



OPEN MINDS

Oregon Health & Human Services Market Profile: 2025



Health & Human Services Market Profile Overview

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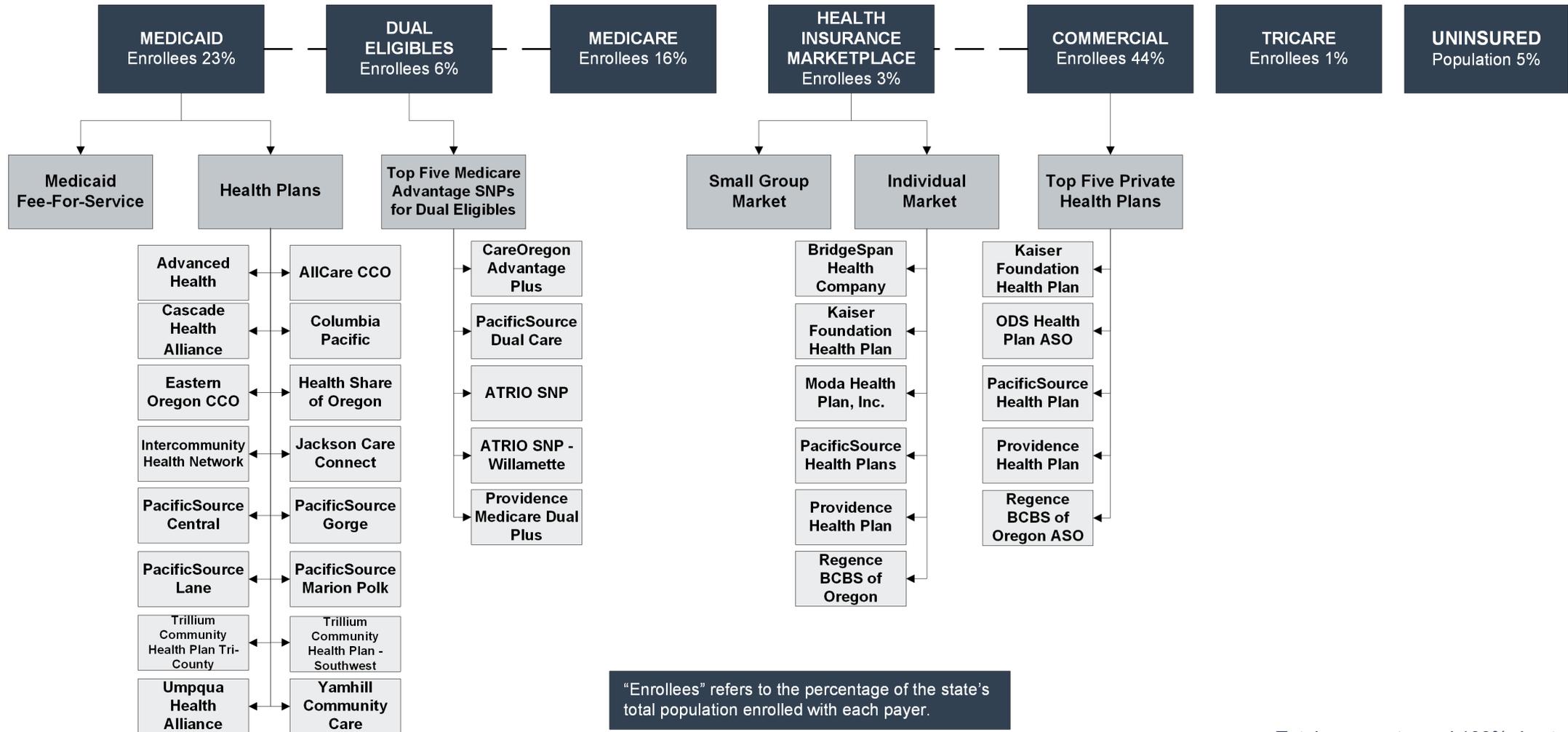
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A. Executive Summary

A.1. Oregon Physical Health Care Coverage by Payer

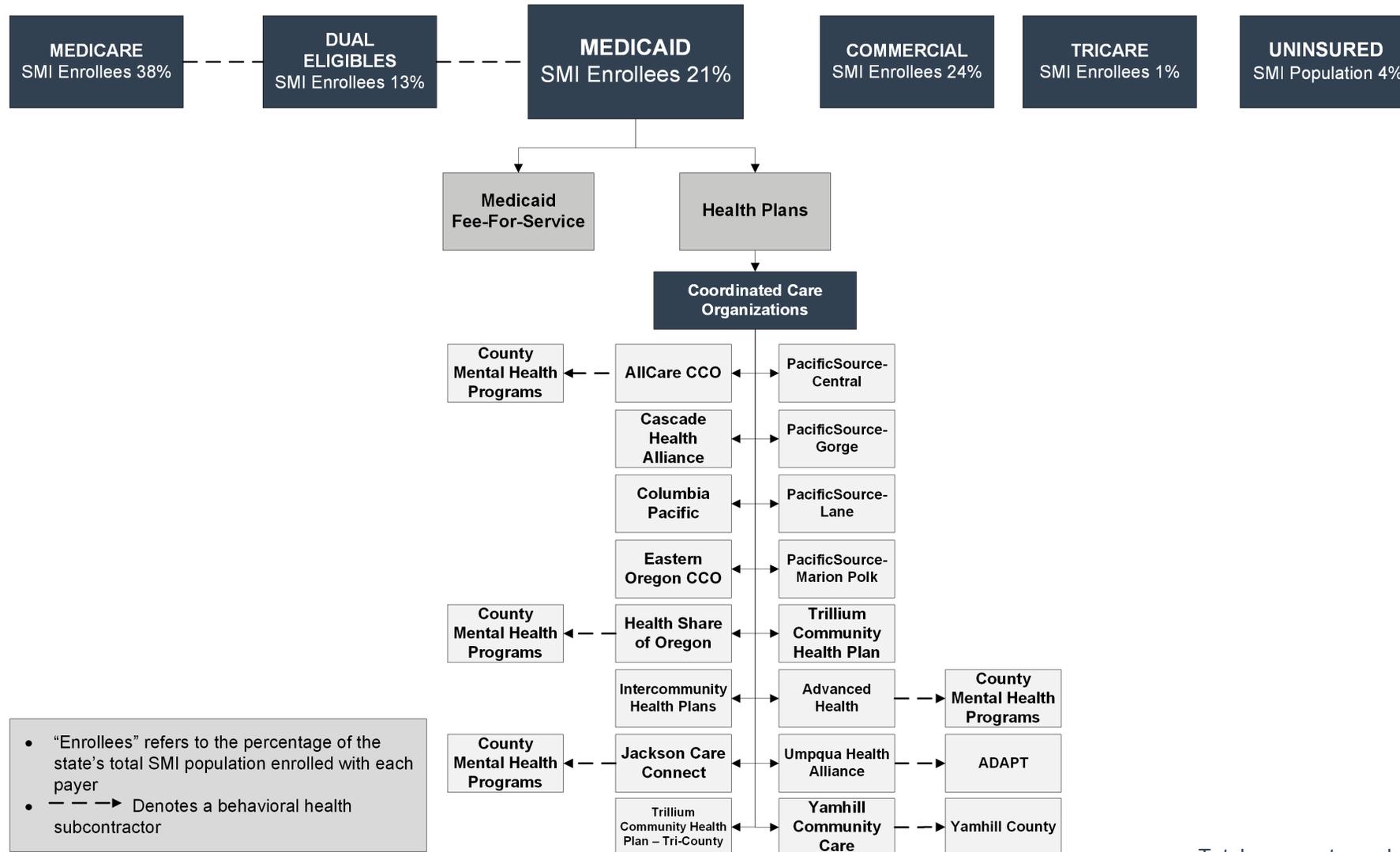
Total Oregon Population- 4,233,358

Estimated SMI Population- 338,669



Totals may not equal 100% due to rounding.

A.1. Oregon Behavioral Health Care Coverage by Payer



Totals may not equal 100% due to rounding.

A.2. Health & Human Services Care Coordination Initiatives

Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	Active Program	Description
Managed Care Health Plan	✓	Coordinated Care Organizations (CCOs) are responsible for coordinating care for their members.
Primary Care Case Management (PCCM)		None
Accountable Care Organization (ACO) Program	✓	CCOs are risk-based ACOs that act like health plans.
Affordable Care Act (ACA) Model Health Home		None
Patient-Centered Medical Home (PCMH)	✓	Oregon operates two PCMH programs: Patient-Centered Primary Care Homes and Comprehensive Primary Care Plus.
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)		None
Certified Community Behavioral Health Clinics (CCBHC) Grant	✓	Oregon currently has two CCBHCs operating under federal grants. There are also 12 state certified CCBHCs.
Other Care Coordination Initiatives	✓	Oregon offers a PACE program.

A.3. Health Care Safety-Net Delivery System

State Agencies Responsible For Uninsured Citizens & Delivery System Model

Physical Health Services

- The Health Policy and Analytics Division of the Oregon Health Authority (OHA) is responsible for providing physical health services to the uninsured population.

Mental Health Services

- The Addictions and Mental Health Services office, within the Health Systems Division of OHA, contracts with local authorities and provider organizations to provide mental health and addiction treatment services to the safety-net population.

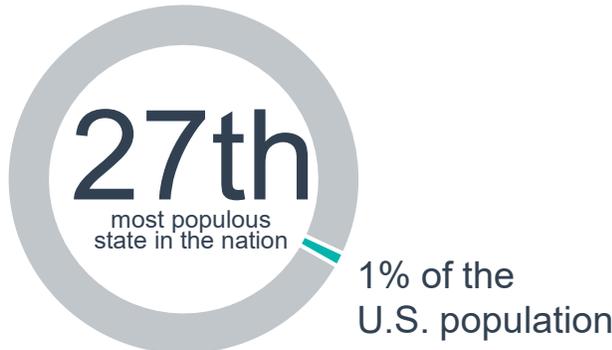
Addiction Treatment Services

- The Addictions and Mental Health Services office, within the Health Systems Division of OHA, contracts with local authorities and provider organizations to provide mental health and addiction treatment services to the safety-net population.

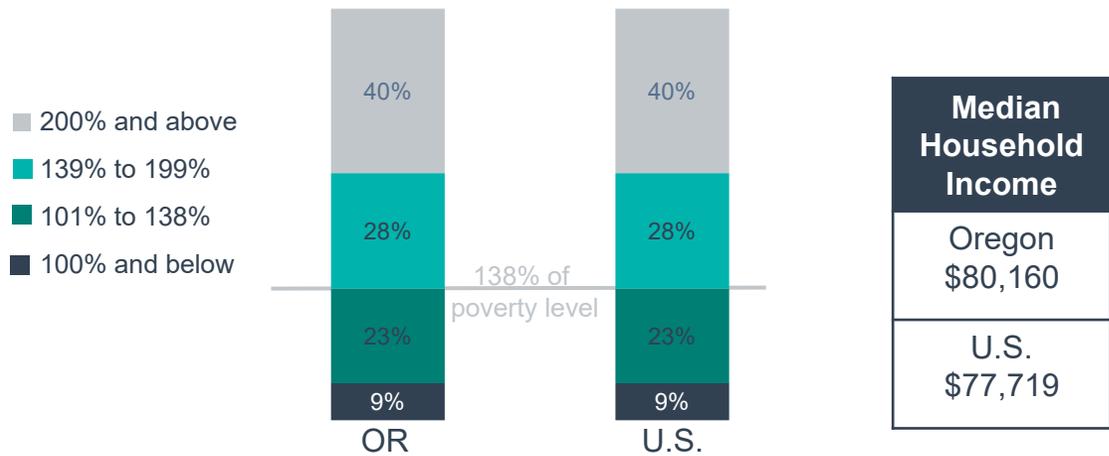
B. Oregon Health Financing System Overview

B.1. Population Demographics

Total Oregon Population- 4,233,358
 Estimated SMI Population- 338,669



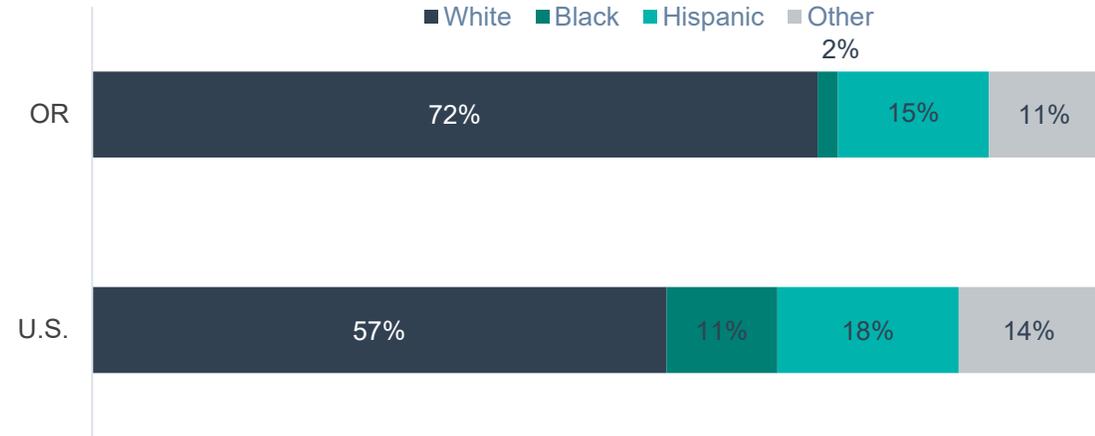
Population Distribution By Income To Poverty Threshold Ratio



