules. Oregon Administrative Rules Chapter 101 Division 20. 2025. [cited 2025 Dec 22]. Available from: https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=166.
[23] Healthcare.gov. Essential Health Benefits. U.S. Centers for Medicare & Medicaid Services. 2025 [cited 2025 Dec 17]. Available from: https://www.healthcare.gov/glossary/essential-health-benefits/.
[24] Oregon Health Authority. The Health Evidence Review Commission (HERC) and the Prioritized List of Services. 2023 March. [cited 2025 Dec 22]. Available from: https://www.oregon.gov/oha/HPA/DSI-HERC/Documents/What-Is-HERC.pdf.
[25] Oregon Legislature. Medical Assistance Programs, Payment for gender-affirming treatment; rules. Chapter 414, Section 769, Payment for gender-affirming treatment; rules. Oregon Revised Statutes, 2025. [cited 2026 Jan 16]. Available from: https://www.oregonlegislature.gov/bills_laws/ors/ors414.html.
[26] Oregon Legislature. House Bill 3391 Enrolled, 2017 Legislative Session. 2017 July 5. [cited 2026 Jan 16]. Available from: https://olis.oregonlegislature.gov/liz/2017R1/Downloads/MeasureDocument/HB3391/Enrolled.
[27] Oregon Health Authority. 2022-2027 Medicaid 1115 Demonstration Waiver. n.d. [cited 2026 Mar 25]. Available from: https://www.oregon.gov/oha/hsd/medicaid-policy/pages/waiver-renewal.aspx
[28] Budnick N. Oregon's landmark evidence-based coverage program is going away, but what's next is unclear. The Lund Report. 2024 July 30. [Cited 2026 Jan 16]. Available from: https://www.thelundreport.org/content/oregons-landmark-evidence-based-coverage-program-going-away-whats-next-unclear.
[29] Oregon Health Authority. CCO HRSN Guidance Document. 2025 Jan 3. [2026 Jan 16]. Available from: https://www.oregon.gov/oha/HSD/OHP/CCO/HRSN-Guidance%20Document0125.pdf.
[30] Oregon Secretary of State. Health Systems Division: Medical Assistance Programs - Chapter 410. Oregon Administrative Rules, 2025. [cited 2026 Jan 16]. Available from: https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=8155.
[31] Oregon Health Authority. Shared Accountability for Long-Term Services and Supports. Oregon Health Plan. n.d. [cited 2026 Jan 8]. Available from: https://www.oregon.gov/oha/hsd/ohp/pages/cco-ltss.aspx.
[32] *Id*.
[33] Oregon Health Authority. Shared Accountability for Long-Term Services and Supports. Health Systems Division. n.d. [cited 2026 Jan 16]. Available from: https://www.oregon.gov/oha/hsd/ohp/pages/cco-ltss.aspx.
[34] Hassoun A., Graupp B., Mautner D., Ways & Means Presentation: Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB). Oregon Health Authority. 2025 Feb 12. [cited 2026 Jan 8]. Available from: https://olis.oregonlegislature.gov/liz/2025R1/Downloads/CommitteeMeetingDocument/290027.
[35] Public Employees' Benefit Board. 2026 PEBB Enrollment Guide. 2025 Sept. [cited 2026 Jan 8]. Available from: https://www.oregon.gov/oha/PEBB/Documents/2026-PEBB-OE-Guide.pdf.
[36] 45 CFR section 155.1000. 2026. [cited 23 Feb 20260. Available from: https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-156
[37] Oregon Health Authority. Qualified Health Plan Carrier Contract. OHA Oregon Health Insurance Marketplace. 2024. [cited 23 Feb 2026]. Available from: https://healthcare.oregon.gov/Documents/Plan%20Contracts%20and%20Lists/2024%20QHP%20Contract%20Template%20Final%20091923.pdf

[38] Oregon Health Authority, Medical Assistance Programs, Provider Enrollment. Oregon Administrative Rules Chapter 410 Division 120, 2025. [cited 2025 Dec 22]. Available from: https://oregon.public.law/rules/oar_410-120-1260.
[39] Enrollment and Screening of Providers, 42 CFR 455.410. 2025. [cited 2025 Dec 22]. Available from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.410.
[40] Oregon Health Authority, Health Care Regulation and Quality Improvement, n.d. [cited 2026 Feb 25]. Available from: https://www.oregon.gov/oha/ph/providerpartnerresources/healthcareprovidersfacilities/healthcarehealthcareregulationqualityimprovement/pages/index.aspx
[41] Oregon Health Authority, About HLO. n.d. [cited 2026 Feb 25]. Available from: https://www.oregon.gov/oha/PH/HLO/Pages/About-Us.aspx
[42] Oregon Health Authority, About Licensing and Certification. n.d. [cited 2026 Feb 25]. Available from: https://www.oregon.gov/oha/hsd/amh-lc/pages/index.aspx
[43] Oregon Secretary of State, OAR 410-120-1396, Provider and Contractor Audits. 2025. [cited 25 Feb 2026]. Available from: https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=305865
[44] Oregon Health Authority. Oregon Common Credentialing Program: Regulations and Reporting. 2024 Dec. [cited 2025 Dec 22]. Available from: https://www.oregon.gov/oha/hpa/ohit-occp/pages/regulations-reporting.aspx.
