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Joint Task Force on Regional Behavioral Health Accountability

Meeting #6

Monday, August 4, 2025

Agenda

- Welcome & Roll Call
- Perspectives on Oregon's Behavioral Health Funding Landscape
    - Task Force Discussion
- Colorado’s Behavioral Health Administrative Service Organization (BHASO) Model
- Arizona’s Health Care Cost Containment System (AHCCCS) Regional Behavioral Health Authority (RBHA) Model
- Task Force Discussion

Legislative Need (“Problem Statement”)

Funding decisions in Oregon's behavioral health system are made based on a variety of factors specific to the funding source and without consistent collaboration across these entities. While there is care coordination at the ground level, at the systems level there is a need to improve ***transparency*** *and* ***collaboration*** *to support efficient funding across the system.*

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Perspectives on Oregon's Behavioral Health Funding Landscape

PREPARED FOR: Joint Task Force on Regional Behavioral Health Accountability
DATE: August 4, 2025
BY: LPRO Staff

Task Force Direction from January 2025

At the January meeting, the Joint Task Force on Regional Behavioral Health Accountability affirmed the following statement of need to guide its work:

> *Funding decisions in Oregon's behavioral health system are made based on a variety of factors specific to the funding source and without consistent collaboration across these entities. While there is care coordination at the ground level, at the systems level there is a need to improve transparency and collaboration to support efficient funding across the system.*

The Legislative Policy and Research Office (LPRO) was asked to gather additional information about Oregon's behavioral health funding landscape, including 1) inventorying major funding conduits and their statutory, regulatory, or contractual elements, and 2) interviewing stakeholders about those conduits.

LPRO Research Aims

1. Identify **primary funding conduits** used to maintain or expand the behavioral health delivery system in Oregon since 2019, including key state, local, and federal awards.
2. Describe and compare **decision making** in the system-level allocation of each funding conduit, including
    - which **actors** determine how funds are allocated between and within regions, systems, and priorities.
    - what **information or tools** are used to guide decisions (including tools used to track regional demand and capacity).
    - what **process** is used to guide decisions, including whether and how collaboration occurs in decision making.
3. Explore stakeholder perspectives on **challenges and opportunities** to better align funding conduits and accountabilities to achieve greater coordination across the statewide behavioral health system.

Activities and Outputs

LPRO activities included

- preliminary scan of behavioral health funding references in Governor's Recommended Budget
- narrowing to funding conduits of interest with Co-Chairs, Legislative Fiscal Office, and other experts
- scan of statutory, regulatory, and contractual elements of funding conduits
- interviews with 25 subject matter experts (typically decision-makers) about how those funding conduits are allocated

Outputs

- **May:** preliminary thematic analysis (system-level themes)
- **Today:** overview of funding conduits including statutory and other requirements for collaboration; additional insights from stakeholder interviews

Funding Conduits

Purpose and Restrictions | Collaboration Requirements | Relevant Policies

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Conduits Reviewed

- Coordinated Care Organization (CCO) contracts
- County Financial Assistance Agreements (CFAA)
- Drug Treatment and Recovery Services Fund (marijuana taxes; Measure 110)
- Medicaid Home and Community-Based Services (HCBS)
- Oregon Health Authority (OHA) directed payments
- OLCC alcohol sales revenues and taxes
- Opioid settlement agreement
- Oregon State Hospital revenues
- SAMHSA block grants (Community Mental Health grant and Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) grant)
- State Opioid Response (SOR) grant
- Tobacco Prevention Education Program (TPEP) (tobacco taxes, Measure 108; tobacco settlement, other)
- Tribal behavioral health grants

What is a “funding conduit”?

“Funding conduit” aims to capture the *pathway* dollars flow along from original source to point of care/service. Labels were selected for clarity/familiarity rather than consistent unit of analysis.

Why?

