HUMAN SERVICES

PROGRAM AREA

COMMISSION FOR THE BLIND

Analyst: To

Agency Totals

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	3,690,478	3,535,937	4,331,786	6,634,036
Other Funds	1,035,705	1,482,049	1,567,683	1,560,451
Federal Funds	14,088,099	17,609,075	16,071,581	15,955,857
Total Funds	**$18,814,282**	**$22,627,061**	**$21,971,050**	**$24,150,344**
Positions	68	68	68	68
FTE	62.53	62.53	62.53	66.00

Overview

The Commission for the Blind's (OCB) mission is to empower Oregonians who are blind to fully engage in life. The agency's programs are focused on two main objectives: employment and independence. The Commission is a consumer-controlled, seven-member board appointed by the Governor. The Board appoints the agency's executive director.

The agency's 2019-21 legislatively adopted budget is $24.1 million total funds and 68 positions (66.00 FTE). The agency is organized into the following five program areas:

- Rehabilitation Services ($13.6 million, 27.25 FTE) is the agency's largest program with the goal of assisting Oregonians who are blind or visually impaired to develop skills to obtain or maintain employment. The program includes vocational rehabilitation counseling and planning, training and education, job placement assistance, and assistance for students making the transition from high school to either college or work. These services are provided in regional offices throughout the state. This program also assists Oregon businesses in hiring, retaining, and promoting qualified employees who are blind.
- Orientation and Career Center ($2.7 million, 9.00 FTE) is a comprehensive teaching center that provides career exploration counseling and comprehensive pre-vocational training on skills such as cane travel, adaptive technology, and Braille. Training facilities and staff are primarily located in Portland with satellite labs located in Salem, Eugene, Redmond, and Medford. The program also performs job site modification evaluations and recommendations.
- Business Enterprises ($2 million, 5.00 FTE) provides business management opportunities, vocational training, and licensing support to business managers who are blind to manage food service and vending machine businesses located in public buildings throughout the state of Oregon. The federal Randolph-Sheppard Vending Stand Act, enacted in 1935, requires managers of federal buildings to offer blind persons opportunities to establish and operate cafeterias or vending machines. Oregon enacted similar legislation in 1957 that was amended in 2017 under HB 3253 and in 2019 under HB 3431.
- Independent Living Services ($1.8 million, 7.75 FTE) provides training and resources to help Oregonians adjust to vision loss and enable them to live independently in their homes and communities in lieu of moving into assisted living or care facilities. Specialized rehabilitation teachers provide in home services such as performing assessments; providing referrals to health providers and other assistance programs; as well as training for techniques of daily living including orientation and mobility, meal prep, adaptive devices, and Braille.
- Administration Services ($4 million, 17.00 FTE) coordinates the mission and goals of the agency and manages the Human Resources, Budget, Accounting, Operations, and Information Systems. The Workforce Innovation and Opportunity Act of 2014 (WIOA) requires states to enhance coordination and partnerships across state agencies and local entities in order to receive federal funding. As part of this reform, beginning with the 2017-19 biennium, the Administration Services unit houses support staff for the Rehabilitation Services Unit as well as performing data collection, auditing, and other accountability functions for the Workforce/Employer

Engagement Team charged with improving collaboration across agencies, workforce boards, employers, and educational institutions to integrate and improve efficiency in service delivery and better align federal investments in job training.

Revenue Sources and Relationships

The Commission is funded with $6.6 million General Fund (28%), $1.5 million Other Funds (6%), and $16 million Federal Funds (66%).

The largest revenue source for the Commission comes from federal grants from the U. S. Department of Education and the U.S. Department of Health and Human Services (HHS) to administer Vocational Rehabilitation, Supported Employment, Independent Living, and Older Blind programs. These federal grants can only be expended for the purposes and in the manner described in federal law and regulations or in grant agreements and require a state contribution in the form of matching grants. Federal Funds revenue projections for the 2019-21 biennium are based on a 1.9% annual inflation on the Vocational Rehabilitation grant award. Supported Employment, Independent Living, and Older Blind programs grants are projected to remain flat, as there have been no increases in federal funding over the past few federal fiscal years.

The majority of the Commission's funding comes from the U. S. Department of Education Rehabilitation Services Administration (RSA) as authorized by the Rehabilitation Act of 1973. The Workforce Innovation and Opportunity Act of 2014 (WIOA) replaces the Workforce Investment Act of 1998 and amended the Rehabilitation Act of 1973. WIOA designates the RSA as the principal funding agency to oversee the national Vocational Rehabilitation (VR) system throughout the nation, in collaboration with the U.S. Department of Labor and other workforce entities. WIOA requires state VR agencies to make pre-employment transition services available to all students with disabilities and to set-aside at least 15% of federal VR program funds towards providing these services for students with disabilities transitioning from secondary school to postsecondary education programs and competitive integrated employment. Additionally, WIOA provides restrictions on the use of administrative costs as applied to the 15% set aside and dedicates half of the federal Supported Employment program funds to provide support for youth with the most significant disabilities, including extended services, to enable them to obtain competitive integrated employment (extended services for adults is not allowed). WIOA also directs states to increase opportunities to assist employers in providing work-based experience for individuals with disabilities and ensure that priority is given to individuals who are otherwise eligible for VR program services and who are at imminent risk of losing their jobs unless they receive additional necessary post-employment services. Vocational Rehabilitation basic support funds are the primary source of funding and have a match rate of approximately $4.70 Federal Funds (78.7%) for every $1 of state or state-matching funds (21.3%). Until the 2017-19 biennium, the Oregon Department of Human Services (DHS) received 87.5% of Section 110 Vocational Rehabilitation basic support grant funding with the Commission receiving the remaining 12.5%. Beginning in the 2017-19, the Commission's budget reflects an update in the Memorandum of Understanding between DHS and the Commission to adjust the percentage of Section 110 Vocational Rehabilitation basic support grant funding for the Commission for the Blind from 12.5% to 15.6% to align Oregon with the national average ratio. Other grants include Supported Employment, Independent Living, and the Older Blind program, which total $1.2 million federal funds. Effective October 2018, the Independent Living grant for those under age 55 moved from a direct grant to an agreement with DHS to comply with rule changes that allow only one grantee per state. Supported Employment as well as Independent Living (Part B) and Older Blind program grants are funded with 90% federal funds and 10% state matching funds.

The Business Enterprises (BE) program administers the Federal Randolph Sheppard Vending Stand Act and Oregon's vending program, contracting with public agencies and sets up cafeteria, snack bar, and vending machine management businesses in public buildings. The program then sub-contracts with licensed blind managers to provide services desired by facilities. Licensed blind managers direct the day-to-day operations, retaining the majority of the profits they generate. Licensed blind managers pay 11% of their net earnings as a set-aside to support the BE program. The set-aside is used for continuing training of the licensed blind managers, as well as maintenance, repair, and purchasing of equipment. As of September 2019, the BE program has 16

individuals operating over 500 food service and vending machines sites throughout Oregon. In 2017, these locations generated approximately $3.2 million in sales. The average income per manager was approximately $53,370. The BE program is funded primarily by federal VR funds that are leveraged by the set-aside and nominal General Fund.

General Fund and a limited amount of Other Funds are used to meet matching Federal Funds requirements. There is also a maintenance of effort requirement that is based on the prior two years of funding. If funding is reduced, an equivalent amount of federal funding is lost. The RSA maintenance of effort agreement, however, is for the state as a whole, including both the Department of Human Services and the Blind Commission. The 2019-21 adopted budget meets the federal matching funds and maintenance of effort requirements.

At present, Other Funds revenue sources for the 2019-21 biennium include: cooperative agreements with school districts and non-profit rehabilitation providers; a transfer from the Department of Education; and business enterprise vendor assessments. The agency also maintains an interest-bearing Blind Bequest and Donation Fund. The fund has an estimated 2019-21 beginning balance of approximately $362,887. In the past, the Commission used only the interest earnings to fund programs. However, beginning in 2003-05, the Commission has been directed to use donation funding to match federal funds in order to supplement General Fund support.

Budget Environment

Most causes of blindness are age-related – caused by macular degeneration, cataracts, diabetic retinopathy, and glaucoma. Other causes include illness, accidents, and injuries. Population trends indicate the elderly population in Oregon will increase significantly in the coming years. Elderly populations have a demonstrated higher rate of vision loss. Furthermore, recent studies have noted spikes in non-elderly adults with uncorrectable vision loss due to increases in obesity and diabetes. The total number of individuals in Oregon age 55 and older who are visually impaired is estimated to grow from approximately 58,000 to 122,000 between 2015 and 2035. As this population grows, there will be increased demand for agency services, especially for those who develop blindness or greater visual impairment later in life. The federal Rehabilitation Act of 1973, as amended, prescribes what services are provided and the eligibility for those services. The number of people served is a function of available revenue.

The Vocational Rehabilitation caseload for federal fiscal year 2018 was 653, which was up 1.08% from the 2017 caseload of 646. The Older Blind program served 851 clients in 2018. Per counselor caseload is currently about 75 cases. In 2015, over 75% of the individuals in the Vocational Rehabilitation program who entered into a plan for employment were successful in reaching their goals. For an average caseload cost of $3,224, individuals who experienced vision loss and returned to work had combined earnings totaling $1.33 million. As taxpayers, individuals on average pay back the state contribution of their rehabilitation program in 11.5 months. The Workforce Innovation and Opportunity Act requires that the Commission reserve and expend 15% of the federal award for pre-employment transition services to in-school youth. This has resulted in a strain on the remainder of the grant resources to maintain the level of services provided to all other eligible clients of the VR program who need services, training, and support to obtain and maintain employment. In addition, new legislation requires the Commission to secure employment in community-based settings at or above minimum wage. This change in the direction of services has increased the cost per case.

Independent Living Services in the form of rehabilitation teaching interventions can delay or eliminate the need for other expensive state funded supports. These successful interventions, which mitigate the need for nursing or assisted living care, result in savings to the state ranging from $19,686 for foster home care to $101,040 for nursing home care per individual per year. In 2015, the average caseload cost was $777. Based on these numbers, when the Commission is able to delay even the lowest level of care for individuals served for only one year, the potential savings to the state is approximately $13 million. Starting in 2018, the Commission does not directly administer the Independent Living grant for individuals under the age of 55. Under WIOA, Congress moved the Independent Living program for individuals under the age of 55 from U.S. Department of Education to the U.S. Department of Health and Human Services, Administration for Community Living. The change also limited grantees to one per state. In Oregon, the designated state entity is the Department of Human Services (DHS). The

Commission has since developed an interagency agreement with DHS to continue the program as a service provider. The agreement requires that the Commission provides the state match required for the portion of the grant that is distributed to the Commission under the agreement.

Order of Selection is a federally required wait list system that mandates vocational rehabilitation agencies to prioritize individuals with the most significant disabilities and rehabilitation needs. An agency is required to enter into an Order of Selection when they are determined to have either inadequate staffing levels or case service funds to serve all eligible clients in the vocational rehabilitation program. The Commission has been in Order of Selection twice in the recent past, both times as a result of insufficient case service funds available to serve all eligible individuals (from August 2000 to September 2005 and from January 2009 to December 2010). The 2019-21 legislatively adopted budget is projected to provide sufficient resources and staff for the Commission to remain outside the Order of Selection.

Legislatively Adopted Budget

The 2019-21 legislatively adopted budget of $24.1 million total funds, 68 positions (66.00 FTE) reflects an increase in General Fund and Other Funds, and a decrease in Federal Funds. The decrease in federal revenues reflects the phase out of $766,416 in re-allotment that the Commission was successful in securing from the U.S. Department of Education to cover the increase in VR client special payments during the 2017-19 biennium. If this federal funding opportunity is available during the 2019-21 biennium, the Commission will request a supplement to the Federal Fiscal Year award.

The adopted budget includes a one-time appropriation of $2,405,350 General Fund and the establishment of 1 position (1.00 FTE) to support the migration of the agency's case management system to a new vendor because the current provider is planning to exit the market after December 31, 2020. In planning this project, the Commission has been working closely with the Legislative Fiscal Office (LFO) and the Office of the State Chief Information Office (OSCIO) and has received Stage Gate 1 endorsement (July 2018) and State Gate 2 endorsement (January 2019). The system is mission critical to OCB operations because it is used to satisfy federal reporting requirements and must be replaced as the current system software vendor has notified OCB that it will discontinue software maintenance and support as of December 31, 2020. Because the project is in the planning phase of its lifecycle, the 2019-21 adopted budget includes a budget note directing the Commission to:

- Continue to work closely with and regularly report project status to the Office of the State Chief Information Office (OSCIO) and LFO throughout the lifecycle of the project.
- Follow the Joint State CIO/LFO Stage Gate Review Process.
- Obtain and retain qualified project management and business analyst services with experience in planning and managing projects of this type, scope, and magnitude.
- Update the Business Case and foundational project management documents as required.
- Work with OSCIO to acquire Independent Quality Management Services as required to:
  - Conduct an initial and ongoing risk assessment(s).
  - Perform quality control (QC) reviews on the Business Case, solution vendor procurement documents, and foundational project management documents as appropriate.
  - Perform ongoing, independent quality management services as directed by OSCIO.
- Submit the updated Business Case, procurement and project management documents, initial risk assessment, and QC reviews to OSCIO and LFO for Stage Gate Review.
- Report back to the Legislature on project status during the 2020 legislative session and/or to interim legislative committees as required.
- Utilize the Office of the State CIO's Enterprise Project and Portfolio Management system for all project review, approval, and project status and closeout reporting activities throughout the life of the project.

The adopted budget meets federal maintenance of effort requirements and allows the Commission to match all available federal funds.

OREGON HEALTH AUTHORITY

Analyst: MacDonald

Agency Totals

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	2,152,357,931	2,162,870,267	3,176,978,132	2,719,376,308
Lottery Funds	11,113,255	12,498,909	13,035,809	17,093,071
Other Funds	5,683,251,462	7,794,873,473	6,872,981,111	7,645,454,433
Other Funds (NL)	212,475,263	40,000,000	40,000,000	40,000,000
Federal Funds	11,189,125,905	11,714,407,633	11,608,886,871	12,663,030,976
Federal Funds (NL)	85,956,641	106,457,226	106,196,261	106,196,261
Total Funds	**$19,334,280,457**	**$21,831,107,508**	**$21,818,078,184**	**$23,191,151,049**
Positions	4,450	4,200	4,121	4,290
FTE	4,394.40	4,281.80	4,096.47	4,243.01

For comparison purposes, the 2019-21 Current Service Level column values for OHA and DHS are from the 2019-21 Governor's Budget; this includes adjustments resulting from the Fall 2018 caseload forecasts so may not be consistent with other LFO tables or publications.

Overview

The Oregon Health Authority (OHA) was created by the 2009 Legislative Assembly to bring most health-related programs into a single agency to maximize the state's purchasing power and contain rising health care costs. The nine-member, citizen-led Oregon Health Policy Board serves as the agency's policy-making and oversight body.

OHA's mission is to help people and communities achieve optimum physical, mental, and social well-being through partnerships, prevention, and access to quality, affordable health care. Known as the *triple aim*, the agency has three goals to transform the health care system in Oregon: improve the lifelong health of Oregonians; increase the quality, reliability, and availability of health care; and lower or contain the cost of health care so it is affordable to everyone. OHA is the largest health care purchaser for the state, purchasing health care for approximately 1.3 million Medicaid beneficiaries, state employees, and local educators. The agency's programs also support treatment and other services to persons with mental illness and substance use disorder; provide 24-hour psychiatric and restorative care to adults committed to the Oregon State Hospital; and promote health outcomes through the state's public health system.

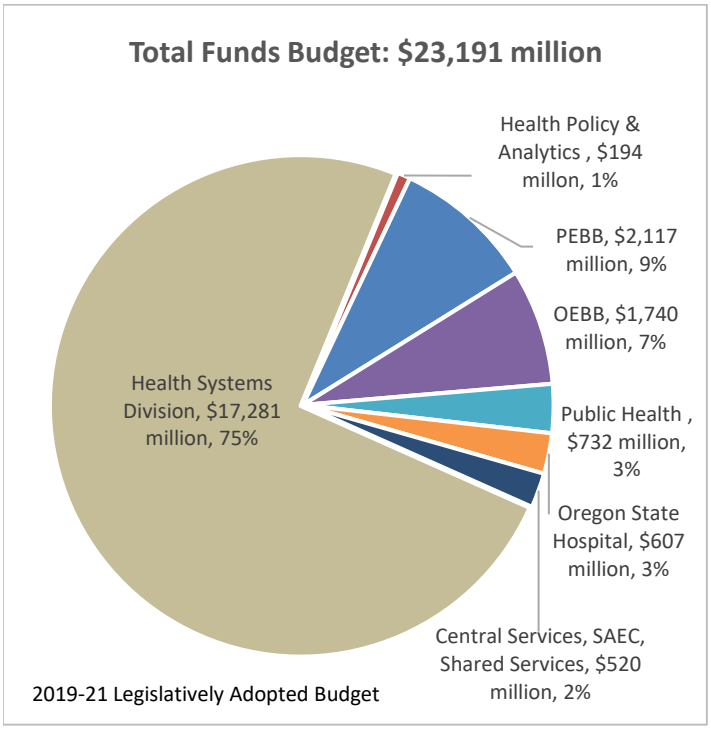
With a 2019-21 legislatively adopted budget of $23.19 billion, OHA is the largest budget within the Human Services program area, making up 65% of total program area expenditures. Compared to the overall state budget, OHA comprises 27% of the state's total funds budget and 12% of the state's General Fund budget. Although its portion of the statewide budget is large, the agency's 4,290 budgeted positions, more than half of which are located in the Oregon State Hospital, represent only 10% of the statewide total. The agency's relatively low position count compared to the size of its budget reflects the nature of the agency's expenditures—nearly 84% of OHA's funding is designated as special payments to non-state government organizations for carrying out the health care services connected to the triple aim.

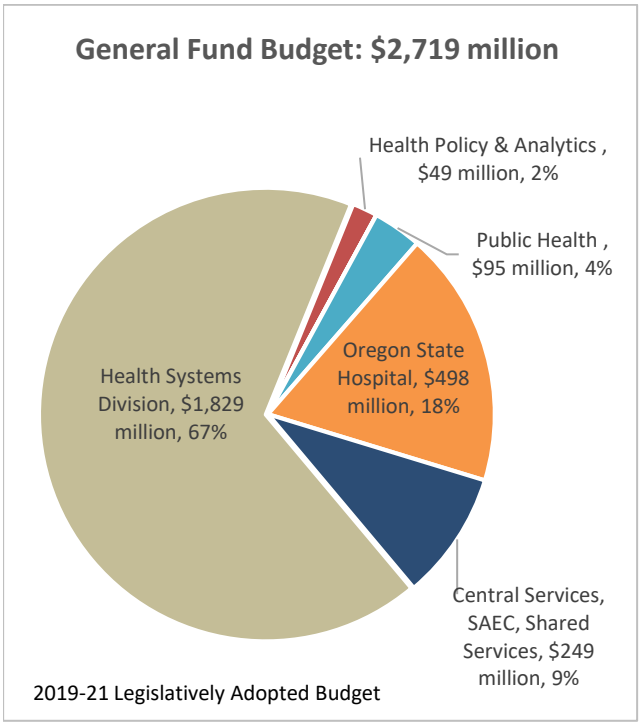
The budget is organized into the following nine program areas:

- ***Health Systems Division*** – Includes Medicaid programs, consisting primarily of the Oregon Health Plan (OHP), and non-Medicaid behavioral health programs.
- ***Health Policy and Analytics*** – Provides policy support, technical assistance, and access to health information statistics and tools to organizations and providers participating in Oregon's health system transformation.

- ***Public Employees' Benefit Board* (PEBB)** – Administers health insurance coverage for state government and university employees.
- ***Oregon Educators Benefit Board (OEBB)*** – Administers health insurance for school districts, education service districts, and community colleges.
- ***Public Health Division*** – Provides various services to protect and promote the health of all Oregonians and their communities.
- ***Oregon State Hospital*** – Provides 24-hour psychiatric care for adults from all 36 counties at the Salem and Junction City campuses.
- ***Central Services*** – Responsible for agency leadership and business support functions.
- ***State Assessments and Enterprise-wide Costs (SAEC)*** – Supports state government assessments, usage charges, agency-wide costs (e.g. rent), and debt service payments.
- ***Shared Services*** – Supports certain business functions for both OHA and the Department of Human Services.

The Health Systems Division comprises the largest share of OHA's budget in terms of both total funds (75%) and General Fund (67%). However, the share of the agency's total funds and General Fund differs for most other OHA programs. PEBB and OEBB, for instance, each have relatively large total funds budgets but are not directly appropriated General Fund dollars. Conversely, the Oregon State Hospital represents a relatively small portion of the total funds budget (3%) but consumes the second highest percentage (18%) of the agency's General Fund budget. The following charts compare the total funds and General Fund budgets for each program area:





Revenue Sources and Relationships

OHA's 2019-21 legislatively adopted budget includes $2.72 billion General Fund, of which more than two-thirds supports OHP and is used as match for federal Medicaid dollars. Large portions of the agency's General Fund also support the Oregon State Hospital and community mental health programs, neither of which rely on federal matching dollars.

The agency's budget includes $17.1 million Lottery Funds from two distinct distributions. First, the agency receives a statutory distribution of 1% of net state lottery proceeds to support prevention and treatment services for gambling addiction, which amounts to $14.6 million in the 2019-21 legislatively adopted budget. Second, the budget now includes $2.5 million to support behavioral health services for veterans. This funding represents a portion of the lottery proceeds that are constitutionally dedicated to support veterans' services pursuant to Ballot Measure 96 (2016).

Other Funds revenue supports 33% of OHA's budget. This revenue comes from a variety of sources, including tobacco taxes, Tobacco Master Settlement Agreement funds, health care provider assessments, the Oregon Health and Science University (OHSU) intergovernmental transfer agreement, recreational marijuana taxes, beer and wine taxes, fees, estate collections, self-insurance payments, health care premiums, third-party recoveries, pharmaceutical rebates, and charges for services. Approximately 84% of the tobacco tax revenue the agency receives is statutorily dedicated to support OHP, 12% for community mental health and 4% for tobacco use prevention and cessation. Tobacco tax revenue, however, is a declining revenue source. As a result, General Fund must consistently backfill lost revenue in OHP to maintain support for eligible individuals who are guaranteed services under federal Medicaid law.

Since 2003, provider assessments have been a prominent source of OHA's Other Funds revenue to leverage federal Medicaid dollars and support OHP. In 2017-19, these assessments were restructured through the adoption of HB 2391 (2017), which temporarily established a 0.7% tax paid by diagnostic related group (DRG) hospitals through June 30, 2019; implemented an assessment on Type A and Type B rural hospitals; exempted OHSU from the hospital assessment program and created a separate intergovernmental transfer (IGT) agreement; and established a new 1.5% premium assessment on managed care and other health care insurance plans through December 31, 2019.

The sunsets included in HB 2391 (2017) and other OHP budget challenges prompted the Governor to establish a Medicaid financing workgroup composed of members from state government and health care stakeholders to recommend a long-term plan to fund the program. The workgroup met throughout the spring and summer of 2018 and developed recommendations that would ultimately be implemented through the adoption of HB 2010 in the 2019 legislative session. The bill reinstates the insurance premium assessment at 2%, expands the premium assessment to include premiums on stop-loss insurance policies, and extends the sunset dates for both the hospital and insurance premium assessments over multi-biennia periods. Also based on the workgroup's recommendations, the 2019-21 budget includes adjustments related to increasing the fully reimbursable DRG assessment from 5.3% to 6% as of January 1, 2020, which OHA is able to do administratively. Similarly, the budget also includes changes to increase the rural hospital assessment from 4% to 5.5% as of January 1, 2020. This change, however, was not proposed by the workgroup.

As part of the exemption of OHSU from the hospital assessment program in 2017-19, the OHSU IGT was established pursuant to OHSU's status as a public academic health center. Instead of paying the hospital assessment, OHSU contributes funding through the IGT, which results in a higher level of Other Funds revenue and corresponding federal matching dollars available for OHP. State government benefits from the agreement as a result of less General Fund needed to support OHP expenses and OHSU benefits through an enhanced payment model known as Qualified Directed Payments, which is predicated on OHSU maintaining access to high quality academic health center services for OHP members. As discussed in further detail below, the 2019-21 budget increases the IGT contribution and includes changes reflecting the IGT's full biennial roll-out and program growth.

Federal Funds support 55%, or $12.66 billion, of OHA expenditures in the 2019-21 legislatively adopted budget. Of this amount, $11.96 billion supports Medicaid programs in the Health Systems Division and is linked to a combined $4.53 billion of General Fund and Other Funds revenue used to satisfy federal Medicaid match requirements. Federal Funds also support significant portions of the budgets for the Public Health and Health Policy and Analytics Divisions. In Public Health, the budget includes Federal Funds expenditure limitation of $276.4 million, which reflects myriad federal grant programs dedicated for specific public health purposes and

Medicaid match for contraceptive care and nurse home visiting programs. Federal Funds support $114.2 million, or 60%, of the Health Policy and Analytics Division's budget. This revenue includes federal Medicaid administrative funds (matched with General Fund) and multiple federal grants, including grants for health information technology and primary care.

In addition to the Other Funds and Federal Funds amounts discussed above, OHA's budget includes certain expenditures designated as Nonlimited, which can be increased administratively if the revenue is available. Nearly all of these expenditures reflect Nonlimited Other Funds of $40 million and Nonlimited Federal Funds of $102.7 million to support the Women, Infants and Children (WIC) program administered by the Public Health Division. The revenue to support these expenditures is available from rebates from manufacturers of infant formula provided to the state's WIC participants and from federal payments to support program costs. The agency's budget also includes Nonlimited Federal Funds of $3.5 million to support debt service payments.

Budget Environment

Given the broad range of services provided and various sources of funding, OHA operates within a complex and dynamic budget environment. Demographics and economics, federal policy, health care cost inflation and utilization, and state policies and politics greatly influence this budget.

- ***Demographics and Economics*** – Population changes, especially the number of people who are elderly, disabled, or living in poverty, greatly affect the need and demand for OHA services. The health of the economy also has an important impact on this budget. Typically, when the economy is poor, demand for OHA services increases and program caseloads grow. Oregon's economy is also linked to the Federal Medical Assistance Percentage (FMAP), which is the federal Medicaid matching rate the state receives to support OHP and other Medicaid caseloads. When Oregon's per capita personal income increases relative to the national average, Oregon's FMAP decreases, meaning additional state funds are needed to support the same level of Medicaid services. Likewise, when Oregon's per capita personal income decreases compared to the national average, Oregon's FMAP increases, thereby saving state dollars.

- ***Federal Policy*** – The federal revenue OHA receives is tied to a significant body of federal law and administrative rules. Some OHA programs, such as OHP, are governed by waivers of certain federal regulations. The waivers must be approved by federal agencies, with the need for reapprovals if the state wants to make program changes. Federal laws generally require state staff to ensure federal policies are appropriately carried out and information management systems produce federally required reports. Most of the General Fund in OHA's budget is used to match Federal Funds or to meet federal maintenance of effort (MOE) requirements. As a result, General Fund budget reductions typically result in the loss of federal revenue and might jeopardize the state's ability to meet federal match or MOE requirements.

- ***Health Care Inflation and Utilization*** – The largest share of OHA's budget is medical costs. Consistent with the 2019-21 legislatively adopted budget, OHA uses $20.35 billion of its $23.19 billion total funds budget to provide comprehensive health care coverage through OHP, PEBB, and OEBB. Health care inflation rates have typically outpaced general economic inflation rates, as well as the rate of state revenue growth. As a result, health care has consumed a larger share of the total state budget. To help contain costs and create more predictable budget environments, the state adopted an approach starting in 2012 to cap health care cost increases for OHP at two percentage points below the national trend, which resulted in a growth cap of 3.4% per member per year. Although the national health care cost trend has fluctuated since that time, the state has maintained the annual 3.4% cap and extended it to health care costs in the PEBB and OEBB budgets.

  Individuals' utilization of health care services and the way the state pays for those services are also significant factors in OHA's budget. Historically, health care services were often paid on a fee-for-service basis, such that providers received a fee for each service provided. This model incentivizes providers to deliver more services, with the risk of patients utilizing services that do not help them become healthier. Oregon's coordinated care model has largely moved the state away from this approach by increasing the number of individuals enrolled in coordinated care organizations (CCOs), which focus on primary care and prevention. Instead of receiving

payments for each service provided, CCOs receive fixed monthly capitation payments for each enrollee regardless of the quantity of services utilized. By holding CCOs accountable for achieving defined quality health metrics, this model incentivizes CCOs to better manage chronic conditions, reduce unnecessary and costly medical services, such as emergency department visits, and improve health outcomes for enrollees. PEBB and OEBB have also adopted the coordinated care model by increasing member enrollment in patient-centered primary care homes.

- ***Politics*** – As mentioned above, approximately 84% of OHA's budget is earmarked for special payments to health care providers, local governments, insurance companies, and others who deliver services. As a result, numerous organizations, trade associations, labor unions, advocates, and clients have a direct economic interest in this budget. When budget reductions need to be made, or major enhancements are proposed, these groups become actively involved in the surrounding politics.

The factors described above tend to make significant policy changes difficult to adopt. A proposed program change might have a significant fiscal impact, be inconsistent with federal law (or at least require a lengthy federal approval process), or challenge past policy direction and create controversy.

Legislatively Adopted Budget

The 2019-21 legislatively adopted budget for OHA is $23.19 billion total funds, $2.72 billion General Fund, and 4,290 positions (4,243.01 FTE). The budget represents an increase of 6% total funds and an increase of 26% General Fund from the 2017-19 legislatively approved budget.

The growth in General Fund is largely driven by the level of funding needed to maintain OHP services due to declines in Federal Funds and Other Funds revenues. Changes to the state's FMAP rates result in a cost shift of $445 million from Federal Funds to the General Fund. Likewise, declines in available tobacco tax and Tobacco Master Settlement Agreement revenues result in a net cost shift of $97.8 million from Other Funds to the General Fund to maintain the state's existing level of both Medicaid and non-Medicaid behavioral health services. Additionally, the budget recognizes a shift of $125.1 million to the General Fund as a result of Other Funds revenue being unavailable to support its share of OHP inflationary expenses. The budget incorporates various revenue and cost-savings measures to address these revenue issues. The most significant of these changes includes the reinstatement of the insurance premium assessment at 2% pursuant to HB 2010 (2019), changes to the OHSU IGT, increasing the DRG hospital assessmens from 5.3% to 6%, and increasing the Type A and B rural hospital assessment from 4% to 5.5%.

Outside of revenue adjustments, the budget includes several General Fund savings measures, with the largest being a $10 million OHP non-caseload savings target OHA is expected to achieve through program efficiencies and cost containment efforts. The budget also recognizes vacancy savings in several programs. The growth of health care costs for OHP, PEBB, and OEBB continues to be capped at 3.4% per person per year despite higher projected levels of health care inflationary expenses. All adjustments preserve the existing level of eligibility and benefits in all health care programs and do not result in cuts to other program services or a reduction in agency staff.

The budget makes notable investments in Oregon's behavioral health and public health systems. Examples include $31.6 million General Fund as part of the $50 million statewide behavioral health investment package, $13 million General Fund and related federal matching dollars to increase behavioral health provider rates (includes $3 million from the behavioral health investment package), $10 million General Fund to advance Public Health Modernization, and $2.9 million for a new voluntary universal nurse home visiting program.

The information below includes more detail for each major program area in OHA.