[45] Oregon Health Authority. OHP Rate Development. Office of Actuarial and Financial Analytics. 2025. [cited 2025 Dec 29]. Available from: https://www.oregon.gov/oha/fod/pages/ohp-rates.aspx.
[46] Oregon Health Authority. Value-Based Payment Technical Guide for Coordinated Care Organizations. Transformation Center. 2023 Sept. [cited 2025 Dec 24]. Available from: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/VBP-Technical-Guide-for-CCOs.pdf.
[47] Hassoun A. Memo Re: Feb. 12 Subcommittee Questions. Public Employees' Benefit Board and Oregon Educators Benefit Board, Oregon Health Authority. 2025 Feb 14. [cited 2025 Dec 29]. Available from: https://olis.oregonlegislature.gov/liz/2025R1/Downloads/CommitteeMeetingDocument/292179.
[48] Hassoun A., Graupp B., Mautner D., Ways & Means Presentation: Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB). Oregon Health Authority. 2025 Feb 12. [cited 2026 Jan 8]. Available from: https://olis.oregonlegislature.gov/liz/2025R1/Downloads/CommitteeMeetingDocument/290027.
[49] *Id*.
[50] Oregon Health Authority. Oregon Health Insurance Marketplace Carrier Request for Application (RFA) Oregonbuys Number S-44300-00012602. 2025 Jan 24. [2026 Jan 1]. Available from: https://healthcare.oregon.gov/Documents/Plan%20Contracts%20and%20Lists/2026-2027%20Marketplace%20Carrier%20RFA.pdf.
[51] Oregon Department of Consumer and Business Services. Division of Financial Regulation. n.d. [cited 2026 Jan 1]. Available from: https://www.oregon.gov/dcbs/about/divisions-programs/pages/dfr.aspx.
[52] Oregon Health Authority. All Payer All Claims Reporting Program. n.d. [cited 2026 Jan 9]. Available from: https://www.oregon.gov/oha/hpa/analytics/pages/all-payer-all-claims.aspx.
[53] Oregon Health Authority and Oregon Department of Consumer and Business Services. Tribal Consultation and Urban Indian Health Program Confer Policy, Policy number ODHSOHA 010-028. 2023 Oct 6. [cited 2026 Jan 16]. Available from: https://www.oregonlegislature.gov/cis/agencypolicies/POLICY%20-%20OHA-ODHS%20(Tribal%20Consultation%20and%20Urban%20Indian%20Health%20Program%20Confer%20Policy).pdf.
[54] Oregon Health Authority. Shared Accountability for Long-Term Services and Supports. Oregon Health Plan. n.d. [cited 2026 Jan 9]. Available from: https://www.oregon.gov/oha/hsd/ohp/pages/cco-ltss.aspx.
[55] Social Security Administration, 42 U.S.C. 1396n. Compilation of the Social Security Laws. n.d. [cited 25 Feb 2026]. Available from: https://www.ssa.gov/OP_Home/ssact/title19/1915.htm
[56] Oregon Secretary of State. ORS 309-014-0000. 2025. [cited 2026 Feb 23]. Available from: https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1011

[57] Oregon Health Authority. Oregon Transforms Behavioral Health Care. Behavioral Health Division. n.d. [cited 2026 Jan 16]. Available from: https://www.oregon.gov/oha/hsd/amh/pages/index.aspx.
[58] Oregon Health Authority. Summary of Behavioral Health Investments. Behavioral Health Division. n.d. [cited 2026 Jan 16]. Available from: https://www.oregon.gov/oha/hsd/amh/pages/bhi-summary.aspx.
[59] Oregon Health Authority. Federally Qualified Health Centers and Rural Health Clinics Program. n.d. [cited 2026 Jan 9]. Available from: https://www.oregon.gov/oha/hsd/ohp/pages/policy-fqhc-rhc.aspx.
[60] Oregon Health Authority. Healthier Oregon. Health Systems Division. n.d. [cited 2026 Jan 16]. Available from: https://www.oregon.gov/oha/hsd/ohp/pages/healthier-oregon.aspx.
[61] Oregon Health Authority. Reproductive Health Equity Act. Reproductive and Sexual Health, Healthy People and Families, Public Health Division. n.d. [cited 2026 Jan 16]. Available from: https://www.oregon.gov/oha/ph/healthypeoplefamilies/reproductivesexualhealth/pages/reproductive-health-equity-act.aspx.
[62] U.S. Department of Health and Human Services. Grantee Details, Oregon Health Authority Public Health Division. Office of Population Affairs, Office of the Assistant Secretary for Health. 2024. [cited 2026 Jan 16]. Available from: https://opa.hhs.gov/grant-programs/title-x-service-grants/current-title-x-service-grantees/oregon-health-authority.
[63] Oregon Health Authority. OHP Rate Development. n.d. [cited 2026 Jan 9]. Available from: https://www.oregon.gov/oha/fod/pages/ohp-rates.aspx.