Population Distribution By Age



Oregon & U.S. Racial Composition

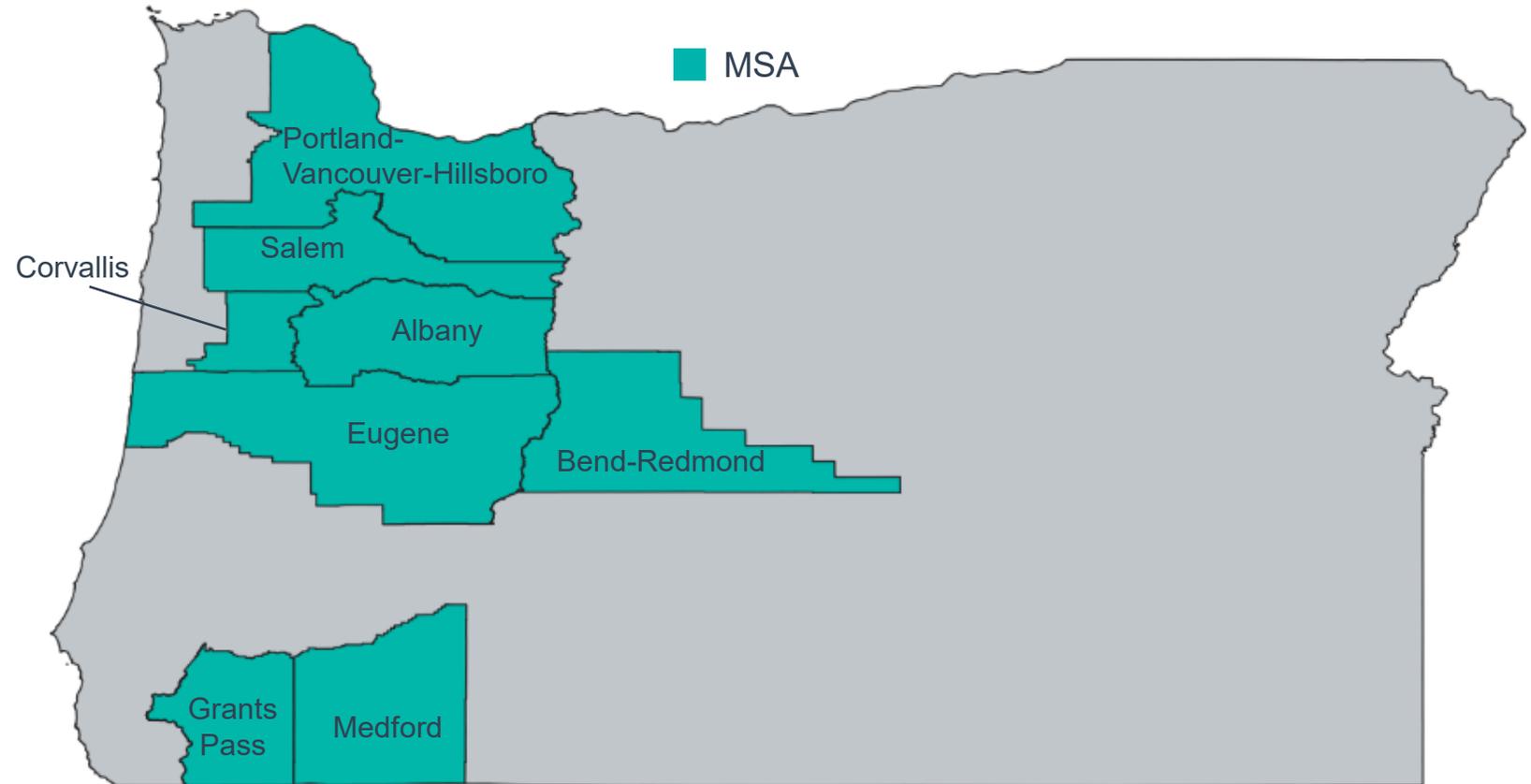


Based on 2023 data.

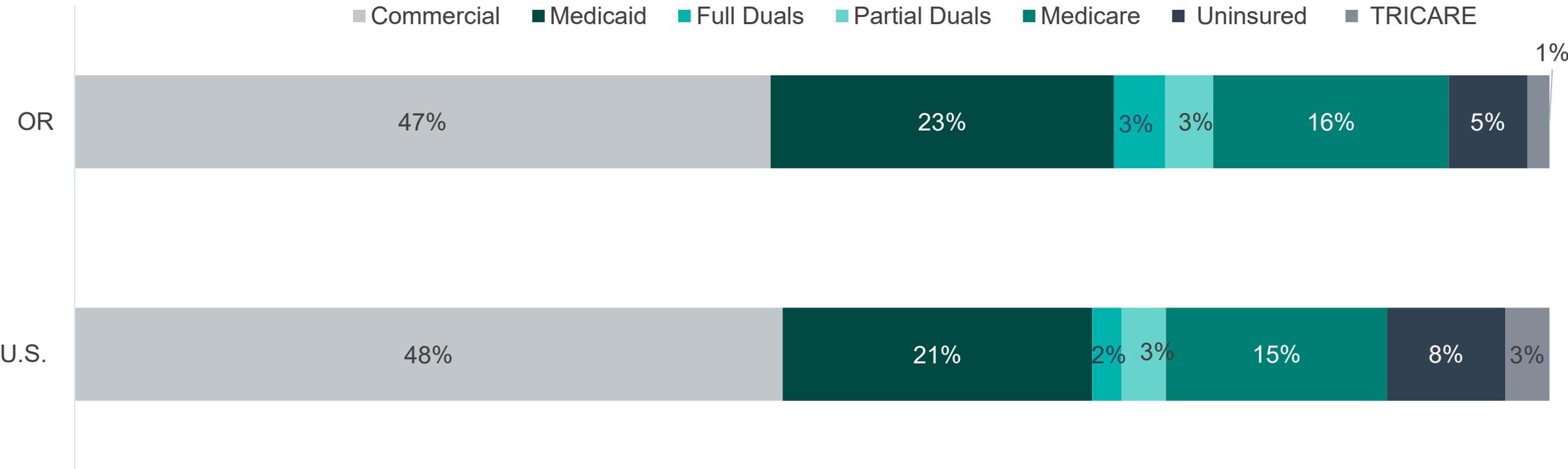
Totals may not equal 100% due to rounding.

B.2. Population Centers

Metropolitan Statistical Areas (MSAs)		
MSA	MSA Residents	Percent Of Population
Total MSA Population	4,123,465	97%
Portland-Vancouver-Hillsboro, OR-WA	2,508,050	59%
Salem, OR	436,546	10%
Eugene, OR	381,181	9%
Bend-Redmond, OR	260,919	6%
Medford, OR	220,768	5%
Albany, OR	130,467	3%
Corvallis, OR	97,713	2%
Grants Pass, OR	87,821	2%

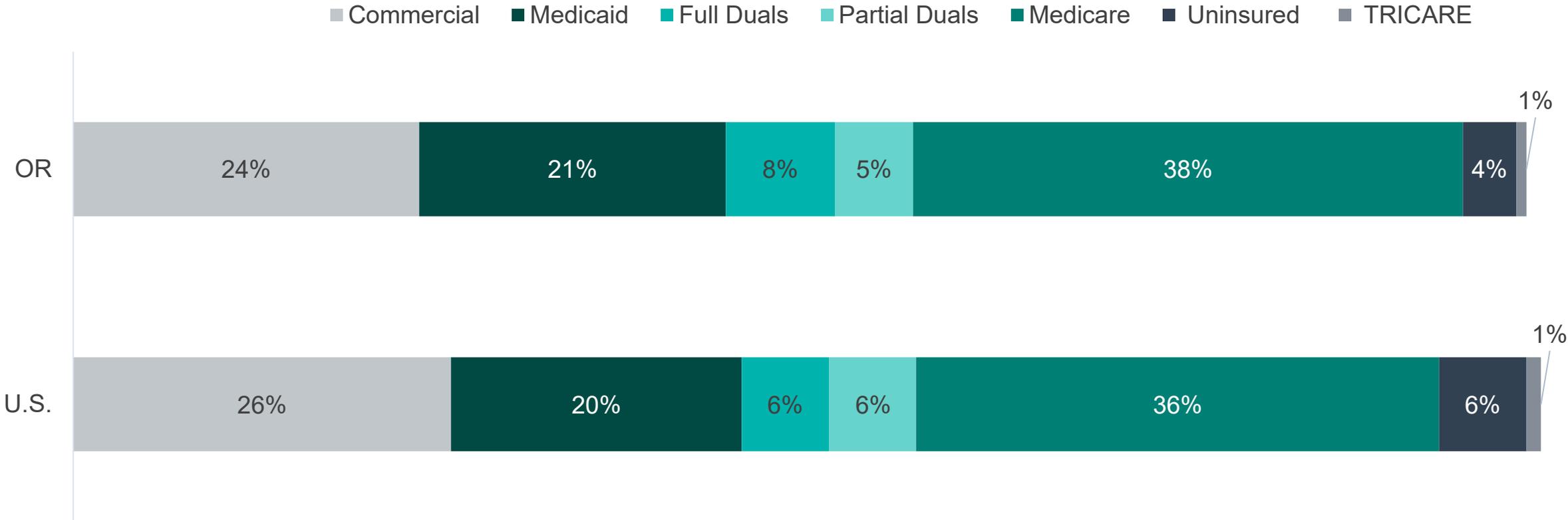


B.3. Population Distribution By Payer: National vs. State



Totals may not equal 100% due to rounding.

B.3. SMI Population Distribution By Payer: National vs. State



Totals may not equal 100% due to rounding.

B.4. Largest Health Plans By Enrollment

Plan Name	Plan Type	Enrollment*
InterCommunity Health Network CCO	Medicaid managed care	1,339,801
Regence BlueCross BlueShield of Oregon	Commercial administrative services organization (ASO)	471,059
Medicare Fee-For-Service (FFS)	Medicare	426,348
Health Share of Oregon	Medicaid managed care	417,605
Kaiser Foundation Health Plan of the Northwest	Commercial	381,580
Providence Health Plan	Commercial	344,747
PacificSource Health Plans	Commercial	161,210
PacificSource CCO – Lane	Medicaid managed care	143,000
UnitedHealthcare ASO	Commercial ASO	108,173
Medicaid FFS	Medicaid	101,104

* Medicaid enrollment as of January 2025; TRICARE as of December 2023; Commercial as of January 2024; Medicare enrollment as of March 2024

B.4. Largest Health Plans By Estimated SMI Enrollment

Plan Name	Plan Type	Enrollment*	Estimated SMI Enrollment
InterCommunity Health Network CCO	Medicaid managed care	1,339,801	117,902
Medicare FFS	Medicare	426,348	96,781
Health Share of Oregon	Medicaid managed care	417,605	36,749
Regence BlueCross BlueShield of Oregon	Commercial	471,059	23,082
Kaiser Foundation Health Plan of the Northwest	Commercial	381,580	18,697
Kaiser Permanente Senior Advantage	Medicare Advantage	74,289	16,864
Regence Medicare Advantage	Medicare Advantage	63,701	14,460
Providence Medicare	Medicare Advantage	61,700	14,006
UnitedHealthcare Benefits of Texas, Inc	Medicare Advantage	59,978	13,615
UnitedHealthcare of Oregon	Medicare Advantage	56,956	12,929

* Medicaid enrollment as of January 2025; TRICARE as of December 2023; Commercial as of January 2024; Medicare enrollment as of March 2024

B.5. Health Insurance Marketplace

Health Insurance Marketplace	
Type of Marketplace	State-based, using federal platform
Individual Enrollment Contact	https://www.healthcare.gov/
	1-800-318-2596
Small Business Enrollment Contact	No small group plans are available through the marketplace. Employers must purchase coverage directly from an insurance carrier or through an insurance broker.