Health Systems Division

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	1,429,495,915	1,315,305,253	2,317,851,205	1,828,675,053
Lottery Funds	11,113,255	12,243,339	12,762,588	16,819,909
Other Funds	1,987,538,640	3,574,960,109	2,539,162,810	3,258,771,550
Other Funds (NL)	57,724,836	--	--	--
Federal Funds	10,783,582,209	11,262,021,067	11,138,814,776	12,176,978,066
Total Funds	**$14,269,454,855**	**$16,164,529,768**	**$16,008,591,379**	**$17,281,244,579**
Positions	623	316	297	337
FTE	609.97	458.20	289.63	325.79

Program Description

The Health Systems Division (HSD) ensures the systematic transformation of health care in Oregon by delivering integrated physical, behavioral, and oral health care services; strengthening the coordinated care model; and improving health outcomes throughout the state. HSD is comprised of the following budget units: 1) Medicaid; 2) Non-Medicaid Behavioral Health; and 3) Program Support and Administration. HSD Medicaid delivers health services to over one million low-income adults, people with disabilities, children, and pregnant women. Most of these health care services are available under a federal-state partnership in which the federal government shares in a substantial share of the costs. The Non-Medicaid Behavioral Health budget is mostly funded with state revenue and supports critical elements of Oregon's community behavioral health system that serves as the safety net for all Oregonians regardless of health care coverage. This includes support for community mental health and addictions programs for low-income people who do not qualify for Medicaid or for services that do not qualify for Medicaid reimbursement even if the person receiving them is a Medicaid beneficiary. These programs provide a system of comprehensive health services to Oregonians and their families to improve their health status and promote independence. All of the positions in HSD are budgeted within Program Support and Administration, which provides the operational and information technology resources to help the division fulfill its mission.

Health Systems Division Budget
2017-19 vs. 2019-21
in millions

2017-19 Leg. Approved Budget	Medicaid	Non-Medicaid	Program Support & Administration	Total
General Fund	970.2	269.9	75.2	1,315.3
Lottery Funds	0.0	9.1	3.2	12.2
Other Funds	3,414.5	141.1	19.4	3,575.0
Federal Funds	11,028.5	85.7	147.8	11,262.0
Total	**$15,413.2**	**$505.8**	**$245.6**	**$16,164.5**
2019-21 Leg. Adopted Budget				
General Fund	1,427.8	316.3	84.6	1,828.7
Lottery Funds	0.0	13.5	3.3	16.8
Other Funds	3,101.3	136.8	20.7	3,258.8
Federal Funds	11,961.0	96.6	119.4	12,177.0
Total	**$16,490.1**	**$563.2**	**$227.9**	**$17,281.2**

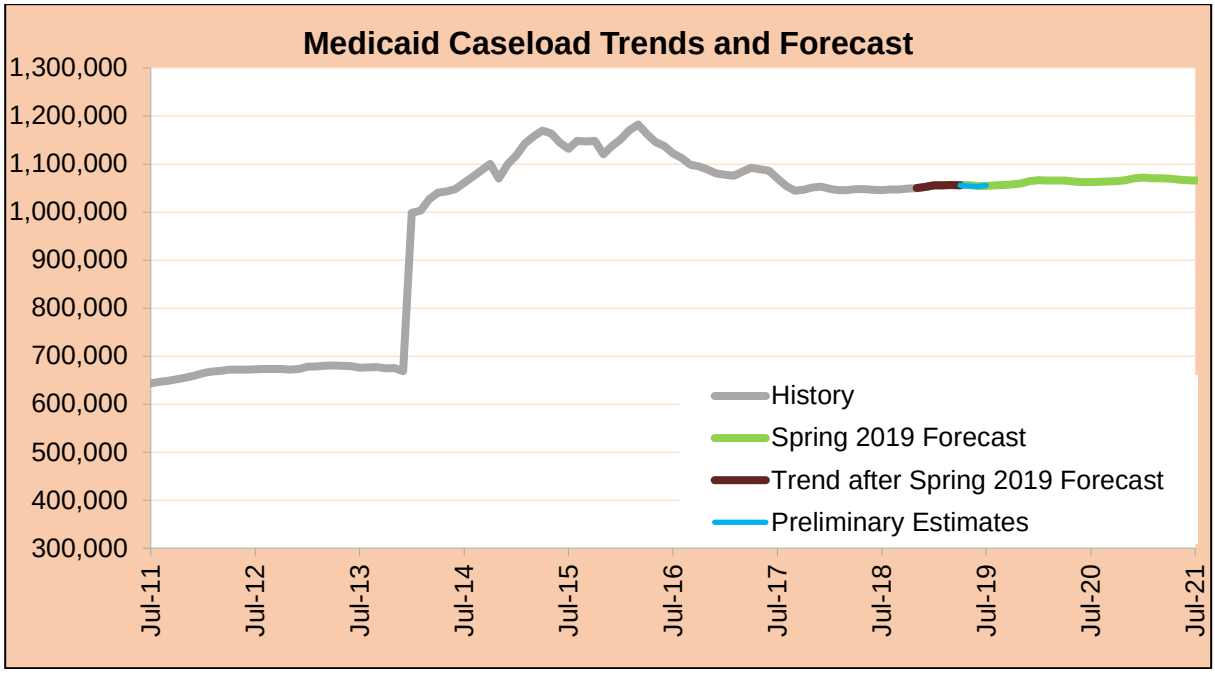
Medicaid Programs

Program Description – Medicaid

Medicaid programs deliver health care services to over one million people in Oregon, primarily through the Oregon Health Plan (OHP), which supports comprehensive health care coverage for low-income adults and children eligible for Medicaid, children eligible under the federal Children's Health Insurance Program (CHIP), and children who would be eligible for Medicaid or CHIP except for their immigration status. This unit also includes Medicaid programs for low-income individuals who do not qualify for OHP's comprehensive level of care but are eligible for more limited Medicaid services based on specific categorical eligibility criteria, such as individuals dually eligible for Medicare and Medicaid. Special payments, primarily to provide medical assistance to clients, represent 100% of this budget.

Oregon's Medicaid programs have experienced significant changes in the last several years. In the 2011-13 biennium, Oregon transformed the way it provides and pays for medical assistance through a new Medicaid health care delivery system managed by coordinated care organizations (CCOs). A CCO is a network of all types of health care providers who agree to work together in local communities to serve OHP members. CCOs focus on prevention; chronic disease management; early intervention; integration of physical, behavioral, and oral health; and the reduction of waste and inefficiency in the health system. OHA compensates CCOs through a global budget model, which represents the total cost of services for which CCOs are held accountable for managing. Starting in 2012, Oregon committed to limiting health care cost growth to 3.4% per member per year in exchange for a total of $1.9 billion in federal Designated State Health Programs (DSHP) matching funds through June 2017 for programs that had not previously received traditional Medicaid support. Oregon's current five-year federal Medicaid demonstration waiver ending in 2022 continues the commitment to contain costs at no more than 3.4% per member per year, but no longer includes federal incentives for doing so.

The state has also made important changes to OHP eligibility and services. Oregon expanded Medicaid in 2014 to all persons under 138% of the federal poverty level, as authorized by the Affordable Care Act (ACA). Approximately 360,000 Oregonians currently have health care coverage as a result of this expansion. Starting in 2017-19, OHP eligibility was expanded through the Cover All Kids program established by SB 558 (2017). This program, which is entirely supported with General Fund, provides OHP coverage to children who are ineligible for Medicaid or CHIP under federal law for the sole reason of their immigration status. Also beginning in 2017-19, state-funded reproductive services were made available to individuals who were only eligible under Medicaid for emergency medical services due to their immigration status. In 2019-21, nearly 1.1 million individuals are forecasted to receive medical assistance through OHP and other Medicaid programs, with approximately 80% of the entire Medicaid population enrolled in CCOs and the remaining 20% in "open card," meaning they can see any provider who accepts Medicaid.



OHP / Non-OHP Services – As mentioned above, there are two broad distinctions regarding the medical assistance programs budgeted under HSD Medicaid. First, ***Oregon Health Plan*** coverage includes medical assistance as part of the state's Medicaid waiver under Title XIX of the Social Security Act, the Children's Health Insurance Program under Title XXI of the Social Security Act, and the state-enacted Cover All Kids program. OHP is largely governed by a Medicaid state plan and waivers to various federal Medicaid regulations. The Medicaid state plan and OHP waivers detail eligibility for the program, the services or benefits offered, and provider reimbursement. These three elements—eligibility, benefits, and reimbursement—are the main cost drivers of the OHP budget. The state plan, proposed amendments to the plan, and waivers to Medicaid regulations all require review and approval by the Centers for Medicare and Medicaid Services (CMS), which is the federal agency responsible for administering Medicaid. This means policy changes to the plan and waivers, particularly those that would have a significant program or budgetary impact, must be approved by CMS.

Although CHIP functions similar to Medicaid, it is technically not a Medicaid program. The federal government created CHIP in 1997 as an option for states to expand health care services to uninsured children whose families earn too much to qualify for Medicaid but not enough to afford insurance, with the household income eligibility level being up to 300% of the federal poverty level (FPL). One of the key differences between CHIP and Medicaid is how the federal government finances the program. Whereas Medicaid has no pre-set limit for total federal expenditures, federal matching funds for CHIP are capped according to allotments using each state's recent spending experience increased by a growth factor. If a state exhausts its allotment, the state can use carryover funds from the prior allotment (if available) or request CMS to reallocate unused funds from other states. Congress must also act periodically to reauthorize funding for the program. After CHIP funding lapsed for over three months starting in late 2017, many states, including Oregon, had to temporarily use carryover or redistributed funds to maintain CHIP services. Congress subsequently reauthorized federal funding for the program for a 10-year period ending September 30, 2027.

The ***non-OHP*** component of the HSD Medicaid budget includes expenditures for more limited programs, including the Citizen-Alien Waived Emergent Medical program and the Qualified Medicare Beneficiary program. Non-OHP expenditures also include General Fund payments to the federal government to comply with requirements under the Medicare Modernization Act for states to help pay for the costs of Medicare Part D outpatient prescription drug coverage for clients dually eligible for Medicare and Medicaid. The mechanism through which states help finance this coverage is commonly knowns as the "clawback," which is intended to represent most of the

expenditures the state would have made had this coverage exclusively remained a Medicaid expense and not transitioned to support from Medicare.

Eligibility – Medicaid is considered an entitlement program under federal law. That is, anyone who meets the eligibility criteria established in a Medicaid state plan must be provided services, without regard to the state's financial ability to pay. If a state wants to reduce eligibility, it must first receive approval from CMS. Prior to Medicaid expansion under the ACA, adults needed to meet specific criteria in addition to income status to be eligible for coverage, such as being pregnant or having a disability. These categorical caseload designations remain after Medicaid expansion; however, for those who do not satisfy one of these designations for enrollment, Medicaid expansion enables adults who would otherwise be eligible to qualify based only on income eligibility.

Another change under the ACA is the determination of income eligibility. Prior to the ACA, income was determined based on a household's income earnings and assets, effectively a calculation of net worth. As a result of the ACA, income eligibility for most Medicaid caseloads is now based on modified adjusted gross income (MAGI), which is a household's adjusted gross income after adjusting for qualifying tax deductions with a few exclusions (or modifications). Eligibility under MAGI does not include an asset test. The switch to MAGI ultimately resulted in CMS rule changes regarding Medicaid beneficiaries' annual eligibility redeterminations that help reduce gaps in coverage while also having meaningful budget implications. Because MAGI is calculated using common taxable income data, CMS now requires states to conduct annual redeterminations for MAGI caseloads by first attempting to use information from available data sources, such as Internal Revenue Service tax records. If eligibility cannot be determined through these means, the state can then request the beneficiary to provide additional information. OHA implemented this process starting with renewals at the end of February 2018. The use of this approach, often referred to as "ex parte" or "passive" renewals, enables more individuals to remain covered by Medicaid without temporarily or permanently dropping off the caseload due to failure to submit a renewal application on time. This change has also resulted in increased budget pressures due to more individuals remaining on the caseload for longer periods of time. A recent example of the impact of this change is with the Parent/Caretaker Relative caseload, which traditionally experienced members frequently exiting and then re-entering the caseload but is now consistently growing each month with fewer exits.

Coverage	Eligibility Description	Income Eligibility (FPL)
Oregon Health Plan (Medicaid & CHIP)	**Children's Medicaid** – children age 0-18 covered eligible for Medicaid based on household income according to age range	100% - 185%
	Children's Health Insurance Program – children age 0-18 ineligible for Medicaid and with household income of up to 300% of FPL	300%
	Affordable Care Act – adults age 19-64 who meet Medicaid's income eligibility requirements and are not eligible under other Medicaid categories	138%
	Foster, Substitute and Adoption Care – children in foster care or adopted by parents who receive adoption assistance and individuals under age 26 who were enrolled in Medicaid and in foster care upon turning age 18; income level is not an eligibility requirement	N/A
	Parent/Caretaker Relative – adults under age 65 with one or more dependent children under age 18 or age 18 and in high school; income eligibility standard does not consistently align with FPL	~38%
	Pregnant Women – pregnant women and their newborns up to age 1	185%
	Aid to the Blind and Disabled – individuals who are blind or have a disability and are eligible for federal Supplemental Security Income (SSI) or Medicaid long-term care (LTC); about 39% of this caseload are also eligible for Medicare; income eligibility standard does not consistently align with FPL	~74% for SSI; ~222% for LTC

	Old Age Assistance – individuals who are age 65 or over and eligible for federal Supplemental Security Income; income eligibility standard does not consistently align with FPL; the majority of this caseload are also eligible for Medicare	~74%
	Breast and Cervical Cancer Treatment – individuals less than age 65, diagnosed as needing treatment for breast or cervical cancer or specific precancerous conditions, and not eligible for other forms of coverage	250%
Oregon Health Plan (non-Medicaid / non-CHIP)	**Cover All Kids** – comprehensive OHP services for children age 0-18 who meet all of the eligibility requirements for Medicaid or CHIP except for citizenship or immigration status	300%
	Citizen Alien Waived Medical – emergency medical services for adults and medical care for pregnant women who meet the eligibility requirements of Medicaid except for citizenship or immigration status	138%
	Medicare Beneficiary – Medicare cost-sharing for premiums and out-of-pocket expenses for individuals dually eligible for Medicare and Medicaid; cost-sharing assistance falls into one of three eligibility categories: Qualified Medicare Beneficiary (100% FPL); Specified Low-Income Medicare Beneficiary (120% FPL); Qualifying Individual (135% FPL)	100% - 135%

Benefits – OHP covers hospital, physician, prescription drug, therapies (e.g. physical, occupational, and speech), durable medical equipment, dental, limited vision services, non-institutional mental health services, drug and alcohol treatment, and certain health-related services (e.g. transportation to medical providers). Clients do not pay premiums or copayments. An important aspect of the benefit package is the "prioritized list of services," which ranks health care conditions and treatment in order of clinical- and cost-effectiveness. The Health Evidence Review Commission, administered by OHA, determines the content and establishes the priority of listed services. Theoretically, the amount of funding available determines the level of covered services. However, in practice, excluding treatments from the bottom of the list is difficult to do and requires approval by CMS, which has historically been reluctant to grant approval.

Provider Reimbursement – Under the coordinated care model, OHA employs global budgets to compensate CCOs for the cost of services and operations. CCO global budgets consist of two components: capitated and non-capitated payments. The capitated portion includes funding for physical, behavioral, and oral health services, and for administration and profit/risk contingency, paid to CCOs on a prospective per member, per month basis according to risk-adjusted rates based on an individual's OHP eligibility status. The non-capitated portion includes maternity case rates paid to CCOs when a pregnant OHP member gives birth and, until the 2020 contract year, payments from the CCO quality incentive pool awarded to CCOs for meeting minimum performance standards. In 2020, funding for the CCO quality incentive pool is being changed to a withhold applied to the capitated payment portion of the global budget.

CCOs have the flexibility to allocate their global budgets to meet the needs of their members and local communities. Notwithstanding forthcoming changes under CCO 2.0 (discussed below), CCOs have been able to choose the payment methodology they use to reimburse their contractual health care providers from their global budgets, including traditional fee-for-service payments or alternative payment methodologies, like value-based payments. Regardless of the payment methodology to providers, CCOs retain the responsibility for managing services and ensuring access to care and quality of care for their members. The process and methodology used to develop the capitation rates is governed by federal and state regulations. CMS requires Oregon's capitation rates to be actuarially sound and to follow applicable actuarial standards.

There are also elements of Oregon's Medicaid programs that continue to be supported through fee-for-service payments to doctors, hospitals, federally qualified health centers, rural health centers, pharmacies, dentists, and other health care providers. These include services provided to individuals who are eligible to be enrolled in a CCO but have opted not to under special exemptions, such as tribal members and those dually-eligible for Medicare

and Medicaid, as well as individuals who are not eligible to be enrolled in a CCO, such as the Citizen Alien-Waived Emergency Medical program. There are also specific costs carved-out of the CCO global budget model and reimbursed on a fee-for-service basis for all individuals. Examples include reimbursement for mental health drugs, residential treatment services, and targeted case management.

Revenue Sources and Relationships – Medicaid

Federal Funds account for 73% of the HSD Medicaid budget. This revenue reflects the federal match received to support Medicaid and CHIP services. These match rates, also known as Federal Medical Assistance Percentages (FMAP), are critical elements during the development of OHA's budget. There are three distinct FMAPs for medical services based on Medicaid eligibility:

- ***Non-ACA FMAP (traditional Medicaid)*** – For services provided to adults and children categorically eligible for Medicaid according to criteria in effect prior to the ACA, states receives an FMAP adjusted each federal fiscal year based on a three-year average of the state's per capita personal income compared to the national average. For these caseloads, no state can receive an FMAP less than 50% or more than 83%.

- ***CHIP FMAP*** – Similar to the rate for the traditional Medicaid population, CHIP uses an annually adjusted FMAP based on each state's per capita personal income. However, unlike the FMAP for the non-ACA caseload, CHIP uses an enhanced FMAP based on states paying a 30% smaller share of spending than under Medicaid. For federal fiscal years 2016 through 2019, the ACA further enhanced each state's CHIP FMAP by increasing it by 23 percentage points, with no state's FMAP being allowed to surpass 100%. This increase is being phased-out over federal fiscal years 2020 and 2021.

- ***ACA FMAP*** – As part of the ACA expansion of Medicaid to nondisabled, nonpregnant adults earning less than 138% of the federal poverty level, the federal government reimbursed participating states for 100% of the medical assistance costs for eligible individuals from calendar years 2014 through 2016. Starting in 2017, the ACA FMAP has phased-down each year until it will reach a floor of 90% in calendar year 2020 in accordance with current federal law.

Based on the magnitude of Medicaid expenditures, even small FMAP changes can result in significant costs or savings to the state. OHA's 2019-21 average biennial FMAPs are declining across the board compared to 2017-19. The largest percentage change is with the CHIP FMAP due to the phase-down of the enhanced rate. However, the smaller decreases in the non-ACA and ACA FMAPs are costlier to the state given caseload sizes. Taken together, the decreased FMAPs resulted in a cost shift of $445 million from Federal Funds to the General Fund in 2019-21.

Oregon's FMAPs	2017-19 Average	2019-21 Average	Change	General Fund Cost
Non-ACA caseload	63.33%	61.36%	-1.97%	$166 million
CHIP caseload	97.33%	81.58%	-15.75%	$76 million
ACA caseload	94.00%	90.75%	-3.25%	$203 million
Total General Fund cost:				**$445 million**

Other Funds account for 19% of the HSD Medicaid budget. Sources of this revenue include tobacco taxes, Tobacco Master Settlement Agreement funding, health care provider assessments, the Oregon Health and Science University (OHSU) intergovernmental transfer (IGT) agreement, drug rebates, third-party recoveries, and other miscellaneous sources.

Health care provider assessments are the largest source of Other Funds revenue in HSD. The extent to which OHA is able to leverage provider assessment revenue reduces the amount of General Fund needed to match federal Medicaid dollars. Consistent with the passage of HB 2010 (2019), the 1.5% insurer assessment is reestablished at 2% and expanded to include stop-loss insurance premiums, which contributes $281 million to support OHP costs

that otherwise would have required General Fund support. The 2019-21 budget also incorporates adjustments to the diagnostic related group (DRG) and Type A and B rural hospital assessments. First, the 0.7% DRG tax authorized by HB 2391 (2017) expired on July 1, 2019. In its place, the budget increases the fully reimbursable DRG assessment from 5.3% to 6% with an effective date of January 1, 2020. The budget increases the rural hospital assessment from 4% to 5.5% as of January 1, 2020. The Other Funds revenue generated by these changes offset OHP General Fund expenses by a combined $131 million. The January 1, 2020 effective data of the increased DRG hospital assessment coincides with the transition of DRG hospital reimbursements to a qualified directed payment (QDP) model, which is already in place for Type A and B rural hospitals. The QDP model aligns with CMS requirements for all states to phase-out pass-through payments by July 1, 2027 and tie payments to the delivery and utilization of Medicaid services, outcomes, and quality of services delivered.

In 2017-19, OHSU was exempted from the hospital assessment program and the OHSU IGT was established as a separate funding model, which collapsed several Medicaid payments into the new program. The 2019-21 budget includes multiple Other Funds adjustments related to the IGT. These include a $25 million increase to OHSU's IGT contribution, which offsets a like amount of General Fund. Other Funds expenditure limitation is also increased to reflect the full biennial roll-out of the IGT agreement, as well as updated IGT revenue estimates consistent with program growth and the use of on-going IGT revenue initially considered to be contingency revenue during the model's infancy. These changes offset General Fund costs by $116 million.

Budget Environment – Medicaid

Health System Transformation – Historically, three main levers have been used to control Medicaid costs: limiting eligibility, reducing benefits, and cutting provider reimbursement. The other option is to structurally change the health care system in terms of how health care is purchased and delivered. This reflects Oregon's current approach, as initiated through the creation of CCOs and the focus on changing the health system through better health, better care, and lower costs. The critical components of this approach include integrated and coordinated benefits and services; the use of global budgets that grow at a fixed rate (currently 3.4% per member per year); the use of performance metrics to ensure Oregonians receive safe and effective care; local accountability for outcomes and costs; and enough flexibility for CCOs to tailor programs to the unique needs of their communities.

The integration of services into CCO contracts and rates has been an important part of Oregon's health care transformation. The integration of behavioral and physical health was incorporated in the original CCO contracts beginning in 2012. Mental health supported employment and assertive community treatment services were integrated in January 2013, alcohol and drug residential services moved as of July 2013, and non-emergency medical transportation as of October 2015. Dental services were integrated into CCOs by July 2014. Since then, CCOs have evolved in how they provide dental services. Some CCOs continue to contract with dental care organizations (DCOs) or former DCOs, while others have developed their own internal capacity to deliver dental services. For individuals who are not enrolled in a CCO, OHA contracts with seven DCOs to provide dental coverage statewide.

Another important part of Oregon's health system transformation is evaluation of the state's progress toward achieving the triple aim. SB 1580 (2012) created the nine-member Metrics and Scoring Committee responsible for developing annual CCO outcome and quality incentive measures, such as targets for diabetes management, tobacco usage, and childhood immunization status. By achieving some or all of the established measures, CCOs earn funds from the quality incentive pool. The maximum amount available to each CCO from the pool is based on each CCO's number of enrollees and the extent to which the measures are achieved.

2018 QUALITY POOL DISTRIBUTION

CCO	Phase 1 Distribution			Challenge Pool		Total	
	# Measures met (of 17 possible)	Payment earned in Phase 1*	% Quality pool funds earned	# Challenge measures met	$ Challenge pool earned	Total payment (Phase 1 + Challenge pool + MCO tax)	Total % quality pool earned
Advanced Health	14	$ 4,550,457	100%	4	$ 280,684	$ 4,904,712	106.1%
AllCare Health Plan	14	$ 9,944,618	100%	3	$ 572,370	$ 10,677,146	105.7%
Cascade Health Alliance	14	$ 3,760,644	100%	4	$ 247,796	$ 4,069,482	106.6%
Columbia Pacific	10	$ 3,672,158	60%	3	$ 277,617	$ 4,009,924	64.5%
Eastern Oregon	14	$ 12,002,400	100%	2	$ 377,883	$ 12,568,815	103.1%
Health Share of Oregon	15	$ 64,511,211	100%	4	$ 4,394,929	$ 69,955,473	106.8%
Intercommunity Health Network	10	$ 7,724,349	60%	1	$ 208,897	$ 8,054,057	61.6%
Jackson Care Connect	13	$ 5,824,153	100%	3	$ 353,145	$ 6,271,369	106.0%
PacificSource – Central Oregon	11	$ 7,630,948	70%	3	$ 568,132	$ 8,323,940	75.2%
PacificSource – Gorge	15	$ 2,712,920	100%	4	$ 173,714	$ 2,930,593	106.4%
PrimaryHealth of Josephine County	14	$ 1,894,422	100%	3	$ 114,278	$ 2,039,290	106.0%
Trillium	14	$ 19,936,807	100%	4	$ 1,259,421	$ 21,519,014	106.3%
Umpqua Health Alliance	13	$ 5,343,796	100%	3	$ 311,771	$ 5,741,693	105.8%
Willamette Valley Community Health	14	$ 19,810,422	100%	4	$ 1,439,743	$ 21,573,771	107.2%
Yamhill Community Care	13	$ 5,202,039	100%	4	$ 338,994	$ 5,625,414	106.5%
Total		$ 174,521,345			$ 10,919,376	$ 188,264,693	

* Quality pool distribution is based on number of measures met and CCO size (number of members). See page 16 for CCO enrollment.

The quality incentive pool is awarded in two phases. In the first phase, CCOs can earn up to 100% of their quality pool by meeting or exceeding targets required for each incentive measure. Funds remaining after this distribution are then available as part of a "challenge pool" and distributed to CCOs according to their performance on specific challenge pool measures. The 2018 quality pool totaled 4.25% of aggregate CCO monthly payments in that year, resulting in a total pool of over $188 million. For this year, 12 out of the 15 CCOs earned 100% of their phase one quality pool dollars. In addition to the CCO incentive measures, there are also quality measures defined in Oregon's Medicaid waiver that OHA is required to report to CMS. Many of these measures overlap with incentive measures established by the Metrics and Scoring Committee.

CCO 2.0 – To guide the next five years of coordinated care, OHA has worked with the Oregon Health Policy Board (OHPB), policymakers, stakeholders, and OHP members to bring forward new ideas to address the gaps and challenges in Oregon's health care system. This next phase of health care transformation is referred to as "CCO 2.0." OHA's focus on this effort is guided by the following four priorities: 1) improve the behavioral health system; 2) increase value and pay for performance; 3) focus on social determinants of health and health equity; and 4) maintain sustainable cost growth. Through a year-long public process, OHA and OHPB organized CCO 2.0 policy development to align with these four priorities for their inclusion in the CCO contracts beginning January 1, 2020.

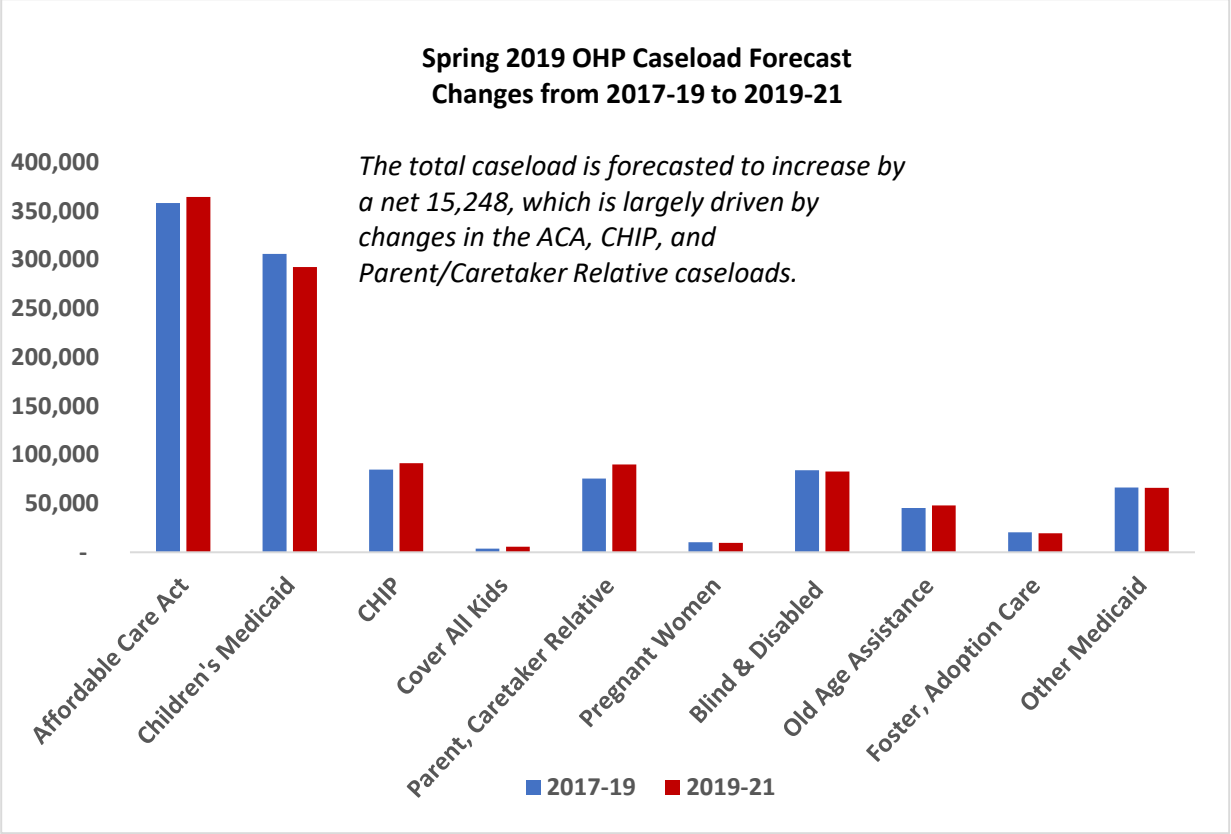
The prioritization of these elements will play an important role in Medicaid spending over the next five years of health care transformation. The move toward requiring CCOs to increase their use of value-based payments, for example, builds off of the quality incentive payment model developed during the first five years of the CCO system and will put upward pressure on achieving both health outcomes and cost savings. Although currently

OHA pays CCOs largely on a capitated basis, many CCO arrangements with providers are based on traditional fee-for-service payments with no financial link to quality or value. OHA has developed a phased-in approach for CCOs to adopt value-based payment models, with no less than 70% of CCO payments to be based on value by 2024. The focus on social determinants of health and equity will also influence the prioritization of CCO investments. OHA will develop strategies to increase CCO spending on the non-clinical activities that impact a person's health and to build the organizational capacity to advance health equity.

A major component for achieving CCO 2.0's objectives is the development of new CCO contracts for the next five-year contract period. In July 2019, OHA announced its intent to award contracts to 15 organizations, which is the same number of CCOs as before but with notable changes. First, two existing CCOs, Primary Health and Willamette Valley Community Health, will no longer provider services, with the latter choosing not to apply for a new contract. Additionally, Trillium and PacificSource Community Solutions have been approved to operate in additional service areas, which results in the choice of a second CCO for enrollees in those regions. Also, four applicants were awarded one-year contracts instead of five-year because they did not fully demonstrate their ability to sufficiently meet the CCO 2.0 criteria. These applicants will be placed on remediation plans and will have one year to show they can meet the higher expectations of CCO 2.0 with technical support from OHA.