[64] Oregon Health Authority. Value-Based Payment Technical Guide for Coordinated Care Organizations. Transformation Center. 2023 Sept. [cited 2025 Dec 24]. Available from: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/VBP-Technical-Guide-for-CCOs.pdf
[65] Oregon Health Authority. Value-Based Payment in Oregon. Transformation Center. n.d. [cited 2026 Jan 9]. Available from: https://www.oregon.gov/oha/hpa/dsi-tc/pages/value-based-payment.aspx.
[66] Oregon Health Authority. Sustainable Health Care Cost Growth Target. n.d. [cited 2026 Jan 9]. Available from: https://www.oregon.gov/oha/hpa/hp/pages/sustainable-health-care-cost-growth-target.aspx.
[67] Oregon Health Authority. Health Care Market Oversight. n.d. [cited 2025 Jan 9]. Available from: https://www.oregon.gov/oha/hpa/hp/pages/health-care-market-oversight.aspx.
[68] Oregon Revised Statutes. Federal grants to be handled by Oregon Health Authority. Chapter 431, Section 250. 2025. [cited 2026 Jan 16]. Available from: https://oregon.public.law/statutes/ors_431.250.
[69] Oregon Health Authority. Medicaid Management Information System, HPA Data Profile. 2025 May. [cited 2026 Jan 16]. Available from: https://www.oregon.gov/oha/HPA/ANALYTICS/Documents/Dataprofile_MMIS.pdf.
[70] Centers for Medicare & Medicaid Services. Transformed Medicaid Statistical Information System (T-MSIS). Medicaid and CHIP Business Information Solution, Data & Systems, Medicaid.gov. n.d. [cited 2026 Jan 16]. Available from: https://www.medicaid.gov/medicaid/data-systems/medicaid-and-chip-business-information-solution/transformed-medicaid-statistical-information-system-t-msis.
[71] *Id*.
[72] Hassoun A., Graupp B., Mautner D., Ways & Means Presentation: Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB). Oregon Health Authority. 2025 Feb 12. [cited 2026 Jan 8]. Available from: https://olis.oregonlegislature.gov/liz/2025R1/Downloads/CommitteeMeetingDocument/290027.
[73] Oregon Health Authority. Equity and Inclusion Division: About Us. n.d. [cited 2026 Jan 9]. Available from: https://www.oregon.gov/oha/EI/Pages/About-Us.aspx.
[74] Oregon Health Authority. Office of Community Health and Engagement. n.d. [cited 2026 Jan 22]. Available from: https://www.oregon.gov/oha/hsd/ohp/pages/community-partners.aspx.
[75] Oregon Health Authority. Ombuds Program Charter. n.d. [cited 2026 Jan 22]. Available from: https://www.oregon.gov/oha/erd/OmbudsProgram/Ombuds-Program-Charter.pdf.
[76] Oregon Legislative Information System. Public Testimony Document 1583. 2021. [cited 2026 Jan 22]. Available from: https://olis.oregonlegislature.gov/liz/2021R1/Downloads/PublicTestimonyDocument/1583.

[77] Oregon Health Authority. Health-Related Social Needs. n.d. [cited 2026 Jan 9]. Available from: https://www.oregon.gov/oha/hsd/medicaid-policy/pages/hrsn.aspx.
[78] Oregon Health Authority. Birth Doulas. Equity and Inclusion Division. n.d. [cited 2026 Jan 16]. Available from: https://www.oregon.gov/oha/ei/pages/thw_birthdoulas.aspx.
[79] Oregon Health Authority. About Traditional Health Workers. Equity and Inclusion Division. n.d. [cited 2026 Jan 16]. Available from: https://www.oregon.gov/oha/ei/pages/about-traditional-health-workers.aspx.
[80] Oregon Health Authority. Partnering with Community-Based Organizations. Public Health Division. n.d. [cited 2026 Jan 16]. Available from: https://www.oregon.gov/oha/ph/about/pages/cbo.aspx.
[81] Oregon Health Authority. All Payer All Claims Reporting Program. Office of Health Analytics, Health Policy and Analytics Division. n.d. [cited 2026 Jan 16]. Available from: https://www.oregon.gov/oha/hpa/analytics/pages/all-payer-all-claims.aspx.
[82] Oregon Health Authority. Medicaid Management Information System, HPA Data Profile. 2025 May. [cited 2026 Jan 16]. Available from: https://www.oregon.gov/oha/HPA/ANALYTICS/Documents/Dataprofile_MMIS.pdf.
[83] Oregon Department of Human Services and Oregon Health Authority. Tribal Consultation and Urban Indian Health Program Confer Policy. Policy number ODHSOHA 010-028. 2023 Oct 6. [cited 2026 Feb 5]. Available from: https://www.oregon.gov/odhs/data/cwdata/cw-apsr-2025-att-66.pdf
[84] Oregon Health Authority. Monitoring Federal Changes and any Impacts on Oregon. n.d. [cited 2026 Jan 9]. Available from: https://www.oregon.gov/oha/pages/federal-changes.aspx.