2025 Individual Market Health Plans
<ol style="list-style-type: none"> 1. BridgeSpan Health Company 2. Kaiser Foundation Health plan of the Northwest 3. Moda Health Plan, Inc. 4. PacificSource Health Plans 5. Providence Health Plan 6. Regence BlueCross BlueShield of Oregon

2025 Small Group Market Health Plans
None

B.6. Accountable Care Organizations (ACOs)

Medicare Shared Savings ACOs

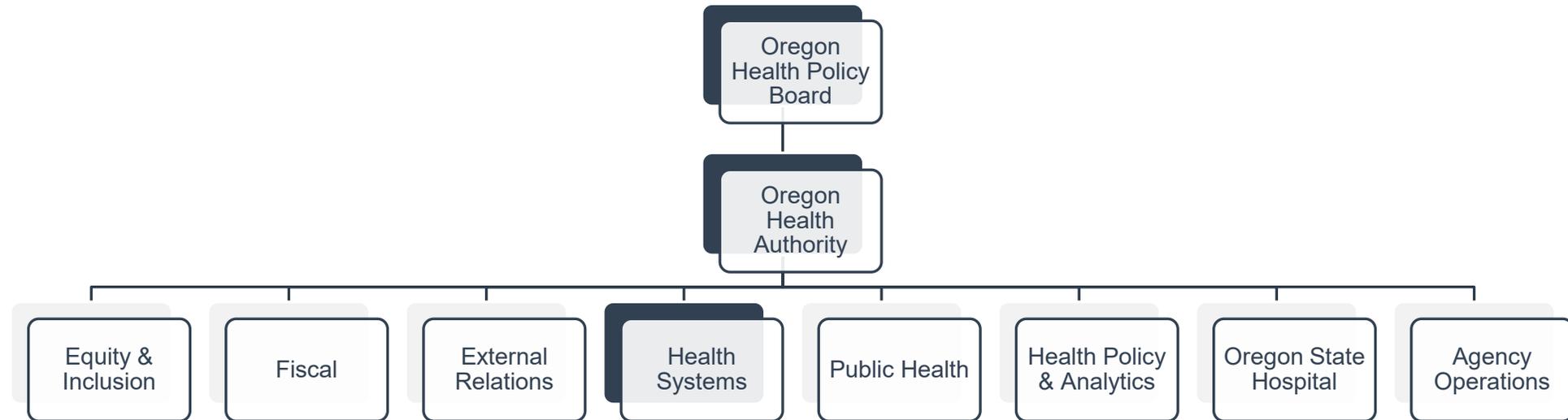
1. Caravan Collaborative Pathways
2. Caravan Health ACO 43, LLC
3. Caravan Health ACO 50, LLC
4. Community Health Center Network of Idaho, LLC
5. Health Connect Partners, LLC
6. ONCJC ACO LLC
7. Pacific Northwest MSSP
8. Praxis Care 2
9. Praxis Care 3
10. Privia Quality Network Gulf Coast II, LLC
11. Stellar Health ACO
12. The Polyclinic
13. Tuality Health Plan Services
14. Aledade 60 CA MSSPO Enhanced
15. Aledade 149 Regional MSSP

Commercial ACOs

ACO	Commercial Insurer
Providence Medical Group	Cigna
Summit Health	Cigna
Willamette Valley Health Solutions	Regence BCBS
Zoom+Care	Aetna

C. Medicaid Administration, Governance & Operations

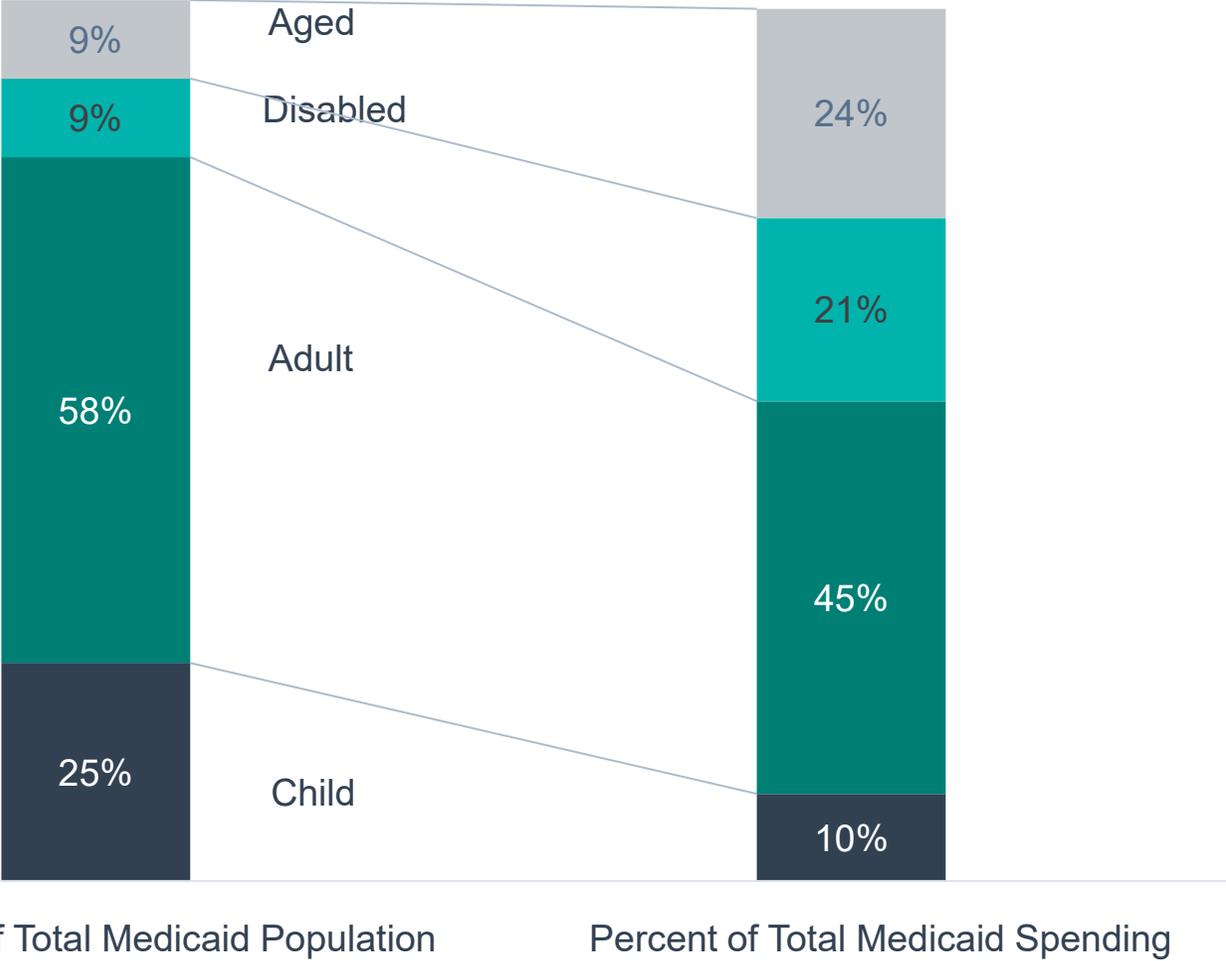
C.1. Medicaid Governance: Organization Chart



C.1. Medicaid Governance: Key Leadership

Name	Position	Department	Email
Sejal Hathi	Director	Oregon Health Authority	sejal.hathi@oha.oregon.gov
Emma Sandoe	Medicaid Director	OHA, Health Systems	emma.sandoe@oha.oregon.gov
Dave Baden	Deputy Director for Policy and Programs	OHA	Not available
Dawn Mautner	Medicaid Medical Director	OHA, Health Systems	dawn.mautner@oha.oregon.gov
David Inbody	Coordinated Care Organizations Director	OHA, Health Systems	david.g.inbody@oha.oregon.gov
Veronica Guerra	Deputy Director	OHA, Health Systems	Not available

C.2. Medicaid Program Spending By Eligibility Group



Medicaid Spending Per Enrollee, FY 2022		
	U.S.	OR
All populations	\$8,813	\$10,522
Children	\$3,786	\$4,586
Adults	\$5,443	\$4,591
Expansion adults	\$7,569	\$8,258
Blind and disabled	\$25,483	\$24,013
Aged	\$19,191	\$28,367

Based on FY 2022 data

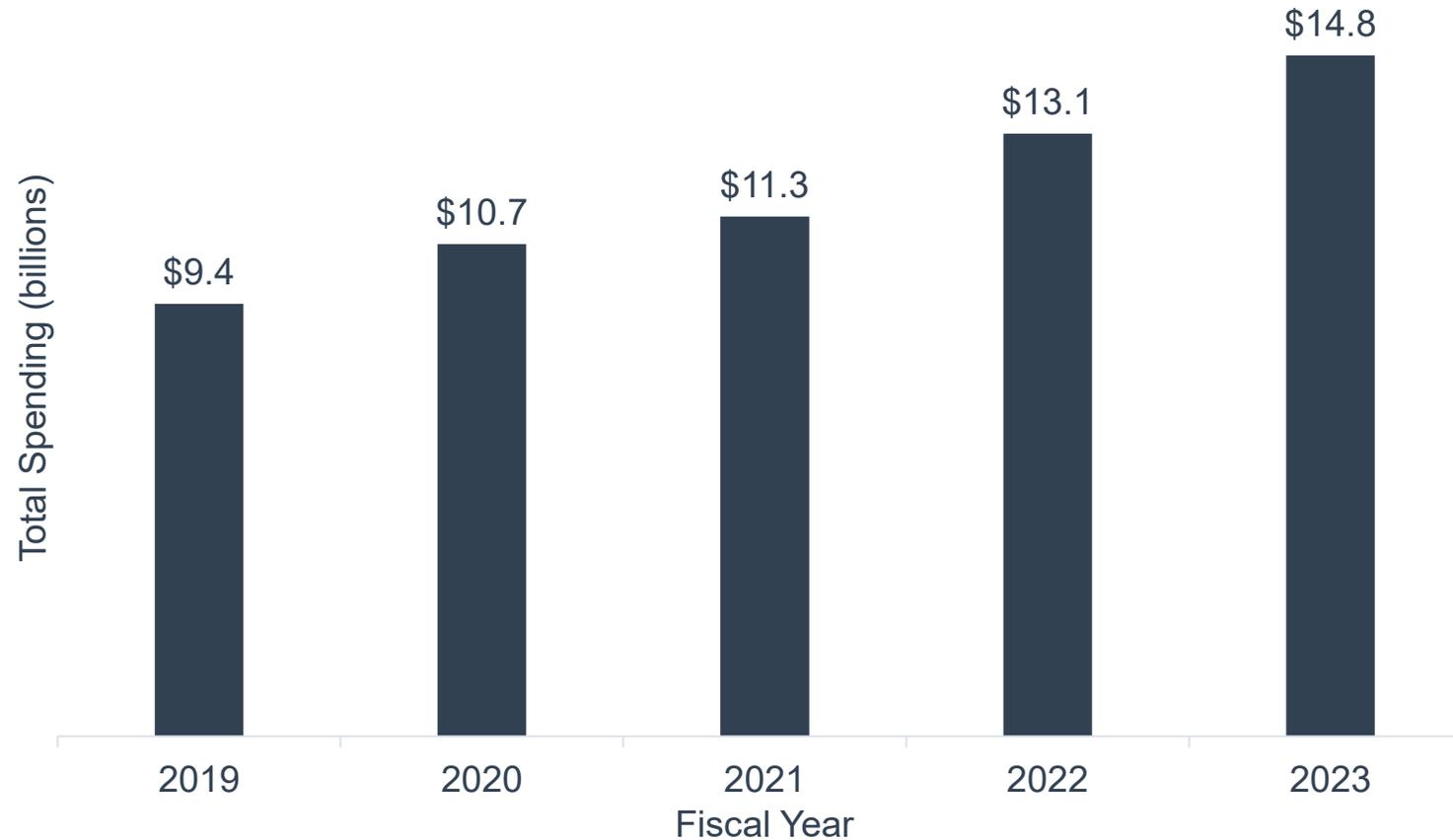
Totals may not equal 100% due to rounding.

C.2. Medicaid Program Spending

Budget Item	SFY23 Spending	Percent Of Budget
Managed care and premium assistance	\$8,601,000,000	58%
Home- and community-based LTSS	\$3,524,000,000	24%
Institutional LTSS	\$736,000,000	5%
Other acute	\$517,000,000	3%
Clinic and health center	\$480,000,000	3%
Hospital	\$427,000,000	3%
Medicare premiums and coinsurance	\$358,000,000	2%
Drugs	\$108,000,000	1%
Physician	\$24,000,000	<1%
Other practitioner	\$20,000,000	<1%
Dental	\$6,000,000	<1%
Budget Total: \$14,801,000,000		

Federal & County Financial Participation	
FY 2025 Federal Medical Assistance Percentage (FMAP)	59.0%
CY 2025 Newly Eligible FMAP (expansion population)	88%
Counties contribute to state Medicaid share	No

C.2. Medicaid Program Spending: Change Over Time



C.3. Medicaid Expansion Status

Medicaid Expansion	
Participating In Expansion	Yes
Date Of Expansion	January 2014
Medicaid Eligibility Income Limit For Able-Bodied Adults	133% of Federal Poverty Level (FPL) Note: The Patient Protection and Affordable Care Act (PPACA) requires that 5% of income be disregarded when determining eligibility.
Legislation Used To Expand Medicaid	HB 5030, 2013 Regular Session
Number Of Individuals Enrolled In The Expansion Group (June 2024)	641,243
Number Of Enrollees Newly Eligible Due To Expansion	532,906
Benefits Plan For Expansion Population	The alternative benefit plan provides the same benefits as the state plan.