Caseload Changes – The OHP budget is based on caseload forecasts and cost-per-case estimates that are projected for each biennium. When caseload forecasts change for the existing biennium, or, in the case of the budget development process, the next biennium, OHA's budget is adjusted to account for the related costs or savings. Unlike commercial insurers, OHP does not have established reserves that can be used if caseloads or costs per case end up being higher than initially forecasted.

The OHP caseload forecast used to determine the 2019-21 legislatively adopted budget was developed in the spring of 2019. This forecast reflects an overall net increase of 15,248 OHP members compared to the 2017-19 forecast at that point in time. Most caseload categories are forecasted to decrease, with the largest being a 13,300 decline in the Children's Medicaid caseload. However, the ACA caseload is expected to increase by approximately 6,000; the CHIP caseload by 6,600; and the Parent/Caretaker Relative caseload by 14,200. The cost of the forecasted increase in the ACA and CHIP populations is largely supported by Federal Funds given the higher FMAP for these caseloads. Conversely, the Parent/Caretaker Relative caseload receives the traditional Medicaid FMAP and results in a much higher cost to the General Fund.



Medical Inflation – Notwithstanding the expiration of federal transformation funding, Oregon has continued its commitment to hold cost growth to 3.4% per member per year in its current federal Medicaid waiver ending June 30, 2022. However, achieving this target has proven difficult in the past two years due to certain cost pressures. The 2018 CCO rates grew by an average of 5.3% compared to the previous year and the 2019 rates grew by 5.1% compared to 2018. Increases in CCO costs for these years were driven by changes in OHP membership resulting in more members with costlier health needs, increasing pharmacy costs, and fluctuations in rural hospital costs. To help offset the cost growth, OHA reduced the 2019 CCO quality incentive pool by 0.75 percentage points as a one-time action. The December 2018 Emergency Board also approved General Fund adjustments to support the cost growth. Looking ahead, OHA is working to address the major cost drivers in the health care system, increase the share of CCO budgets tied to performance, and find opportunities for improved long-term efficiency through the CCO 2.0 process.

Non-Medicaid Behavioral Health Programs

Program Description – Non-Medicaid Behavioral Health

The Non-Medicaid Behavioral Health budget supports prevention and treatment services for Oregonians at risk of developing or who have been diagnosed with a behavioral health disorder. The programs supported by this budget are focused on providing services for people who have a slightly higher income level and do not qualify for OHP, have insurance but not enough to cover the services they need, and for services that are not eligible for Medicaid coverage, such as early outreach and engagement, peer-based recovery, and housing services. The budget unit is comprised of two main components: community mental health services, including suicide prevention, intervention, and post-suicide response, and addiction services, including substance use disorder treatment and problem gambling prevention and treatment. Although these two components might be discussed separately, both intersect in terms of the treatment of persons with co-occurring mental health and substance use disorders and rely on partnerships with the same organizations and providers to develop and administer a community-based continuum of care.

HSD administers contracts and agreements with community mental health programs, non-profit providers, and tribes to develop and administer behavioral health services. Services are delivered in outpatient treatment facilities, residential facilities, schools, hospitals, and other community settings. These programs are designed to deliver evidence-based services in the least restrictive and most integrated setting possible, and to restore individuals and their families to the highest level of functioning possible. They employ peer support specialists, qualified mental health professionals, psychologists, psychiatrists, psychiatric nurse practitioners, qualified health service providers, other independently licensed providers, certified alcohol and drug counselors, certified gambling addiction counselors, and personal care providers.

State law establishes the framework for non-Medicaid mental health services, which are largely administered by ***community mental health programs (CMHPs)***. Each of Oregon's 36 counties has either a county-run CMHP or contracts with a separate organization to serve as its CMHP. Subject to the availability of funds, CMHPs are required to offer an array of both mental health and addiction services, including, but not limited to, outpatient services, residential care, aftercare for persons released from hospitals, screening and evaluation, crisis stabilization, and medication monitoring. A key role of the CMHP network is to provide pre-commitment services that help prevent the need to admit individuals to the Oregon State Hospital. For individuals and services not covered under OHP, HSD funds a variety of services that include supportive housing and employment opportunities, clinic-based outpatient care, local crisis services, regional acute care facilities, and, as a last resort, referral to the Oregon State Hospital.

Like community mental health services, ***addiction treatment, recovery, and prevention services*** are offered throughout the state by CMHPs, tribes, CCOs, hospitals, residential and non-residential treatment facilities, and other public or private organizations. The budget provides funding for a variety of treatment services, including outpatient, intensive outpatient, residential, and detoxification services for adults and children. The budget also supports beds for dependent children of adults receiving residential treatment services. Outpatient services include specialized programs that use medication assisted treatment, such as methadone, to assist in the treatment of opioid use disorder. Outpatient services also include Driving Under the Influence of Intoxicants (DUII) education and treatment for first offender diversion referrals, as well as convicted repeat offenders. This program area also supports gambling addiction prevention and treatment.

<u>Revenue Sources and Relationships – Non-Medicaid Behavioral Health</u>
General Fund comprises $316.3 million, or 56%, of the Non-Medicaid Behavioral Health budget. Nearly all of the General Fund supports mental health services, primarily through the CMHP system. A small amount is budgeted for addiction services and is used as maintenance-of-effort for the state's Temporary Assistance for Needy Families block grant administered by the Department of Human Services. Other Funds revenue represents the next largest share of program support at 24%. The program receives Other Funds revenue from several statutory dedications, including tobacco taxes, marijuana taxes, beer and wine taxes, intoxicated driver prevention funds, driving under the influence of intoxicant funds, and community housing trust funds. The Legislature has also continued to dedicate a share of the state's Tobacco Master Settlement Agreement funds for this purpose. The largest shares of Other Funds revenue are from marijuana taxes and tobacco taxes, which are budgeted at $64.9 million and $43 million, respectively, in the 2019-21 legislatively adopted budget.

The share of the Non-Medicaid budget supported by Other Funds revenue has grown considerably since 2015-17 upon legalization of recreational marijuana and the related marijuana tax revenue dedicated to behavioral health services starting in the 2017-19 budget. Similar to the treatment of available Other Funds revenue in Medicaid, marijuana tax revenue has been used to help offset costs that would otherwise have been paid with General Fund. Under the initial statutory designation, the marijuana tax revenue distribution to OHA was restricted to supporting addiction services. SB 1555 (2018) expanded the use of the revenue to also include support for community mental health services through June 30, 2019. HB 2377 (2019) subsequently made permanent the expanded use of this revenue for both addiction and community mental health services.

Federal Funds revenue represents 17% of the Non-Medicaid budget and is available for specific mental health and addiction treatment services. Most of this revenue is available from three consistent grant awards: the Substance Abuse Prevention Treatment (SAPT) grant, Mental Health Services block grant, and the Projects for Assistance in Transition from Homelessness grant. Federal policy requires 20% of the SAPT block grant be spent on prevention, which is carried out by the Public Health Division.

Lottery Funds support non-Medicaid behavioral health services from two distinct lottery distributions. First, state law allocates 1% of net lottery proceeds for the prevention and treatment of gambling addiction, most of which is budgeted in HSD Non-Medicaid. This distribution totals $14.3 million in the 2019-21 legislatively adopted budget. Additionally, starting in 2019-21, the HSD Non-Medicaid budget includes a new source of Lottery Funds for OHA—$2.5 million to support veterans' behavioral health services. This revenue is available from constitutionally-dedicated net lottery proceeds for veterans' services, as approved through Ballot Measure 96 (2016).

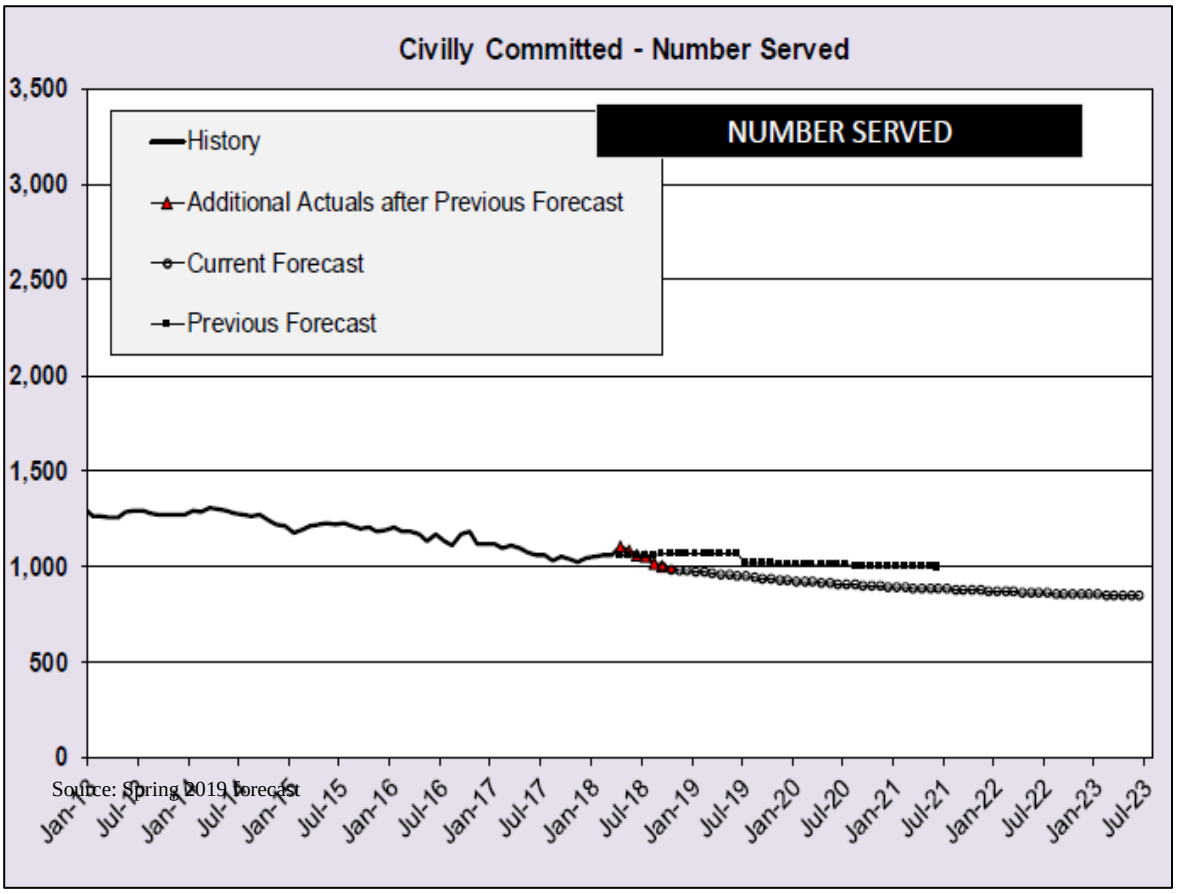
Budget Environment – Non-Medicaid Behavioral Health

Having access to a full continuum of care is critical to successfully address behavioral health problems and ensure continuity of care, seamless transitions, ongoing care coordination, and peer support. This understanding of effective treatment for people with mental illness and/or addictions will continue to be a critical factor in budgeting for non-Medicaid behavioral health services. The Oregon Performance Plan (OPP) reflects an integral part of the state's recent approach to delivering these services. In July 2016, OHA finalized the OPP, which is the result of a collaborative process with the U. S. Department of Justice (USDOJ) and calls for Oregon's community mental health services to help avoid unnecessary institutionalization of adults with mental illness. Under this three-year plan, the state is required to: 1) improve the way adults with mental illness transition to integrated community-based treatment from higher levels of care; 2) increase access to crisis services to avoid incarceration or unnecessary hospitalization; and 3) expand services that enable adults with mental illness to successfully live in the community, including strengthening housing and peer support services. The data collection period for the OPP ran through June 2019 and the final report is due in January 2020. After a subsequent review of this report and discussions with USDOJ, OHA will have a clearer indication regarding the next steps, if any, USDOJ recommends for the OPP.

Another important consideration of the Non-Medicaid Behavioral Health budget is the nature by which it is developed. Contrary to Medicaid, which federal law requires to support all individuals who are eligible for services and is largely based on caseload levels and the CCO rates process, most of the Non-Medicaid Behavioral Health budget functions similar to a grant program and, with certain exceptions, provides services not guaranteed to clients under state or federal law. With some exceptions, this means the budget process does not, by rule, require funding adjustments commensurate with the number of individuals treated in the community. A subset of the Non-Medicaid caseload is, however, defined as "mandated" as part of the state budgeting process pursuant to Executive Branch budget instructions. In general, *mandated caseloads* are those for which services are required by the federal government, state constitution, or court action. Three mental health caseloads fall under the mandated caseload criteria in terms of court actions: individuals who are civilly committed, found guilty of a crime except for insanity (GEI), or determined to need restorative services to be able to "aid and assist" in their defense in criminal proceedings.

The Non-Medicaid Behavioral Health budget has traditionally been adjusted up or down based on forecasted changes to civil commitment and GEI caseloads, which represent a relatively small portion of the number of individuals served in the community. Until recently, the Aid and Assist population was almost entirely served in the Oregon State Hospital; therefore, adjustments to the Non-Medicaid budget have historically not occurred bases on changes to the Aid and Assist caseload forecast. Starting in 2017-19, OHA's budget includes additional funding to support the treatment of more Aid and Assist individuals in the community to help alleviate capacity challenges at the State Hospital and ensure these individuals are placed in treatment within a federal court-mandated seven-day timeframe. For the other two mandated caseloads, the spring 2019-21 caseload forecast reflects a significant decrease in the civil commitment caseload and a small increase in the GEI population, which resulted in a net decrease to the Non-Medicaid community mental health budget in terms of caseload

adjustments. However, due to concerns regarding the potential impact this decrease may have on incentivizing outcomes related to non-mandated community mental health caseloads, the budget report for OHA's 2019-21 legislatively adopted budget includes a budget note instructing OHA to work with stakeholders to evaluate the caseload process and make recommendations to the Legislature, as necessary.



Source: Spring 2019 forecast

Apart from caseload adjustments, the Legislature has approved significant investments in the Non-Medicaid budget over the past several years. Examples of these investments include:

- ***2013-15 biennium*** – $16.7 million General Fund to increase capacity in the community mental health system; $14.3 million General Fund to expand mental health services for children and young adults; $4.2 million General Fund for supported housing and peer-delivered services; and $1.5 million for community mental health supported employment.

- ***2015-17 biennium*** – $17.6 million General Fund for new programs, including crisis services, jail diversion, rental assistance, peer-delivered services, and the expansion of the Oregon Psychiatric Access Line for Kids; $6.2 million General Fund for regional mental health specialist coordinators; $6 million General Fund for addictions treatment and recovery support; $4.1 million to expand Aid and Assist restoration levels in the community; and $14.3 million General Fund to support the roll-up of program investments made in 2013-15.

- ***2017-19 biennium*** – $17.7 million in unspent tobacco tax revenue from 2015-17 for mobile crisis services, rental assistance, school-based access to behavioral health services, and veterans' behavioral health services; this one-time carryover funding was replaced with on-going General Fund in 2019-21 to maintain these services.

Oregon's implementation of Medicaid expansion also significantly changed the way behavioral health services are funded and delivered. Prior to expansion, the Non-Medicaid Behavioral Health budget paid for many of the services needed by uninsured individuals who did not qualify for Medicaid. After Medicaid expansion, a significant

number of these clients qualified for Medicaid and the related treatment costs were subsequently shifted to the Medicaid budget and supported by the enhanced federal match available for the ACA expansion population. This cost shift to Federal Funds was estimated to save $45 million General Fund in the 2013-15 Non-Medicaid budget. This savings, however, was not removed from the Non-Medicaid budget and was instead reinvested for specific purposes in addition to the investments described above. The federal government also did not reduce the level of SAPT or Mental Health Services block grants, which further added capacity for services delivered through the Non-Medicaid budget.

Program Support and Administration

Program Support and Administration provides the support needed to ensure HSD Medicaid and Non-Medicaid programs have the administrative infrastructure, operational resources, and technology necessary to fulfill HSD's mission and statutory requirements. A key goal of the integrated HSD program is to ensure the systematic transformation of health care and that operations are effective, efficient, and fiscally sustainable. The unit organizes its work according to the following two sections:

- ***Business Operations*** – Works with program staff, leadership, community mental health programs, and other agency partners to support nearly all Medicaid and behavioral health programs. It oversees county contracts and grants, intergovernmental agreements with community mental health programs and local mental health authorities, contracts with tribes and tribal organizations, and all other physical, dental, and behavioral health contracts administered by OHA.

- ***Business Systems*** – Includes business-related functions and expenditures for information technology. The supported functions include the Medicaid Management Information System (MMIS), the Oregon Eligibility (ONE) system, Community Outcome Management and Performance Accountability Support System (COMPASS), special projects, and business systems training.

The budget for Program Support and Administration also includes funding for the Actuarial Services Unit and the Office of Program Integrity, which are functionally organized in the Central Services Division and report to OHA's chief financial officer. Prior to mid-2017, Program Support and Administration included the Medicaid eligibility processing center. With the implementation of the ONE Integrated Eligibility and Medicaid Eligibility System, which handles eligibility determinations for OHP and programs in the Department of Human Services (DHS), this function was transferred to DHS.

Legislatively Adopted Budget

The 2019-21 legislatively adopted budget for HSD totals $17.28 billion, which represents a 7% increase from the 2017-19 legislatively approved budget. The General Fund budget is $1.83 billion and represents a 39% increase from 2017-19.

The net General Fund increase totals $513.4 million and is largely driven by Medicaid revenue and cost issues. These issues include the decreased availability of federal revenue due to FMAP changes, declines in tobacco tax and Tobacco Master Settlement Agreement revenue, and Medicaid inflationary expenses. The level of General Fund needed to maintain Medicaid services would have been more significant had the Legislature not approved several changes related to provider assessments and the OHSU IGT. These changes include renewing the insurer assessment at 2% through adoption of HB 2010 (2019) for General Fund savings of $281 million; increasing the DRG hospital assessment from 5.3% to 6% for General Fund savings of $98 million; increasing the rural hospital assessment from 4% to 5.5% for General Fund savings of $33 million; and increasing and recognizing the full-biennial roll-out of the OHSU IGT for combined General Fund savings of $141 million.

There are also revenue adjustments in the Non-Medicaid Behavioral Health program resulting in General Fund costs and savings. Similar to the Medicaid program, the budget preserves Non-Medicaid services by backfilling declining tobacco tax revenue and Tobacco Master Settlement Agreement funding with $9.6 million General

Fund. The budget also continues to offset General Fund costs by using increasing marijuana tax revenue dedicated to behavioral health services. Overall, the 2019-21 legislatively adopted budget includes $64.9 million for Non-Medicaid Behavioral Health services that were previously supported with General Fund. This represents an increase of $14.2 million compared to 2017-19.

The HSD budget also includes the following investments:

- ***Behavioral Health Investment Package*** – As part of the $50 million General Fund behavioral health package, the HSD budget includes $31.3 million to support investments related to recommendations from the Children and Youth with Specialized Needs workgroup, as well as other targeted behavioral health investments. In addition to the $31.3 million, $5.7 million General Fund is included in a Special Purpose Appropriation in HB 5050 (2019) for the establishment of behavioral health interdisciplinary assessment teams, as outlined in SB 1.

- ***Behavioral Health Provider Rates*** – $13 million General Fund and related federal matching funds support a net 20% increase in SUD provider rates and, to the extent funds are available, increases in non-residential mental health provider rates. Of the $13 million General Fund, $3 million is from the $50 million behavioral health investment package.

- ***Rental Assistance*** – $4.5 million General Fund provides partial biennium support for individuals living in permanent supportive housing units. This investment corresponds to the planned construction of 500 new permanent supportive housing units funded through the capital construction process. Of the total amount, $2.9 million will be transferred to Oregon Housing and Community Services to support rental assistance payments, with OHA using the remainder to provide supportive services to help individuals successfully live in the new housing units.

- ***Project Nurture*** – $2.5 million General Fund supports a pilot project in up to four counties to provide Substance Use Disorder treatment to pregnant women based on the multi-generational treatment approach of the Project Nurture program. The parameters of the pilot project are defined in SB 2257 (2019).

- ***Behavioral Health IT System*** – $1.5 million General Fund will support the initial stage of OHA's non-Medicaid behavioral health IT system replacement project.

- ***Project ECHO*** – $1 million General Fund will help increase patient access to care for chronic and complex physical and behavioral health issues through the Project ECHO (Extension for Community Healthcare Outcomes) model, which connects primary care providers to specialists through video teleconferencing and mentoring.

- ***Sobering Centers*** – $1 million General Fund supports competitive grants to sobering centers for planning and startup costs, including operational expenses during a center's first five years of operations. This funding is appropriated in HB 5050 (2019) and is one-time in nature.

Health Policy and Analytics

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	22,205,930	45,220,124	48,127,235	48,952,426
Lottery Funds	--	24,000	24,912	24,912
Other Funds	5,803,968	38,582,250	35,186,855	31,034,920
Federal Funds	84,426,282	107,900,414	114,161,855	114,229,882
Total Funds	**$112,436,180**	**$192,726,788**	**$197,500,887**	**$194,242,140**
Positions	137	163	155	163
FTE	130.04	144.84	147.30	149.96

Program Description

The Health Policy and Analytics (HPA) Division provides policy support, technical assistance, and access to health information statistics and tools to all organizations and providers participating in Oregon's health system transformation, including other programs within OHA. HPA includes the following offices:

- ***Office of Health Policy*** – Supports the Oregon Health Policy Board, the Medicaid Advisory Council, OHA programs, and other stakeholders engaged in the design of Oregon's health system transformation. The office conducts policy analysis and development and provides technical assistance on topics such as primary care workforce development, resource leveraging, and grant development for health system transformation projects.

- ***Office of Health Analytics*** – Collects and statistically analyzes utilization, quality, and financial data to evaluate OHA program performance, provides data to support health system and program planning and implementation, analyzes trends across all payers and claims data, and performs actuarial analysis to support rate development and benefit design.

- ***Office of Clinical Improvement Services*** – Supports the implementation of the coordinated care model in all provider and payer organizations by aligning and integrating clinical resources and policies.

- ***Office of Health Information Technology*** – Provides coordination across programs, departments, and agencies in developing policies and procedures accelerating state and federal health reform goals through implementation and integration of health information technologies; leverages health IT funding opportunities from federal grants, philanthropic organizations and the private sector; and increases collaboration and communication among agencies and programs for planning and shared decision making, leveraged IT purchases, and coordination of service delivery.

- ***Office of Business Operations*** – Responsible for all of the division's operational functions. The office partners with other Shared Services offices and acts as a liaison to internal and external stakeholders related to operational functions.

- ***Public Employees' Benefits Board (PEBB) / Oregon Educators Benefit Board (OEBB)*** – Develops and administers health care insurance plans and other employment benefits, such as short-term and long-term disability, for employees in state government, universities, and the K-12 system. While these programs are operationally situated in HPA, their budget structures are distinct from HPA and discussed separately.

Revenue Sources and Relationships

HPA is mostly supported by General Fund matched with federal Medicaid administrative dollars. The federal match rates vary depending on the type of work being performed. For example, general Medicaid administrative expenses are matched at 50% whereas expenses related to technology, such as the Medicaid Management Information System, are typically matched at 75% or 90% depending on whether the money is spent on planning, implementation, or operations. In addition to Medicaid funding, HPA receives various federal grants from the U.S.

Department of Health and Human Services that help support a variety of health reform and transformation activities. Of these, the two most prominent are: 1) a Primary Care program grant to help expand access to primary care by recruiting providers and sustaining clinical resources; and 2) Health Information Technology for Economic and Clinical Health (HITECH) funding to provide incentive payments to Oregon hospitals and providers related to health care information technology, including incentives to use electronic health record systems.

The division's Other Funds revenue primarily comes from the Primary Care Provider Loan Repayment program. A significant portion of Other Funds expenditure limitation was previously included in the budget for Common Credentialing Program fees. However, the project to create a new common credentialing system and process was cancelled in July 2018 and the remaining expenditure limitation of $13.8 million was removed in the 2019-21 legislatively adopted budget. HPA also receives funds from various non-federal sources, including the National Association of Chronic Disease Directors, the American Cancer Society, and the Robert Wood Johnson Foundation, as well as fees related to the All Payer All Claims system, Oregon Prescription Drug Program, health care workforce data, ambulatory surgical data, inpatient data, and the Physician (or "J-1") Visa Waiver Program.

Budget Environment

Most of the programs in HPA were transferred from OHA's Central Services budget structure in the 2013-15 biennium. Since then, the demands of the program have continually increased regarding HPA's prominent role in transforming Oregon's health care system. Examples of this growing work include advancing the coordinated care model within the CCO system while also expanding it to PEBB and OEBB; providing the data analytics essential to reducing the long-term cost of health care and addressing unique challenges, such as the opioid epidemic; assessing the impact of potential federal changes to Medicaid policy and financing; and developing the large body of policy work to implement the next five years of health care transformation through CCO 2.0. As a result, HPA continues to face cost pressures in terms of demands on its professional staff and data analytic tools.

HPA's 2019-21 budget attempts to fund the division's immediate program needs through the addition of on-going General Fund resources and permanent staff to support the CCO 2.0 initiative. Given the significant policy and financial management changes under CCO 2.0, HPA's 2017-19 staffing levels were insufficient to continue supporting this initiative long-term. As the elements of CCO 2.0 are put into practice, any additional changes to the model will require further evaluation of HPA's budgetary and staffing constraints. In terms of technology, the All Payer All Claims (APAC) database, which reports health insurance claims, enrollment, premium costs, and provider information, is an example of a system required to help HPA address the rising cost of health care and improve health outcomes. HPA is currently maintaining and, to the extent possible, improving the APAC database and other systems within existing budgetary resources to meet growing needs. However, these systems may eventually require substantive enhancements outside the scope of the division's current budget given the complexity and criticality of these problems.

Legislatively Adopted Budget

The 2019-21 legislatively adopted budget for HPA totals $194.2 million, of which $48.9 million is General Fund. The total funds budget represents an increase of 0.8% from the 2017-19 legislatively approved budget and the General Fund budget represents an increase of 8.3%. The modest net increase in the total funds budget is driven by the $13.1 million decrease in Other Funds expenditure limitation to reflect the suspension of the Common Credentialing program and a combined $5.7 million decrease in General Fund and Other/Federal Funds limitation resulting from technical adjustments and position transfers between budget structures in the agency. The budget recognizes anticipated vacancy savings of nearly $0.2 million General Fund but does not include reductions impacting program services. The budget also includes the following investments:

- ***CCO 2.0 Staffing*** – To support HPA's role in the CCO 2.0 initiative, the budget includes $2.2 million, of which $1.3 million is General Fund for eight new positions (6.28 FTE). These positions are responsible for implementing value-based payment models, addressing social determinants of health and equity, and improving cost containment and financial accountability across the system. This adjustment also includes

$150,000 General Fund to process and analyze emergency department discharge abstract records consistent with the passage of SB 23 (2019).

- ***Behavioral Health Homes*** – $0.3 million General Fund and related federal matching dollars support two positions (1.76 FTE) responsible for monitoring, and regulating behavioral health homes, as authorized in SB 23 (2019). This adjustment is funded as part of the $50 million behavioral health investment package.

- ***Mental Health Clinical Advisory Group*** – $0.4 million General Fund and related federal Medicaid matching funds support two positions (2.00 FTE) to assist the ongoing work of the Mental Health Clinical Advisory Group, which is reestablished by SB 183 (2019).

- ***Health Information Exchange Onboarding*** – $0.4 million General Fund supports providers connecting to health information exchange entities. This funding is one-time and represents the amount of unspent funds available in 2017-19 for the same purpose.

Public Employees' Benefit Board

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
Other Funds	1,846,192,434	2,046,798,409	2,098,771,459	2,116,601,419
Total Funds	**$1,846,192,434**	**$2,046,798,409**	**$2,098,771,459**	**$2,116,601,419**
Positions	19	19	19	20
FTE	18.50	18.50	18.50	19.50

Program Description

The Public Employees' Benefit Board (PEBB) designs, contracts for, and administers health plans, group insurance policies, and flexible spending accounts for over 139,000 state and university employees and their dependents. PEBB also selects and administers life and disability insurance coverage for eligible state and university employees. The Board consists of eight voting members, of which six are appointed by the Governor and two are ex officio members (the OHA director and HPA director or their designees). The Board also includes two non-voting members from the Legislative Assembly. Program operations are administered by 20 state employees (19.50 FTE), with actuarial and third-party administrator services provided under contract.

Revenue Sources and Relationships

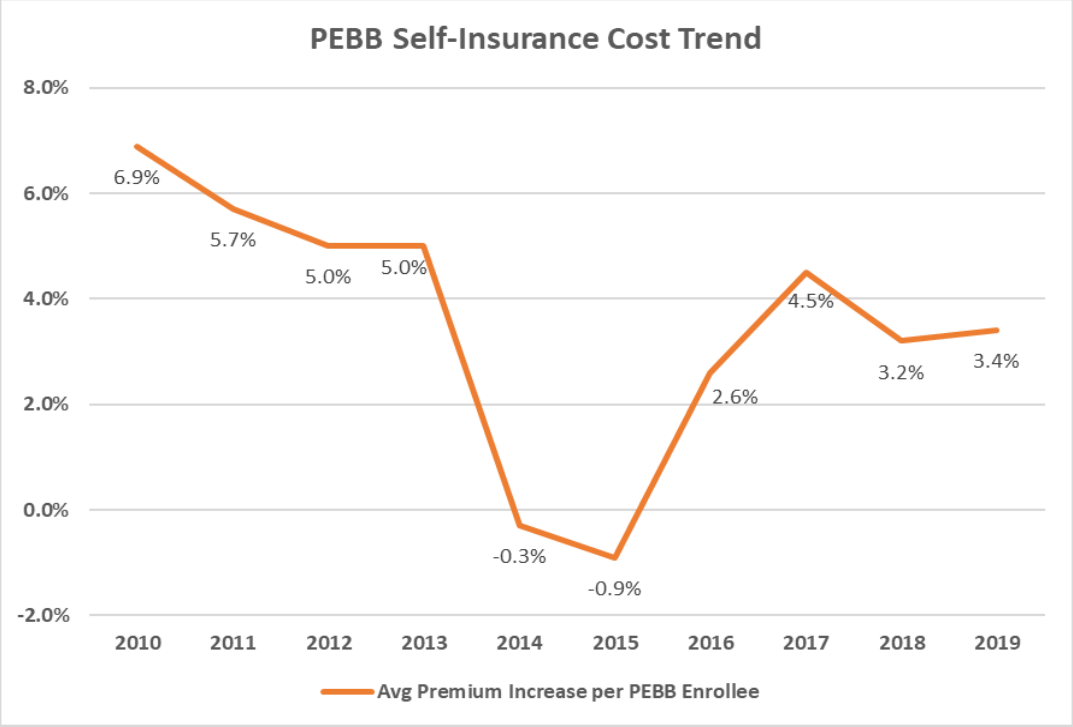
PEBB is budgeted entirely with Other Funds revenue received from premium payments for all insured individuals. The resources to pay for employee health insurance are budgeted in state agency budgets according to how each agency pays for employee salaries and benefits, be it from the General Fund, Lottery Funds, Other Funds, or Federal Funds. Once the resources are transferred to PEBB, they are accounted for as Other Funds. Approximately 45% of PEBB benefit costs are paid from General Fund in the 2019-21 legislatively adopted budget.