- “Revenue” versus “expense” is a matter of one’s position within the BH funding system
- Some dollars pass through multiple entities; get divided and apportioned out along the way
    - general fund (GF) vs directed, state vs. local, multiple agencies, agencies + subcontractors, etc.
    - labels change along the way
- Labels can describe various elements of a conduit
    - funding sources (e.g. alcohol sales tax)
    - agency, program or trust receiving the funds (e.g. Tobacco Prevention Education Program)
    - funding purpose or allocation (e.g. “OHP open card”)

Funding Conduit – OHP Coordinated Care Organization Contracts

Description	Requirement to Collaborate	Relevant Policies
Coordinated Care Organizations (CCO) contracts require coverage of certain BH services for enrollees (see ORS 414.766 and CCO contract Exhibit M). CCO contracts outline the state's requirements for how CCOs may pay providers. The federal government must approve payment requirements. State law requires CCOs to follow a minimum fee schedule and participate in certain directed payments for BH providers (see slide 15). They may utilize value-based payment arrangements tying payments to provider reporting or outcomes. They may not require prior authorization for certain BH services on a list maintained by OHA.	ORS 414.619 requires OHA and ODHS to coordinate actions and responsibilities necessary to implement the CCO system. ORS 414.592 requires contracts between OHA and CCOs to align with the quality metrics and incentives developed by the Behavioral Health Committee. ORS 414.153(4) requires CCOs to enter into an agreement with the Local Mental Health Authority serving their region (also see slide 12). ORS 414.577 requires CCOs to collaborate with local public health authorities and hospitals in developing their community health improvement plan. HB 2208 (2025) added local mental health authorities to this collaboration requirement. ORS 414.655 requires CCOs to implement primary care homes and BH homes for their members. CCOs must require their provider networks to communicate and coordinate care with the homes. CCO contracts also require CCOs to work with hospitals and CMHPs to collect data on emergency department utilization for BH reasons and develop plans to reduce reliance on institutional BH care.	ORS 414.572-578 related to CCO community advisory councils and community health improvement plan requirements ORS 414.590-5609 related to CCO contracts with OHA ORS 414.153 related to CCO collaboration with LMHAs and other local entities ORS 414.655 related to CCO requirements for BH homes Oregon Health Authority template for CCO contracts (v. January 1, 2025)
CCOs reimburse for certain social services under a provision for Health-Related Services (HRS). CCOs are required to report on HRS and other community spending.	CCOs are required to designate a role for their Community Advisory Council in HRS spending decisions (see OAR 410-141-3845(5). There is not a requirement that CCOs coordinate community benefit investments with other funds such as Measure 110 grants. CCOs are not required to work with the same community-based organizations over time.	OAR 410-141-3845 related to Oregon Health Plan "Health-Related Services"

Funding Conduit – County Mental Health

Description	Requirement to Collaborate	Relevant Policies
County Financial Assistance Agreements (CFAA) are "omnibus contracts" between OHA and the counties serving as local mental health authorities (LMHA). CFAAs bundle a variety of state and federal funding sources to support 1) court-ordered treatment (aid and assist, civil commitment, and guilty except for insanity), 2) mobile crisis services, and 3) other outpatient mental health care for people without insurance. Approximately half of clients accessing mobile crisis services are estimated to be Medicaid-eligible. Counties may bill Oregon Health Plan (CCOs or OHA) for these services though barriers can exist to doing so.	ORS 430.610 and OAR 309-014-0015 require OHA to assist county LMHAs in assessing needs, identifying priorities, obtaining and managing resources efficiently, and providing technical assistance related to mental health services. ORS 430.630 requires LMHAs to provide guidance and assistance to Behavioral Health Resource Networks for joint development of programs and activities […]. ORS 414.153 requires a written agreement between each CCO and the LMHA in its service area. HB 2208 (2025) amended ORS 414.577 and will require that CCOs collaborate with public health agencies, hospitals, **and LMHAs** to develop a shared community health improvement plan that address behavioral health. OHA is required to update its rules to align timelines for development of CHIPs and related reporting by CCOs.	ORS 430.630 and OAR 309-014-0035 (relating to requirements for LMHAs, and OHA duties to assist and supervise) ORS 414.153(4) (related to CCO and CMHP agreements) HB 2208 (2025) (related to alignment of community health improvement plans)
The **9-8-8 Trust Fund** collects state, federal, and private funds to be used for operation of the 988 crisis call center and statewide hotline. Funds are administered by OHA.	ORS 430.627(4) requires OHA to ensure the crisis hotline center collaborates with other agencies and the LMHAs to provide care for people accessing 988 services. ORS 430.628 requires that when a city operates a state-funded mobile crisis intervention program, the city must enter a memorandum of understanding with the county LMHA regarding the program's operations.	ORS 430.627-8 (related to crisis intervention programs)