C.4. Medicaid Program Benefits

Federally Mandated Benefits

1. Inpatient hospital services other than services in an institution for mental disease (IMD)
2. Outpatient hospital services
3. Rural Health Clinic services
4. Federally Qualified Health Center (FQHC) services
5. Laboratory and x-ray services
6. Nursing facilities for individuals 21 and over
7. Early and Periodic Screening and Diagnosis and Treatment (EPSDT)
8. Family planning services and supplies for individuals of child-bearing age
9. Physician services
10. Medical and surgical services of a dentist
11. Home health services
12. Nurse midwife services
13. Nurse practitioner services
14. Pregnancy services, including tobacco cessation programs
15. Free standing birth centers
16. Non-emergency transportation to medical care

Oregon's Optional Benefits

1. Chiropractor services
2. Other practitioner services
3. Clinic services
4. Dental services, including dentures
5. Physical, occupational, speech, and hearing therapy
6. Private duty nursing services
7. Prescribed drugs and dentures
8. Prosthetic devices
9. Diagnostic, screening, preventive, and rehabilitative services
10. Services for individuals aged 65 or older in an IMD
11. Intermediate care facility (ICF) services for I/DD
12. Inpatient psychiatric facility for individuals under age 21
13. Hospice care
14. Case management
15. Nursing facility services for consumers 21 and over
16. Personal care services
17. Optometric services

D. Medicaid Financing & Service Delivery System

D.1. Medicaid Financing & Service Delivery System

Medicaid System Characteristics		
Characteristics	Medicaid Fee-For-Service (FFS)	Medicaid Managed Care
Enrollment (January 2025)	101,104	1,405,912
SMI Enrollment	<ul style="list-style-type: none"> • Oregon does not specifically preclude individuals with SMI from enrolling in managed care; therefore, most of the SMI population is enrolled in managed care • <i>OPEN MINDS</i> estimates 7% of the population in FFS, 93% in managed care 	
Management	Oregon Health Authority	16 Coordinated Care Organizations (CCOs)
Payment Model	FFS	Capitated rate
Geographic Service Area	Statewide	Statewide; CCOs available by county or ZIP code

Total Medicaid: 1,507,016 | Total Medicaid With SMI: 132,617

D.1. Medicaid System Overview

Medicaid Financial Delivery System Enrollment	
Total Medicaid population distribution	As of January 2025: 7% in fee-for-service (FFS), 93% in managed care
SMI population inclusion in managed care	<ul style="list-style-type: none"> Oregon does not specifically preclude individuals with SMI from enrolling in managed care; therefore, most of the SMI population is enrolled in managed care. Estimated 7% of SMI population in FFS, 93% in managed care
Dual eligible population inclusion in managed care	<ul style="list-style-type: none"> Dual eligibles are passively enrolled in managed care with the ability to opt-out. Estimated 7% of population in FFS, 93% in managed care
Long-term services and support (LTSS) inclusion in managed care	<ul style="list-style-type: none"> All LTSS beneficiaries are enrolled in Medicaid FFS

Medicaid Financing & Risk Arrangements: Behavioral Health		
Service Type	FFS Population	Managed Care Population
Traditional behavioral health	Covered FFS by the state	Included in the health plan's capitation rate
Specialty behavioral health	Covered FFS by the state	Included in the health plan's capitation rate, except for long-term psychiatric care and residential services for individuals aged 18 and over
Pharmaceuticals	Covered FFS by the state	Mental health drugs are excluded from the health plan's capitation rate; all other drugs are included in the health plan's capitation rate.
Long-term services and supports (LTSS)	Covered FFS by the state	Covered FFS by the state

D.1. Medicaid Care Coordination Initiatives

Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	Active Program	Description
Managed Care Health Plan	✓	Coordinated Care Organizations (CCOs) are responsible for coordinating care for their members.
Primary Care Case Management (PCCM)		None
Accountable Care Organization (ACO) Program	✓	CCOs are risk-based ACOs that act like health plans.
Affordable Care Act (ACA) Model Health Home		None
Patient-Centered Medical Home (PCMH)	✓	Oregon operates two PCMH programs: Patient-Centered Primary Care Homes and Comprehensive Primary Care Plus.
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)		None
Certified Community Behavioral Health Clinics (CCBHC) Grant	✓	Oregon currently has two CCBHCs operating under federal grants.
Other Care Coordination Initiatives	✓	Oregon offers a PACE program.

D.1. Medicaid Service Delivery System Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory Managed Care Enrollment
Parents and caretakers			X
Children			X
Blind and disabled individuals			X
Aged individuals			X
Dual eligibles	X (Partial benefit)	X (Full benefit)	
Medicaid expansion			X
Individuals residing in nursing homes			X
Individuals residing in ICF/IDD			X
Individuals in foster care		X	
Other populations	<ul style="list-style-type: none"> Individuals with third-party liability Persons not meeting citizenship or alien status requirements Individuals who are eligible only to receive an Administrative Examination Transplant prescription program 	Tribal members	Breast and cervical cancer treatment program enrollees

D.2. Medicaid FFS Program

- FFS enrollment as of January 2025 was 101,104.
- Oregon's FFS program is called Open Card.

D.2. Medicaid FFS Program: Behavioral Health Benefits

All behavioral health benefits are financed and delivered on an FFS basis.

FFS Mental Health Benefits	
1.	Evaluation, assessment, and screening
2.	Brief intervention
3.	Crisis and stabilization services
4.	Medication and medication management
5.	Peer support
6.	Case management
7.	Residential treatment
8.	Skills training
9.	Inpatient hospitalization
10.	Individual, group, and family psychotherapy
11.	Mental health services provided in residential settings

FFS Addiction Treatment Benefits	
1.	Screening, assessment, and treatment
2.	Individual, group, and family counseling
3.	Care coordination
4.	Medication assisted treatment (MAT)
5.	Medication management
6.	Specimen collection and handling
7.	Interpretation services
8.	Acupuncture
9.	Detoxification
10.	Relapse prevention
11.	Peer support

D.2. Medicaid FFS Program: SMI Population

- Oregon does not specifically preclude individuals with SMI from enrolling in managed care; therefore, most of the SMI population is enrolled in managed care.
- As of January 2025, *OPEN MINDS* estimates 7% of the SMI population is enrolled in FFS.

D.2. Medicaid FFS Program: Pharmacy Benefit

Oregon FFS Program Pharmacy Benefit & Utilization Restrictions	
State Uses Pharmacy Benefit Manager	No
Responsible For Financing General Pharmacy Benefit	Medicaid FFS
Responsible For Financing Mental Health Pharmacy Benefit	Medicaid FFS
State Uses A Preferred Drug List (PDL) For General Pharmacy	Yes
State Uses A PDL For Mental Health Drugs	Yes, antidepressants and antipsychotics are included on the PDL.
State Uses A PDL For Addiction Treatment Drugs	Yes, opioid and alcohol agonists are included on the PDL.
Coverage Of Antipsychotic Injectable Medications	Yes, the state includes injectable antipsychotics on the PDL.
Utilization Restrictions For Mental Health Or Addiction Treatment Drugs	While the state lists preferred drugs on the PDL, it does not require prior authorization for non-preferred mental health drugs. All drugs, whether preferred or non-preferred, may be subject to clinical safety edits and quantity limits. Starting January 2021, providers are required to distribute the following brand name prescriptions instead of their generic counterparts: Invega (paliperidone), Strattera (atomoxetine), Sabril (vigabatrin), and Lamictal (lamotrigine ODT).
State Has A Pharmacy Lock-In Program Or Other Restriction Program	Yes, the state operates a pharmacy lock-in program for individuals who used three or more pharmacies during the prior six months; fills prescriptions from more than one prescriber for the same or comparable medications; altered a prescription; or exhibits behaviors identified as indicative of overutilization or misuse. Individuals are locked-in to a single pharmacy for no more than 12 months.

D.3. Medicaid Managed Care Program

- Managed care enrollment as of January 2025 was 2,502,732.
- Most individuals enrolled in Medicaid managed care receive services through Coordinated Care Organizations (CCOs). As of January 2025, CCO enrollment was 1,330,656, reflecting 93% of the Medicaid population.
 - CCOs are managed care entities that are either local community-based organizations or statewide organizations that have community-based participation in governance.
 - Individuals only have a choice of CCO if more than one CCO is available where they live. CCO service areas are currently defined by ZIP code and/or county.
- CCOs receive a “global budget” that represents the total cost of care for all services for which the CCOs are responsible and held accountable for managing, either through performance incentives and/or being at financial risk for paying for health care services.
 - The 2024 CCO capitation rate increased by 3.4% from 2023 rates.
- A small group of individuals still receive managed care benefits through the pre-2012 managed care delivery system. These include PACE, Dental Care Organizations, Mental Health Organizations, and Primary Care Organizations.
- Starting in 2024, 70% of CCO payments will be in value-based arrangements and CCOs will have VBPs in all five care delivery areas.

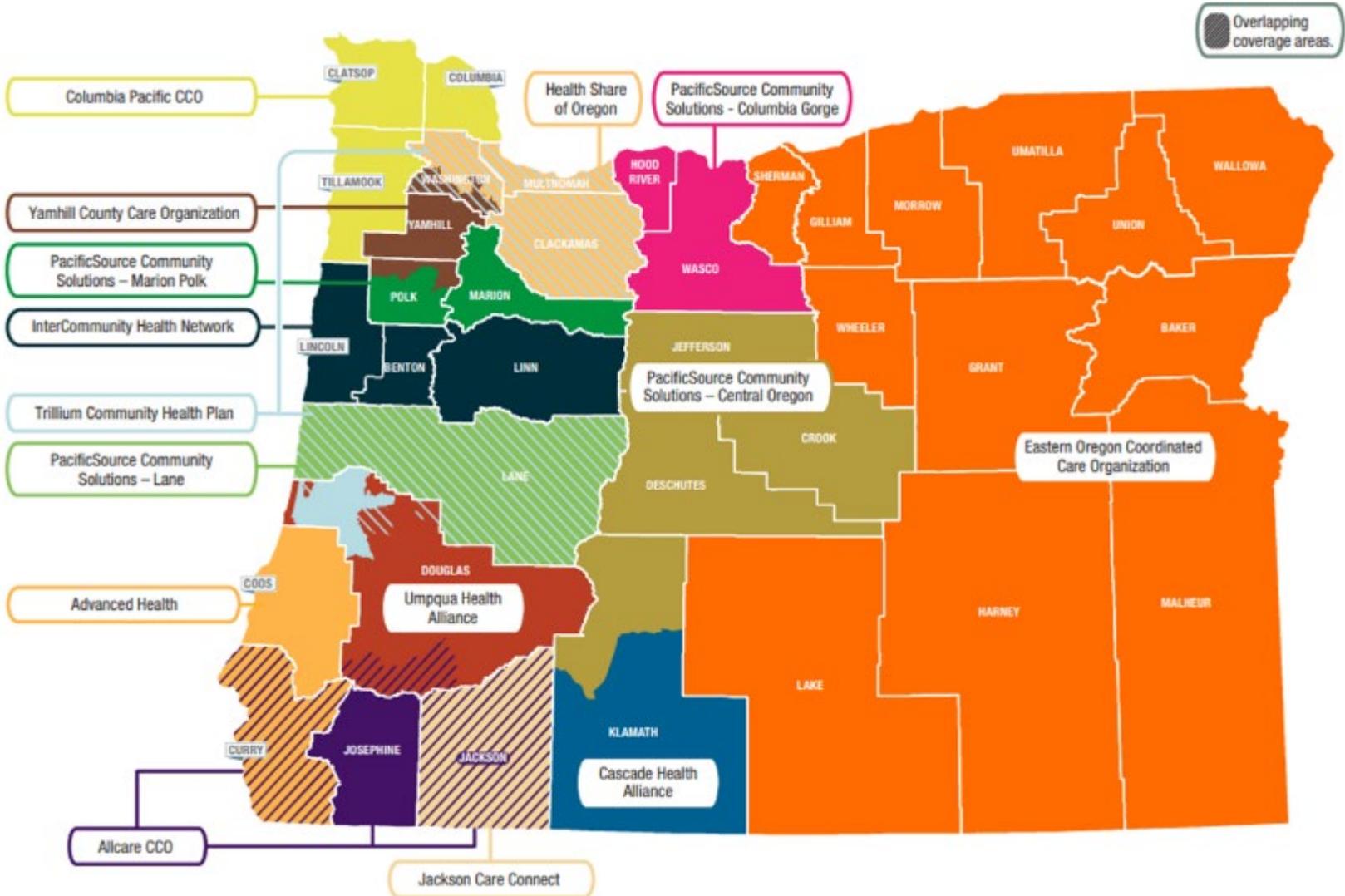
D.3. Medicaid Managed Care Program: CCO 2.0

- There are currently 16 organizations that serve as CCOs. See [next slide](#) for more information.
- CCOs must remove the barriers between physical, behavioral, and oral health, and provide comprehensive services.
- Contracts require the CCOs to increase the number of payments in value-based arrangements year after year. As of 2024, 70% of payments were required to be in value-based arrangements, and CCOs must have VBPs in all five care delivery areas.
 - The contract requires CCOs to implement at least one value-based payment (VBP) per year until the end of the contract. In 2021, the CCOs are required to develop three new or expand three existing VBPs associated with care delivery areas; one VBP must be associated with behavioral health care and the other two must be hospital or maternity care related.
- In an effort to move away from traditional FFS, the CCOs are required to provide PMPM infrastructure and operations payments to the PCPCHs.
 - Each CCO will vary PMPM rates to provide higher payments to higher tier PCPCHs and lower payments to lower PCPCHs.
- The contracts also require the CCOs to increase their investment in social determinants of health, and the state will develop measurement and evaluation strategies to track outcomes and increase understanding of spending in this area.

D.3. Medicaid Managed Care Program: CCO 2.0 Service Regions

Awardee	Service Area
Advanced Health	Coos, Curry
AllCare CCO	Curry, Douglas (partial), Jackson, Josephine
Cascade Health Alliance	Klamath County (partial)
Columbia Pacific CCO	Clatsop, Columbia, Tillamook
Eastern Oregon Coordinated Care Organization	Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler
Health Share of Oregon	Clackamas, Multnomah, Washington
InterCommunity Health Network CCO	Benton, Lincoln, Linn
Jackson County CCO, dba, Jackson Care Connect	Jackson County
PacificSource Community Solutions – Central Oregon	Crook, Deschutes, Jefferson, Klamath (partial)
PacificSource Community Solutions – Columbia Gorge	Hood River, Wasco
PacificSource Community Solutions – Lane	Lane County
PacificSource Community Solutions – Marion Polk	Marion, Polk
Trillium Community Health Plan - Southwest	Lane, Linn (western), Douglass (western)
Trillium Community Health Plan – Tri-County	Clackamas, Multnomah, Washington
Umpqua Health Alliance	Douglas County (partial)
Yamhill County Care Organization	Polk (partial), Yamhill, Washington

D.3. Medicaid Managed Care Program: CCO 2.0 Service Regions



D.3. Medicaid Managed Care Program: Quality Measures

- As part of Oregon’s goal to advance quality, the state collects and publicly reports on CCO quality. OHA has implemented a quality pool based on the outcome and quality measures adopted by the Metrics and Scoring Committee and distributes funds to the CCOs.
- The quality pool allotment will include 3.5% of aggregate CCO payments, plus a 2.0% increase to account for the insurer assessment. This results in a total withhold of 5.5%.
- The maximum quality pool funds each CCO can earn is based upon:
 - Scoring at least 0.68 on Patient-Centered Primary Care Home (PCPCH) enrollment;
 - Reporting data for both the Alcohol and Drug Misuse: Screening, Brief Intervention, and Referral to Treatment (SBIRT) and Depression screening and follow-up measures; and
 - Meeting or exceeding the benchmark or the improvement target on at least 75% of the remaining incentive measures (14 of 19 measures).
- Any remaining quality pool funds that were not disbursed will be distributed to CCOs that meet criteria on a subset of four “challenge” measures. The challenge measures are marked with an asterisk.