PEBB's operational costs are funded through an administrative assessment added to medical and dental insurance premiums and premium equivalents. By statute, the assessment cannot exceed 2% of monthly contributions from employees and employers. The assessment for the 2020 plan year is currently at 0.48% and overall administrative expenditures are estimated at $11.2 million for the 2019-21 biennium.

In 2006, PEBB began moving employee coverage toward self-insurance, which gives the Board more flexibility in plan design and cost containment. With Moda's transition to self-insurance in the 2019 plan year, 81% of PEBB members are now enrolled in self-insured medical plans and 19% are enrolled in the remaining fully-insured plan offered by Kaiser. For the fully-insured plan, the premiums PEBB collects are passed through to the insurer who carries the risk on the plan. For self-insured plans, PEBB carries the risk and must maintain a stabilization fund to cover large claims risk. Per HB 2377 (2019), $15 million of the Stabilization Fund is required to be transferred to the General Fund on May 31, 2021.

Budget Environment

The budget pressures for employer-sponsored health care such as PEBB are unique compared to Medicaid coverage. In particular, the cost trend in Oregon's self-insurance market is markedly higher and typically fluctuates between 7% and 8% each year. Despite this, the state began holding PEBB's annual per member cost growth to 3.4% in 2015-17 consistent with the state's cost containment strategy for Medicaid. During the 2017 legislative session, the Legislature adopted SB 1067, which officially required both PEBB and the Oregon Educators Benefit Board (OEBB) to adopt policies and procedures to limit annual per member per month cost increases to the 3.4% threshold. With the exception of 2017, PEBB has held annual cost increases below 3.4% since 2014.



SB 1067 also required both PEBB and OEBB to implement the following other cost containment actions:

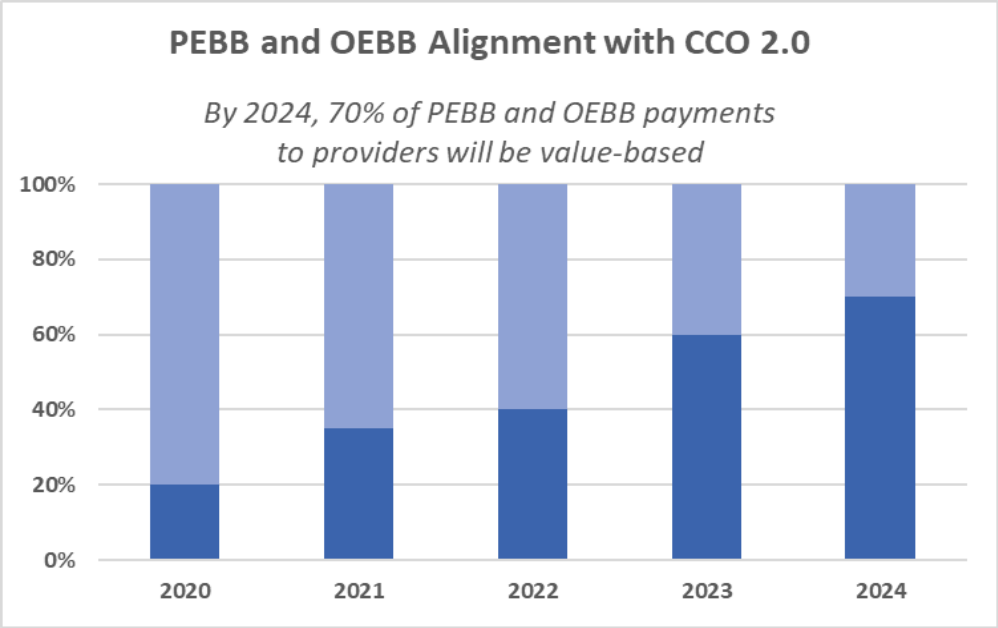
- Limit hospital reimbursement rates to 200% of Medicare rates for in-network providers and 185% of Medicare rates for out-of-network providers as of the 2020 plan year for PEBB (starting January 1, 2020) and 2019-20 plan year for OEBB (starting October 1, 2019);
- Eliminate double coverage and opt-out incentive payments for covered employees who have family members also employed by a PEBB or OEBB employer;
- Appoint the PEBB director to also serve as the director of OEBB in a permanent capacity; and
- Form a combined PEBB-OEBB executive committee and develop a plan for the merger of the boards and combine administrative functions and operations.

The adoption of SB 2266 (2019) reversed the elimination of double coverage and opt-out incentive payments before the provision went into effect. Instead, the bill requires PEBB and OEBB to impose a surcharge on an eligible employee who arranges coverage for family members if they have access to coverage as an employee in another plan offered by the boards. This change is not expected to have a material impact on expenditures.

The executive committee elected to merge the two boards through a hybrid approach, which would maintain each board's separate legal structure and governance and create an innovation subgroup and a shared services subgroup to create administrative efficiencies. Staff from both programs have already merged in the areas of

financial services, contracts, information technology systems, member services, and communications. These steps have allowed both PEBB and OEBB to each reduce their authorized positions by two. The current estimated impact of all of these changes is net savings of $81.7 million for both PEBB and OEBB in the first plan year.

Another part of PEBB's current strategy to improve health outcomes while containing costs is applying the coordinated care model (CCM) to a limited number of quality medical plans—currently five—with modest deductibles and cost-sharing. The CCM model focuses on primary care and prevention and has defined quality and access standards. CCM plans help reduce the utilization of unnecessary services, improve coordination of disease management among varying providers, and use innovative reimbursement models. PEBB's CCM focus is also indicative of its alignment with CCO 2.0. For example, PEBB plans to increase the level of reimbursements based on value-based payments according to the same schedule planned for Oregon Health Plan reimbursement to CCOs. Under this plan, at least 70% of PEBB's and OEBB' payments will be value-based by 2024.



Legislatively Adopted Budget

The 2019-21 legislatively adopted budget for PEBB is $2.12 billion Other Funds. Consistent with SB 1067 (2017), the budget caps PEBB's total core program expenditure growth at 3.4% per member per year. The budget also adds two positions and increases expenditure limitation by $0.9 million to support the planning stage of a project to replace the benefit management systems used by PEBB and OEBB with an integrated system. The current benefit management systems used by each program were built on antiquated legacy technologies and are difficult and costly to maintain. A similar adjustment is included in the OEBB budget to support its share of the planning.

The only other substantive adjustment to the PEBB budget is an expenditure limitation increase of $17.2 million to support the continuation of the insurer assessment at 2%. As specified in HB 2010 (2019), the impact of the assessment on PEBB plans is excluded from determining the 3.4% annual per capita growth cap.

Oregon Educators Benefit Board

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
Other Funds	1,507,266,355	1,709,882,105	1,739,526,870	1,740,140,020
Total Funds	**$1,507,266,355**	**$1,709,882,105**	**$1,739,526,870**	**$1,740,140,020**
Positions	22	19	19	20
FTE	22.00	19.00	19.00	20.00

Program Description

The Oregon Educators Benefit Board (OEBB) administers medical, dental, vision, and other benefits for Oregon's school districts, education service districts, and community colleges, as well as some cities, counties, and special districts. More than 150,000 participating employees, early retirees, and their eligible dependents are enrolled in benefit plans. Unlike PEBB, all OEBB plans are fully-insured and participating insurers carry the risk for cost overruns. OEBB has prioritized choice in plan options for employers and employees, resulting in a large number of different plans. Employers can choose to offer all available plans or a subset of plans to their employees.

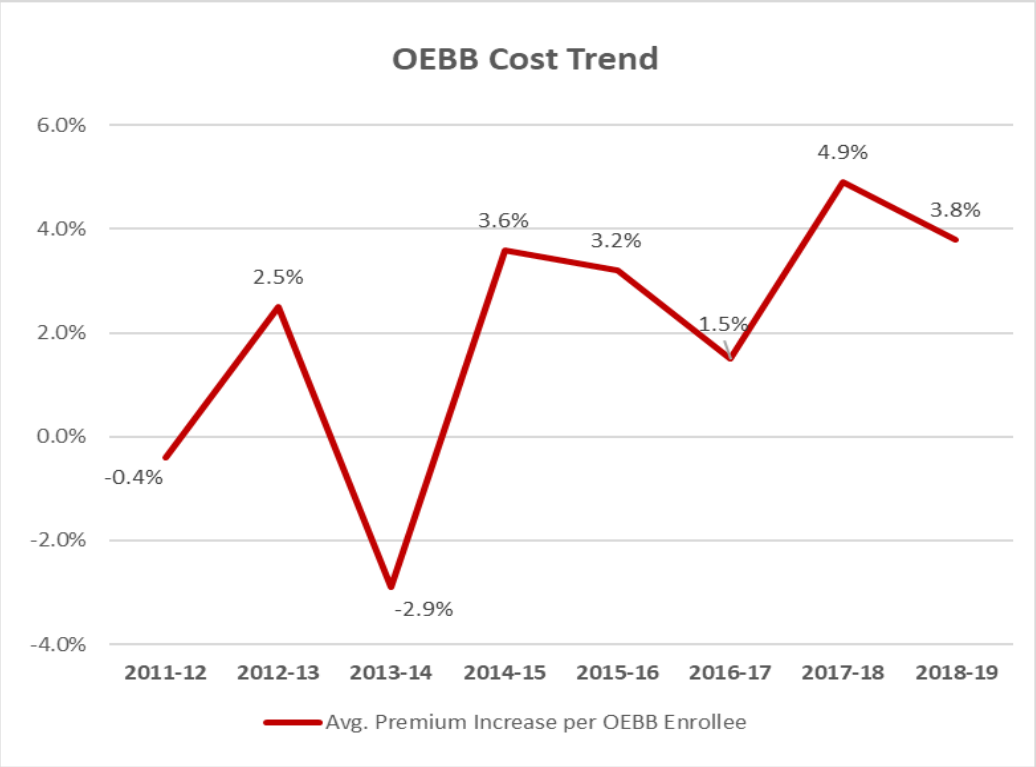
Under state law, OEBB is comprised of at least 10 members appointed by the Governor and confirmed by the Senate. Of these 10 members, the following representation must be covered: two members representing school boards; two members representing education management; two members representing education non-management; one member representing local government management; one member representing local government non-management; and two members who have expertise in health policy or risk management.

Revenue Sources and Relationships

OEBB is funded entirely with Other Funds revenue received from premium payments for all insured individuals. Operational costs are funded through an administrative assessment built into the health, dental, and vision insurance premiums. By law, the assessment cannot exceed 2% of monthly premiums. OEBB's assessment for the 2019-21 plan year is 1.3% and estimated administrative expenses total $12.6 million for 2019-21.

Budget Environment

OEBB has mostly been successful at keeping the rate of growth of average cost per employee below the 3.4% threshold since the 2011-12 plan year. However, this has been challenging due to the even higher cost trends OEBB faces in the commercial insurance market, which have ranged from 8% to 9% compared to the 7% to 8% cost trends PEBB typically faces in the self-insurance market. To keep costs down, OEBB has often relied on its breadth of available plans and member selection of lower cost options.



Notwithstanding the option of lower cost plans, containing costs over the long-term is challenging unless the underlying costs of care are addressed and health outcomes improved. OEBB has taken steps toward this goal through an initiative to move more members from preferred provider organization (PPO) plans into coordinated

care model (CCM) plans. The migration into CCM plans has increased from approximately 13,300 in 2014 to 30,900 in 2018, resulting in approximately 57% of members enrolled in a CCM plan as opposed to a PPO plan. OEBB's five-year strategy focuses on strengthening CCM participation and the model itself by ensuring plan designs have the right incentives in place for members to choose patient centered primary care homes. OEBB is also committed to the goals of CCO 2.0, including increasing the level of value-based payments according to the same schedule as PEBB and Medicaid.

Legislatively Adopted Budget

The 2019-21 legislatively adopted budget for OEBB is $1.74 billion Other Funds, which represents a 1.8% increase from the 2017-19 legislatively approved budget. Consistent with PEBB, the budget caps OEBB's total annual core program expenditure growth at 3.4% per employee and invests $0.9 million and two positions (2.00 FTE) to support OEBB's share of the planning stage of the project to replace the benefit management systems used by OEBB and PEBB with an integrated system.

Public Health

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	39,805,881	65,325,147	73,292,764	94,764,237
Other Funds	154,540,730	196,801,605	192,218,213	218,058,929
Other Funds (NL)	25,249,525	40,000,000	40,000,000	40,000,000
Federal Funds	211,115,309	248,100,646	262,783,627	276,352,311
Federal Funds (NL)	81,902,469	102,729,051	102,729,051	102,729,051
Total Funds	**$512,613,914**	**$652,956,449**	**$671,023,655**	**$731,904,528**
Positions	784	771	739	767
FTE	760.59	741.37	731.11	755.53

Program Description

The Public Health Division administers a variety of programs addressing behavioral and social drivers of health by working to ensure physical and social environments promote health and make it easier for people to make healthy choices. The program manages more than 100 prevention-related programs that halt the spread of disease, protect against environmental hazards, and promote healthy behaviors. Public Health programs can complement and amplify investments in other health care programs, and, by focusing on prevention, have the potential to reduce the need for costly health care services. Public health also helps clinical health care providers, including coordinated care organizations, adopt evidence-based best practices for the delivery of clinical preventive health services.

Oregon's public health system includes federal, state, county, and local agencies, private organizations, and other diverse partners working together to protect and promote the health of Oregonians. As the state component of the system, the Public Health Division serves in a unique leadership role. Public health services in Oregon are delivered directly by the Public Health Division or through contracts with local and tribal public health authorities, nonprofit organizations, and clinics.

The Public Health Division has four general program areas:

- ***Office of the State Public Health Director*** – Responsible for strengthening the application of policy, planning, and performance measurement across the programs. The office guides the strategy, operations, scientific activities, communications, and policies of public health programs and ensures Oregon's public health system is effective and coherent. The office also provides support and technical assistance to county health departments and oversees county health plans and the division's fiscal responsibilities and policies.

- ***Center for Prevention and Health Promotion –*** Helps communities and residents achieve and sustain lifelong health, wellness, and safety through the prevention of chronic diseases, child developmental delays, injuries and unsafe relationships, and physical and behavioral problems. The program also works to promote health outcomes by creating environments, policies, and systems that support wellness, such as access to healthy food, physical activity, and safe, tobacco-free environments. The center has the following five sections: Adolescent, Genetics and Reproductive Health; Health Promotion and Chronic Disease Prevention; Injury Prevention and Violence Prevention; Maternal and Child Health; and Nutrition and Health Screening. These programs promote health throughout the lifespan, including pregnancy, early childhood, adolescence, and adulthood.

  An important example of the center's prevention efforts includes activities focused on pregnancy and early childhood to promote the health and well-being of pregnant women and children. Home visiting is one of the most commonly used and effective approaches in serving families with pregnant women, newborns, and young children. Pursuant to legislation adopted during the 2019 session, the center is currently developing a new voluntary universal home visiting model available to all families with newborns.

- ***Center for Health Protection*** – Protects the health of individuals and communities through establishing, applying, and ensuring compliance with regulatory and health-based standards. The center's six sections include: Radiation Protection Services; Drinking Water Services; Environmental Protection; the Oregon Medical Marijuana Program; Health Care Regulatory and Quality Improvement; and the Health Licensing Office. Within this capacity, the center monitors the health status of communities and the performance of the health care systems and has a regulatory role in ensuring 3,400 drinking water systems, 20,000 restaurants, 14,000 radiation sources, 3,400 swimming pools, 2,300 tourist facilities, 18,000 medical marijuana grow sites, and 363 miles of coastline are safe. The center regulates and monitors over 40,300 licensed health professionals and oversees an array of health care facilities, such as ambulatory surgical centers, birthing centers, and dialysis facilities. Services are provided primarily through county health departments and other community and tribal health organizations. The center also works with public and private entities to ensure Oregonians have access to the health care they need and that these entities meet established standards.

- ***Center for Public Health Practice*** – Supports a strong public health system by strengthening the partnership between the state and local public health departments, and by ensuring core public health functions are sustained in the areas of infectious disease prevention and control, laboratory services, and vital records. The center has the following six sections: Center for Health Statistics (vital records); Acute and Communicable Disease Prevention; State Public Health Laboratory; HIV, Sexually Transmitted Diseases and Tuberculosis Prevention; Immunizations; and Health Security, Preparedness and Response. The center's programs work with local and tribal governments, a wide range of community partners, health care providers, and affected communities to prevent, investigate, and control infectious diseases, and reduce the burden of disease and health inequities across the state. The center coordinates interventions to control disease outbreaks; screens all newborn infants for biochemical disorders to prevent disability or death; and collects and analyzes vital records data needed to understand and plan for health trends. As part of public health emergency preparedness, the center conducts testing for biological agents of mass destruction (e.g. anthrax) and emerging public health events and diseases, such as wildfires, Zika, and Ebola.

Oregon's public health system relies strongly on the role of local public health authorities. In 2018, Wallowa County returned its local public health authority status to the Public Health Division. With this change, there are currently 33 local public health authorities in Oregon, which include one public health district covering three counties (Wasco, Sherman, and Gilliam). Local public health authorities provide public health prevention services and some clinical services including public health nurse home visiting, HIV screening and counseling, immunization programs, and communicable disease testing, treatment, and follow-up. Some authorities, such as Multnomah County, provide primary care through safety net clinics.

Prior to 2017, each local public health authority was required to deliver or assure ten specific public health services outlined in statute. Subsequent to recommendations from the Task Force on the Future of Public Health

Services and the passage of HB 3100 (2015), local public health authorities must, at a minimum, meet the following seven foundational capabilities: assessment and epidemiology; emergency preparedness and response; communications; policy and planning; leadership and organizational competencies; health equity and cultural responsiveness; and community partnership development. The authorities must also establish the following foundational programs: communicable disease control; environmental public health; and prevention of injury and diseases and promotion of health. In addition, local public health authorities must adopt and continually update a local public health modernization requirement and satisfy other capabilities identified by OHA.

Revenue Sources and Relationships

More than half of the Public Health Division's budget is funded through Federal Funds, including Medicaid match for contraceptive care and voluntary universal home visiting, payments to support the WIC program, and over 90 grants categorically dedicated for specific purposes, such as emergency and hospital preparedness, cancer prevention and control, and safe drinking water. Given the categorical designation of Public Health's myriad federal grants, the division is limited in terms of how a significant portion of its budget can be expended. The division must continuously monitor and manage how those funds are spent, ensure that positions supported with one or multiple federal grants are appropriately financed according to the work they perform, and plan for any changes in federal revenue and the expiration of one-time grants. The Federal Funds budget also includes funding authorized as Nonlimited, which allows the agency to increase this portion of the budget administratively if the revenue is available. The Nonlimited federal revenue is currently budgeted at $102.7 million and represents federal payments to support WIC program costs.

Approximately 35% of the budget is from Other Funds revenue. Similar to the federal grant revenue received, the division's Other Funds revenue is received from various sources and must be used for specific purposes established in statute. Additionally, some of this Other Funds revenue is from various fees established in statute. Public Health must carefully manage expenditures to these fee levels from year to year because they do not grow with the cost of inflation unless the Legislature enacts statutory changes to raise the levels. Examples of the division's Other Funds revenue include tobacco taxes dedicated to tobacco cessation and prevention activities and various fee-based programs, such as newborn screening tests, licensing of hospital and inpatient care facilities, professional licensing, vital records, and licensing and inspection of public places (e.g. food, pool, and lodging). Similar to Public Health's Nonlimited Federal Funds, the division's Other Funds budget also includes Nonlimited revenue supporting the WIC program. The Nonlimited Other Funds totals $40 million and represents rebates from manufacturers of infant formula.

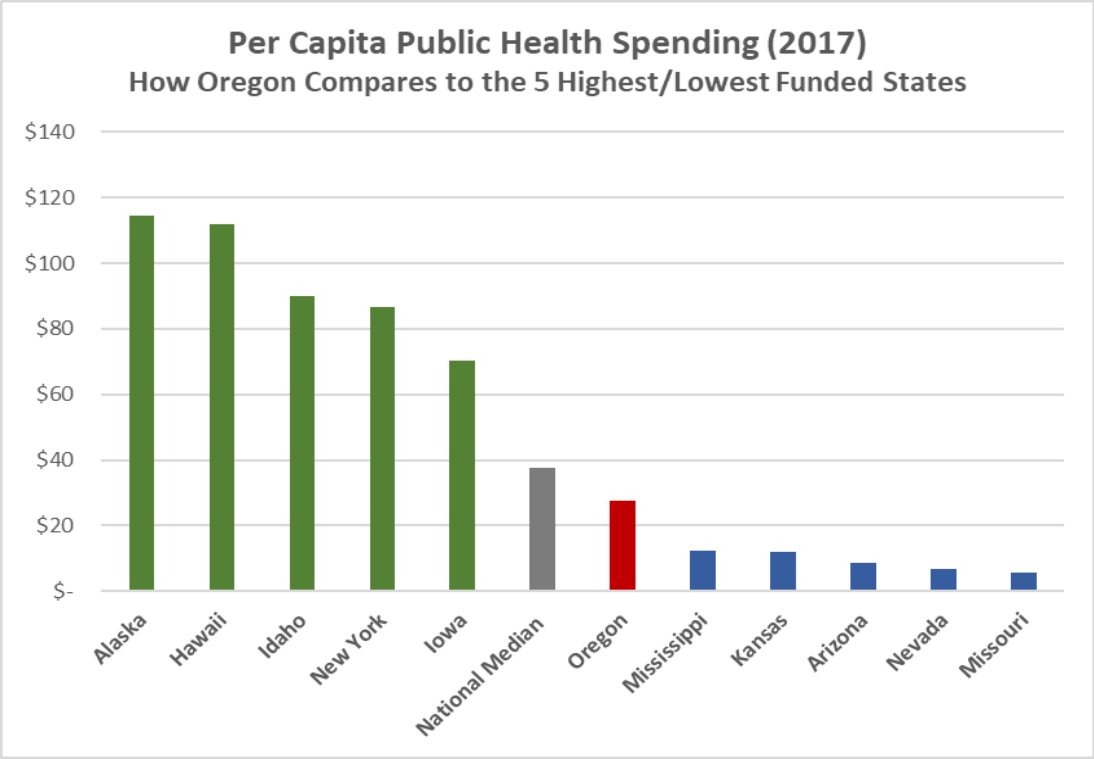
General Fund currently supports 13% of Public Health's budget and has grown considerably over the past two biennia. The 2019-21 legislatively approved budget includes $94.8 million General Fund, which is more than double the amount of General Fund appropriated in 2015-17. Most of the growth in General Fund can be attributed to three issues. First, $17.6 million General Fund was used to backfill declines in medical marijuana revenue in both 2017-19 and 2019-21. Prior to legalization of recreational marijuana, available medical marijuana revenue was used to offset General Fund in several Public Health programs. Subsequent to legalization, the number of medical marijuana cardholders has declined, and many medical marijuana licensees have chosen to transition to the recreational regulatory structure under the Oregon Liquor Control Commission, which significantly decreased the available amount of medical marijuana revenue. Even with the $17.6 million backfill, $1.5 million in medical marijuana revenue still supports non-medical marijuana programs and will eventually need to be backfilled in light of on-going declines in revenue. Second, the 2017-19 budget included an increase of $6.7 million General Fund to support reproductive health services required under HB 3391 (2017). In 2019-21, this investment included roll-up costs of $5.1 million for full biennialization. Finally, the Legislature appropriated $15 million over the course of 2017-19 and 2019-21 to support Public Health Modernization.

Budget Environment

From 1900 to 2017, life expectancy in the United States increased from an average of 47.3 years to 78.6 years. According to the Centers for Disease Control and Prevention, approximately 25 years of this roughly 30-year gain in lifespan is attributable to advancements in public health and the remaining five years from medical care

innovations. Studies also suggest that the public perception of this historical increase in lifespan is due to the reverse. This scenario is emblematic of a theme often raised when considering the Public Health Division's budget—when public health programs work well, fewer people are aware of them.

A critical public health function is to improve well-being and achieve health outcomes through prevention, which is less expensive than caring for people with health problems in clinical settings. However, like many other health and human services programs, public health faces significant funding challenges. According to State Health Access Data Assistance Center at the University of Minnesota, Oregon ranked 30th in per capita state funding of public health in 2017, with funding of $27.71 per person. This compares to a nationwide median of $37.48 per person. Oregon also ranks lower than neighboring Idaho at $90.01 (ranked 3rd), California at $61.70 (ranked 7th), and Washington at $41.39 (ranked 21st).



An important issue related to Oregon's public health budget environment is adequately supporting Public Health Modernization. Threats to public health continue to grow in terms of increased opportunities for the spread of communicable diseases, changes in climate, and other 21st century challenges. HB 2348 (2013) created the Task Force on the Future of Public Health Services to study the regionalization and consolidation of public health services, assess the future of Oregon's public health system, and make recommendations for legislation. The 2015 Legislature subsequently required OHA to adopt and update a statewide public health modernization assessment, including developing a plan for the distribution of funds to local public health authorities. The assessment, which was completed in 2016, addressed two issues: 1) the extent to which the existing system meets the requirements of a modern public health system; and 2) the resources needed to fully implement public health modernization.

To address the gaps in the public health assessment and to build a sustainable infrastructure to support public health modernization over the long-term, the assessment recommended an initial investment of $30 million in the 2017-19 biennium, with an eventual increase of $210 million in additional funding to fully implement public health modernization. Achieving an investment anywhere near this level is improbable in the near term due to budget constraints and the multitude of other statewide spending priorities. As of the 2019-21 legislatively adopted budget, approximately $15.6 million General Fund has been authorized for Public Health Modernization, which includes a $5 million initial investment in 2017-19, an additional $10 million investment in 2019-21, and an inflationary increase as part of the 2019-21 current service level budget process.

Legislatively Adopted Budget

The 2019-21 legislatively adopted budget for the Public Health Division totals $731.9 million total funds, which represents a 12.1% increase from the 2017-19 legislatively approved budget level. The General Fund budget is $94.8 million and represents a 45.1% increase from 2017-19. The growth in funding is largely due to increased support for Public Health Modernization, new funding for a voluntary universal home visiting program, and the backfill of declining medical marijuana revenue. The following summarizes the key changes:

- ***Public Health Modernization*** – $10 million General Fund adds to the $5 million General Fund investment in the 2017-19 biennium to advance Public Health Modernization activities. The additional investment will increase communicable disease prevention and response activities, support efforts to improve health equity, increase emergency response planning, and help develop tribal modernization plans, among other key modernization priorities.

- ***Universal Home Visiting*** – $4.7 million, of which $2.9 million is General Fund, supports a new voluntary universal nurse home visiting program for families with newborns. In order for coverage of these services to be available for all Oregon families, SB 526 (2019) requires health benefit plans offered in Oregon to reimburse the cost of the newborn home visiting services without any cost-sharing. For those who do not have health care through the commercial market, OHA is seeking a Medicaid State Plan Amendment for these services to be available to families who receive health care through the Oregon Health Plan. The Public Health Division will design the program consistent with the Family Connects home visiting model and implement it over a three-biennia period. This investment supports program design activities and the incremental rollout of services to individuals eligible for Medicaid.

- ***Medical Marijuana Revenue Decline*** – $5.5 million General Fund backfills declining medical marijuana revenue used to support local public health authorities. In the past, this revenue had replaced General Fund in several core public health programs, including support for local public health authorities, Drinking Water Services, Emergency Medical Services, and others. Laws passed during the 2015, 2016, and 2017 sessions related to recreational marijuana have significantly reduced medical marijuana program revenue. In 2017-19, the Legislature approved $12.1 million General Fund to mitigate this issue across multiple Public Health programs, leaving state support for local public health authorities as the last non-medical marijuana program budget dependent on this revenue stream. Even with the $5.5 million General Fund backfill, $1.5 million in medical marijuana revenue remains budgeted for local public health pass-through funds and will eventually need to be backfilled to maintain current services given the continued decline of this revenue source.

- ***Fee Adjustments*** – The budget increases Other Funds expenditure limitation to account for fee increases in three separate programs. This includes $1.9 million and five positions (5.00 FTE) for the revised structure of Drinking Water Services fees approved in SB 27 (2019); $0.1 million for a new fee established through the administrative rules process to all manufacturers of children's products to apply for waivers under the Toxic Free Kids Program; and $0.06 million for increased food, pool, and lodging fees approved by SB 28 (2019). The impact for the food, pool, and lodging fee increases is minimal because most of the related regulatory work is delegated to local public health authorities, which directly collect the fees to support their programs.

- ***Senior/WIC Nutrition Programs*** – $0.2 million General Fund provides fresh Oregon-grown fruits and vegetables from farmers' markets and roadside stands to eligible low-income seniors under the Senior Farm Direct Nutrition Program. The budget also includes $1 million for the same purpose for individuals eligible through the WIC program.

- ***Tobacco Tax Forecast*** – Consistent with the May 2019 revenue forecast, Other Funds expenditure limitation is decreased by $0.3 million to reflect lower-than-anticipated tobacco tax revenue available for public health cessation and prevention activities. Unlike declines in tobacco tax revenue dedicated for the Oregon Health Plan and community mental health services, the budget does not backfill the revenue decline in Public Health with General Fund.

Oregon State Hospital

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	453,736,884	509,076,125	494,313,354	497,517,027
Other Funds	17,734,460	36,145,203	70,340,663	70,328,792
Federal Funds	45,372,776	34,852,587	38,792,314	38,929,554
Total Funds	**$516,844,120**	**$580,073,915**	**$603,446,331**	**$606,775,373**
Positions	2,269	2,286	2,283	2,284
FTE	2,268.82	2,279.45	2,282.82	2,283.82

Program Description

The Oregon State Hospital (OSH) is an integral part of the statewide behavioral health system, providing the highest level of psychiatric care for adults with severe mental illness from all 36 counties at the Salem and Junction City campuses. The OSH budget also supports the 16-bed Pendleton Cottage, which is Oregon's only state-operated secure residential treatment facility and is located on the grounds of the former Easter Oregon Training Center in Pendleton. The hospital's services include 24-hour nursing, psychiatric care, treatment planning, pharmacy, laboratory, food and nutritional services, and vocational and educational services. By leveraging these resources, OSH's main role is to treat individuals and prepare them to safely return to their communities as soon as they are ready.

Patients receiving treatment at OSH fall into one of the following three commitment types:

- ***Civil Commitment*** – People who have been found by a court to be an imminent danger to themselves or others, or who are unable to provide for their own basic health and safety needs, due to their mental illness. A subset of this population includes people who have significant co-occurring medical issues, such as dementia, Alzheimer's, or traumatic brain injury.

- ***Guilty Except for Insanity (GEI)*** – People who have committed a crime but could not be convicted because their mental illness prevented them from following the law or understanding the act was illegal. The Psychiatric Security Review Board (PSRB) has statutory jurisdiction over GEI clients receiving treatment in OSH or on conditional release in the community.

- ***Aid and Assist*** – People who have been arrested but determined unable to participate in their legal proceedings due to a mental illness and need restorative mental health services in order for them to understand the criminal charges against them and "aid and assist" in their own defense. These patients are often referred to as the ".370 population" since they are referred to OSH by courts under ORS 161.370.

Management of the overall behavioral health system has a large impact on the success of OSH. The hospital's key partners include the OHA Health Systems Division, the PSRB, regional hospitals, community mental health programs, advocacy groups, and other community stakeholders. To ensure only people who need hospital-level care are admitted, a robust array of preventive, treatment, and crisis services must be available in the community. The community behavioral health system must also have sufficient capacity to provide services and supports in a variety of integrated and independent settings tailored to each individual's needs for patients to be released from the hospital when they are ready.