Funding Conduit – Measure 110 grants

Description	Requirement to Collaborate	Relevant Policies
The Department of Revenue imposes taxes on marijuana sales at OLCC licensed retailers. Measure 110 redirected most tax revenues to the **Drug Treatment and Recovery Services Fund** (DTRSF). The remaining portion is distributed to cities according to a formula. ORS 430.388 established an **Oversight and Accountability Council** to oversee distribution of DTRSF grants to **Behavioral Health Resource Networks** (BHRN) and other entities. BHRNs are entities that individually or jointly provide some or all of the behavioral health services listed in ORS 430.389(2)(e). SB 610 (2025) amended administration of DTRSF to make OAC an advisory body to OHA for grantmaking decisions and require OHA to consult with the OAC in its grantmaking.	ORS 430.390(4) requires OHA to "encourage and take all reasonable measures to ensure that grant recipients cooperate, coordinate and act jointly with one another" to offer services. OHA rules require BHRNs to maintain partnerships and clear referral pathways. See OAR 944-001-0020(7). OAR 944-001-0030(3) requires written agreements among service providers in a BHRN prior to receipt of funds.	ORS 475C.674 and 475C.726 (relating to marijuana taxes and distributions) ORS 430.383 to 430.384 (relating to the DTRSF) OAR Chap 944 Div. 1 and Div. 10 related to BHRN OAR Chap 944 Div. 20 related to DTRSF grants Sample Memorandum of Understanding for parties operating a BHRN

Funding Conduit – OHP Long Term Services and Supports (1915i) and SUD waiver services (1115)

Description	Requirement to Collaborate	Relevant Policies
A federal exclusion prohibits Medicaid from paying for mental health stays in facilities with more than 16 beds ("institutions for mental disease" or IMDs). OHA's contract with CCOs only requires coverage of short-term inpatient mental health stays and allows for limited IMD stays paid as In Lieu of Services (ILOS) (see CCO contract Exhibit B, Part 2, Section 11). Long-term mental health care stays for Medicaid enrollees are covered through separate eligibility pathways under the state's **Section 1115 demonstration waiver** for Substance Use Disorder**, Section 1915(i) state plan option, and K-plan for Home- and Community-Based Services (HCBS).** Oregon's SUD waiver includes a benefit for people transitioning out of institutional care settings to a home; OHA has not yet implemented a billing system for this benefit in MMIS. HCBS include stays in residential treatment homes and adult foster homes for behavioral health needs.	Providers billing Medicaid for SUD and HCBS services are subject to requirements to participate in person-centered care planning and care coordination. See OAR 410 Div. 172 and 173. There are no other collaboration requirements specifically tied to payments for HCBS or SUD services. Some stakeholders perceive a communication breakdown occurring between Oregon's primary care system and residential care system for Medicaid clients.	OAR 410 Div. 173 related to 1915(i) state plan option OAR 410 Div. 172 related to Medicaid behavioral health services Oregon's Section 1115 Medicaid Demonstration Waiver for SUD (approved April 2021; extension pending March 2025) Oregon's Medicaid State Plan (November 2023) and 1915(i) amendment for HCBS (December 2021)