D.3. Medicaid Managed Care Program: CCO Quality Measures

CCO Quality Measures	
1. All-cause readmissions	16. Depression screening and follow up plan
2. Ambulatory care: avoidable Emergency Department utilization and utilization.	17. Development screening in the first 36 months of life
3. Ambulatory Care: Emergency Department utilization	18. Drug and alcohol misuse screening
4. Ambulatory care: Outpatient utilization	19. Effective contraception use
5. Any dental service	20. Follow up after ED visit for mental illness
6. Assessments for children in DHS custody	21. Follow up after ED visit for non-traumatic dental reasons
7. Access to care composite	22. Follow up after hospitalization for mental illness
8. CAPHS: access to care, dental care, needed care composite, health status, how well doctors communicate composite, medical assistance with smoking and tobacco use cessation, overall ratings, satisfaction with care	23. Immunization for adolescents: combo 1 & 2
9. Childhood access to primary care providers.	24. Oral evaluation for adults with diabetes
10. Childhood immunization status	25. PCPCH enrollment
11. Cigarette smoking prevalence	26. PQI 01: Diabetes short-term complication admission rate
12. Colorectal cancer screening	27. PQI 05: COPD or asthma in older adults admission rate
13. Comprehensive diabetes care: HbA1c poor control & testing	28. PQI 08: Congestive health failure admission rate
14. Controlling high blood pressure	29. PQI 15: Asthma in younger adults admission rate
15. Dental sealants on permanent molars for children	30. Postpartum care
	31. Timeliness of prenatal care
	32. Preventative dental visits for ages 1-14.
	33. Topical fluoride varnish
	34. Well-child visits in the first 15 months of life
	35. Well-child visits for the first 30 months of like – ages 15 months to 30 months

D.3. Medicaid Managed Care Program: Health Plan Characteristics 2493376

Advanced Health
<ol style="list-style-type: none"> Profit status: For-profit Parent company: None Behavioral health subcontractor: Adapt (addiction only), Coos Health & Wellness, Curry Community Health Pharmacy benefits manager: MedImpact Enrollment share: <1%

AllCare CCO
<ol style="list-style-type: none"> Profit status: For-profit Parent company: None Behavioral health subcontractor: Allied Health Services, Addictions Recovery Center (addictions only) Pharmacy benefits manager: Options for Southern Oregon, Curry Community Health Enrollment share: 2%

Cascade Health Alliance
<ol style="list-style-type: none"> Profit status: For-profit Parent company: ATRIO Behavioral health subcontractor: None Pharmacy benefits manager: None Enrollment share: <1%

Columbia Pacific CCO
<ol style="list-style-type: none"> Profit status: Non-profit Parent company: CareOregon Behavioral health manager: None Pharmacy benefits manager: None Enrollment share: 1%

Eastern Oregon CCO
<ol style="list-style-type: none"> Profit status: For-profit Parent company: Coalition of eight owners Behavioral health subcontractor: None. Pharmacy benefits manager: MedImpact Enrollment share: 3%

Health Share of Oregon
<ol style="list-style-type: none"> Profit status: Non-profit Parent company: CareOregon Behavioral health subcontractor: Clackamas County (Centerstone), Multnomah County, Washington County Pharmacy benefits manager: None Enrollment share: 17%

Totals may not equal 100% due to rounding.

D.3. Medicaid Managed Care Program: Health Plan Characteristics

InterCommunity Health Network CCO
<ol style="list-style-type: none"> Profit status: Non-profit Parent company: Samaritan Health Services Behavioral health subcontractor: None Pharmacy benefits manager: None Enrollment share: 54%

Jackson Care Connect
<ol style="list-style-type: none"> Profit status: Non-profit Parent company: CareOregon Behavioral health subcontractor: Addictions Recovery Center, ColumbiaCare, Kairos, Phoenix Counseling Center Pharmacy benefits manager: None Enrollment share: 2%

PacificSource Community Solutions CCO Central Region
<ol style="list-style-type: none"> Profit status: Taxable non-profit Parent company: PacificSource Behavioral health subcontractor: None Pharmacy benefits manager: None Enrollment share: 3%

PacificSource Community Solutions CCO Columbia Gorge Region
<ol style="list-style-type: none"> Profit status: Taxable non-profit Parent company: PacificSource Behavioral health subcontractor: None Pharmacy benefits manager: None Enrollment share: <1%

PacificSource Community Solutions CCO Lane Region
<ol style="list-style-type: none"> Profit status: Taxable non-profit Parent company: PacificSource Behavioral health subcontractor: None Pharmacy benefits manager: None Enrollment share: 3%

PacificSource Community Solutions CCO Marion Polk Region
<ol style="list-style-type: none"> Profit status: Taxable non-profit Parent company: PacificSource Behavioral health subcontractor: None Pharmacy benefits manager: None Enrollment share: 6%

Totals may not equal 100% due to rounding.

D.3. Medicaid Managed Care Program: Health Plan Characteristics

Trillium Community Health Plan
<ol style="list-style-type: none"> Profit status: Non-profit Parent company: Agate Resources/Centene Behavioral health subcontractor: None Pharmacy benefits manager: None Enrollment share: 1%
Trillium Community Health Plan- Tri-County
<ol style="list-style-type: none"> Profit status: Non-profit Parent company: Agate Resources/Centene Behavioral health subcontractor: None Pharmacy benefits manager: None Enrollment share: <1%

Umpqua Health Alliance
<ol style="list-style-type: none"> Profit status: For-profit Parent company: Catholic Health Initiatives Mercy Medical Center and Douglas County Individual Practice Association Behavioral health subcontractor: ADAPT Pharmacy benefits manager: MedImpact Enrollment share: 1%
Yamhill Community Care
<ol style="list-style-type: none"> Profit status: Non-profit Parent company: None Behavioral health subcontractor: Yamhill County Health & Human Services Pharmacy benefits manager: None Enrollment share: 1%

Totals may not equal 100% due to rounding.

D.3. Medicaid Managed Care Program: CCO 2.0 Behavioral Health Services

- CCOs associated with CCO 2.0 will be fully responsible for the behavioral health benefits, including comprehensive mental health and addiction treatment services, as a part of the CCO's capitation rate. CCOs are now required to provide additional behavioral health and addiction treatment services, see the charts below for more information.
 - CCOs will be required to cover and reimburse up to 15 days for inpatient psychiatric services, excluding addiction disorder treatments, in institutions for mental diseases.
- CCOs are financially responsible for long-term psychiatric care.
- CCOs are responsible for and share in the financial risk for individuals on the waitlist to receive Oregon State Hospital services.
- Mental health drugs are excluded from the CCO's capitation rate and covered by the state.
- CCOs will be required to establish metrics to track integration of behavioral health in primary care, as well as integration of primary care in behavioral health.
- The CCOs will still be required to contract with the county-operated community mental health programs in their service areas.

D.3. Medicaid Managed Care Program: Behavioral Health Benefits

Managed Care Mental Health Benefits	
1.	Inpatient services
2.	Outpatient services
3.	Intensive outpatient services
4.	Therapy services
5.	Care coordination
6.	Sub-acute inpatient services
7.	Assessment, evaluation, and screening
8.	Case management
9.	Consultation
10.	Interpretation services
11.	Medication management

Managed Care Addiction Treatment Benefits	
1.	Outpatient treatment
2.	Intensive outpatient treatment
3.	Individual, group, and family therapy
4.	Inpatient detoxification
5.	Residential detoxification
6.	Case management
7.	Medication assisted treatment (MAT)
8.	Opioid substitution
9.	Methadone dosing and dispensing

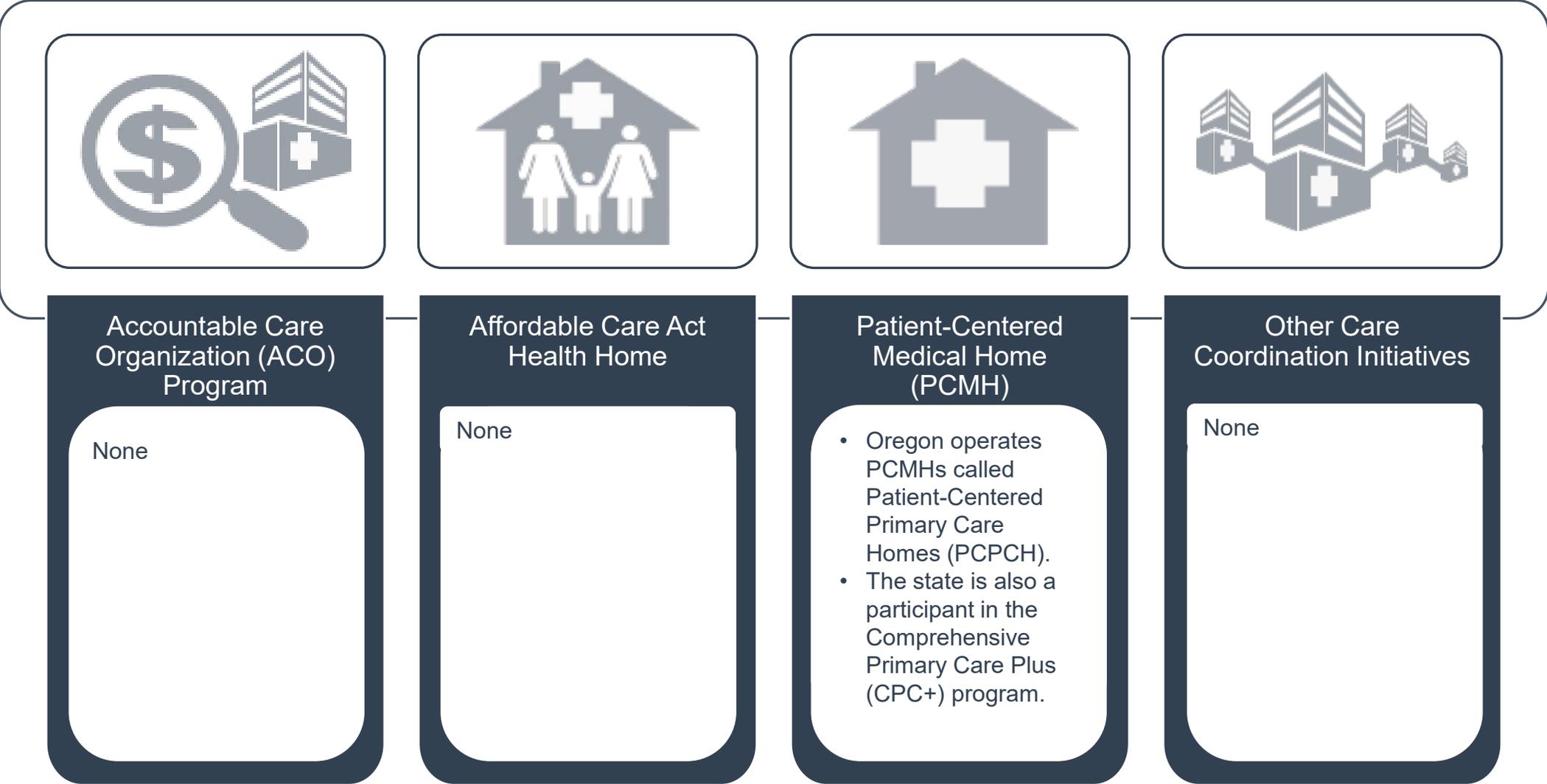
D.3. Medicaid Managed Care Program: SMI Population

- Oregon does not specifically preclude individuals with SMI from enrolling in managed care; therefore, most of the SMI population is enrolled in managed care.
- As of January 2025, *OPEN MINDS* estimates that 93% of the SMI population was enrolled in managed care.

D.3. Medicaid Managed Care Program: Pharmacy Benefit

Oregon Managed Care Program Pharmacy Benefit	
Responsible For Financing General Pharmacy Benefit	CCO
Responsible For Financing Mental Health Pharmacy Benefit	Therapeutic Class 7 ataractics-tranquilizers and Therapeutic Class 11 psychostimulants-antidepressants, Depakote, Lamictal, and their generic equivalents are excluded from the CCO's capitation rate and covered FFS by the state.
Health Plan Uses A Preferred Drug List (PDL) For General Pharmacy	Yes, health plans can set their own PDLs.
Health Plan Uses A PDL For Mental Health Drugs	No, mental health drugs are excluded from the CCO's capitation rate. The state includes mental health drugs on the general PDL.
Health Plan Uses A PDL For Addiction Treatment Drugs	Yes, health plans are able to set their own PDLs.
Health Plan Use Of Utilization Restrictions For Mental Health & Addiction Treatment Drugs	While the state lists preferred drugs on the PDL, it does not require prior authorization for non-preferred mental health drugs. All drugs, whether preferred or non-preferred, may be subject to clinical safety edits and quantity limits.
Health Plan Allowed To Implement Pharmacy Lock-In Program	Information is not available on whether the CCOs are able to implement a pharmacy lock-in program.