The hospital has gone through significant programmatic changes over the past several years. The antiquated facilities in Salem were replaced at the end of 2011 with a modern psychiatric treatment and recovery hospital, which has a maximum capacity of 586 beds, of which 554 are currently active. A second new hospital, located in Junction City, was opened in March 2015. This facility has a maximum capacity of 174 beds, of which 112 are active through the utilization of four wards (96 beds) and two cottages (16 beds). With the opening of the

Junction City facility, the OSH campus in Portland was closed and all patients were transferred to the Salem and Junction City campuses. The Blue Mountain Recovery Center in Pendleton was closed in early 2014.

The replacement of the old state hospital involved a long process of study and assessment, beginning in the 2003-05 biennium. The first assessment report was released in May 2005 and concluded the previous facilities were not conducive to best practices of contemporary mental health treatment. In 2006, the agency released a report titled, *Framework Master Plan, Phase II Report*, which contained an analysis of the demand for hospital services for the next 25 years and made recommendations to meet that demand. The report noted that hospital demand was predicated on a robust array of community-based mental health services—a mental health system not yet in place in Oregon.

In response to the report, the construction of two new facilities was authorized—one in Salem at the original OSH campus and a smaller one near Junction City adjacent to a planned Department of Corrections facility. Construction began on the new Salem facility in September 2008. This outcome was based on a number of critical assumptions, including the closure of the Portland campus and Blue Mountain Recovery Center, as well as continued development of the community mental health system. The cost of the entire project, including the Salem and Junction City facilities, project management and staffing, and the implementation of an electronic health records system through the Behavioral Health Integration Project, was slightly over $500 million.

Revenue Sources and Relationships

Consistent with the 2019-21 legislatively adopted budget, OSH's budget is comprised of 82% General Fund, 12% Other Funds, and 6% Federal Funds. A small portion of the hospital's General Fund budget ($0.8 million) is distinctly appropriated for capital improvements at the Salem and Junction City campuses. Consistent with ORS 276.285, these funds will be transferred to an account dedicated for capital improvement projects, which the agency has the flexibility of using during the biennium or saving for capital improvement projects in future biennia, as necessary.

The hospital receives most of its Other Funds revenue from insurance reimbursements and settlements for billable services for covered patients, principally through Medicare-eligible services and, to a lesser extent, third-party (commercial) insurance. Some revenue also comes from patients' Social Security benefits, private donations and grants, and miscellaneous revenue from certain hospital services, such as cafeteria and coffee shop sales. Most of the hospital's federal revenue comes from federal Disproportionate Share Hospital (DSH) payments available to eligible psychiatric institutions to help defray the cost of providing uncompensated care. It also includes Title XIX Medicaid, which supports services for eligible patients under age 21 or 65 and older, as well as patients in the Pendleton Cottage. Federal law otherwise prohibits Medicaid reimbursement for patients age 21 through 64 who are in mental health and substance use disorder residential treatment facilities larger than 16 beds. This rule is known as the "Institutions for Mental Diseases (IMD) exclusion."

The relationship between the hospital's General Fund, Other Funds, and Federal Funds resources is important given the high cost necessary to maintain 24-hour care at the hospital and the General Fund savings or costs that can occur commensurate with fluctuations in Other Funds and Federal Funds revenue. Over the past four years, the hospital has undertaken a significant effort to improve its ability to bill for services reimbursed by Other Funds and Federal Funds revenue. Upon the completion of hospital improvements in 2016, the number of beds certified by the Centers for Medicare and Medicaid Services (CMS) increased from 115 to 569, which means the hospital can bill for patients covered by Medicare, Medicaid, and third-party insurance. To maintain CMS certification, the hospital must continue meeting certain quality and safety standards.

The 2017-19 legislatively adopted budget recognized the anticipated new revenue by increasing Other Funds expenditure limitation by $40.5 million. Of this amount, $10.4 million was approved to help maintain CMS compliance through safety improvements, staffing levels (increase of 32 positions), and standing up the new billing processes and systems. The remaining $30.1 million of additional revenue was used to reduce OSH's General Fund budget by the same amount as a budget-saving measure. Throughout 2017-19, however, the

hospital experienced significant challenges and delays in implementing the new billing processes and systems, which resulted in the Legislature restoring most of the General Fund reduction through two separate agency budget rebalances—$15 million in the December 2018 rebalance and $11 million in the May 2019 rebalance. In addition to the Other Funds reimbursement challenges, the estimated amount of federal DSH revenue is expected to decline by roughly $10 million. The 2019-21 budget continues to rely on the anticipated Other Funds and Federal Funds revenue given OHA's on-going work to assess and resolve these challenges. However, to the extent the agency's efforts to improve billings and identify other solutions do not mitigate the revenue challenge, a General Fund investment will be necessary to maintain services at the hospital.

Budget Environment

As a 24-hour institution operating every day of the year, OSH functions very differently from the rest of the agency. The primary cost driver is staff, with over 70% working in direct care positions, such as nurses, psychiatrists, and psychologists. Employee salaries and benefits comprise 85% of the budget. A significant amount of the program's services and supplies expenditures are also directly related to patient care, such as prescription drugs and food.

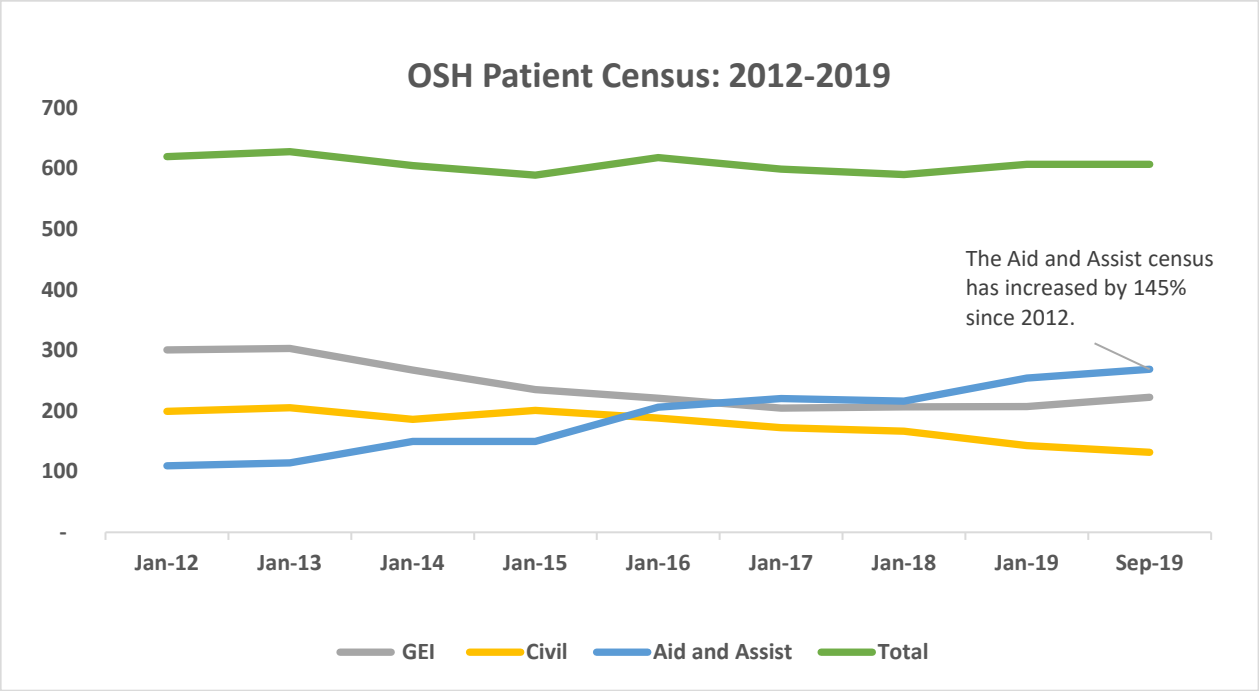
Per ORS 441.154 and ORS 441.155, the hospital's staffing plan is set by the nurse staffing committee, composed of both nurse management and members represented by collective bargaining (AFSCME-RN). The staffing needs are based on the level of acuity (the severity of symptoms and level of care patients need) and commitment type (civil commitment, GEI, and Aid and Assist). Sufficient staffing is key to OSH's ability to remain compliant with U.S. Department of Justice (USDOJ) guidelines for the Civil Rights of Institutionalized Persons Act, specifically those areas related to adequate nursing care, adequate protection from harm, ability to provide adequate mental health care, and appropriate use of seclusion and restraints. A consequence of this budget structure is that the agency has very little flexibility to manage cost increases or budget reductions without directly impacting the quality of care and safety of patients and staff. Holding positions vacant, a common cost-saving strategy in other parts of the agency, directly results in increased costs for overtime or contractual nursing services.

Another challenge is finding the appropriate balance within the continuum of care for institutional and community-based services. The continued development of community residential capacity and the advancement of pharmacological treatment has enabled more mental health services to be provided at the community level rather than the institutional level. Recognizing that effective treatment requires a strong continuum of care involving various venues, the state shifted significant resources from large, state-owned institutional settings to local, community-based care and treatment for mental health services. As a result, OSH has gone from a peak patient population of over 5,000 in the 1950s to a current population fluctuating between 600 and 650. In the process, the role of the hospital has changed from a focus on custody and care to providing active specialized psychiatric treatment.

USDOJ has been actively involved in Oregon's mental health system. It conducted a review of OSH under the Civil Rights of Institutionalized Persons Act and issued a highly critical report in January 2008, before the new facilities were built. Many of the issues identified by USDOJ have been addressed through the new facilities, although concerns remain that patients are often not moved out of the hospital quickly enough. Again, a critical element of this situation is the availability of adequate services in the community. In 2011, USDOJ requested extensive documentation relating to services available in Oregon's community mental health system, with a focus on ensuring patients receive care in the least restrictive settings possible. The availability of these services is important from a legal perspective. In 1999, the U.S. Supreme Court ruled in *Olmstead v. L.C.* that unjustified segregation of persons with disabilities constitutes discrimination in violation of the Americans with Disabilities Act. In 2012, the State of Oregon and USDOJ entered into an agreement to address gaps in the state's delivery of community mental health services. In July 2016, OHA finalized the three-year Oregon Performance Plan, which requires the state to: 1) improve the way adults with mental illness transition to integrated community-based treatment from higher levels of care; 2) increase access to crisis services and community-based supports to avoid incarceration or unnecessary hospitalization; and 3) expand services and supports that enable adults with mental illness to successfully live in the community, including strengthening housing and peer support services. The plan's

data collection period ended July 1, 2019 and OHA's final report is due January 2020. A final report from an independent contractor assessing the state's compliance is due in May 2020.

Throughout this time, the GEI and civil commitment populations have decreased, but the Aid and Assist population has more than doubled, from approximately 110 at the beginning of 2012 to over 260 in 2019. At times, more than 50 individuals under Aid and Assist court orders have been placed on an admissions list pending the availability of bed space in the hospital. This scenario carries significant budget and legal risks to the extent Aid and Assist patients are not admitted within a federal court-ordered seven-day period (*Oregon Advocacy Center v. Mink*). In June 2019, a Washington County court held the state in contempt for not meeting the seven-day requirement for four Aid and Assist admissions. A separate contempt proceeding was brought against OHA in federal court, with the judge requiring OHA to report within 90-days the agency's efforts to return to compliance with the seven-day requirement.



The state has taken multiple actions over the past few years to address the increase in court-ordered Aid and Assist admissions. In 2015-17, the community mental health budget received a General Fund investment of $4.1 million to provide more services for Aid and Assist patients in the community. The December 2018 Emergency Board increased this amount by $1.5 million General Fund for additional support through the remainder of the 2017-19 biennium. In turn, the 2019-21 legislatively adopted budget includes an additional $7.6 million General Fund in on-going support for this purpose. These funds will focus on building community capacity for restorative Aid and Assist services in the counties with the highest court-ordered Aid and Assist admissions.

The Legislature also adopted legislation in the 2019 session to enhance the process for determining defendants' fitness to participate in their own trials and the restorative services they receive under court orders. SB 24 (2019) requires courts to consider ordering rehabilitation services in the least restrictive setting possible or finding an alternative disposition for a defendant who does not require a hospital level of care. It also allows for the commitment of misdemeanor defendants to OSH only when a hospital level of care is necessary. SB 25 (2019) creates timelines for courts to deliver orders for fitness to proceed evaluations and for public and private entities to deliver relevant mental health records to fitness evaluators.

At the end of the 2019 session, OHA announced the opening of two cottages at the Junction City campus to help the state remain in compliance with the court-ordered seven-day requirement. This action allowed for the transfer of civil commitment patients from Salem to Junction City and, in turn, made available a new 26-bed unit

for Aid and Assist patients in Salem. The full effect of these changes on the Aid and Assist population has not yet been determined, but the agency currently remains in compliance with the seven-day requirement.

Legislatively Adopted Budget

The 2019-21 legislatively adopted budget for OSH totals $606.8 million, which represents a 4.6% increase from the 2017-19 legislatively approved budget. The General Fund budget is $497.5 million, which represents a decrease of 2.3% from 2017-19. This decrease from 2017-19 to 2019-21 is the result of a General Fund increase approved as part of the agency's May 2019 budget rebalance to support cost increases identified as one-time only in 2017-19.

The 2019-21 budget supports the existing census level without any administrative reductions. The budget also includes the following investments:

- ***Suicide prevention*** – $1 million General Fund supports ligature removal, facility alterations, and other environmental changes to reduce the risk of patient injury and suicide. This investment helps OSH conform to heightened safety requirements by CMS and The Joint Commission.
- ***Hepatitis C treatment*** – $1.6 million General Fund expands hepatitis C treatment to OSH patients who remain in the hospital long enough to receive the treatment regimen. This adjustment mirrors the coverage now available under the Oregon Health Plan for treatment of members with any stage of the disease.
- ***Shift differentials*** – $1.9 million General Fund pays for the cost of nursing staff shift differentials that were negotiated as part of the collective bargaining process.

As mentioned earlier, the agency's 2019-21 budget continues to rely on Other Funds revenue that may not materialize due to delays in the agency's effort to increase Medicare and third-party insurance reimbursements. This issue, plus a forecasted decrease in available federal DSH money, remain a significant 2019-21 budget risk. The budget report for OHA's budget bill (SB 5525) requires the agency to continue monitoring revenue collections for the hospital throughout 2019-21 and present solutions to address the revenue shortfall in each agency budget rebalance report submitted to the Legislature.

Central Services

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	19,819,362	27,941,146	28,476,390	35,951,670
Lottery Funds	--	31,570	32,769	32,710
Other Funds	1,973,783	2,671,614	2,340,214	2,585,222
Federal Funds	7,324,597	9,546,389	6,001,227	10,865,911
Total Funds	**$29,117,742**	**$40,190,719**	**$36,850,600**	**$49,435,513**
Positions	109	113	108	139
FTE	107.61	107.37	107.11	138.89

Program Description

Central Services provides the leadership and business support to achieve the agency's mission. This budget structure supports the following programs:

- ***Director's Office*** – Responsible for the overall leadership, policy development and administrative oversight for the agency. This includes coordination with the Governor's Office, Legislature, other state and federal agencies, partners and stakeholders, local governments, advocacy and client groups, and the private sector.

- ***External Relation's Division*** – Responsible for building strong relationships with the public, media, Legislature, and other agencies at the state and federal levels. The division also helps create a broad understanding of how OHA contributes to the health of Oregonians.

- ***Agency Operations Division*** – Provides operational support and human resources services to OHA. The division includes Central Operations and Human Resources.

- ***Fiscal Division*** – Provides leadership and oversight of financial policies and coordinates budget development and execution for OHA. The division includes the functional areas of budget and health care finance.

- ***Office of Equity and Inclusion*** – Works on behalf of OHA and the broader health care system in the state to ensure the elimination of avoidable health care gaps and to promote optimal health for Oregonians.

Revenue Sources and Relationships

Central Services is funded based on a federally approved cost allocation plan where programs are charged according to their respective state and federal funding sources for the support they receive from the programs within Central Services. The transfer of programs into or out of OHA, as well as the enhancement or reduction of existing OHA programs, can impact the model's cost allocation statistics and result in changes to the amount of General Fund, Other Funds, or Federal Funds supporting Central Services.

Budget Environment

General Fund cost pressures in Central Services over the past several years have largely related to process and program changes impacting the agency's cost allocation model. The most notable example of this occurred when the Oregon State Hospital was brought into the agency's cost allocation model during the 2015-17 biennium, which had a significant impact on the General Fund because of its use as the primary resource for State Hospital expenditures. The transfer of programs to and from the agency have also had an impact, such as the transfer of the Oregon Health Plan eligibility processing center to the Department of Human Services in 2017-19. Based on changes like these, the impact on the cost allocation statistics resulted in cost shifts from Other Funds and Federal Funds to the General Fund in the amounts of $3.8 million in 2015-17, $4.2 million in 2017-19, and $3.9 million in 2019-21. Similar General Fund increases to support the cost allocation model also occurred in the State Assessments and Enterprise-wide Costs and Oregon State Hospital budgets during this period.

Legislatively Adopted Budget

The 2019-21 legislatively adopted budget totals $36 million, which represents a 23% increase from the 2017-19 legislatively approved budget. The General Fund budget is $27.9 million and represents a 29% ($7.5 million) increase from 2017-19. The large percentage increases in both the total funds and General Fund budgets are due to the following adjustments:

- ***Community Partner Outreach Program*** – This program was transferred from OHA to the Department of Human Services (DHS) as part of the transfer of Medicaid eligibility services in 2017-19. Based on the subsequent determination by DHS and OHA that this program was not sufficiently aligned with the Medicaid eligibility process, the program has been returned to OHA. This results in the transfer of $9.6 million total funds, which includes $4.9 million General Fund and 21 positions from DHS to OHA. In addition to the return of this program to OHA, the budget increases program support through a one-time $2.4 million General Fund appropriation to increase outreach for the Cover All Kids program.

- ***Cost allocation*** – A fund shift of $3.9 million from Other Funds and Federal Funds to the General Fund reflects changes in the agency's cost allocation statistics due to the transfer of the Oregon Health Plan eligibility processing center to DHS in 2017-19.

As an administrative savings measure, the budget recognizes vacancy savings of $0.2 million General Fund. It also includes a series of net-zero technical fund shifts and position transfers, and adjusts position and FTE counts without increasing funding to true-up position double-fills and recognize positions that have transitioned from permanent part-time to permanent full-time.

State Assessments and Enterprise-wide Costs

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	187,293,959	200,002,472	214,917,184	213,515,895
Lottery Funds	--	200,000	215,540	215,540
Other Funds	30,520,145	21,524,699	28,884,476	26,711,053
Other Funds (NL)	129,500,902	--	--	--
Federal Funds	57,304,732	51,986,530	48,333,042	45,675,252
Federal Funds (NL)	4,054,172	3,728,175	3,467,210	3,467,210
Total Funds	**$408,673,910**	**$277,441,876**	**$295,817,452**	**$289,584,950**

Program Description

State Assessments and Enterprise-wide Costs (SAEC) includes the budget for costs that affect the entire agency. This includes central government assessments and usage charges, such as state government service charges, risk assessments, State Data Center usage charges, Secretary of State audit charges, mass transit charges, and information technology direct charges. This budget also includes all facilities costs, including rent, maintenance, and utilities. In addition, the SAEC budget includes most of the funding for OHA to pay for shared services provided by both OHA and the Department of Human Services (DHS). Debt service costs became part of the SAEC budget in 2013-15 to pay for bonds issued through the federal Build America Bonds program. OHA's debt service costs are for the repayment of bonds for the construction of the Oregon State Hospital facilities in Salem and Junction City. The SAEC budget does not include any staff.

Revenue Sources and Relationships

Of SAEC's $286.1 million total funds budget, $67.4 million supports debt service, which includes $63.7 million General Fund, $0.2 million Other Funds, and $3.5 million Federal Funds (Nonlimited). Apart from debt service, the SAEC budget is similar to Central Services regarding its reliance on a federally approved cost allocation plan where programs are charged according to their respective state and federal funding sources for the costs they incur.

Budget Environment

Assessments and usage charges are paid to other state agencies, in particular the Department of Administrative Services, the Department of Justice, and the Secretary of State. As those budgets are adjusted by the Legislature, this budget is also adjusted to reflect those changes. Similar to the Central Services budget, the transfer of programs into or out of OHA, as well as the enhancement or reduction of existing OHA programs, can impact the model's cost allocation statistics and result in changes to the amount of General Fund, Other Funds, or Federal Funds supporting SAEC.

Legislatively Adopted Budget

The 2019-21 legislatively adopted budget for SAEC totals $289.6 million, which represents a 4.4% increase from the 2017-19 legislatively approved budget. The General Fund budget is $213.5 million and represents a 6.8% increase from 2017-19. The key budget adjustments include the following:

- ***Cost allocation*** – A fund shift of $4.1 million from Other Funds and Federal Funds to the General Fund is included as a current service level budget adjustment due to the transfer of the Oregon Health Plan eligibility processing center to DHS in 2017-19.

- ***Budget transfer*** – $3.7 million total funds, which includes $2.6 million General Fund, is transferred from Central Services to SAEC as an agency-wide net-zero budget adjustment to properly budget for Office of Administrative Hearings costs.

- ***Administrative savings*** – As a budget-saving measure, above-standard inflation applied during the current service level budget process for usage-based items is eliminated, which saves $1.2 million General Fund.

Shared Services

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
Other Funds	131,680,947	166,507,479	166,549,551	181,222,528
Total Funds	**$131,680,947**	**$166,507,479**	**$166,549,551**	**$181,222,528**
Positions	487	539	501	560
FTE	476.87	528.34	501.00	549.52

Program Description

Shared Services supports costs associated with business functions used by both OHA and the Department of Human Services (DHS) under a joint governance agreement. Shared Services supports both agencies by providing consistent and coordinated administrative services to all programs within both agencies. The budget is reflected entirely as Other Funds expenditure limitation. The OHA and DHS budgets both have a Shared Services budget structure housing different programs and services used by each agency.

The only program currently housed in OHA's Shared Services budget is the Office of Information Services (OIS). This program deploys and maintains the information technology hardware and software needed by OHA and DHS employees to do their jobs; oversees the implementation of enterprise-wide technology solutions; ensures the back-up and integrity of data used by employees and partners throughout Oregon; and provides the information infrastructure and technical support necessary to maintain key business services, such as payroll distribution, vendor payments, and personnel actions.

Prior to 2019-21, OHA's Shared Services budget also included the Information Security and Privacy Office (ISPO). Upon the passage of SB 90 (2017), the state's information technology security functions were centralized within the Department of Administrative Services Office of the Chief Information Officer (OSCIO). This resulted in the transfer of four positions and OHA security oversight from the ISPO to OSCIO. As a result, the 2019-21 budget transfers the remaining ISPO positions and funding to the OIS budget structure. Whereas OIS is budgeted within OHA's Shared Services structure, OHA uses the following services that are budgeted within DHS's Shared Services budget: Office of Forecasting; Office of Financial Services; Office of Human Resources; Facilities; Office of Imaging and Records Management; Office of Payment, Accuracy, and Recovery; and Internal Audit.

Revenue Sources and Relationships

Shared Services expenditures are allocated to OHA and DHS based on a federally-approved cost allocation plan. The distribution of expenditures through the cost allocation process determines the payments received as Other Funds from both DHS and other parts of OHA for purchased services. The revenues to pay for Shared Services within the OHA budget are primarily in the State Assessments and Enterprise-wide Costs budget and paid from General Fund, Lottery Funds, Other Funds, and Federal Funds.

Budget Environment

The shared services model began in the 2011-13 biennium when the once-combined OHA and DHS were reorganized into separate agencies. The Shared Services structure was chosen to ensure the cost effectiveness of administrative services and to eliminate the duplication of resources. Reductions made in the shared administrative services operations result in corresponding reductions elsewhere in the OHA and DHS budgets.

Legislatively Adopted Budget

The 2019-21 legislatively adopted budget for Shared Services totals $181.2 million Other Funds, which represents a 9% increase from the 2017-19 legislatively approved budget. The key budget adjustments include the following:

- ***ONE IE/ME*** – $11.2 million Other Funds and 41 positions (30.52 FTE) support the shared services component for the continuation of the ONE Integrated Eligibility/Medicaid Eligibility project for both OHA and DHS. Corresponding budget adjustments are made in OHA's Health Systems Division budget and the DHS budget.

- ***Comprehensive Child Welfare Information System (CCWIS)*** – $2.8 million Other Funds and nine positions (9.00 FTE) support the continuation of the planning and initiation work related to the CCWIS project in DHS. A corresponding adjustment is made in the DHS budget to support these expenses.

- **C*entralized Abuse Management (CAM) System*** – $0.5 million Other Funds and two positions (2.00 FTE) support maintenance and operations costs to build on the CAM System project implemented in 2017-19. The system will provide an integrated solution for tracking, reporting, and supporting investigations of adult abuse. A corresponding adjustment is made in the DHS budget to support these expenses.

DEPARTMENT OF HUMAN SERVICES

Analyst: Byerly

Agency Totals

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	2,713,968,780	3,203,132,651	3,723,069,270	3,855,078,525
Other Funds	484,567,909	666,808,960	570,282,885	673,915,109
Federal Funds	4,601,139,098	5,575,122,100	5,823,621,440	6,094,787,849
Federal Funds (NL)	2,129,912,523	2,214,345,331	2,214,345,331	1,939,345,331
Total Funds	**$9,929,588,310**	**$11,659,409,042**	**$12,331,318,926**	**$12,563,126,814**
Positions	8,029	9,075	9,162	9,444
FTE	7,877.90	8,616.92	9,084.50	9,324.14

Overview

The Department of Human Services (DHS) supports children, families, seniors, people with physical disabilities, and individuals with intellectual and developmental disabilities by providing a range of services through 170 field offices and many community partners. The agency's mission is to help Oregonians in their own communities achieve safety, well-being, and independence through services that protect, empower, respect choice, and preserve dignity. In 2009, responsibility for health programs (physical, public, mental) was shifted from DHS to the Oregon Health Authority (OHA). The two agencies work closely together to serve their many common clients and also share several administrative functions to leverage efficiencies and economies of scale.

Trends that influence demand on DHS programs and the agency's budget include a growing population of older adults, an increasing number of people with disabilities, the rate of economic growth, a tight labor market in which housing and other living costs outpace wage increases, and regional dynamics that have limited economic recovery in many parts of rural Oregon.

To provide services, the agency operates through five distinct separate program areas:

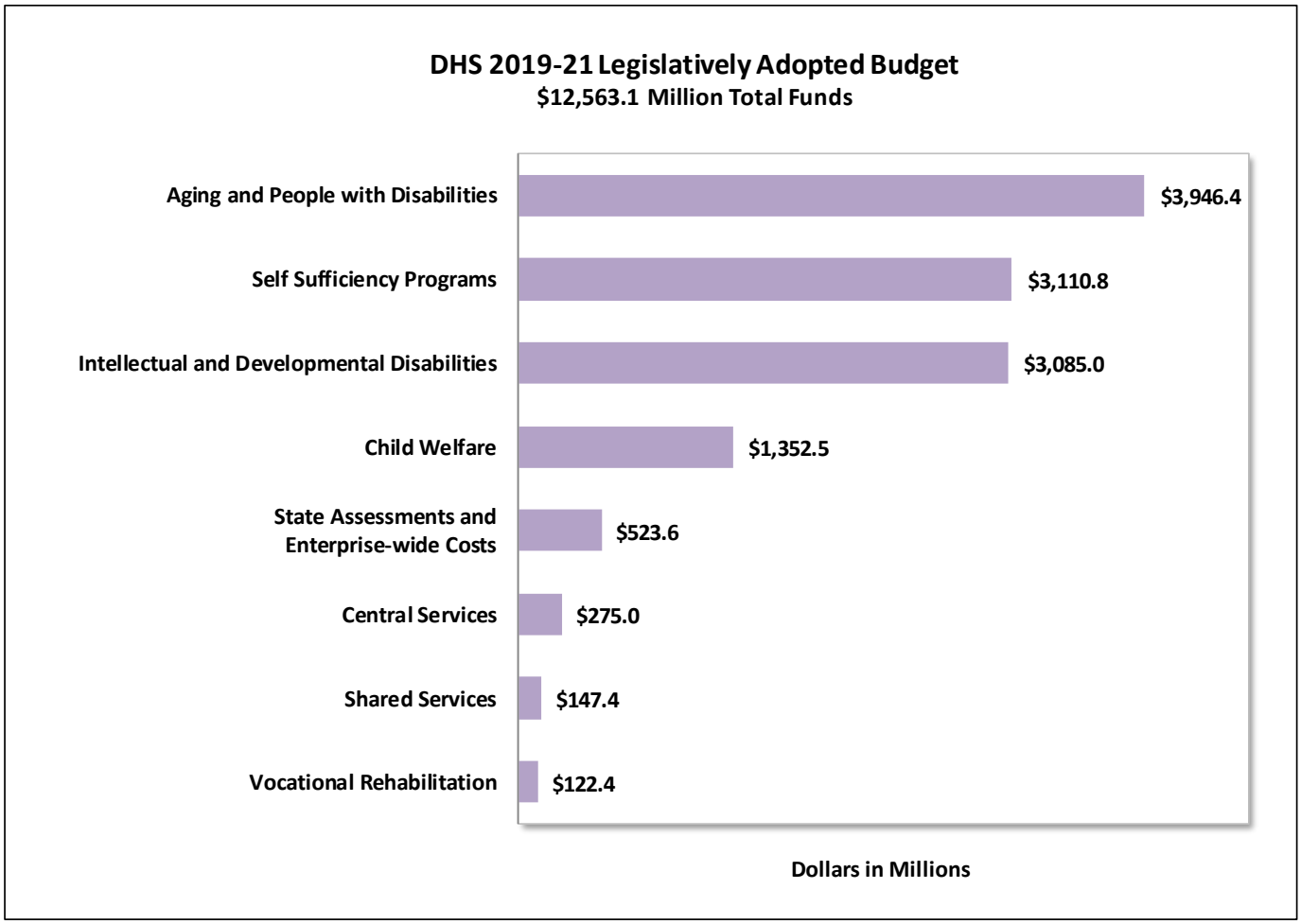
- Self Sufficiency Programs (SSP) – Assists low-income families by promoting family stability and helping them become self-supporting. Programs help clients meet basic needs, such as food and shelter, and provide job training, employment assistance, parenting supports, health care, and childcare.
- Child Welfare (CW) – Provides prevention, protection, and regulatory programs for Oregon's vulnerable children. This includes programs that offer safe and temporary or, if necessary, permanent families for children that have been abused or neglected through child protective services, in-home services, out-of-home services, and adoptions.
- Vocational Rehabilitation (VR) – Works with businesses, schools, and community programs to assist youth and adults with disabilities other than blindness to obtain, maintain, or advance in employment.
- Aging and People with Disabilities (APD) – Provides long-term care and other services to seniors and people with physical disabilities. Clients receive services in their own homes, in community-based care settings, and in nursing facilities.
- Intellectual and Developmental Disabilities (IDD) – Serves children, adults, and families affected by intellectual and developmental disabilities. Program services include in-home family support, intensive in-home supports, and out-of-home, 24-hour services delivered by foster or residential care providers.

In addition to these programmatic budget groupings, DHS uses three administrative budget structures to capture an array of services and supports for DHS and, in the case of some shared functions, also for OHA. Central Services includes activities directly related to policy and program in the agency, such as the director's office, communications, organizational development, and budget planning. DHS' portion of Shared Services includes budget, forecasting, financial services, human resources, facilities, imaging and records, contracts and

procurement, training, internal audit, payment recovery, and background checks. The budget for State Assessments and Enterprise-wide Costs pays for various assessments or charges paid by all state agencies and certain centralized agency costs.