Funding Conduit – OHA directed payments

Description	Requirement to Collaborate	Relevant Policies
OHA uses **Qualified Directed Payments** to raise Medicaid behavioral health provider rates and allow OHP members to visit out-of-network BH providers. Four directed payment programs are outlined in CCO contract exhibit C. These costs are built into CCO capitation rates and require CCOs to match the OHA fee-for-service schedule. Directed payments are one of the only mechanisms OHA and the state can use to directly raise Medicaid provider reimbursements. CMS does not allow states to otherwise dictate provider reimbursements in Medicaid managed care without a directed payment in place. In addition to directed payments through CCO contracts, OHA makes separate Medicaid directed payments to hospitals. A DRG hospital registers an encounter. OHA issues a payment that is paid out of provider taxes. There is no financial risk to the CCO.	There are no specific statutory or contractual requirements related to collaboration and directed payments, other than general collaboration requirements of CCOs and OHA.	Directed payments are a federal flexibility that CMS began offering in 2016 and updated in 2020. Directed payments are at the discretion of the federal government. See 42 CFR Parts 438 and 457. CCO Contract Exhibit C relates to directed payment authorities and requirements and cites related Oregon Administrative Rules. The 2025 Federal Budget Reconciliation Bill limited states' ability to implement new directed payments and will phase in reductions in existing state directed payments that exceed published Medicare payment rates.

Funding Conduit – alcohol sales and taxes

Description	Requirement to Collaborate	Relevant Policies
OLCC regulates alcohol sales and collects related revenues. Most funds are transferred from the **Oregon Liquor and Cannabis Commission Account** to the state General Fund, with smaller portions transferred to cities, counties, and Oregon Health Authority's Mental Health Alcoholism and Drug Services Account, according to a formula.	OHA is required to consult with state agencies and counties to develop guidelines to minimize duplication of auditing and program review for providers receiving state funds, including alcohol revenues. See ORS 430.256(4).	ORS 471.810(2) (relating to OLCC distribution of alcohol revenues)
OHA administers the **Mental Health Alcoholism and Drug Services Account (MHADS)**. Funds are distributed as grants to counties according to a formula.	Counties receiving MHADS grants must report to ADPC on use of funds. There are no collaboration requirements of counties tied to use of funds. See ORS 430.366.	ORS 430.380 (relating to OLCC transfer to the Mental Health Alcoholism and Drug Services Account and use of funds)
OHA may make **grants to counties for initiatives addressing substance use disorder**. The Alcohol and Drug Policy Commission (ADPC) is authorized to create regions corresponding to local planning committees for these SUD-related grants. Counties are authorized to appoint committee members or designate an existing group to act as the committee in their county. Applicants for grants must have approval from the local ADPC-designated committee.	ORS 430.420 requires that a local planning committee collaborate with law enforcement agencies, district attorney, public safety coordinating council, and local mental health advisory committee to develop a plan […]	ORS 430.335 through 430.345 (related to SUD grants to counties)

Funding Conduit – Opioid Settlement Grants

Description	Requirement to Collaborate	Relevant Policies
Oregon's opioid settlement agreement is part of a national settlement reached in 2021. The national agreement provides broad direction regarding how states may use settlement funds, but states have discretion to determine how funds are distributed and whether to impose additional restrictions. Oregon's settlement agreement directs that 55% of its settlement funds are **distributed directly to counties and some cities**. There are no restrictions imposed by the state on how counties and cities may use these dollars (beyond the restrictions that exist in the national settlement agreement). The remaining 45% of settlement funds are distributed to the **Opioid Settlement Prevention, Treatment and Recovery Fund** for distribution as grants under the direction of an opioid settlement board. State law directs the board to make grants addressing specific policy and program priorities. See HB 4098 (2022). The settlement board has no formal schedule for grantmaking and uses direct allocations rather than an RFP process.	State law dictates that the opioid settlement board includes balanced representation from state and local representatives. Though not required to do so, the settlement board consults with the Alcohol and Drug Policy Commission and OHA on its funding strategy. Per it's implementation plan, OHA must engage specific partners prior to making recommendations to the board regarding funding. The plan includes consideration of how settlement grants may complement or supplant other state investments. Local subdivisions are required to report annually on the use of settlement grant funds through a centralized reporting portal. There are no other collaboration requirements of counties receiving opioid settlement grants. More frequent reporting is desired by some parties.	See 2022 National Opioid Settlements for national restrictions. See Oregon's Intrastate Allocation Agreement regarding division of state and local distributions. See notes Sect. 4-7 following ORS 430.381, related to how settlement funds may be used (enacted through HB 4098 in 2022 and sunsets 2040) See OHA 2024 implementation plan for details on agency allocation of funds.