D.4. Medicaid Program: Care Coordination Initiatives



D.4. Medicaid Program: Care Coordination Initiatives- PCPCH Program

- The Patient-Centered Primary Care Home (PCPCH) program provides medical home services to all Medicaid enrollees receiving services from a participating provider organization. Provider organizations eligible for PCPCH include FQHCs, RHCs, clinical professionals, and community health centers.
 - Community mental health programs and drug and alcohol treatment programs are eligible to participate if they have integrated primary care provider organizations.
 - More than 600 primary care clinics are recognized as PCPCHs in Oregon – about 75% of PCPCHs are primary care clinics.
- The state designates practices as PCPCHs based on its own criteria and accepts NCQA recognition as a basis for designation.
 - There are six core attributes, each with its own measures and standards, that a PCPCH must provide to become certified. They include: (1) Comprehensive, (2) Patient and Family Centered, (3) Coordinated, (4) Continuous, (5) Accessible, and (6) Accountable.
- PCPCHs are reimbursed using five tiered levels of payment dependent upon the level of care coordination offered.
 - The PCPCHs are responsible for providing care coordination, health promotion, comprehensive care management, individual and family services, comprehensive transitional care, and referral to community and social support services.
- PCPCH is a multi-payer initiative and, in addition to Medicaid, includes the Public Employee's Benefit Board and commercial payer, Aetna.
 - CCOs are required to provide per member per month (PMPM) payments and supplementary payments, such as FFS and value-based payments, to PCPCH clinics.

D.4. Medicaid Program: Care Coordination Initiatives- CPC+ Program

- CPC+ is a model developed by the Centers for Medicare & Medicaid Innovation primarily focused on Medicare members, but open to other payers. Both the state Medicaid program and commercial insurers in Oregon are participating in CPC+.
 - See the [next slide](#) for a detailed list of payers.
- To participate as an Oregon Medicaid CPC+, a provider organization must be a PCPCH and be selected by CMS.
 - Provider organizations are divided into two tracks: Track 1-CPC+ and Track 2- Advanced CPC+.
 - The state defines Track 2 provider organizations as PCPCH five-star clinics, clinics with risk-stratified population management and registered nurse complex care management, clinics with behavioral health integration, or clinics with pharmacy integration.
- There are currently over 150 practices in Oregon participating in CPC+.
- There are three components to the CPC+ payment structure provided by the state for Medicaid FFS enrollees.
 - Care management fee: Tracks 1 and 2 receive a non-visit-based care management fee PMPM adjusted for amount of care coordination, based on the individual enrollment and PCPCH tier levels.
 - Performance-based incentive payment: Tracks 1 and 2 may receive PMPM incentive payments based on performance-based incentive measures, individuals' experiences, quality of care, and utilization measures that affect total cost of care.
 - Payment under the Medicare Physician Fee Schedule: Track 1 practices will continue to bill Medicare FFS and receive payments. Track 2 practices will continue to bill Medicare FFS, but a portion of FFS payments will be reduced as some Medicare payments will be shifted into Comprehensive Primary Care Payments (CPCP) to be paid on a quarterly basis. Track 2 practices are expected to provide more comprehensive care, allowing CPCP's to replace and exceed FFS payments.

D.4. Medicaid Program: Care Coordination Initiatives- CPC+ Program

CPC+ Care Management PMPM Fee

Tier	Track 1	Track 2
1	\$6.00	\$9.00
2	\$8.00	\$11.00
3	\$16.00	\$19.00
4	\$30.00	\$33.00
5-star	--	\$100.00

CPC+ Incentive Payment Amounts

Type	Track 1	Track 2
Utilization	\$1.25	\$2.00
Quality	\$1.25	\$2.00

CPC+ Quality Measures

1. Depression remission at 12 months
2. Controlling high blood pressure
3. Diabetes blood sugar control
4. Diabetes eye exam
5. Use of high-risk medications in the elderly
6. Dementia cognitive assessment
7. Screening for future fall risk
8. Initiation and engagement of addiction treatment
9. Receipt of specialist report after referral
10. Cervical cancer screening
11. Colorectal cancer screening
12. Tobacco use screening and cessation intervention
13. Use of imaging studies for low back pain
14. Breast cancer screening

CPC+ Payers

- Commercial Payers**
1. CareOregon
 2. Moda Health Plan, Inc.
 3. PacificSource
 4. Providence Health Plan and Providence Health Assurance
 5. UnitedHealthcare
- FFS Medicaid CCOs**
1. Advanced Health
 2. AllCare CCO, Inc.
 3. Columbia Pacific
 4. Eastern Oregon CCO
 5. HealthShare of Oregon*
 6. InterCommunity Health Network
 7. Jackson Care Connect
 8. PacificSource Central Oregon
 9. PacificSource Columbia Gorge
 10. PrimaryHealth
 11. Trillium
 12. Willamette Valley Community Health Organization
 13. Yamhill Community Care Organization

*Not a payer, but represented by other payer partners

D.5. Medicaid Program Waivers: Demonstration & Care Management Waivers

Waiver Title	Waiver Description	Waiver Type	Enrollment Cap	Effective Date	Expiration Date
APD Case Management Freedom of Choice Waiver OR-11	Provide case management services as a 1915 (c) Waivered service through the existing service delivery model for Aged and Physically Disabled individuals.	1915(b)	None	01/01/2022	12/31/2026
Oregon Health Plan	Allows the use of CCOs to provide services to the Oregon Medicaid population, as well as authorizes use of value-based payments in CCO contracts.	1115	None	02/01/1994	09/30/2027
Oregon Contraceptive Care (formerly Oregon Family Planning Program)	Authorizes the state to provide family planning services only to individuals with income up to 250% of the federal poverty level who are not otherwise eligible for Medicaid.	1115	None	01/01/2024	12/31/2028
Oregon Health Plan Substance Use Disorder 1115 Demonstration	Allow the state to broaden the SUD continuum of care throughout the state. This will also allow the state to use Federal Financial Participation for services provided at SUD residential settings that have been designated as IMDs.	1115	None	04/08/2021	03/31/2026
Oregon Project Independence - Medicaid	Provides services to individuals ages 18 and older who are older adults or adults with physical disabilities and enables beneficiaries to coordinate with case managers to create a limited-service plan to maintain a beneficiary's level of independence and quality of life in their home.	1115	None	02/13/2024	01/31/2029

D.5. Medicaid Program Waivers: Section 1915 (c) HCBS Waivers

Waiver Title	Target Population	2025 Enrollment Cap	Operating Unit	Concurrent Management Authority
OR Aged and Physically Disabled (0185.R07.00)	Individuals over the age of 65 and individuals who are aged 18-64 who are physically disabled.	47,864	Oregon Department of Human Services	Yes, with the state's 1915 (b) waiver for care management and a 1915 state plan amendment.
OR Adults HCBS (0375.R05.00)	Individuals over the age of 18 with I/DD.	25,056	Oregon Department of Human Services	Yes, with the state's 1915 (b) waiver for care management and a 1115 demonstration waiver.
OR Children's HCBS (0117.R07.00)	Individuals aged 0-17 with I/DD.	11,276	Oregon Department of Human Services	Yes, with the state's 1915 (b) waiver for care management and a 1115 demonstration waiver.
OR Medically Involved Children's Waiver (0565.R04.00)	Individuals aged 0-17 who are physically disabled.	212	Oregon Department of Human Services	Yes, with the state's 1915 (b) waiver for care management and a 1115 demonstration waiver.
OR Behavioral (ICF/IDD) Model (40194.R05.00)	Individuals aged 0-17 with I/DD.	165	Oregon Department of Human Services	Yes, with the state's 1915 (b) waiver for care management and a 1115 demonstration waiver.

D.5. Medicaid Program Waivers: Section 1915 (c) HCBS Waivers (cont.)

Waiver Title	Target Population	2025 Enrollment Cap	Operating Unit	Concurrent Management Authority
OR Medically Fragile (Hospital) Model (40193.R05.00)	Individuals aged 0-17 who are medically fragile.	123	Oregon Department of Human Services	Yes, with the state's 1915 (b) waiver for care management and a 1115 demonstration waiver.
OR Children's Extraordinary Need Waiver (2386.R00.00)	Individuals with physical disabilities ages 0-17, individuals who are medically fragile ages 0-17, and individuals with intellectual disabilities or developmental disabilities ages 0-17 years who meet a hospital, nursing facility, or an ICF/IID level of care.	171	Oregon Department of Human Services	Yes, with the state's 1915 (b) waiver for care management.

D.6. Medicaid System: New Initiatives

- There are no new or pending initiatives currently.

E. Medicare Financing & Service Delivery System

E.1. Medicare Financing & Service Delivery System

Medicare System Characteristics		
Characteristics	Traditional Medicare (FFS)	Medicare Advantage
Enrollment (March 2024)	426,348	713,773
SMI Enrollment	<ul style="list-style-type: none"> • OPEN MINDS estimates 62% of the population in Medicare Advantage, 38% in Traditional Medicare. 	
Management	<ul style="list-style-type: none"> • Part A: Inpatient hospital, skilled nursing facility care, nursing home care, hospice and home health care • Part B: Clinical research, ambulance services, durable medical equipment, mental health and limited outpatient prescription drugs 	<ul style="list-style-type: none"> • Medicare Advantage Plans provide Part A and Part B benefits, plus additional benefits based on plan chosen
Payment Model	<ul style="list-style-type: none"> • Part A & B cover up to 80%, remaining costs can be paid out of pocket 	<ul style="list-style-type: none"> • Fixed amounts paid based on health plan chosen
Geographic Service Area	Statewide	Statewide

Total Medicare: 1,140,121 | Total Medicare With SMI: 258,807

E.1. Medicare Financing & Service Delivery System

Medicare Financial Delivery System Enrollment	
Total Medicare population distribution	As of March 2024: 62% Medicare Advantage, 38% in traditional Medicare.
SMI population inclusion in managed care	Estimated 62% of population in Medicare Advantage, 38% in traditional Medicare.
Medicare population inclusion in Chronic special needs plan or (C-SNP).	Estimated that less than 1% of population is enrolled in C-SNP plans.
Medicare population inclusion in Institutional Special Needs Plan (I-SNP).	Estimated that around 2% of population is enrolled in I-SNP plans.

E.2. Medicare System Overview

- Medicare enrollment as of March 2024 was 1,140,121.
- In Oregon, Medicare enrollees accounted for 23% of the state's population.
- As of early 2024, 713,773 of Oregon's Medicare beneficiaries had Medicare Advantage plans.
 - That was 62% of the state's total Medicare population, as opposed to about 48% of Medicare beneficiaries nationwide who have opted for private Medicare coverage.
- In 2025, there are 21 insurers that offer Medigap plans in Oregon.
- As of September 2024, there were over 270,000 Oregon Medicare beneficiaries enrolled in stand-alone Medicare Part D plans. Another 495,000 beneficiaries had Medicare Part D coverage integrated with their Medicare Advantage plans.
 - For 2025 coverage, there are 14 stand-alone Medicare Part D plans available in Oregon, with premiums starting at \$0/ month.
- Many Medicare beneficiaries receive financial assistance through Medicaid with the cost of Medicare premiums, prescription drug expenses, and services not covered by Medicare – such as long-term care.

E.3. Medicare ACOs

Medicare Shared Savings ACOs

1. Caravan Collaborative Pathways
2. Caravan Health ACO 43, LLC
3. Caravan Health ACO 50, LLC
4. Community Health Center Network of Idaho, LLC
5. Health Connect Partners, LLC
6. ONCJC ACO LLC
7. Pacific Northwest MSSP
8. Praxis Care 2
9. Praxis Care 3
10. Privia Quality Network Gulf Coast II, LLC
11. Stellar Health ACO
12. The Polyclinic
13. Tuality Health Plan Services
14. Aledade 60 CA MSSPO Enhanced
15. Aledade 149 Regional MSSP

E.4. Medicare System: New Initiatives

- There are no new or pending initiatives currently.

F. Dual Eligible Financing & Service Delivery System

F.1. Dual Eligible Medicaid Financing & Service Delivery System

Dual Eligible* Medicaid System Characteristics			
Characteristics	Medicaid Fee-For-Service (FFS)	Managed Care	PACE
Enrollment (March 2024)	7,997	170,836	1,979
Estimated SMI Enrollment	1,679	35,875	415
Management	Oregon Health Authority	16 Coordinated Care Organizations (CCOs)	One non-profit organization and One for-profit corporate organization
Payment Model	FFS	Capitated rate	Blended capitated rate
Geographic Service Area	Statewide	Statewide; CCOs available by county or ZIP code	Certain ZIP codes

Total Dual Eligible Enrollment: 180,812 | Total Dual Eligible Enrollment With SMI: 37,969

*Unless otherwise noted, the term *dual eligibles* in this section refers to Medicare enrollees with full Medicaid benefits.