At the 2019-21 legislatively adopted budget level, DHS has the second largest budget of any state agency, after OHA. DHS makes up 17.2% of the statewide General Fund budget and 14.6% of statewide total funds spending.

The following chart shows how the agency's 2019-21 legislatively adopted budget of $12,563.1 million total funds is allocated across programs and budget structures:



Revenue Sources and Relationships

For the 2019-21 biennium, General Fund supports 30.7% of DHS' budget. Almost all of the General Fund is used as match or to meet state maintenance of effort (MOE) requirements for receiving Federal Funds. The overall General Fund share of DHS' budget is 3.2% higher than it was in the 2017-19 biennium and includes General Fund added to offset one-time non-General Fund revenues used in 2017-19, General Fund savings from one-time revenues assumed in the 2019-21 biennium, and ongoing or new General Fund investments.

Other Funds revenues support 5.4% of DHS expenditures. These come from a wide variety of sources including nursing home provider assessments, grants, the unitary tax assessment, estate collections, third party recoveries, fees, and charges for services. Federal Child Care and Development Fund (CCDF) moneys are received from the Department of Education (Office of Child Care – Early Learning Division) and spent as Other Funds in DHS on the Employment Related Day Care (ERDC) program.

Federal Funds support 64% of DHS expenditures for the 2019-21 biennium. The largest single Federal Funds source is for the Supplemental Nutrition Assistance Program (SNAP, previously known as food stamps), which makes up 15.4% of DHS' total budget; these benefits are reflected in the budget as Federal Funds Nonlimited. Federal Funds subject to expenditure limitation include the Title XIX Medicaid program, Temporary Assistance to Needy Families (TANF), Title IV-E Foster Care and Adoption Assistance, Child Welfare Services, Title XX Social Services Block Grant, and Basic 110 Rehabilitation funds. Some of these sources are capped block grants (e.g., TANF, Social Services Block Grant), while others provide federal matching funds as partial reimbursement of state costs (e.g., Medicaid, Foster Care, and Adoption Assistance).

Three major methodologies are used to project revenues: 1) the category of expenditures based on estimated average daily populations and cost per case is primarily used for federal entitlement grants; 2) grant cycles and where they fall within the biennium are considered for block grants; assumptions based on the results of prior grant averaging and the anticipated effect of the federal budget process are both used to project the amount of funds to be received; and 3) the historical receipt trends method is used for Other Funds sources such as collections of overpayments and fees unless the agency has additional information, such as anticipated special projects, which would increase revenue and change projections for a specific time period.

Assumptions about the agency's federal funding streams for 2019-21 are based primarily on federal fiscal year 2019 budget levels and federal programs as currently authorized. A key factor affecting federal revenue is the Federal Medicaid Assistance Percentage (FMAP); this federal reimbursement rate is used for multiple programs and is calculated based on a three-year average of state per capita personal income compared to the national average. For 2019-21, the FMAP adjustment is not working to the state's advantage; the federal matching share will decrease from a biennial average of 63.33% in 2017-19 to 61.36% in the 2019-21 biennium. In addition, recent projections show the state's FMAP dropping again in federal fiscal year 2021, which will lower the 2019-21 currently budgeted average rate even further; this translates into needing more General Fund support for mandated programs and will likely require an interim budget adjustment. Since federal fiscal year 2017, Oregon's FMAP rate has declined by 3.63 percentage-points, which is the largest decrease for a state over that time period.

Budget Environment

DHS operates within a complex and dynamic budget environment primarily due to the broad range of Oregonians it serves and its multiple funding sources. Oregon's economy, demographics, federal law and funding levels, and state human services policy all affect demand for DHS' services and influence its budget.

Oregon's economy has a significant impact on DHS' budget; a poor economy creates more need for basic services for those who have few or no financial resources. Economic effects are felt most strongly in safety net programs such as TANF and SNAP but can also help create family circumstances that drive other needs served by the agency, such as interventions to keep children safe or in-home care services.

Demographics have a long-term impact, most notably for services to seniors. As the number of Oregonians aged 65 and up continues to grow, particularly those 75 and older, there is greater demand for long-term care services. Even individuals who were financially stable when younger may seek help when needing more costly in-home or out-of-home care as they age.

With federal dollars supporting close to two-thirds of DHS' budget, federal law and funding levels can give the state more or less capacity to meet the needs of Oregonians. DHS must adjust its budget on an ongoing basis for FMAP changes and ever-evolving federal law and regulations. DHS' long-term care program for seniors and people with disabilities, for example, is governed by waivers of certain federal Medicaid regulations. Most proposed program or rate changes must be approved by the Centers for Medicare and Medicaid Services (CMS) before being implemented.

In many programs, such as TANF, the federal government establishes outcome standards, reviews state performance against those standards, and can levy penalties and/or develop program improvement plans to force

progress towards those standards. (On a much more limited basis, some performance improvements can result in a financial award to the state.)

A number of federal funding streams also have state Maintenance of Effort (MOE) funding requirements, which prevent states from reducing state program funding below identified levels without risking penalties. For example, in exchange for the $166.8 million from the annual federal TANF block grant, Oregon must meet both MOE requirements and client work participation rate requirements. The MOE requirement means non-federal support from the General Fund or other state resources must be at least $91.6 million per year (75% of the state contribution in the 1994 base year) unless JOBS participation has not been met at which point 80% is required; this level, or $97.7 million in MOE per year, is currently required.

Dependence on federal funding also leaves agency programs vulnerable when there is uncertainty at the federal level with respect to either funding amounts or program requirements. For example, federal sequestration (automatic spending cuts) has affected DHS programs differently; most large programs – SNAP, Medicaid, TANF – have been exempt from sequester, but many smaller and often discretionary grant programs in Child Welfare, Self Sufficiency, and Vocational Rehabilitation have seen funding reduced under sequester.

Uncertainty and unknown costs tied to program requirements may be driven by potential reauthorization of federal laws governing those programs or a reinterpretation or clarification under federal rules. A renewed program may include changes, for example, in eligibility or authorized spending, that increase workload or restrict program availability. Timing for changes frequently does not mesh well with state legislative or budget development timelines, leaving financial or other risks unquantified and difficult to address in the budget.

The Office of Forecasting, Research, and Analysis (OFRA), which is a DHS/OHA shared service housed in DHS, issues client caseload forecasts semiannually (spring and fall) for the major DHS program areas. OFRA staff use a combination of time-series techniques, deterministic models, and information from program experts to produce each forecast. Monthly reports track accuracy by comparing forecast caseloads with actual caseload counts. This information is used to develop program budgets, monitor budget versus actual expenditures, and make management decisions.

The 2019-21 legislatively adopted budget is based on the Spring 2019 caseload forecast, which was released in May 2019. Routinely, after each caseload forecast, DHS re-projects its budget using the updated caseload numbers and associated costs. Then, depending on the outcome of that repricing, the agency may develop a rebalance plan to adjust expenditures across the agency. This allows DHS flexibility to manage its budget on an ongoing basis, often without needing to request more funding or spending authority from the Legislature. The rebalance plan and associated changes to legal appropriations can be approved by the Emergency Board during the interim or as part of a budget bill during a legislative session. In recent biennia, rebalance actions have typically occurred during the short session, in December of even numbered years, and in late spring during the long legislative session.

The agency's service delivery system relies on both state staff and contracted community partners for child care, foster care, residential treatment, long-term care, and other services. Approximately 74% of the DHS budget will be spent directly on provider services and in direct payments to clients. The application of inflationary, cost of living, or other adjustments to provider reimbursement rates vary by program but most do not have a formal review cycle or consistent pricing methodology. Typically, the rates are reviewed in response to federal actions, stakeholder concerns, or when access to services becomes an issue. An ongoing legislative concern tied to rates has been on how those rates translate into direct care worker wages.

About 17% of the budget pays for DHS employees who directly serve clients in communities across Oregon. For most programs, the agency uses a model to determine the number of direct service staff and supervisors that are needed to serve agency clients. Over the past several years, DHS has contracted for staffing studies to review current workload and staffing needs. The studies made recommendations for potential efficiencies and process

improvements, but also supported a move from caseload-based staffing models to models that reflect workload standards. Due to budget constraints, these models are frequently funded at less than 100%, but the funded percentage of the model may be used as a target or reference point. For context, at the agency request budget stage, DHS projected it would take $128.6 million General Fund ($178.8 million total funds) and 640 positions (612.98 FTE) to fund agency program staffing models at 100%. To manage caseloads within budget, DHS continues to refine its workload models, leverage process improvements, and seek technology solutions.

State human services policy has a direct effect on DHS' programs and service delivery. Over the past few decades, Oregon's human services programs have moved to intervene earlier and in less-costly ways to prevent or mitigate the problems these programs address. As an example, in the early 1980s, the Medicaid long-term care system received federal waivers to implement the nation's first home and community-based care system. In-home services are delivered to help elderly Oregonians and people with intellectual and developmental disabilities stay at home rather than be moved to out-of-home care. More recently, many of these services have moved under the K Plan, which is a Medicaid state plan option authorized under the Affordable Care Act.

The TANF program is in part a family safety program, using cash assistance and other services to help stabilize families. Child welfare is focusing more on in-home services, where appropriate, instead of foster care. Prevention and early intervention have been clear policy choices. The dilemma comes when available funding is not sufficient to support earlier, less-costly services while still paying for more intensive, and often more expensive services, to meet emergent needs and address changing caseloads.

When budget reductions are needed, options in human services programs focus on client eligibility, benefit levels, staffing, and service delivery costs. In some programs, such as Medicaid, the agency has limited flexibility in determining eligibility and providing services. Benefit levels in some programs are direct payments to individuals; in others they reflect reimbursements to providers for services. The cost of delivering services, such as individual supports, community programs, or residential services, in theory, could be reduced through provider rate reductions. However, in practicality, providers' operational costs, collective bargaining requirements for some providers, and state statutory requirements are all factors that may make that reduction untenable. The agency has made efforts to better tie reimbursement to levels of need, but provider reimbursement has historically been determined by the type of provider group and is not consistent across programs or services provided.

Legislatively Adopted Budget

The 2019-21 legislatively adopted budget for the Department of Human Services is $3.855 billion General Fund, $12.563 billion total funds, and 9,444 positions (9,324.14 FTE). The budget is 20.4% General Fund and 7.8% total funds more than the agency's 2017-19 legislatively approved budget. The 9,444 positions (9,324.14 FTE) approved for 2019-21 reflect a 4.1% increase (369 positions) over the 2017-19 level; the percentage increase for FTE is greater, at 8.2% (707.22 FTE), due to the roll-up of positions phased in over the 2017-19 biennium.

Over 60% of the net growth in General Fund (and total funds) is attributable to costs of caseload growth and associated cost per case; expenditures are driven by the roll-up of rate increases from the prior biennium and changes in the caseload mix across programs. About 25% of the growth is tied to personal services, which includes impacts of collective bargaining (salary increases) and position phase-ins.

The adopted budget continues core programs, adjusts for caseload changes, and adds new or expanded funding for some programs. Key elements of the budget include:

- Uses repurposed federal TANF funding to expand housing assistance and employment/training services for families served by Self Sufficiency Programs.
- In Child Welfare, adds approximately 350 new positions, primarily for caseworker, foster parent retention and recruitment, and centralized hotline positions.
- Provides additional funding for Vocational Rehabilitation to deliver pre-employment services and maintain current service level.

- Includes additional funding for provider rate increases in the Intellectual and Developmental Disabilities program to help providers increase wages for direct support professionals who work in their organizations.
- For the Aging and People with Disabilities program, increases the Medicaid case management workforce by about 10% and funds rate increases for long-term care providers.

A significant cross program budget component is funding for the final development phase, implementation, and transition to Maintenance and Operations (M&O) of an integrated eligibility system, called the Integrated Eligibility (IE) project. This effort integrates enrollment and eligibility activities for several DHS programs into the system used by OHA. The 2019-21 estimated project cost of $200.6 million total funds covers state staff costs of $20.7 million, $94 million for contracted information technology services, $11.2 million for payments to OHA for its project work, and $5.8 million for debt service. Other elements addressed in the project plan include cost allocation, contingency, legacy system work, hosting services, disaster recovery, and security enhancements.

Six budget notes were approved in budget reports for two of the five budget bills impacting the agency's 2019-21 budget; budget notes are non-binding directives setting out legislative intent for a specific budget component or expected actions associated with the agency's execution of its budget. The budget note topic, bill number, and applicable reporting requirements are as follows:

- Breaking out the agency's budget appropriations into more detail for 2021-23 budget development; HB 5026 (2019); the DHS budget bill submitted for the 2021 session should contain the lower level appropriations.
- Working with Child Welfare residential providers to identify strategies to help attract, develop, and retain a quality workforce; HB 5026 (2019); report to appropriate policy committee(s) no later than September 2020.
- Exploring opportunities to obtain federal funding for the Oregon Project Independence program and a family caregiver respite program; HB 5026 (2019); report to appropriate policy committee(s) no later than December 21, 2020. Budget note also provides direction regarding a potential Medicaid wavier for these services.
- Reporting on case management duties and training requirements for case managers serving individuals with intellectual and developmental disabilities; HB 5026 (2019); report to human services policy committees during the 2020 legislative session.
- Providing direction on how $30 million General Fund approved for rate increases for providers serving people with intellectual and developmental disabilities is to be applied to help bring the direct support professional wage as close as possible to $15.00 per hour by the end of the 2019-21 biennium; HB 5026 (2019); report by February 1, 2020, to the Interim Joint Committee on Ways and Means.
- Updating the Legislature on development of a new rate model for adult foster homes serving people with intellectual and developmental disabilities; HB 5050 (2019); report by February 1, 2020, to the Joint Interim Committee on Ways and Means.

More detail on the DHS budget is presented through the following narratives for the following programs or functional areas: Self Sufficiency, Child Welfare, Vocational Rehabilitation, Aging and People with Disabilities, Intellectual and Developmental Disabilities, Central Services, Shared Services, and State Assessments and Enterprise-wide Costs.

Self Sufficiency Programs

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	437,708,507	395,195,756	457,882,613	448,736,284
Other Funds	101,806,247	108,963,729	91,182,241	120,449,792
Federal Funds	299,664,391	534,237,954	571,902,877	602,221,798
Federal Funds (NL)	2,129,912,523	2,214,345,331	2,214,345,331	1,939,345,331
Total Funds	**$2,969,091,668**	**$3,252,742,770**	**$3,335,313,062**	**$3,110,753,205**
Positions	2,043	2,514	2,522	2,498
FTE	2,034.49	2,358.29	2,519.10	2,494.60

Program Description

Self Sufficiency Programs (SSP) assist low-income families by meeting critical needs while helping them become self-supporting. The major programs in this area are:

- The Supplemental Nutrition Assistance Program (SNAP) – Federally funded benefits that help low-income families, single adults, and childless couples buy the food they need to stay healthy. In July 2019, 597,121 people – about 1 in 7 Oregonians – received SNAP benefits worth almost $73 million for the month. The benefit costs are included in the Self Sufficiency budget as Federal Funds Nonlimited; eligibility determination staff costs are part of the budget as limited expenditures.
- Temporary Assistance to Needy Families (TANF) – Provides cash assistance grants, which, when coupled with SNAP benefits, supply basic supports for families with children under the age of 19 that meet eligibility criteria. In July 2019, a total of 20,660 families (single and two parents combined) received TANF cash assistance. Income qualification and benefit amounts are based on family size and expenses. TANF also provides Job Opportunity and Basic Skills (JOBS) services, which include education, training, job placement, and support services. Other program services include limited TANF transition payments; assistance and support services for domestic violence survivors; services to families eligible for Supplemental Security Income or Supplemental Security Disability Income (pre-SSI/SSDI); and Family Support and Connections services to help families at risk of child abuse or neglect.
- Employment Related Day Care (ERDC) – Designed to help parents stay employed by subsidizing child care services for low-income working families. Clients make a co-payment based on income and household size, and the state subsidizes the remaining costs up to the DHS maximum rate. In July 2019, 7,878 families received ERDC subsidies for 14,903 children in day care.
- Refugee Program – Works with community groups and social and workforce agencies to provide time-limited cash and medical assistance, SNAP benefits, and employment services to new refugees in Oregon.
- Youth Services – Supports teen pregnancy prevention and other youth development initiatives related to juvenile crime, drug and alcohol use, youth suicide, school dropout, and sexual assault prevention and education programs.

SSP administers these programs through coordination and collaboration with families and individuals as well as community partners, and through direct services provided by state staff. Field staff provide program services and benefits to clients through more than 100 field and branch offices throughout the state.

Revenue Sources and Relationships

For the 2019-21 biennium, General Fund supports 14.4% of this budget, Other Funds, 3.9%, and Federal Funds, 81.7%. The SSP adopted budget includes an additional $40 million in federal TANF dollars that were transferred in from Child Welfare; however, this revenue increase is masked by an updated projection tied to SNAP benefit payments that indicates the revenue is expected to be $275 million lower in 2019-21.

The major source of Other Funds is $114.3 million in federal Child Care Development Fund (CCDF) dollars transferred from the Department of Education for ERDC. The budget also includes child support recoveries and

client trust account funds from client resources, such as federal Supplemental Security Income (SSI) disability payments. Overpayment recovery revenues are also used to offset costs and preserve General Fund.

Nonlimited SNAP benefits are the single largest source and use of Federal Funds in SSP. SNAP benefits are projected at $1.9 billion for the 2019-21 biennium. SNAP caseloads are still above pre-recession levels but are expected to continue to decline over the biennium. Federal dollars also help pay for program administrative costs.

Other Federal Funds come from capped or formula-based block grants, payments for partial reimbursement of eligible state costs, and miscellaneous grants for specific amounts and purposes. Oregon receives $166.8 million a year from the base federal TANF block grant, which pays for cash assistance, JOBS services, child care, and other self-sufficiency programs, as well as child welfare services, such as foster care and residential care.

Budget Environment

Demand for many SSP services increase in poor economic times as demonstrated by significant increases in caseloads for SNAP benefits and TANF cash assistance during the most recent recession. Federal funds supporting TANF and child care programs are capped; TANF program cash benefits and employment services are funded primarily with the capped TANF block grant. The block grant does not increase based on higher caseload demands or costs, so the state is faced with adding state funds or decreasing services when costs exceed the available federal funding. Similarly, the federal CCDF that supports ERDC is a capped federal grant.

Frequently, clients face barriers to employment such as drug and alcohol problems, lack of reliable transportation or affordable child care, or a work disability, such as mental illness. Timely access to treatment programs and support services is critical to address these problems and move clients off cash assistance. Many of these needed services are funded in DHS or by other government programs.

SNAP benefits make up over half of the SSP budget. The benefits are Federal Funds Nonlimited expenditures without a direct General Fund cost but staffing to determine and monitor eligibility for the program is a 50% state/50% federal cost. The SNAP caseload grew dramatically between 2008 and 2012 as a result of both Oregon's economic conditions and program outreach to encourage eligible individuals and families, especially the elderly, to apply for the assistance.

The caseload peaked at 444,277 households in 2012 and dropped to 351,717 by July 2019, which is a decrease of 92,560 or 20.8%. The projected biennial caseload average for 2019-21 is 324,970 households, which is 10.9% lower than the 2017-19 biennial average forecast. While the economy and job growth influence the caseload, general population growth and SNAP clients working in low paying and frequently part-time jobs will add or keep more individuals on the caseload. Embedded in the overall decline is an increase in senior participation, which DHS expects will continue to grow along with Oregon's aging population.

While federal SNAP funding has not been capped, efforts at the federal level to reduce spending or change policy could impact the program. For example, while not yet final, a proposed rule change would eliminate categorical eligibility under SNAP. Oregon uses this eligibility pathway, which lets states simplify and streamline eligibility determination processes for multiple state and federal assistance programs by aligning the programs' eligibility rules. This change would mean that some current recipients would lose benefits and DHS would need to redetermine eligibility for SNAP, incurring additional administrative costs.

The federal government may also change criteria for awarding of funds, as the U. S. Department of Agriculture did in the most recent round of grant funding offered for summer SNAP food benefits. In both 2017 ($5.7 million) and 2018 ($7.5 million), Oregon received additional federal SNAP funds to provide $30 per month to eligible children during the summer to increase access to food. For the 2019 grant cycle, the federal agency made the grant more competitive and prioritized states that had not previously been a grant recipient; as a result, Oregon's application was denied.

Along with an MOE requirement, the TANF program also has client work participation rate requirements. If Oregon fails to meet the work participation rate (states must reach 50% work participation for most families and 90% for two-parent families), the MOE requirement increases from 75% to 80%. Oregon's MOE has come from several agencies, including DHS, the Employment Department, and the Department of Education. Budget decisions on General Fund appropriations in those agencies can affect the state's ability to meet TANF MOE requirements. In recent years, Oregon has also counted the refundable Working Family Child Care tax credit towards its MOE. Oregon has been able to meet MOE funding requirements, but it has not been able to meet federal work participation rates, and faces potential penalties for federal fiscal years 2007, 2008, and 2009.

Many adults must meet certain additional work or activity requirements to receive TANF services. The Job Opportunity and Basic Skills (JOBS) program provides employment and skill-building services to help TANF clients gain skills necessary to join the workforce and retain employment.

After finding employment success and exiting TANF, families can access ERDC, which helps low-income, working families arrange and pay for quality child care. Federal guidelines emphasize providing these families with the same opportunity for reliable, quality child care as other families with higher incomes. Providers are required to meet a set of health and safety standards, along with passing required background checks before they can become DHS providers and receive payment.

For the 2019-21 biennium, TANF caseloads are projected to average 17,405 families per month, which is about 7.9% lower than the average monthly caseload for 2017-19. Another demographic trend affecting program participation is the number of Oregon households with children; while the overall population is increasing, over the last decade or so the number of households with children has decreased from 416,133 in 2008 down to 410,152 in 2017.

Legislatively Adopted Budget

SSP's 2019-21 legislatively adopted budget is $448.7 million General Fund and $3,110.8 million total funds, with 2,498 positions (2,494.60 FTE). The total funds budget is 4.4% below the 2017-19 legislatively approved budget; this is due to lowering SNAP benefit expenditures by $275 million to align the budget with projected benefit payments. This Federal Funds Nonlimited expenditure limitation makes up more than 60% of SSP's total budget. Federal Funds limited expenditures increased by a net $68 million, primarily due to moving $40 million in federal TANF funding from the Child Welfare program to Self Sufficiency.

The General Fund budget is 13.5%, or $53.5 million, above the prior biennium; the change is primarily due to current service level growth attributed to base salary adjustments, inflation, phase-ins and phase-outs, and fund shifts. Regarding fundshifts, $20 million General Fund backfills one-time TANF carryforward funding that was used to balance the 2017-19 budget. Budget savings due to cost per case adjustments, statewide charges for services, lower PERS rates, adjusted rates for services provided by the Department of Justice, and transfers of work out of SSP total $4.8 million General Fund and more than offset new program costs.

The legislatively adopted budget maintains core programs, including the TANF One and Two-Parent programs and related services. A permanent resolution to ongoing suspensions in TANF requirements (these were put into place just prior to the last recession), which represent $12.2 million in 2019-21 General Fund cost avoidance, was addressed by HB 3183 (2019). Along with eliminating the need for TANF statute suspensions, the measure establishes a stronger focus on family stability, effective engagement, mental health and substance use, and housing considerations for TANF families.

As noted previously, $40 million in federal TANF funding is moved from Child Welfare to SSP; this is made possible due to a corresponding investment of $40 million General Fund in the originating program. The adjustment helps address a problem in which non-program or "administrative" spending within the TANF program, for both state and federal expenditures, was exceeding the federal limit (or cap) of 15%. The $40 million Federal Funds is

redeployed into several strategies, some of which received statutory guidance through language in HB 2032 (2019), to sustain the program and help TANF families:

- Retaining $13 million in the TANF program to cover caseload costs; while caseloads are still trending downward, the pace of decrease has slowed since the current service level was originally developed.
- Applying $7.5 million to continue benefits to eligible TANF participants who are over the 60-month time limit.
- Using $3.5 million for a vocational training and education pilot program targeted at families receiving TANF in rural locations (HB 2032).
- Backfilling $1.5 million General Fund in the Job Opportunity and Basic Skills (JOBS) program; this frees up General Fund to be sent to OHA which will administer a mental and behavioral health pilot program to award grants to up to four coordinated care organizations to assess potential gaps in access by TANF recipients to mental and behavioral health services (HB 2032).
- Sending $10.5 million to the Housing and Community Services Department (HCSD) for a TANF housing pilot; applicants will receive grant funds through a competitive process and pair those dollars with funds from similar programs to provide TANF families with housing assistance for longer time periods (HB 2032).
- Adding $4 million to $1 million in federal TANF funds already going to HCSD for the housing stabilization program. The program provides temporary (up to four months) assistance to stabilize housing for low-income, eligible families who are homeless or at-risk of losing their housing.

The adopted budget includes an overall ERDC funding component of $179.8 million total funds ($65.5 million General Fund and $114.3 million Other Funds). This resource level, which is a 12% increase over the 2017-19 legislatively approved budget, is expected to allow the program to serve an average of 8,230 families over the biennium. The caseload estimate is based on a cost per case of $910 per month, but that cost will likely end up higher as rate increases, effective January 1, 2019, fully begin to impact child care costs; this will potentially have a chilling effect on the number of families and children served.

The bulk of the funding increase will help cover those rate increases, which were bargained in 2017-19, with consideration for additional revenues available at the federal level. That federal funding authorization also includes a no-supplant clause limiting flexibility to redirect state funds supporting the program. In addition, about $2.7 million of the budget will be used, on a one-time basis, to support a pilot incentive program for child care providers offering evening, night, and weekend child care.

New spending includes a one-time investment of $2 million General Fund associated with HB 2508 (2019), which directs DHS to award grants to eligible refugee resettlement agencies providing services to refugees who reside in Oregon. Two food-related, one-time General Fund proposals were approved; $1.3 million to help the Oregon Food Bank acquire and distribute food and $1.5 million for the Double Up Food Bucks program, which matches SNAP benefits used at farmers' markets and helps clients take home more healthy food. Another budget item, primarily related to SNAP, adds $1.7 million Federal Funds expenditure limitation and 7 limited duration positions (7.00 FTE) to continue work under several federal grants.

Other budget actions include the transfer in of the Runaway and Homeless Youth program from Child Welfare into SSP. The move is expected to improve service delivery and provide youth access to additional services, such as employment training; it results in an increase of $3.2 million total funds and one position (1.00 FTE). Positions and funding are also transferred out from SSP to other programs, mostly driven by a need to correct the placement of Oregon Health Plan (OHP) Medicaid eligibility positions transferred to DHS SSP in an action taken during the 2018 session. The net change is a reduction of nine positions (9.00 FTE) and $1.7 million total funds.

Another set of positions that were part of the transfer of the OHP Medicaid eligibility move are also transferred out but instead of to other agency programs, these go back to OHA since their work does not have a close nexus with eligibility activities. These 21 positions (21.00 FTE) support the Community Partnership Outreach Program and Cover All Kids efforts; the move drives a decrease of $4.9 million General Fund ($10.1 million total funds).

Child Welfare

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	396,011,542	601,121,145	705,519,866	775,531,048
Other Funds	18,124,012	33,823,561	40,052,237	38,997,487
Federal Funds	498,823,061	540,082,805	591,606,400	537,988,342
Total Funds	**$912,958,615**	**$1,175,027,511**	**$1,337,178,503**	**$1,352,516,877**
Positions	2,590	2,920	3,139	3,274
FTE	2,544.82	2,761.73	3,081.46	3,222.90

Program Description

Child Welfare (CW) programs work to assure the safety of children and provide services to their families, including responding to reports of child abuse or neglect, providing in-home supports or out-of-home care when necessary, and arranging adoption or guardianship services and supports. The children served are dependent, neglected, abused, mentally or physically disabled, and/or placed in the state's legal custody.

- Child Safety Services – Assesses reported child abuse or neglect and, if needed, prepares and implements safety plans for children, including case management or contracted services for families. Services may include substance abuse treatment, domestic violence and sexual abuse services, in-home safety and reunification services, and System of Care flexible funding.
- Substitute Care, or out-of-home care – Represents a broad range of care, supervision, and treatment services for children in temporary or permanent custody of the state. Family foster care homes and "special rates" foster care are the primary service elements. Residential Care is provided by private agencies in residential or therapeutic foster care settings for children who cannot live in a family setting. Providers are reimbursed for a portion of the cost of a child's room and board, clothing, school supplies, and personal incidentals; medical, dental, and mental health services are also provided for children in the state's custody. For older youth, independent living services help with the transition out of the foster care system.
- Adoptions Program – Provides adoption and guardianship services to help achieve permanent living placements for children in the child welfare system who cannot return home, including subsidy payments to help remove financial barriers to adoption or guardianship for special needs children.

Revenue Sources and Relationships

For the 2019-21 biennium, General Fund supports 57.3% of the budget and Federal Funds cover 39.8% of the budget; Other Funds contribute less than 3%. General Fund is picking up a higher percentage than in prior biennia due to moving federal TANF funds to Self Sufficiency and replacing those with state dollars ($40 million).

The federal government partially reimburses eligible state program costs through Title XIX Medicaid and Title IV-E Foster Care and Adoption Assistance. Medicaid funding is used for case management services, special rates for some children in foster care, residential treatment, and related administrative services. Title IV-E funding is used for child welfare services, adoption assistance, and related administrative costs; this source is estimated to cover about $300 million in agency expenditures for 2019-21. Overall, federal reimbursement for the programs varies with federal match rate changes, the number of children served, and eligibility of the services provided. For 2019-21, the state's base FMAP is estimated at 61.36%; at this rate, which is used for Title IV-E match as well as for Medicaid, Oregon pays 38.64% of allowable program costs for eligible children. Most administrative functions are paid on a 50% state/50% federal share.

About $15 million in federal dollars come through Title IV-B formula grants, which support basic child welfare services and family preservation and support activities. The latter includes family reunification and post-adoption services. Child Welfare will also transfer about $12 million in Federal Funds to the Department of Education to support Early Learning and Youth programs.

The Title XX Social Services Block Grant (SSBG) is estimated at about $41 million for the biennium; these flexible dollars are used for field staff, residential treatment beds, and administrative services. Proposals at the federal level regarding repeal of the SSBG are concerning, as the grant fills gaps in Child Welfare services that are otherwise not funded by Title IV-E or are under-funded by other federal fund sources, such as Title IV-B.

Other Funds revenues include Criminal Fine Account funds to support grants for Domestic Violence Services and the Sexual Assault Victims Fund. Domestic Violence Services also receives Other Funds from a surcharge on marriage licenses. he budget also includes child support recoveries and client trust account funds from client resources, such as federal Supplemental Security Income disability payments. These are used to offset state assistance and maintenance costs for children in care.

Budget Environment

In federal fiscal year (FFY) 2018, CW received 84,233 reports of suspected child abuse or neglect; 43,317 of those reports were referred for further investigation. Out of those assessments, 8,167 were founded for abuse and involved 12,585 victims; 2,906 (23.1%) were removed from their homes. The number of victims represent about 1.4% of the estimated 869,457 Oregon children aged 0 to 18 in 2018. A little less than half (46.3%) of the victims are age 6 or younger.

The number of reports received in 2018 is the largest annual number over the last decade; the lowest volume in that time period was 64,305 reports for FFY 2013. With launch of the Oregon Child Abuse Hotline (ORCAH) in April 2019, the number of reports coming in during 2019 are expected to be much higher; this new centralized reporting function saw a dramatic increase in the number of contacts and reports, which was expected based on experience in other states.

Child safety expenditures in this program area are designed to give early intervention and support services to families to help prevent the need for out-of-home placement or to return children home more quickly. However, funding for the services in this budget has not kept pace over time with the continuing growth in reports of abuse and neglect. Other agency or external programs, such as Family Support and Connections in the Self-Sufficiency program area or the Healthy Start and relief nurseries programs in the Oregon Department of Education (Early Learning Division), provide complementary services for at-risk families.

The estimated average Child Welfare monthly caseload for 2019-21 is forecasted to be 21,456, or about 1% below the average caseload of 21,680 children in 2017-19. Within the projected caseload, 7,077 children, or 33% of the caseload, are expected to be in out-of-home placements; these include both foster and residential care settings.

In FFY 2018, 11,445 children spent at least one day in some kind of foster care, a slight decrease from the 11,645 children in the prior year. Family foster care is the primary setting. There were 4,082 certified foster family homes in 2018 and over 49% of the children placed in family foster care were placed with relatives. The agency reports that 59.7% of children who left foster care during 2018 were reunited with their families.

Families and other foster care providers receive partial reimbursement for the cost of room and board, clothing, school, and personal items for foster children. Many children in foster care require special services (and special rate payments), based on emotional, behavioral, mental, or physical problems that require increased skills and supports for foster parents and caregivers. Children in foster care also are eligible for physical and mental health services through the Oregon Health Plan, funded in the OHA budget.

Other, higher cost services may be required in residential treatment or specialized service plans for children whose needs cannot be met in existing service settings. Capacity in residential treatment programs has been constrained by budget and many providers' costs have increased more rapidly than the rates paid by DHS.

The Adoptions Program provides adoption and permanent guardianship options for children in foster care who are unable to safely return to the care of their biological parent(s). During FFY 2018, 666 adoptions were finalized,

which is slightly lower than the 673 adoptions finalized in 2017; the count of finalized adoptions has not exceeded the 1,000 mark since 2009. A total of 454 children exited foster care and entered into a guardianship, which continues an increase in this program in recent years; most children go to guardianship with relatives. In almost all cases, adoptive parents or guardians receive assistance payments. These payments help cover a child's needs that the family would have difficulty providing without financial assistance; they are not intended to fully cover the cost of raising a child.

Media coverage, interim reporting, legislative interest, and the Secretary of State audit on foster care continue to highlight concerns about the CW programs. While some investments have been made, it is difficult to assess to what extent the agency is making progress on child safety, provider oversight, policy alignment, program performance, system accountability, and culture change. In April 2019, the Governor issued Executive Order 19-03 to help more effectively address these issues. An oversight board and external contractor have been established to provide guidance and implement recommendations. Some of this work is likely to result in additional funding requests during the 2019-21 biennium.

Another dynamic very likely to drive cost is implementation of the federal Family First Prevention Services Act (FFPSA); this federal law was passed in February 2018, but related federal guidance and instructions were not issued until late fall 2018. The Act makes substantial changes to federal financing of child welfare and has significant implications for the structure of Oregon's program. A state statutory framework consistent with FFPSA was created in SB 171 (2019) but many unknowns around program requirements, solutions, and associated costs still remain. These will need to be identified prior to July 2020, when changes around residential services are scheduled to take effect. Areas for consideration include the following: developing appropriate in-state placements for children, minimizing out-of-state placements, returning children to Oregon, recommending how providers can successfully move to the residential program model, identifying rate adjustments or other financial changes needed to meet new requirements, and ensuring crisis placement capacity.

Legislatively Adopted Budget

At $775.5 million General Fund and $1,352.5 million total funds, the 2019-21 legislatively adopted budget for Child Welfare is 29% General Fund and 115.1% total funds higher than the prior biennium's budget. The position count of 3,274 (3,222.90 FTE) reflects a 12.1% increase over 2017-19. Budget increases are primarily tied to maintaining base positions at risk of loss due to federal TANF funding realignment, adding new positions to address workload issues, and investing in efforts to help foster families.

A total of 272 positions (271.50 FTE) are added between biennia to help stabilize the program; the position mix was developed using mandated caseload workload model calculations coupled with a "best practices standard" approach. As the Department is working to update the workload model and workload continues to be a challenge for caseworker recruitment and retention, these resources are not expected to fully meet program needs. The budget also includes 16 (14.08 FTE) Mentoring, Assisting, and Promoting Success (MAPS) positions, which provide mentoring and other supports to first-year caseworkers; these positions augment 50 added in the prior biennium.

Other investments targeted at helping improve program performance and capacity include:

- $8.9 million General Fund and 46 permanent positions (38.51 FTE) for the Oregon Child Abuse Hotline. The agency's move to this centralized screening operation was initially accomplished by realigning existing positions and staff over an eight month period ending in early April 2019; more staff are needed to help handle a high volume of calls and mitigate caller wait times.
- $3.8 million total funds and 17 positions (17.00 FTE) to develop a data-informed statewide foster family recruitment and retention team. A centrally located program manager will oversee a recruitment specialist located in each of the agency's 16 districts.
- $3.1 million General Fund ($7.8 million total funds) will pay for the statewide expansion of a former pilot program called Keeping Foster and Kin Parents Supported and Trained. The program provides weekly training to small groups of parents; the sessions cover parenting techniques and skills tailored specifically to each cohort's needs.

- $2.3 million General Fund ($3.9 million total funds) and 17.60 FTE to continue the Leveraging Intensive Family Engagement program at its current, limited level in five counties. The program was initially scheduled to be phased out by October 2019 since it was funded with expiring federal Title IV-E Waiver funds. The program supports monthly case planning meetings, enhanced family finding activities, parent mentors, and team collaboration.

To signal support for ongoing program improvement efforts, a $10 million reservation within the general purpose Emergency Fund was created for the Department to access to help pay for efforts or initiatives not covered within the existing budget upon evidence that the additional funding will result in demonstrative improvements in Oregon's child welfare system.

Consistent with state law, the Department of Justice began providing full legal representation to DHS caseworkers during 2017-19. In the 2019-21 legislatively adopted budget, the last phase of program implementation is funded with $12.7 million General Fund ($23.3 million total funds). The funding covers program rollout costs for Clackamas, Clatsop, Marion, Multnomah, Union, and Washington counties, along with other position-related adjustments needed to adequately operate the program. Another investment continues planning and initiation work related to the OR-KIDS system, which is the state's primary child welfare data system, with 3.8 million General Fund ($7.5 million total funds) and nine permanent positions (9.00 FTE). Federal rules require these systems to meet new standards regarding data quality and modularity.

A $50 million General Fund statewide behavioral health investment package tied to SB 1 (2019) has two Child Welfare components. The first is $3.5 million General Fund ($8.5 million total funds) to pay for therapeutic foster care home recruitment, training, and support. The second appropriates $4 million General Fund to the Emergency Board to help increase capacity for non-Medicaid in-home services under the Family First Prevention Services Act. In addition to allowing federal dollars to help pay for prevention services, this new federal law also limits federal funding for children placed in a setting that is not a foster family home unless the setting is a qualified residential treatment program. The restriction is expected to affect services offered by existing providers, many of whom were already having difficulty attracting and retaining staff even before addressing new programmatic requirements. A related budget note directs DHS to assess and report back on workforce issues associated with the residential provider community and ways to help surmount regulatory barriers or other challenges.

To help pay for investigation and system changes driven by SB 155 (2019), which deals with sexual misconduct reporting requirements in schools, the budget includes $1.1 million General Fund and 7 positions (5.25 FTE). In addition, technical adjustments and position transfers are also accounted for in the budget, along with standard reductions due to changes in statewide charges for services, lower PERS rates, and adjusted rates for attorney services provided by the Department of Justice.

Three budget reduction actions were approved to help make General Fund available for other program needs. These reduce the enhanced foster care budget by $2.3 million General Fund; decrease the Strengthening, Preserving, and Reunifying Families budget by 50% (just under $7 million General Fund); and trim the budget for Focused Opportunities for Children Utilizing Services placements by 25% ($6.3 million General Fund, $6.6 million total funds). This last program is supported mostly by General Fund and primarily serves children with specialized needs placed out-of-state; as the state develops in-state placements to help meet those needs, federal dollars can potentially be leveraged to help cover placement costs and stretch the state dollars further.

Vocational Rehabilitation

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	24,965,718	29,533,924	35,629,792	35,576,784
Other Funds	2,315,297	2,337,472	2,436,795	3,012,926
Federal Funds	83,526,341	85,660,464	83,014,868	83,842,517
Total Funds	**$110,807,356**	**117,531,860**	**$121,081,455**	**$122,432,227**
Positions	260	259	258	261
FTE	258.09	258.25	257.04	260.04

Program Description

Vocational Rehabilitation (VR) works with businesses, schools, and community programs to help youths and adults with disabilities other than blindness prepare for and find employment. In federal fiscal year 2014, the program served a total of 17,203 individuals with disabilities.

- Vocational Rehabilitation "Basic Services" – Provides training, vocational, and educational services to persons with disabilities that are substantial impediments to obtaining or maintaining employment. These services are delivered through field offices and employees out stationed across the state.
- Youth Transition Program – Provides coordinated vocational rehabilitation services to students who are currently in school to ensure a smooth transition to adult services and employment after school completion.
- Supported Employment Services – Provides intensive training, job placement, and job coaching services to individuals with the most significant disabilities who can obtain competitive employment.
- Independent Living Program – Supports the State Independent Living Council and community-based Centers for Independent Living, which help persons with severe disabilities maintain independence at home, in the community, and in employment.

Revenue Sources and Relationships

For the 2019-21 biennium, General Fund supports 29.1% of this budget; Other Funds, 2.5%; and Federal Funds, 68.5%. Section 110 of the Rehabilitation Act of 1973 (Basic 110 Grant) provides federal support for vocational rehabilitative services, which is distributed upon state population and per capita income. The federal grant requires General Fund or Other Funds match at a 21.3% state/78.7% federal rate.

In 2019-21, DHS will receive 84.4% of Oregon's allocation of Section 110 Federal Funds and the Commission for the Blind will receive the remaining 15.6%; this split continues an increase (up from 12.5%) in the percentage going to the Commission that began in the 2017-19 biennium. That change placed the Commission's percentage in line with the national average for states having standalone agencies providing vocational rehabilitation services to people who are blind.

Since this formula grant is essentially capped, the purchasing power of the federal revenue component is decreasing and putting more pressure on state funds in both agencies. However, each agency can apply for federal reallotment dollars and successfully received these funds in the past. Under the federal law, if a state is not able to fully spend its annual vocational rehabilitation funds, then those dollars are made available to other states through a reallotment application process; applicants must have adequate state match to draw funds.

Budget Environment

Almost all clients receiving vocational rehabilitation services have severe disabilities (cognitive, psychosocial, physical, or mental impairments) which require a broad array of services. The severity of the disabilities, and the extent of the services needed to correct or address the disabilities, increase the cost and difficulty of rehabilitation and employment. In addition, even while Oregon's economy has improved, the program continues to face challenges in finding employment for clients due to limited availability of and tight competition for jobs.

VR is not an entitlement program like SNAP or Medicaid long-term care services where funding is tied directly to the number of people eligible. For the past two decades, federal funding for vocational rehabilitation services has been generally flat, with only cost-of-living adjustments. This has not always kept pace with increased costs and demands for services, and state budget resources have not always been able to fill the gap. Periodically, when demand for services exceed capacity and budget, the program has operated under an Order of Selection, which mandates that services be provided first to the most severely disabled individuals. People who cannot be served are put on a wait list. DHS has not had to use the list since July 2010, but the program continues to assign priority levels to individuals. While VR does not currently expect to need a wait list in 2019-21, if one is needed, this action positions the agency for reinstituting a wait list in a manner that minimizes both client and program impacts.

The agency's budget has been growing since the 2013-15 biennium primarily due to an increase in level of effort and engagement with IDD clients in the Employment First program. While not directly budgeted within this program, VR works closely with the DHS IDD program on helping these clients find community-based employment rather than participate in sheltered work settings.

The Department is still adapting to program adjustments associated with reauthorization of the federal Rehabilitation Act, as part of the Workforce Innovations and Opportunities Act (WIOA) in July 2014; these may affect state service delivery and budget adequacy. Some provisions of the Act include changes in plan timelines, pre-employment transition services, program performance metrics, employment definitions, subminimum wage, order of selection priorities, and services to employers. It also required shifting from annual to quarterly reporting, which has a workload impact, and ensuring 15% of the federal budget is used to serve youth.

Legislatively Adopted Budget

At $122.4 million total funds, the legislatively adopted budget for VR is 4.2% above the 2017-19 approved budget level. However, embedded in the modest total funds increase is a 20.5% increase in General Fund (from $29.5 to $35.6 million), primarily due to $4.9 million General Fund added to backfill one-time federal reallotment funds received during the 2017-19 biennium. While another successful round of reallotment funding is expected in 2019-21, those funds are expected to cover a shortfall driven by inflation and other budget drivers; the additional General Fund is also needed to help meet MOE and match requirements to draw reallotment funds.

The budget continues essential services with an emphasis on improving employment outcomes for people with intellectual and developmental disabilities under the Employment First initiative and managing program changes driven by WIOA. Consistent with recent practice, $4.5 million Federal Funds expenditure limitation is included to spend one-time FFY 2018 reallotment revenue carried forward from the 2017-19 biennium; this action offsets a projected federal funding shortfall.

To collaborate with school districts in providing pre-employment transition services for all eligible students, the budget includes $0.6 million Other Funds expenditure limitation and 3 permanent positions (3.00 FTE). Budget savings due to statewide assessment changes, lower PERS rates, and adjusted rates for attorney services provided by the Department of Justice are also reflected in the budget.

Aging and People with Disabilities

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	866,700,420	1,018,971,037	1,207,637,026	1,207,013,810
Other Funds	187,143,856	265,740,017	218,081,806	250,840,663
Federal Funds	1,958,014,226	2,255,802,269	2,435,466,260	2,488,511,056
Total Funds	**$3,011,858,502**	**$3,540,513,323**	**$3,861,185,092**	**$3,946,365,529**
Positions	1,348	1,488	1,457	1,570
FTE	1,337.90	1,407.26	1,447.97	1,516.87

Program Description

Aging and People with Disabilities (APD) and its partners provide services for seniors and adults with physical disabilities. Historically, APD administered Oregon's Medicaid long-term care program through a federal Home and Community-Based Care (HCBS) waiver under Section 1915(c) of the Social Security Act. Since July 2013, many services now fall under the K Plan, which is a Medicaid state plan option authorized under the Affordable Care Act. Oregon Project Independence provides in-home services outside of the Medicaid program. Federal Older American Act services include abuse prevention, caregiver supports, medication management, nutrition services, senior employment, legal issues, and other support services. The program also includes federally required supports to aged, blind, and disabled persons who receive Supplemental Security Income.

Medicaid long-term care services for the elderly and clients with physical disabilities fall into one of three major delivery categories: in-home programs, community-based settings, and nursing facilities. In-home services are provided by home care workers who are employees of the client, with oversight by the Home Care Commission and by providers working through local Area Agencies on Aging (AAAs). Community-based facilities include adult foster care homes, assisted living, residential care, and enhanced residential care. Providence Elder Place is a jointly funded Medicare and Medicaid Program of All-Inclusive Care for the Elderly (PACE), a program that integrates acute medical care and community-based care under a system of capitated rates, serving people at high risk of needing nursing facility care. The program integrates acute and long-term care services, with seniors in this program generally attending adult day care services while living in a variety of care settings.

Eligibility for Medicaid long-term care is based in part upon the ability to perform certain activities of daily living. Applicants for Medicaid long-term care are evaluated on their ability to perform activities of daily living such as eating, toileting, mobility, bathing, and dressing. This evaluation is used to rank the applicant within Service Priority Level (SPL) categories; SPL 1 clients are those most unable to perform activities of daily living and more likely to need services offered in nursing facilities, while those at lower priority levels (higher SPL numbers) are less impaired and more likely to receive in-home assistance. Oregon provides services for clients in categories 1 through 13. Participation can also be tied to income, assets, and eligibility under other programs.

Medicaid law requires states, at a minimum, to provide nursing facility care. Since the 1980s, however, Oregon has operated its long-term care program under a waiver allowing individuals who would otherwise require the level of care furnished in a nursing facility to opt instead for a home and community-based care option. This change shifted the service split between community-based care and nursing facilities. In the 1980s, about half of the caseload resided in nursing facilities; today those cases represent only about 13% of the Medicaid long-term care cases. In-home cases represent about 53% of the caseload and community-based facility cases, 34%.

Oregon Project Independence (OPI) provides in-home services to about 2,000 Oregonians each month. Under the traditional program, clients must be 60 years of age or older or have Alzheimer's or other related dementia, and be assessed as SPL 1 through 18 (a broader range than the levels 1 through 13 served in Medicaid long-term care). Those with incomes over 100% of the federal poverty level pay all or part of the cost of services. With funding initially approved in the 2013-15 biennium as a pilot project, younger individuals may also be served by OPI.

APD is the state administrator of the Older Americans Act (OAA), a federal program targeted to people 60 years of age and older. The state distributes the funds to local AAAs, which deliver a variety of services including information and referral, transportation, congregate meals and "meals on wheels," senior employment programs, legal services, insurance counseling, and family caregiver counseling and training. During 2019-21, APD expects more than 227,000 older Oregonians will receive OAA services.

The Oregon Supplemental Income Program (OSIP) provides special needs cash payments for items such as prescription drug copayments, non-medical transportation, or one-time emergency payments for low-income aged and disabled individuals receiving federal Supplemental Security Income (SSI) benefits though the Social Security Administration.

Field services for seniors and people with physical disabilities are delivered through two different structures:

- "Type A" Area Agencies on Aging (AAAs) provide Older Americans Act (OAA) and Oregon Project Independence (OPI) services in most counties. Type A AAAs are typically private non-profit agencies. Staff are employees of the AAA. In areas served by Type A AAAs, local APD offices administer Medicaid, cash assistance, and SNAP services.
- "Type B" AAAs are local government bodies, such as counties or councils of governments. "Transfer AAAs" are staffed by local government employees; in "Contract AAAs," services are provided by state employees supervised by the county. Both administer Medicaid, cash assistance, SNAP services, OAA, and OPI programs.

The budget includes funding, but not positions and FTE, for staff who work in the Type A AAAs and for Transfer AAAs. While under statute DHS is required to establish a budget level for Transfer AAAs that is not less than 95% of the cost to run a similarly staffed state office, budget constraints at different times have suppressed that level.

Local APD office staff are part of this budget, which include SNAP eligibility staff; however, the SNAP benefit payments are part of the Self-Sufficiency Programs (SSP) budget.

The Disability Determination Services (DDS) program assesses clients' eligibility for Social Security Disability Insurance (SSDI) and SSI programs; staffing for this work is 100% federally funded.

Revenue Sources and Relationships

General Fund makes up 29% of the APD budget, which is about a 1% increase over the prior biennium. Most of the program's General Fund is used to match federal Title XIX Medicaid and other Federal Funds.

Other Funds revenue is 6.4% of the overall budget. The Other Funds come primarily from nursing facility Medicaid provider taxes, clients' contributions towards their care, and estate recoveries. The nursing facility provider tax, described in statute as the Long Term Care Facility Assessment, is used to match federal Medicaid funds for facilities that serve Medicaid clients, allowing for higher levels of nursing facility reimbursement. The provider tax is currently authorized through June 30, 2026; the previous 2020 sunset was extended in HB 4162 (2018).

Federal Funds make up 63.1% of the budget and are predominately Medicaid funds. Federal matching funds for the Medicaid program are determined by the FMAP rate, which is the federal share of eligible program expenditures. The program match rate changes each federal fiscal year and depends on Oregon's per capita income relative to other states. Under the K Plan, the state draws down an additional 6% in Medicaid funds for some APD services.

Most Medicaid administrative functions are paid only on a 50% state/50% federal share. Federal OAA funding also supports program services. For the state's funding commitment, the program uses OPI funding as well as local AAA resources to meet the required match and OAA maintenance of effort requirements. APD also receives Federal Funds for SSDI and SSI eligibility determination through Titles II and XVI of the Social Security Act. In addition, a modest amount of federal revenue comes from Medicare and SNAP.

Budget Environment

For several biennia, the APD budget has grown significantly due to mandated caseloads, service cost increases, and program improvements such as provider rate increases and new program services. DHS' ability to maintain current services is and will continue to be a challenge, with ongoing growth in the number of Oregonians who receive those services and increasing costs to provide quality care on one side, and limited resources on the other.

Over the last three decades, the delivery of services for seniors and people with disabilities has shifted from institutional care to community-based care. In Oregon, long-term care for Medicaid-eligible seniors and people with disabilities has moved from nursing facilities to other settings: in-home care, adult foster homes, group homes, and residential care and assisted living facilities. Federal waivers have allowed continued use of Federal Funds to support more community-based care at a lower overall cost than institutional care.

Demand for services to seniors and adults with physical disabilities is driven largely by demographics. The number of Oregonians aged 65 or older, the population most likely to require long-term care services, increased by almost 80,000, or 18%, in the decade from 2000 to 2010. From 2000 to 2019, this same population grew by 230,174, or 43%. The Department of Administrative Services' Office of Economic Analysis projects the 65+ age group will grow by 7.6% during the 2019-21 biennium, reaching over 819,668 by July 1, 2021. As of July 2019, APD was serving 34,730 seniors and adults with physical disabilities in its long-term care programs for the elderly and the physically disabled (which include in-home services, community-based care, and nursing facilities). The agency's Spring 2019 caseload forecast projects APD will serve an average of 35,070 clients over the 2019-21 biennium, which is 1% (or 340 clients) higher than the 2017-19 biennial average forecast.

Given the demographic projections, the issue of sustainability of the long-term care system has been a recurring topic of discussion. Currently, APD is updating its strategic plan in collaboration with stakeholders to address a variety of challenges, such as how to serve an older population having lower levels of retirement savings and experiencing poorer health than prior generations.

In addition to population growth, provider reimbursement is a major driver in APD costs. Adequate provider reimbursement assures access for clients and allows providers to operate effectively with an appropriate number of skilled workers, while inadequate reimbursement puts access and services at risk. Reimbursement rates are based on a mix of where clients live and the extent of individual client needs. For example, the rates DHS pays nursing facilities for services are set in Oregon statute, which establishes the reimbursement levels at certain percentiles of audited allowable nursing facility costs. Community-based provider rates, such as those for assisted living facilities and residential care facilities, are tiered based upon client impairment. In-home service caregivers and adult foster home rates are now subject to collective bargaining.

With the K Plan and updates to existing waivers, DHS was able to expand person-centered and community-based services for eligible seniors and people with physical and developmental disabilities. The plan also allows Oregon to receive a six percentage point increase in the matching rate the state receives from the federal government. These additional dollars are built into the budget but have not been able to offset growth in caseload and cost per case, some of which are associated with the K Plan or other policy changes.

Legislatively Adopted Budget

At $1,207 million General Fund and $3,946.4 million total funds, the legislatively adopted budget for APD is 18.5% General Fund and 11.5% total funds greater than the 2017-19 legislatively approved budget.

The General Fund budget is 18.5% or $188.1 million above the prior biennium; the change is primarily due to current service level growth attributed to base salary adjustments, inflation, phase-ins and phase-outs, mandated caseload, and fundshifts. Regarding caseload, while the pace of overall caseload growth is forecasted to slow in 2019-21 compared to recent history, the trend is steadily upward and shifts between lower cost (in-home) and higher cost (nursing facility) caseloads can heavily influence the budget; exceptional inflation and caseload costs account for about $75 million of the net General Fund increase. With APD heavily reliant on Medicaid, the FMAP rate change accounts for an increase of $46.4 million General Fund and a corresponding decrease in Federal Funds expenditure limitation. The roll-up of positions and rate increases funded for only a portion of the 2017-19 biennium are driving about $20 million in new General Fund costs.

The budget includes $5.8 million total funds and 19 permanent positions (19.00 FTE) to implement two actions approved at the December 2018 meeting of the Emergency Board. Fifteen positions help comply with a federal mandate requiring all nursing facility complaint investigations to be handled by APD's Nursing Facility Survey unit; federal funding pays for 75% of the work. The other four positions will be used to embed case managers in hospitals to more quickly assess and place hospitalized individuals needing long-term care Medicaid services upon discharge. The full cost of the positions will be paid for by the hospitals.

In the nursing facilities program, $32.2 million from a projected carryforward balance in the long-term care facility assessment (Other Funds revenue) is used in place of the same amount of General Fund on a one-time basis; the General Fund, along with federal matching funds, is then used to pay for several program needs:

- Rate increases, at a cost of $52.6 million total funds, for assisted living facilities, residential care facilities, memory care facilities, and in-home care agencies. Rates were increased 5% on July 1, 2019 and will increase another 5% on July 1, 2020. Providence ElderPlace funding will also increase by 5% on July 1, 2019.
- Dollars are also provided ($15.3 million total funds) to increase rates for adult foster homes within the APD program; these rates are also subject to collective bargaining but are expected to increase by 10% on January 1, 2020 and by 5% on July 1, 2020.
- Twenty full-time permanent community-based care surveyor positions (10.00 FTE; phased in July 1, 2020) to help reduce a backlog of inspections and keep up with facility oversight.
- To address workload issues and a workload model that is out of sync with duties in both APD and AAA local offices serving seniors and people with physical disabilities, the equivalent of 143 positions (71.50 FTE; phased in July 1, 2020) are added; most of these are case manager positions. The current workload model does not reflect job duties and expectations that have significantly changed over the last six years with increasingly complex consumers, high expectations from federal partners, and frequent policy changes.
- Two permanent full-time positions (1.76 FTE) were added to promote the effective use of emergency medical services by residents of licensed long-term care settings and support efforts of the quality measurement council.

The adopted budget also includes $28.1 million General Fund to maintain Oregon Project Independence at existing levels and $3.7 million General Fund to continue the caregiver training program through a relationship with Oregon Care Partners. To support work under HB 2600 (2019), which deals with communicable disease prevention in long-term care facilities, the budget includes 3 positions (1.14 FTE) and $270,759 Other Funds expenditure limitation. General Fund in the amount of $125,000, along with $125,000 Federal Funds expenditure limitation, was added to cover DHS's costs for contracting with a vendor to develop recommendations for assessing and monitoring services provided by home care workers; this is needed to comply with SB 669 (2019).

In addition to reflecting budget savings due to changes in statewide charges for services, lower PERS rates, and adjusted rates for attorney services provided by the Department of Justice, the budget contains one reduction action eliminating $1.3 million General Fund paying for evidence-based health promotion programs operated through local AAAs.

Intellectual and Developmental Disabilities

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	750,571,318	880,473,687	997,381,374	1,054,370,325
Other Funds	39,769,895	28,113,604	28,964,390	28,647,741
Federal Funds	1,592,951,485	1,810,396,130	1,883,854,298	2,001,975,798
Total Funds	**$2,383,292,698**	**$2,718,983,421**	**$2,910,200,062**	**$3,084,993,864**
Positions	958	914	913	917
FTE	893.69	909.70	912.42	916.30

Program Description

The Intellectual and Developmental Disability (IDD) program serves more than 28,000 people (8,650 children and 19,420 adults) with intellectual and developmental disabilities throughout their life span. This program's mission is to help individuals be fully engaged in life and, at the same time, address critical health and safety needs. The state, counties, brokerages, providers, families, and self-advocates are all critical parts of Oregon's Developmental Disabilities service system that focuses on individuals with IDD living in the community and having the best quality

of life at any age. Oregon no longer has an institutional facility for persons with developmental disabilities, so all clients are served in the community. Most of these services are administered under Medicaid waivers.

To receive services, individuals must meet Medicaid financial eligibility requirements and have intellectual or developmental disabilities that impede their ability to function independently. These disabilities include mental retardation, cerebral palsy, Down's syndrome, autism, and other impairments of the brain that occur during childhood. Some program clients also have significant medical or mental health needs.

Community Developmental Disability Program (CDDP) offices at the county level determine eligibility for IDD services, assess client needs, determine service rates, arrange and oversee contracts with providers, and respond to protective services issues. Regional brokerages provide case management and link individuals with services. Local providers deliver support and residential services. The budget covers payments to counties and brokerages for program administration as well as for program services. Brokerage enrollment is capped, so when service demand increases, the CDDPs try to cover the gap.

Core program services are described below; clients may receive services from more than one category and require services from different categories at different points of their lives:

- Support services are for adults and children who live at home and are typically provided by individuals hired by the client, with the help of a personal agent, who gives them the assistance they need to remain in their own homes. Primary support services available include home modifications and services to help clients function appropriately within their communities, respite care for primary caregivers such as parents, and non-medical transportation. In addition, support services are provided for children living at home to help prevent out-of-home placements. Regional non-profit brokerages work with clients and their families to arrange appropriate support services.
- Comprehensive services assist adults and children who are living at home and receiving 24-hour supports or are living in residential facilities or group homes. Adult residential programs provide 24-hour group home care or supported living services for people aged 18 and over with a developmental disability. Children's residential care includes foster care and community residential group homes. Children's Intensive In-Home Services are provided 24-hours a day for medically fragile children, medically involved children, and children with intensive behavioral disabilities. Clients receiving comprehensive services may also receive diversion services (to prevent a crisis) or transportation, if needed.
- The Stabilization and Crisis Unit (SACU) provides 24-hour community residential care for approximately 104 people who have intensive support needs because of medical or behavioral conditions. State employees operate and work in the group homes serving these clients.

Revenue Sources and Relationships

General Fund makes up 34.2% of the IDD budget. Most of the General Fund is used to match federal Title XIX Medicaid and other Federal Funds. Other Funds revenue is 1% of the overall budget. The Other Funds come primarily from clients' contributions towards their care.

Federal matching funds for the Medicaid program are determined by the FMAP rate, which is the federal share of eligible program expenditures. The program match rate changes each federal fiscal year and depends on Oregon's per capita income relative to other states. For the 2019-21 biennium, the average Medicaid match rate is estimated at 61.36%; at this rate, Oregon will pay 38.65% of eligible program costs. For K Plan services, the state draws an additional 6% in federal match.

Budget Environment

A major budget driver for IDD programs is caseload growth. Based on the Spring 2019 forecast, the 2019-21 case management (overall client count) biennial average caseload forecast is 30,592 clients, which is 9.8 % higher than the 2017-19 average forecast of 27,860 clients; the budget accounts for this caseload growth and associated cost per case increases.

While the forecast represents the best estimate currently available, it continues to be an area of concern and volatility. Under K Plan changes, access to services for children is virtually unrestricted while lifting caps on support services make programs more attractive to adult clients. Trying to estimate how many more clients, particularly children, may seek services is challenging. Over time, it is likely this influx of children will age into the adult caseload.

Lawsuits or other legal actions have historically impacted the program, such as the class action settlement agreement for a 2012 lawsuit (*Lane v. Brown*) that alleged Oregon unnecessarily segregated individuals with IDD in sheltered workshops in violation of the rights of these individuals under federal law. In 2013, under executive orders and with funding from the Legislature, the agency committed to phasing out sheltered workshops and to replace them with employment services directed toward integrated workplaces. The settlement agreement largely instituted the changes already underway, which include "closing the front door," or ending new entries to sheltered workshops, as well as providing career development plans to people who have worked in workshops, certifying service providers, coordinating more closely with the schools, and increasing services designed to achieve integrated employment.