F.2. Largest Dual Eligible Health Plans By Estimated SMI Enrollment

Health Plans	Parent Company	Plan Type	March 2024 Enrollment	Estimated SMI Enrollment
CareOregon Advantage Plus	CareOregon, Inc	Medicare Advantage D-SNP	15,675	3,292
PacificSource Dual Care	PacificSource Community Health Plans	Medicare Advantage D-SNP	4,987	1,047
ATRIO Special Needs Plan	ATRIP Health Plans, Inc	Medicare Advantage D-SNP	2,743	576
ATRIO Special Needs Plan Willamette	ATRIO Health Plans, Inc	Medicare Advantage D-SNP	2,493	524
Providence Medicare Dual Plus	Providence Health and Services	Medicare Advantage D-SNP	1,996	419
Providence Health Plans	Providence Health and Services	PACE	1,890	397
Samaritan Advantage	Samaritan Health Plans	Medicare Advantage D-SNP	1,526	320
Trillium Advantage Dual	Trillium Community Health Plan, Inc	Medicare Advantage D-SNP	1,096	230
AllCare PACE	AllCare Health Plan, Inc	PACE	89	19

F.3. Dual Eligible Medicaid Financing & Delivery System: Overview

- Dual eligible enrollment as of March 2024 was 180,812.
- Medicare covers most acute services (which may include psychiatric care), while Medicaid, the payer of last resort, covers LTSS and non-physician behavioral health services.
- Dual eligibles have the option to enroll in Medicaid managed care or remain in the FFS system for their Medicaid health care services. Additionally, dual eligibles in Oregon have the option to enroll in a D-SNP.
- D-SNP enrollment as of March 2024 was 30,516, SMI enrollment for D-SNP was 6,408.

F.4. Dual Eligible Medicaid Financing & Delivery System: New Initiatives

- There are no new initiatives regarding dual eligibles in Oregon.

G. Long-Term Services & Supports Financing & Service Delivery System

G.1. LTSS Financing & Service Delivery System

The state excludes individuals in need of Long-term Services and Supports (LTSS) and dual eligible beneficiaries from enrolling in managed care. Therefore, beneficiaries are enrolled in FFS.

LTSS* Medicaid System Characteristics	
Characteristics	Medicaid Managed Care
Enrollment (December 2023)	N/A
Estimated SMI Enrollment	N/A
Management	All services are provided through Oregon Health Authority <ul style="list-style-type: none">• Physical health: FFS• Behavioral health: FFS
Payment Model	<ul style="list-style-type: none">• Physical health: FFS• Behavioral health: FFS
Geographic Service Area	Statewide

G.1. Medicaid LTSS Service Delivery System Enrollment By Eligibility Group

The state excludes individuals in need of Long-term Services and Supports (LTSS) and dual eligible beneficiaries from enrolling in managed care. Therefore, beneficiaries are enrolled in FFS.

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory Managed Care Enrollment
Disabled adults	X		
Disabled children			X
Blind individuals	X		
Aged individuals	X		
Dual eligibles	X		
Individuals with I/DD	X		
Individuals residing in nursing homes	X		
Individuals residing in ICF/IDD	X		
Other HCBS Recipients	X		
Other populations			

G.2. LTSS Medicaid Financing & Delivery System: Overview

- In Oregon, LTSS beneficiaries are excluded from the state's managed care program. Instead, beneficiaries receive long-term services and supports through the state fee-for-service program, Open Card.
- Open Card covers most health care services that can be provided at home, in an alternative living facility (i.e., community residential care facility, assisted living facility, or adult family home), or a nursing facility. These services include:
 - Doctor visits, hospitalizations, pharmaceuticals, immunizations, dental treatments, vision exams, behavioral health services, medical transportation, and Medicare cost-sharing requirements.

G.3. Medicaid LTSS Program: Health Plan Characteristics

- In the state, Medicaid LTSS beneficiaries are excluded from managed care and receive services FFS.

G.4. Medicaid LTSS Program: Health Benefits

- Physical health, behavioral health, and addiction treatment services for the LTSS population are financed through the state's FFS program.

LTSS Mental Health Benefits

1. Evaluation, assessment, and screening
2. Brief intervention
3. Crisis and stabilization services
4. Medication and medication management
5. Peer support
6. Case management
7. Residential treatment
8. Skills training
9. Inpatient hospitalization
10. Individual, group, and family psychotherapy
11. Mental health services provided in residential settings

LTSS Addiction Treatment Benefits

1. Screening, assessment, and treatment
2. Individual, group, and family counseling
3. Care coordination
4. Medication assisted treatment (MAT)
5. Medication management
6. Specimen collection and handling
7. Interpretation services
8. Acupuncture
9. Detoxification
10. Relapse prevention
11. Peer support

LTSS Specific Health Care Benefits

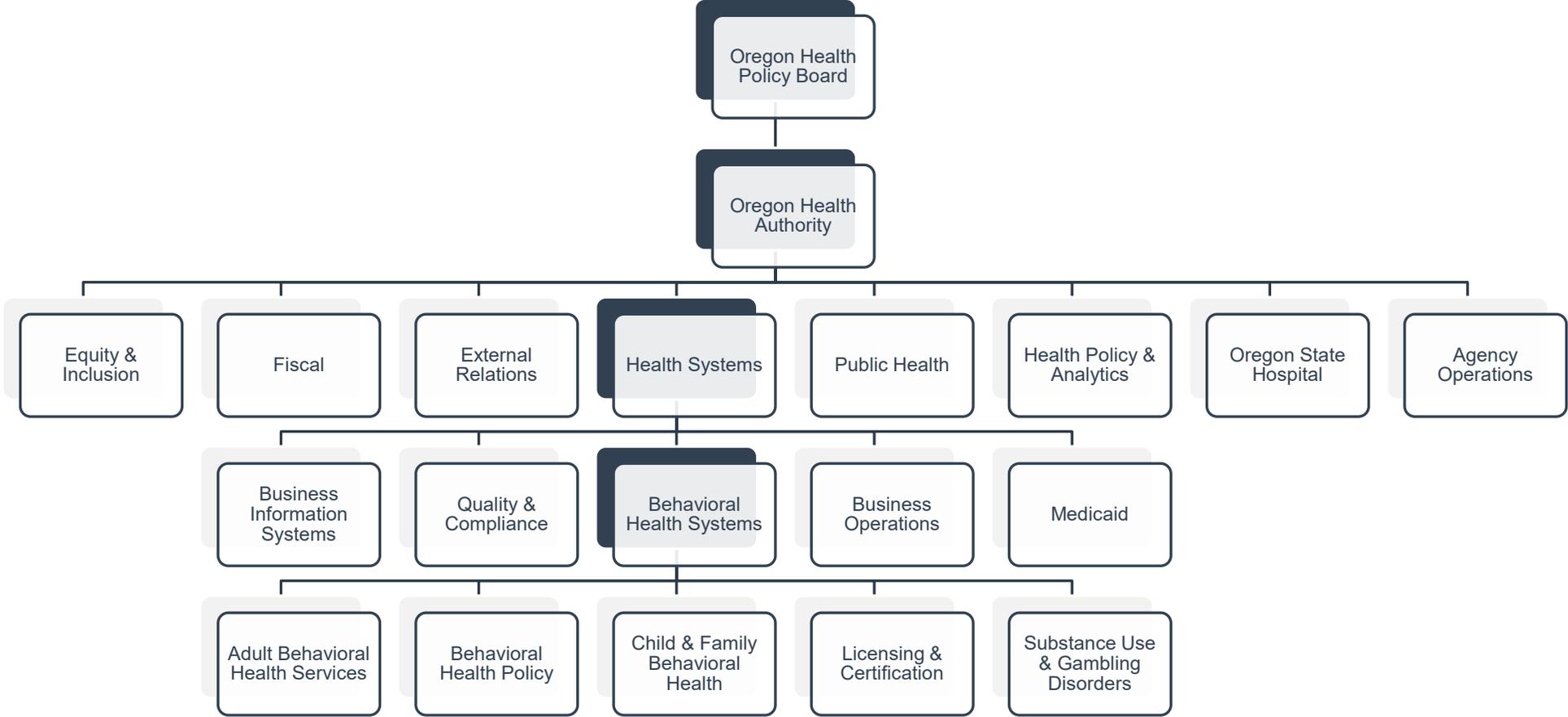
1. Hearing aids and hearing aid exams
2. Private duty nursing
3. End-of-life/Hospice care
4. Medical equipment and supplies
5. Physical, occupational, and speech therapy
6. Medical transportation
7. Prescription drugs
8. Vision medical services (only for beneficiaries with aphakia or keratoconus, or after cataract surgery)

G.5. LTSS Medicaid Financing & Delivery System: New Initiatives

- There are no new or pending initiatives currently.

H. State Behavioral Health Administration & Finance System

H.1. Oregon Health Authority: Organization Chart



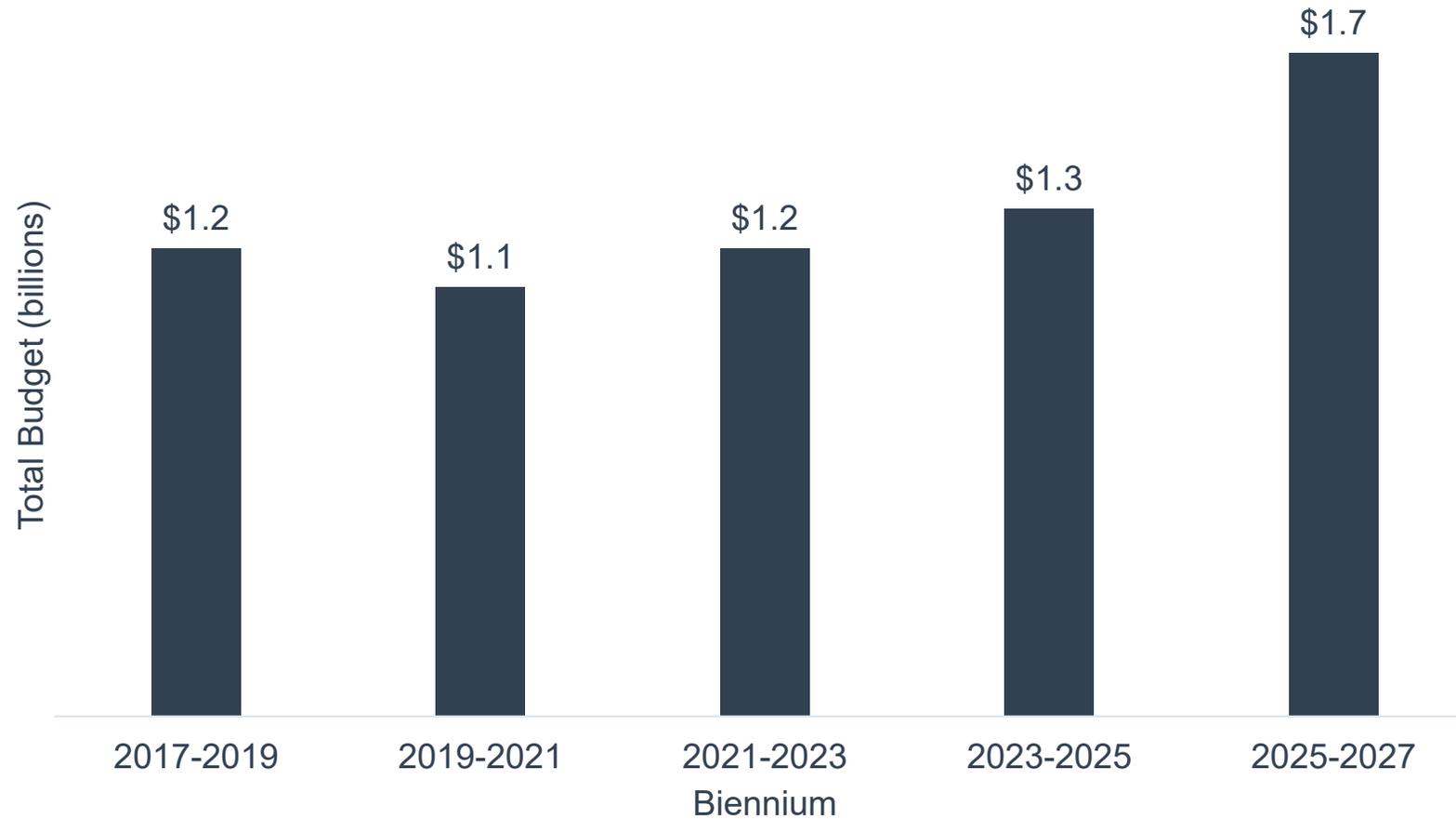
H.1. Oregon Health Authority Governance: Key Leadership

Name	Position	Department	Email
Sejal Hathi	Director	Oregon Health Authority (OHA)	sejal.hathi@oha.oregon.gov
Dave Baden	Deputy Director for Policy and Programs	OHA	Not available
Ebony Clarke	Director, Behavioral Health Programs	OHA, Health Systems	ebony.s.clarke@oha.oregon.gov
Meg Cary	Behavioral Health Medical Director	OHA, Health Systems	Not available
Chelsea Holcomb	Child and Family Behavioral Health Director	OHA, Health Systems	chelsea.holcomb@oha.oregon.gov
Sam Byers	Adult Behavioral Health Director	OHA, Health Systems	Not available

H.2. Oregon Health Authority: Budget Request

Budget Item	2025-2027 Governor's Budget Request	Percent Of Budget
Oregon State Hospital	\$1,025,900,000	62%
Non-Medicaid behavioral health	\$624,228,905	38%
Budget Total: \$1,650,128,905		

H.2. Oregon Health Authority: Budget Request Over Time



H.3. State Psychiatric Institutions

State Psychiatric Institutions		
Institution	Location	Beds
Oregon State Hospital – Salem site	Salem	554
Oregon State Hospital – Junction City site	Junction City	96
Total		650

H.4. Behavioral Health Safety-Net Delivery System

- The Oregon Health Authority administers contracts with local mental health authorities, community mental health programs, non-profit provider organizations, and tribal authorities to deliver mental health and addiction disorder treatment services to the uninsured population.
- Individuals access these services through their county community mental health program (see [slide 75](#)).

H.4. Behavioral Health Safety-Net Delivery System: CMH Service Areas

County	Mental Health Program	County	Mental Health Program	County	Mental Health Program
Baker	New Directions NW, Inc.	Hood	Mid-Columbia Center for Living	Multnomah	Multnomah County Mental Health and Addiction Services
Benton	Benton County Mental Health Program	Jackson	Jackson County Health & Human Services	Polk	Polk County Behavioral Health
Clackamas	Clackamas County Mental Health	Jefferson	Best Care Treatment Services	Sherman	Mid-Columbia Center for Living
Clatsop	Clatsop Behavioral Healthcare	Josephine	Options	Tillamook	Tillamook Family Counseling, Inc.
Columbia	Columbia Community Mental Health, Inc.	Klamath	Klamath Basin Behavioral Health Care	Umatilla	Lifeways
Coos	Coos County Mental Health	Lake	Lake County Mental Health Center	Union	Center for Human Development
Crook	Crook County Mental Health	Lane	Lane County Behavioral Health Services	Wallowa	Wallowa Valley Mental Health Center
Curry	Curry Community Health	Lincoln	Lincoln County Mental Health Program	Wasco	Mid-Columbia Center for Living
Deschutes	Deschutes County Mental Health and Adult Treatment Services	Linn	Linn County Health Services	Washington	Washington County Health & Human Services
Douglas	Compass Behavioral Health	Malheur	Lifeways	Wheeler	Community Counseling Solutions
Gilliam	Community Counseling Solutions	Marion	Marion County Behavioral Health	Yamhill	Yamhill County Mental Health Program
Grant	Community Counseling Solutions	Morrow	Community Counseling Solutions		
Harney	Symmetry Care				

H.5. Behavioral Health System: New Initiatives

- There are no new behavioral health initiatives currently.

I. Appendices

I.1. OPEN MINDS Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Commercial	4.9% of the commercially insured population over age 18	Substance Abuse and Mental Health Services Administration. (2022). Results from the 2023 National Survey on Drug Use and Health: Mental Health detailed Tables. Retrieved December 2024 from https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect6pe2021.htm#tab6.8a
Medicaid	8.8% of persons enrolled in traditional Medicaid	Substance Abuse and Mental Health Services Administration. (2022). Results from the 2023 National Survey on Drug Use and Health: Mental Health detailed Tables. Retrieved December 2024 from https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect6pe2021.htm#tab6.8a
Medicare	22.7% of persons in the Medicare population, not dually eligible for Medicaid	Figuroa, J. F., Phelan, J., Orav, E. J., Patel, V., & Jha, A. K. (2020). Association of mental health disorders with health care spending in the Medicare population. Retrieved July 2023 from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2762948#:~:text=Results%20Of%204%20358%20975,had%20no%20known%20mental%20illness

I.1. OPEN MINDS Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Medicare-Medicaid Dual Eligibility	21% of persons in the Medicare population dually eligible for partial Medicaid benefits	ATI Advisory. (2022). A Profile of Medicare-Medicaid Dual Beneficiaries. Retrieved March 2023 from https://atiadvisory.com/wp-content/uploads/2022/06/A-Profile-of-Medicare-Medicaid-Dual-Beneficiaries.pdf
	16% of persons in the Medicare population dually eligible for full Medicaid benefits	
Other Public	4.5% of persons served by the Veterans Administration health care system or the TRICARE military health system	U.S. Census Bureau (2023). Table HHI-01. Health Insurance Coverage Status and Type of Coverage--All Persons by Sex, Race and Hispanic Origin: 2017 to 2023. Retrieved March 2023 from https://www.census.gov/data/tables/time-series/demo/health-insurance/historical-series/hic.html
No Health Care Insurance	6.7% of uninsured persons over age 18	Substance Abuse and Mental Health Services Administration. (2022). Results from the 2023 National Survey on Drug Use and Health: Mental Health detailed Tables. Retrieved December 2024 from https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetailedTabsSect6pe2021.htm#tab6.8a

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Alternative Benefit Plan	ABP	State designed benefit package for the Medicaid expansion population (childless adults with income below 138% of the FPL). The benefit package must include the ten essential benefits as laid out in the PPACA. The Medicaid expansion population deemed medically frail (including those with SMI) are exempt from receiving benefits through the ABP.
Accountable Care Organizations	ACO	ACOs are groups of provider organizations—such as physicians and hospital systems—that form an agreement to coordinate care for a set group of individuals. If the ACO delivers high quality care—measured through performance metrics—and lowers the cost of providing care against a baseline, then the organization receives a portion of the savings generated. ACOs can exist alongside all payment structures (fee-for-service and managed care delivery systems) and payers (Medicare, Medicaid, commercial).
Administrative Services Organization	ASO	An arrangement in which an organization hires a third party to deliver administrative services to the organization, such as claims processing and billing. The ASO is not at-risk.
Capitation		A set amount of money paid per enrollee per month to a health care entity to cover the cost of health care services. Capitation can cover the cost of all health care services or subset of services, such as care coordination or home- and community-based services.
Carve-out		A carve-out is a Medicaid managed care financing model where some portion of Medicaid benefits—dental services, pharmacy services, behavioral health services, etc.—are separately managed and/or financed. Carve-out services can be financed on an at-risk basis by another organization or retained by the state Medicaid agency on a fee-for-service basis.
Certified Community Behavioral Health Clinic	CCBHC	Behavioral health clinics specially certified in a demonstration established by section 223 of the Protecting Access to Medicare Act of 2014. The clinics are designed to provide community-based mental health and addiction treatment services, to advance the integration of behavioral health with physical health care, and to provide care coordination across the full spectrum of health services.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Community Mental Health Center	CMHC	An organization that can demonstrate that it is actively providing all services in section 1913(c)(1) of the Public Health Services Act, including a.) Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of the CMHC’s mental health service area who have been discharged from inpatient treatment at a mental health facility; b.) 24 hour-a-day emergency care services; c.) Day treatment, or other partial hospitalization services, or psychosocial rehabilitation services; and d.) Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission. Additionally, the organization must meet the specifications for the state where it provides services.
Dual Eligible		An individual who is eligible for Medicare (Part A and B) and Medicaid. Medicare serves as the individual's primary insurance, and Medicaid acts as a supplement. Dual eligibles are sometimes referred to as Medicare-Medicaid enrollees (MMEs).
Federal Poverty Level	FPL	The U.S. Department of Health and Human Services sets a standard level of income that is used to determine eligibility for services and benefits, including Medicaid. In 2025, the FPL is \$15,060 for an individual and \$31,200 for a family of four.
Fee-For-Service	FFS	A system where the payer, in this case Medicaid, contracts directly with provider organizations and pays for providing care on a unit-by-unit basis. Health plans may also reimburse provider organizations on a FFS basis meaning they pay for each unit of care or test.
Health Home		A “whole person” care coordination model that specifically targets populations with chronic conditions including those with SMI. Health homes provide six essential functions: 1.) Comprehensive care management; 2.) Care coordination and health promotion; 3.) Comprehensive transitional care from inpatient to other settings, including appropriate follow-up; 4.) Individual and family support; 5.) Referral to community and social support services; 6.) Use of health information technology to link services. Health homes were originally developed as a Medicaid program; but have been adopted by other payers. For a state to have an official health home program they must have an approved state plan amendment.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Health Insurance Marketplace	HIM	Created by the PPACA, the health insurance marketplace is an online service where individuals and small businesses can purchase health insurance. The federal government subsidizes coverage purchased on the marketplace through premium tax credits for individuals with income up to 400% of the FPL.
Home- & Community-Based Services	HCBS	Long-term services and supports provided in the home or community in order to avoid institutionalization. Traditionally provided through 1915(c) waivers, HCBS services are usually limited to specific populations and a specific number of people. HCBS services include skilled nursing care, personnel care services, assistance with activities of daily living, and custodial care.
Institutions For Mental Disease	IMD	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including addiction. Federal financial participation is available for Medicaid IMD services for individuals under the age of 21 and age 65 and over. In recent years, CMS has relaxed the rules prohibiting payments in IMDs for individuals age 21-64. Medicaid health plans may provide up to 15 days of IMD services per month in lieu of state plan services if medically appropriate, cost effective, and consented to by the individual. Additionally, states may be granted a 1115 waiver authority to allow individuals to receive residential addiction treatment in IMDs.
Long-Term Services & Supports	LTSS	Services provided in the home, community, or institutional setting to those who experience difficulty living independently and completing activities of daily living as a result of cognitive disabilities, physical impairments, disabling chronic conditions and/or age.
Managed Care		A health care delivery and financing system designed to manage cost, utilization, and quality. In Medicaid, states generally implement managed care through contracts with health plans, which provide a limited set of benefits to enrollees through a capitated or per person per month (PMPM) rate. The health plans generally assumes full-risk for the cost of treatment, and therefore contracts with a network of provider organizations to provide care at the most efficient rate possible while still maintaining member health.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicaid		Medicaid is a joint federal-state program that provides health coverage to economically disadvantaged populations, such as low-income adults, children, and aged, blind, and disabled (ABD) individuals. States establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines. Financing is a shared responsibility of the federal government and the states.
Medicaid Waiver		Granted by CMS, waivers allow states to make temporary changes to their Medicaid program in order to test out new ways to deliver health coverage.
Medicaid Waiver Section 1115	1115 waiver	Known as research and demonstration waivers, states can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
Medicaid Waiver Section 1915(b)	1915(b) waiver	States can apply for waivers to provide services through managed care delivery systems, or otherwise limit an individual's choice of health plan or provider organization.
Medicaid Waiver Section 1915(c)	1915(c) waiver	States can apply for waivers to provide long-term care services in home- and community-based settings, rather than institutional settings.
Medical Home		A medical home is not a physical place, but a model for care coordination. Medical homes provide primary care services, care coordination, enhanced access to care, and care that is culturally and linguistically appropriate. Medical homes exist across multiple payers.
Medicare		Federal health insurance for individuals over the age of 65, individuals with certain disabilities, and individuals with end stage renal disease. Medicare covers most acute care services (which may include psychiatric care), but does not cover LTSS or non-physician behavioral health services.
Medicare Advantage	MA	Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicare Advantage Special Needs Plan	SNP	A special type of Medicare Advantage plan that is designed to provide targeted coordinated care to individuals who are a) institutionalized; b) dual eligible; and/or c) meet the severe chronic disabled conditions set forth by CMS. Plans emphasize improved care primarily through continuity of care and care coordination.
Medicare Part A		Hospital Insurance: Covers hospital, skilled nursing care, hospice, and home health care for most eligible individuals at no cost. Financed through payroll tax and deductibles, copayments are only charged if a stay becomes long-term.
Medicare Part B		Supplementary Medical Insurance: Covers most outpatient services, and consumers pay a premium based on income level.
Medicare Part C		Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.
Medicare Part D		Outpatient Prescription Drug Benefit: Private plans contract with Medicare to provide coverage for prescription drugs. Most consumers pay premiums based on their income.
Metropolitan Statistical Area	MSA	An urbanized area with a population of at least 50,000 plus adjacent territory that has a high degree of social and economic integration as measured by commuting ties.
Patient-Centered Medical Home	PCMH	See Medical Home.
Patient Protection & Affordable Care Act	PPACA or ACA	U.S. health care reform signed into law in 2010. The legislation regulates certain aspects of private and public health insurance programs and authorizes an individual mandate to secure essential health coverage, premium tax credits for the purchase of private health insurance, and increased insurance coverage of preexisting conditions. In 2012 the Supreme Court ruled that state participation is optional for provisions of the law expanding Medicaid coverage to adults ages 18 to 64 with incomes under 138% of the FPL. In 2017, Congress repealed the tax penalties associated with the individual mandate essentially ending the mandate.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Primary Care Case Management	PCCM	A health care delivery system model with limited utilization and cost control. Under the PCCM model, Medicaid enrollees choose a primary care physician who acts as a gatekeeper for more intensive services. The primary care physician generally receives a per person per month (PMPM) fee for care coordination, and is reimbursed fee-for-service for all medical services provided.
Program Of All Inclusive Care For The Elderly	PACE	PACE serves populations over the age of 55 who are eligible for skilled nursing home care by utilizing a comprehensive delivery system of social, medical, and long-term care services to keep enrollees in the community for as long as possible. PACE is an optional state Medicaid program, and may only be available in certain states, or regions within states.
Serious Mental Illness	SMI	A mental, behavioral, or emotional disorder that lasts for a sufficient duration of time and causes impairment of major life activities. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.
Supported Employment		Provides services and supports to help individuals with disabilities become employed in an integrated or competitive work environment, and retain that employment.
Supported Housing		Housing provided for as long as needed at little or no cost to individuals with mental illness, or other vulnerable populations who are homeless or at-risk for homelessness. Mental health and social services are offered to participants; but are not a condition for participation in the program. The goal is to allow individuals to live as self-sufficient, independent lives as possible.
Value-Based Reimbursement	VBR	Reimbursement model in which payers financially reward or penalize health care provider organizations for performance on quality and cost of care. VBR payment mechanisms include P4P; capitation; shared savings models; shared risk models; and payments based on clinically-defined episodes, called episodes of care or bundled payments.

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