Historically, the IDD budget has been driven less by demographics and more by state policy, federal Medicaid policy, and the Staley Settlement Agreement. State policy and budget issues directed the closure of the Fairview Training Center in Salem, and later the Eastern Oregon Training Center in Pendleton, with clients moving from the institutions to community homes. The 1999 Olmstead decision, which said states must provide Medicaid services in the most integrated setting appropriate to the needs and wishes of people with disabilities, further reinforced the shift out of institutions. In 2000, in lieu of a federal class action lawsuit, Oregon entered into the Staley Settlement Agreement, which eliminated waiting lists and phased-in universal access to support services via the brokerage system. Most recently, access and general service demand aside, there are policy components within the K Plan, such as parental income disregard, that continue to influence the budget.

Similar to many other agency programs, IDD relies heavily on partners and providers to meet program and client needs. Rate reductions in recent biennia, along with policy changes, make this relationship especially challenging. While the current budget does include some rate increases, many providers indicate rates are inadequate and make it difficult to run their operations and pay competitive wages. Wages continue to be an issue for discussion, due to differences in wage assumptions DHS makes when pricing rates versus the decisions providers actually make about wages and other costs of doing business.

Legislatively Adopted Budget

The 2019-21 legislatively adopted budget for this program area is $1,054.4 million General Fund and $3,085 million total funds; the General Fund portion is 19.8% higher than the 2017-19 legislatively approved budget while the total fund amount increased by 13.5% between biennia.

Caseload and cost per case changes based on the Spring 2019 forecast are covered in the budget and include adjustments (increases) to workload models for the CDDPs and brokerages to help address that growth. The legislatively adopted budget for IDD reflects continued caseload growth and budget pressure due to expanded services and costs per case for children and adults, primarily resulting from implementation of the K Plan.

To help cover associated case management costs for CDDPs and Brokerages, the budget includes an additional investment of almost $13 million General Fund ($22.9 million total funds) which equates to an increase of 149.55 FTE. However, due to General Fund constraints, the funding provided is $10 million General Fund less than the level requested by the agency. The case management entities were hoping for a much larger funding increase due to a newly updated workload model that captures complex case management activities and efforts required to use a new assessment tool, the Oregon Needs Assessment. The adopted budget does represent a 20% increase from 2017-19 levels for these services.

To support higher wages for direct support professionals, the adopted budget includes $30 million General Fund ($91.8 million total funds) to increase IDD provider rates (Adult and Children 24 Hour Residential, Attendant Care, Supported Living, Non-Medical Transportation, Day Support Activity, Employment Path, and Small Group Employment), with the goal of raising wages as close as possible to $15.00 per hour by the end of the 2019-21 biennium. Since the program is also transitioning to new rate models during the biennium, a budget note provides direction about limiting rate increases under the old models to no more than 4% and applying this investment in a manner that prioritizes supporting individuals with the highest need.

Another investment supports SB 1 (2019) efforts, which center around improving the effectiveness and efficacy of state and local systems of care that provide services to youth with specialized needs. The measure, which was the product of an interim work group, establishes a System of Care Advisory Council to develop and maintain a state system of care policy and a comprehensive, long-range plan for a coordinated state system of care that encompasses public health, health systems, child welfare, education, juvenile justice, and services and supports for mental and behavioral health and people with intellectual or developmental disabilities. For IDD, the associated funding component adds $4.9 million General Fund ($10.5 million total funds) and one permanent position (0.88 FTE) to provide enhanced foster care services to about 140 youth and the development of small group home settings for 12 youth; these services are being called "host homes."

Other budget changes include eliminating $3 million General Fund for the receipt of enhanced federal match for the program's payment and reporting system (eXPRS), which is contingent on approval from the Centers for Medicare and Medicaid Services (CMS). In addition to standard reductions due to changes in statewide charges for services, lower PERS rates, and adjusted rates for attorney services provided by the Department of Justice, the budget reduces funding for community housing maintenance and job coaching to make General Fund available for other needs.

Central Services

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	29,097,958	35,751,624	35,453,622	49,192,572
Other Funds	1,102,870	46,080,695	1,671,017	44,907,776
Federal Funds	19,476,084	173,572,073	38,807,942	180,890,447
Total Funds	**$49,676,912**	**$255,404,392**	**$75,932,581**	**$274,990,795**
Positions	180	290	196	244
FTE	178.62	250.75	195.12	240.54

Program Description

The Central Services budget captures cross-program and executive-level policy and program work. Efforts are organized into the following offices: Director and Policy; Human Resources; Budget, Planning, and Analysis; Public Affairs; Equity and Multicultural Services; Reporting, Research, Analytics, and Implementation; Program Integrity; Business Information Services; and the Integrated Eligibility Project. These functions support agency leadership initiatives and guide programs in carrying out the Department's mission.

Revenue Sources and Relationships

The 2019-21 legislatively adopted budget is 17.9% General Fund, 16.3% Other Funds, and 65.8% Federal Funds; the funding mix is dependent on the services provided. Federal funding is subject to a federally approved cost allocation plan that charges programs for the services received and is also constrained by block grant capacity.

Budget Environment

Programs falling under the Central Services budget structure are heavily influenced by agency leadership interest and focus. For example, during the 2017-19 biennium, the reporting office was established and an emphasis on

transformation led to an extensive internal assessment of the agency conducted by the director of organizational development (a new role). However, to support initiatives such as these, the agency has frequently double filled positions to hire additional staff rather than wait for the Legislature to approve new positions. Early in the 2019-21 biennium budget development, DHS indicated the agency would need 68 positions (68.30 FTE) to clean up double fills and correctly align positions in Central Services; the request and its cost of $11.7 million General Fund ($20.3 million total funds) did not make it through the Governor's budget stage.

Unlike program workload models, there is no model or mechanism in place for the agency to "earn" positions in Central Services as agency programs grow in size or complexity; while that growth may truly be driving work for central functions, there are challenges in empirically determining an appropriate level of staffing, especially when a portion of the work is assigned directly by agency leadership. This mismatch between budget and how DHS operates is unlikely to be resolved without legislative action, although with the state's new human resources information system (Workday) double fills no longer exist; positions are either budgeted or non-budgeted.

Legislatively Adopted Budget

For Central Services, the 2019-21 legislatively adopted budget is $19.2 million General Fund, $275 million total funds, and 244 positions (240.54 FTE). The General Fund increase from the prior biennia is $13.4 million (37.6%), while the total funds increase is $19.6 million (7.7%). If costs related to the Integrated Eligibility (IE) project are disregarded, the General Fund increase is only $2.6 million, or about 6.4%.

The adopted budget funds the final development phase, implementation, and transition to Maintenance and Operations (M&O) for the IE project. This effort integrates enrollment and eligibility activities for several DHS programs: Non-MAGI Medicaid, SNAP, TANF, and ERDC into the OregonONEligibility (ONE) system used by OHA. Due to schedule changes and issues with the user acceptance testing vendor, the 2019-21 cost estimate for the project increased over the budget development timeframe; some costs also shifted between biennia. The project's current cost estimate and approved amount for the 2019-21 biennium is $200.6 million total funds. This overall amount includes state staff costs of $20.7 million, $94 million for contracted information technology services, $11.2 million for payments to OHA for its project work, and $5.8 million for debt service. Other elements addressed in the project plan include cost allocation, contingency, legacy system work, hosting services, disaster recovery, and security enhancements. The state staffing component consists of 33 positions (30.78 FTE) and primarily supports business analytics, system program support, and training activities; 17 of the positions (14.78 FTE) are limited duration for system rollout and short-term training needs.

The bulk of the project budget, at $139.7 million, or 70%, of 2019-21 costs, is supported by Federal Funds; this is because enhanced federal funding (74% federal/26% state) was approved for the Design, Development, and Implementation (DDI) phase of the work, which is expected to be completed by January 31, 2021. Once the system transitions to M&O in the last six months of the biennium, the federal cost share decreases. General Fund supports $16.9 million of project costs and debt service; the bulk of the state share will be covered by $43.9 million in ending balance or new proceeds from Article XI-Q bonds. Project debt service is paid out of the SAEC budget structure.

The budget also includes $2 million General Fund ($4.1 million total funds) and 5 positions (4.64 FTE) for 1) continuation of planning and implementation activities for modularization of the systems supporting Oregon Medicaid, and 2) ongoing operations and maintenance, including software licensing cost, of the Centralized Abuse Management system.

Technical adjustments and position transfers are also accounted for in the budget, along with standard reductions due to changes in statewide charges for services, lower PERS rates, and adjusted rates for attorney services provided by the Department of Justice. A $500,000 General Fund ($1 million total funds) reduction to services and supplies for the Business Information Services Office helps balance the agency's overall budget.

Shared Services

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
Other Funds	122,707,504	139,935,177	148,896,729	147,436,690
Total Funds	**$122,707,504**	**$139,935,177**	**$148,896,729**	**$147,436,690**
Positions	650	690	677	680
FTE	630.29	670.94	671.39	672.89

Program Description

With the transition of some former DHS programs to OHA, a new model was developed to provide administrative functions for the two agencies. A number of support activities, including information technology, financial services, budget, human resources, facilities, and procurement were designated as shared services. Some of the functions are housed in OHA and some in DHS, but all shared services units support both agencies. The two agencies developed a joint governance model under which service-level agreements define the relationship between the agency providing service and the agency receiving the service.

DHS' Shared Services budget includes the Shared Services Administration; Budget Center; Office of Forecasting, Research, and Analysis; Office of Financial Services; Office of Human Resources; Office of Facilities; Office of Imaging and Records Management; Office of Contracts and Procurement; Internal Audit and Consulting Unit; Office of Payment Accuracy and Recovery; and the Office of Adult Abuse Prevention and Investigations.

Revenue Sources and Relationships

Shared Services funding is all Other Funds, based on revenues received from other parts of DHS and from OHA for purchased services, primarily in those agencies' budgets for State Assessments and Enterprise-wide Costs.

Budget Environment

The Shared Services model was implemented to help make sure administrative services for the two agencies are provided cost-effectively without duplication of resources. As a result of this model, however, the Other Funds expenditures for those services are counted twice in the budget (technically known as "non-add" funding); once in Shared Services as work is completed and again in DHS and OHA programs as they pay for those services.

Legislatively Adopted Budget

The 2017-19 legislatively adopted budget of $125.3 million Other Funds is 2% below the 2015-17 legislatively approved budget. The change in staffing is a net decrease of 1.7% and 10 positions (12.86 FTE).

To help implement and optimize use of the Centralized Abuse Management (CAM) system, the budget adds 1 position (0.75 FTE) to provide training to system users. This increase and other position transfer actions are masked by position reductions, including decreasing capacity (phasing out positions) for the Oregon Enterprise Data Analytics program by 2.61 FTE ($1 million total funds), which leaves a total of nine positions between DHS and OHA. The effort, first approved in 2015, supports integration and analysis of client and customer service information across state agencies and programs. Nine long term vacant positions (9.00 FTE) are also eliminated, for savings for $1.1 million totals funds. This action primarily impacts financial and human resources functions.

The budget also accounts for technical adjustments/transfers and standard agency-wide reductions. Statewide reductions tied to DAS assessments or charges, inflation, travel, and legal expenditures are also captured in the funding plan.

State Assessments and Enterprise-wide Costs

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	208,913,317	242,085,478	283,564,977	284,657,702
Other Funds	11,598,228	41,814,705	38,997,670	39,622,034
Federal Funds	148,683,510	175,370,405	218,968,795	199,357,891
Total Funds	**$369,195,055**	**$459,270,588**	**$541,531,442**	**$523,637,627**

Program Description

The State Assessments and Enterprise-wide Costs (SAEC) budget structure contains assessments and charges paid by all state agencies, which include various Department of Administrative Services' (DAS) assessments/charges, Central Government Service Charges, and assessments for Oregon State Library services and Secretary of State audits. The budget also reflects expenditures for covering Shared Services' program components in both DHS and OHA, which includes position costs supporting those functions; no positions or FTE are budgeted directly in this program unit. The budget also includes agency-wide and/or centralized costs, such as rent, utilities, mass transit taxes, unemployment, debt service, and computer replacements.

Revenue Sources and Relationships

For the 2019-21 legislatively adopted budget, revenues are split 54.4% General Fund, 7.6% Other Funds, and 38.1% Federal Funds; the funding mix is dependent on the nature of specific assessments or charges being billed and is regulated by the agency's cost allocation model. Reliance on General Fund is expected to increase as the purchasing power of capped federal funding sources continues to erode. The program budget contains $31 million Other Funds expenditure limitation for an interagency line of credit agreement with the Oregon State Treasury to manage cash flow issues through the biennium close-out period. This allows the agency to borrow funds from the state treasury to finance prepayments and account for a lag in receipt of certain revenues, such as provider taxes.

Budget Environment

Assessments supporting third parties, such as DAS, are generally fixed costs over which the agency has no control; these also directly tie to the legislatively adopted budget for the receiving agency. While per unit charges for many services are set by the statewide price list, the agency does have some influence over usage and resulting costs. Usage is influenced by agency staffing levels; more employees can drive higher information technology costs or a need for more facility square footage. Assessments based on FTE are also affected by the number of agency positions. Some expenditures, such as mass transit taxes and performance audit charges, cannot be covered with federal dollars and rely primarily on state General Fund.

Legislatively Adopted Budget

The 2019-21 legislatively adopted budget of $284.6 million General Fund and $523.6 million total funds is 17.6% General Fund and 14% total funds more than the 2017-19 legislatively approved budget. The largest components, collectively at $31.9 million or 75%, of the $42.6 million General Fund increase between biennia are statewide assessments, shared services funding, and debt service. The latter expenditure totals $22.7 million General Fund for 2019-21, primarily for debt service on Article XI-Q bond proceeds that are being used to help finance the Integrated Eligibility project; the amount includes both prior and projected bond issuances.

Starting in 2019-21, the SAEC budget includes $1.6 million General Fund ($2.2 million total funds) to pay for contested case hearing services provided by the Office of Administrative Hearings. The office, which is housed at the Employment Department, bills agencies for actual expenses based on usage and cost but does provide an estimate for pricelist and budget building purposes. The budget for these services was formerly in the DHS Central Services program unit.

An increase of $2.2 million General Fund is expected to help cover performance audit billings from the Secretary of State. Federal rule changes no longer allow federal dollars to be used for this purpose, but they can still help pay for financial audits related to federally funded programs.

Adjustments to the shared services funding line include the addition of $1.3 million General Fund ($1.7 million total funds) to pay for investigation and system changes driven by SB 155 (2019), which deals with sexual misconduct reporting requirements in schools. A reduction of $500,000 General Fund ($1 million total funds) accounts for changes made in the budget for business information services; this was an action taken to help balance the overall agency budget. Technical adjustments and transfers are also reflected in the adopted budget.

LONG TERM CARE OMBUDSMAN

Analyst: Byerly

Agency Totals

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	4,929,019	6,401,552	7,212,903	7,728,112
Other Funds	679,823	908,057	954,159	845,016
Total Funds	**$5,608,842**	**$7,309,609**	**$8,167,062**	**$8,573,128**
Positions	25	27	27	30
FTE	24.50	25.50	26.50	29.14

Overview

The Long Term Care Ombudsman (LTCO) program is a federally-mandated consumer protection program supporting a network of certified volunteers who investigate and resolve complaints for people living in Oregon's nursing facilities, residential care facilities, assisted living facilities, and adult foster homes. The program was first established in 1981 within the Governor's Office and eventually became an independent state agency in 1985; in statute the agency is referred to "the office" of the LTCO. Over time the agency's responsibilities have expanded.

Since 2013, the agency has operated the Residential Facilities Ombudsman (RFO) program which addresses the needs of care facility residents who have a mental illness or a developmental and/or intellectual disability. In 2015, the Legislature passed SB 307 which requires LTCO to also advocate for residents of the independent living section of a Continuing Care Retirement Community.

The agency continues to face program development and caseload challenges in ramping up new work approved by the Legislature during the 2014 legislative session, when the Oregon Public Guardian (OPG) program was established under SB 1553. The program helps people who do not have a relative or friend able to serve in a fiduciary capacity, lack the financial ability to pay someone to serve as a fiduciary, and are at serious and imminent risk of harm or death without a fiduciary. OPG activities range from making residential and medical decisions to handling financial issues.

An eleven-member Residential Ombudsman and Public Guardian Advisory Board is responsible for monitoring the agency, advising state leadership on programs, and nominating people for "the" LTCO position as it comes open; this position also functions as the agency head.

Revenue Sources and Relationships

Agency programs rely primarily on General Fund, which pays for 90% of expenditures. The remaining 10% of the budget is covered by federal Older American Act (OAA) funds and civil penalties assessed on residential facilities and adult foster homes that serve persons with mental illness or intellectual or developmental disabilities. A portion of the OAA funding is specifically for work under the Senior Medicare Patrol (SMP) program, which is a federal fraud protection effort.

Budget Environment

Demand for ombudsman services is directly related to the number of care facilities and clients falling under the agency's umbrella of services; in 2019-21, potential clients are expected to exceed 53,000 people living in almost 4,500 licensed facilities. Continued growth in the number of clients served is expected well into the future as the population ages; however, the complement of beds by facility type may shift or fluctuate. Annually, the LTCO program handles more than 7,200 requests for assistance from consumers, the public, facility staff, and other agencies. The ability to provide public guardian services is particularly constrained by the budget; even with

additional positions approved in 2017-19 the program is estimated to be able to meet only about 10-15% of the statewide need for public guardian and conservator services.

Legislatively Adopted Budget

The 2019-21 legislatively adopted budget of $7.7 million General Fund is 20.7% more than the 2017-19 budget of $6.4 million General Fund, primarily due to the addition of three new deputy ombudsman positions that were approved in HB 3413 (2019). In addition, the adopted budget includes roll-up costs for two OPG positions that were added during the 2018 session. The overall budget, at $8.6 million total funds, is a 17.4% increase above the prior biennium funding level and supports 30 positions (19.14 FTE). The budget also includes standard statewide adjustments (decreases of $60,461 General Fund and $8,161 Other Funds) in various assessments and charges for services, legal rates, and retirement system rates. More details on the budget are included in the subsequent program narratives.

Long Term Care Ombudsman

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	3,601,908	4,708,514	5,234,413	5,771,922
Other Funds	679,823	908,057	954,159	845,016
Total Funds	**$4,281,731**	**$5,616,571**	**$6,188,572**	**$6,616,938**
Positions	20	21	21	24
FTE	19.50	20.50	20.50	23.14

Program Description

The LTCO program was created in 1972 under authorization of the federal Older Americans Act and established as a state agency in 1985. Core services include the investigation and resolution of complaints made by and on behalf of more than 45,000 residents of over 2,100 licensed nursing homes, assisted living and residential care facilities, and adult foster homes. Between 160 and 200 certified volunteers advocate for these clients, monitor facilities, and respond to resident complaints or problems. Twelve professional staff (11.64 FTE) provide technical support and training to the volunteers. LTCO also advocates for system change to promote and protect the rights and interests of long term care facility residents.

The number of certified volunteers providing ombudsman services has historically been constrained by the number of LTCO staff available to support them. Usually, one Deputy Long Term Care Ombudsman position will be responsible for 25 to 35 volunteers, with a typical volunteer covering 2 to 5 facilities and providing advocacy to an average of 140+ residents. In fiscal year 2018, volunteers donated 26,122 hours of service on behalf of long term care residents. Over that same time period, the program assisted residents with 4,813 complaints ranging from concerns about food portion size to issues with medication and discharge processes.

The RFO program was created by SB 626 (2013) and is responsible for assisting individuals with intellectual or developmental disabilities or mental health conditions with advocacy related to residential care issues. The program has 8 positions (7.50 FTE) to reach an estimated 8,000 residents of over 2,400 residential facilities. The RFO volunteer component is growing slowly but the program expects to complete face-to-face connections with all homes over the 2019-21 biennium.

The other 4 positions (4.00 FTE) are responsible for executive/operational leadership and administrative support across the agency.

Legislatively Adopted Budget

The 2019-21 legislatively adopted budget of $5.8 million General Fund is 22.6% more than the 2017-19 legislatively approved budget of $4.7 million General Fund; total funds increased by 6.3% between biennia. The

disproportionate total funds net increase is due to a decrease of $100,982 Other Funds expenditure limitation tied to SMP program revenue estimates; these are not expected to cover projected current service level needs. As a result, 2019-21 program activities will likely be more limited than in prior biennia unless federal support for the program is increased. Under this program, volunteers help protect Medicare beneficiaries from the economic and health-related consequences of Medicare fraud, errors, and abuse.

About half of the General Fund increase between biennia is due to HB 3413 (2019), which appropriated $575,670 General Fund to pay for three new deputy long term care ombudsmen positions (2.64 FTE). With these new positions, which are effective October 1, 2019, the agency will have a total of 10 deputy ombudsmen; this is also the maximum number of deputy ombudsmen set out in the measure. The additional program capacity provided is expected to support enough volunteers to cover 100% of long term care facilities.

As noted previously, the adopted budget includes reductions tied to statewide adjustments; these are not anticipated to create any financial challenges. However, the program will need to continue to manage its budget carefully, especially around expenditures related to personal services, travel, information technology, and volunteer supports.

Oregon Public Guardian

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	1,327,111	1,693,038	1,978,490	1,956,190
Total Funds	**$1,327,111**	**$1,693,038**	**$1,978,490**	**$1,956,190**
Positions	5	6	6	6
FTE	5.00	5.00	6.00	6.00

Program Description

This program allows the state to serve as a statewide court-appointed guardian and/or conservator, trustee, and payee for incapacitated Oregonians who have no other resources to serve in such capacity. Individuals in need of OPG's services include persons with age-related neurocognitive issues, persons with serious and persistent mental health issues, and persons with intellectual or developmental disabilities who are at imminent risk of harm. Along with providing direct services, the program contracts with local service providers, produces training materials, and works with local programs and organizations to identify less restrictive alternatives to guardianship.

The OPG program was approved in SB 1553 (2014); the funding level authorized was only enough to pay for a very limited program – serving about 60 people – and was not expected to support anywhere near the potential full need for services. In 2012, a report from the Public Guardian and Conservator Task Force estimated that between 1,800 and 3,400 Oregonians needed services.

During the 2013-15 biennium, the program got off to a slow start because it took several months to find and hire the first program lead. Other initial, and to a certain extent ongoing, challenges included development of service contracts, costs associated with diversion activities, and legal expenses. In addition, due to legislative uncertainty about program service delivery options and associated funding levels, during the 2017-19 biennium the agency was directed to assess the OPG program and report on that work prior to the 2018 legislative session.

The report was made in January 2018 and included updates on efforts to minimize legal costs, streamline banking processes, maximize caseload capacity, tap local partners, and leverage pro bono services. In response to this work, the Legislature approved two new permanent, full-time deputy public guardian positions; the positions are stationed in rural areas of the state, helping overcome barriers to contracting in certain areas, providing maximum support for volunteers, and serving clients.

The current program funding level supports a caseload of about 100 clients; 80 of these are served directly by agency deputy guardians and the remainder through current or prospective contracts. During 2019-21, OPG plans to establish a volunteer component that will serve an additional 8 to 10 clients. With the program at maximum capacity, a waitlist is maintained to move quickly on to new cases as current clients exit the program. Most exits are usually due to death, but sometimes a client may legally regain decision-making ability or an alternate guardian for a client is found.

Legislatively Adopted Budget

The 2019-21 legislatively adopted budget of $2 million General Fund is 15.5% above the 2017-19 legislatively approved budget of $1.7 million General Fund; the increase reflects standard inflationary adjustments and the costs associated with the phase-in of the two deputy public guardian positions authorized for only half of the prior biennium. With this last change, the program has a total of 6 positions (6.00 FTE): the Oregon Public Guardian and Conservator, one administrative assistant, and four deputy public guardians.

While the budget does not include funding for program-identified needs around more staff and expanded access to services, it does represent the most robust level of program support since the OPG was authorized. In addition to managing a demand for services that exceeds capacity, another budget challenge for the program has been covering employee salaries. Due to pay equity and salary negotiations tied to deputy public guardian skill sets, the program has offered salaries outside those fitting within typical position budgeting practices.

For 2019-21, the Legislature also approved two new key performance measures for the OPG program; the program did not have any formal measures previously. One measure addresses client stability by looking at the number of hospitalizations, emergency room visits, arrests, or psychiatric holds for OPG clients, and the other looks at the number of potential clients diverted to other, less restrictive service alternatives.

PSYCHIATRIC SECURITY REVIEW BOARD

Analyst: MacDonald

Agency Totals

	2015-17 Actual	2017-19 Legislatively Approved	2019-21 Current Service Level	2019-21 Legislatively Adopted
General Fund	2,658,376	3,047,827	3,229,021	3,198,150
Other Funds	6,090	2,248	--	--
Total Funds	**$2,664,466**	**$3,050,075**	**$3,229,021**	**$3,198,150**
Positions	11	11	11	11
FTE	11.00	11.00	11.00	11.00

Overview

The mission of the Psychiatric Security Review Board (PSRB) is to protect the public by ensuring that persons who have a psychiatric illness and/or intellectual disability and have been placed under the Board's jurisdiction as a result of committing a crime receive the support they need to reduce the risk of future dangerous behavior. The PSRB was created in 1977 to supervise adults in Oregon who are found guilty of a crime except for insanity (GEI). Since then, the Board's statutory charge has been broadened to also include supervision of juveniles found responsible except for insanity (REI) and certain adults who are civilly committed; processing relief petitions for persons barred from possessing a firearm due to a mental health determination; and conducting sex offender classification and relief hearings for GEI sex offenders.

In addition to the state employee staff who administer the operational aspects of the PSRB, the Governor appoints a 10-member board to monitor and help manage the on-going progress of individuals under its jurisdiction. The Board consists of a five-member panel for adults and a five-member panel for juveniles. The Board's responsibilities include holding administrative hearings; overseeing treatment outcomes for GEI clients placed in the Oregon State Hospital; coordinating the treatment and case management of clients placed on conditional release; helping clients safely reintegrate into communities; and communicating with the victims of crimes.

Adults adjudicated GEI represent the largest population under the PSRB's jurisdiction and can be committed to the Oregon State Hospital or conditionally released to a lower level of care, ranging from secure residential treatment facilities to independent living. The Board determines which type of facility is appropriate based on both a clinical and risk assessment, including the level of treatment, care, and supervision required. Conditional release is conferred on a client once the Board determines he or she can be adequately supported and treated with the supervision and treatment available in the community.

Revenue Sources and Relationships

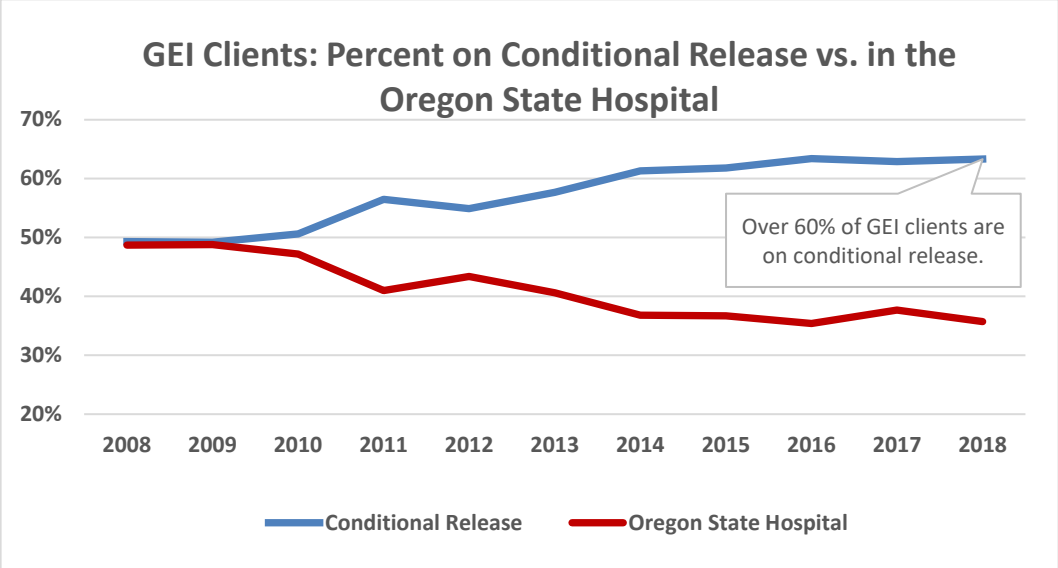
The PSRB's operations are funded entirely with General Fund resources. Until 2017-19, the PSRB supported some staff training activities with a small amount of Other Funds revenue received from a one-time award by the American Psychiatric Association. This award has now been fully expended.

Budget Environment

The PSRB budget includes only the funding necessary to support the Board and monitor the individuals placed under its jurisdiction, nearly all of which reflects salaries and benefits for program's 11 state employees. The PSRB's success in helping clients manage their mental illness and reduce the risk of recidivism largely relies on the continuum of care being adequately funded through other state and local programs. Most of the resources to provide treatment for these individuals are part of the Oregon Health Authority budget for the Oregon State Hospital and community mental health programs. A small number of individuals also receive services through the developmental/intellectual community programs supported in the Department of Human Services budget.

Despite the expansion of the Board's responsibilities over the past several years, the PSRB's primary workload remains focused on adults adjudicated GEI. SB 65 (2017) enhanced this workload by broadening the PSRB's jurisdiction over GEI clients. SB 420 (2011) had changed the jurisdiction of certain GEI offenders by placing those who committed a "tier one" crime under the jurisdiction of the PSRB and those who committed a "tier two" crime under the jurisdiction of the Oregon State Hospital Review Panel while committed to the Oregon State Hospital. SB 65 (2017) eliminated the State Hospital Review Panel and consolidated the oversight of all GEI persons to the PSRB as of July 1, 2018. This resulted in the transfer of 75 individuals to the PSRB's jurisdiction, as well as any future GEI individuals who would have previously been under the jurisdiction of the State Hospital Review Board. The bill also directed the Board to develop a restorative justice program to assist in the recovery process for crime victims. The PSRB absorbed these changes within existing staffing levels. The agency has not increased staff to address workload issues since 2011.

The total number of GEI adults either on conditional release or at the Oregon State Hospital has declined from over 700 in 2008 to 604 as of September 2019. The treatment system for these clients has also changed significantly during this timeframe commensurate with increased focus on serving more individuals with mental illness in the community. Prior to 2008, more GEI adults were treated at the State Hospital than the number placed on conditional release. This trend has reversed with a significant decline in the GEI population at the State Hospital; now more than 60% of the GEI clients supervised by the PSRB are on conditional release.



The PSRB's census levels are driven not only by factors like state policy, but also by the progress of individuals with a mental illness, especially a severe mental illness. According to data published by the federal Substance Abuse and Mental Health Administration in 2016, 23% of adults in Oregon have a mental illness compared to 18% nationwide. Also, 4% of adult Oregonian's live with a serious mental illness, such as schizophrenia, major depression, or bipolar disorder. On average, only 48% of Oregonians with any mental illness received mental health services each year from 2011 through 2015. Although these statistics represent only a small part of Oregon's behavioral health experience, they highlight the challenges faced by the PSRB and its community stakeholders. When the demand for behavioral health services increases and community services are not sufficiently funded or available, individuals unable to obtain the assistance they need to manage their mental illness are more likely to have an episode resulting in engagement with law enforcement and the court system.

Legislatively Adopted Budget

The 2019-21 legislatively adopted budget for the Board is $3.2 million General Fund, which represents a 4.9% increase from the 2017-19 legislatively approved budget. The budget includes 11 positions (11.00 FTE) and funds all current programs.