Funding Conduit – Oregon State Hospital funding

Description	Requirement to Collaborate	Relevant Policies
OSH is primarily funded through an appropriation from the state General Fund to the **Mental Health Services Fund**. OSH services are typically not Medicaid-billable though they do bill Medicare and commercial plans when possible (infrequently). OSH funding is not based on caseload forecasts for demand for court-ordered treatment (aid and assist, civil commitment, etc.). Use of county and/or OHA population health data to inform OSH budget planning is limited. Stakeholders note there may be opportunities to share county or OHA data to forecast future demand for OSH services. OSH data is available on a publicly facing dashboard but there is no known use of the dashboard for planning by community partners. OSH' Chief Analyst participates in a caseload group to forecast demand for OHA behavioral health services.	No known requirements for OSH to collaborate in its use of appropriated general funds.	ORS 426.010 (related to operation of state hospitals) ORS 426.241 (related to OHA collection of costs for OSH care) OAR 410-141-3870(6)(b) (related to CCO care coordination and OSH transfers)

Funding Conduit – SAMHSA block grants

Description	Requirement to Collaborate	Relevant Policies
Federal grants to states include the **Community Mental Health (CMH) and Substance Use Prevention, Treatment, Recovery Services (SUPTRS) block grants**. Block grants are awarded by SAMHSA on a two-year cycle. States submit a needs assessment and workplan with each grant application. Funding must support evidence-based programs and follow federal requirements that can change with each grant cycle. Block grants primarily fund services provided by Community Mental Health Programs with a smaller portion directed to other programs. Funds are distributed from the state via County Financial Assistance Agreements (CFAA) but must be used for specific SAMHSA priorities, and cannot supplant other federal or state funds. OHA recently restructured CFAAs to provide clearer delineation between block grants and other funds distributed via CFAAs.	SAMHSA requires each state to appoint an advisory body to oversee how block grants are used. See 42 USC 300x-3. In Oregon, this is the Addictions and Mental Health Planning and Advisory Council (AMPHAC) housed at OHA. The council advises OHA but is not a decision-making body. No state laws or regulations require collaboration specifically by block grant administrators or recipients. Counties are subject to collaboration requirements related to the CFAAs as a whole. See slide 12.	CMH is federally authorized by sections 1911-1920 of Title XIX, Part B, Subpart I and III of the Public Health Service (PHS) Act SUPTRS is federally authorized by section 1921 of Title XIX, Part B, Subpart II and III of the Public Health Service (PHS) Act. Also see Final Rule, 61 Federal Register 1492 ORS 430.140 designates OHA the state agency authorized to seek federal mental health grants

Funding Conduit – State Opioid Response grant

Description	Requirement to Collaborate	Relevant Policies
The **State Opioid Response Grant** program administered by SAMHSA provides two-year grants to support opioid prevention, harm reduction, treatment, and recovery services. The SOR is not intended to cover addiction services beyond opioids and stimulants. Funding is allocated among states based on a federal overdose burden formula. Federal requirements and priorities may change each grant cycle, and state proposals must include a needs assessment and implementation plan. Unlike other SAMHSA grants, there are few other restrictions on how SOR funds may be used within the overall focus area. OHA staff typically identify local partners through outreach and engagement rather than an open RFP process. OHA aims to ideally direct SOR funds to pilot and innovation projects, transitioning existing programs needed sustained funding to other revenue sources.	There is no requirement for OHA to collaborate in its administration of the SOR specifically. OHA may impose collaboration requirements on grantees as a condition of funding.	ORS 430.140 relating to OHA authorization to pursue federal grants for mental health services SAMHSA grant program information (C.F.D.A. #93.788)

Funding Conduit – Tobacco Prevention Education Fund grants (tobacco tax revenues, settlement)

Description	Requirement to Collaborate	Relevant Policies
Oregon participates in the Tobacco Master Settlement Agreement (TMSA) reached with the tobacco industry in 1998. Settlement funds are received by DAS and allocated by the Legislative Assembly through budget notes. There are no state restrictions on use of the settlement funds though historically a portion of funds are directed by the Assembly to the Oregon Health Plan and tobacco programs. See ORS 293.537.	None	ORS 323.800 related to the TMSA ORS 293.537 establishing the TMSA ORS 180.400 to 180.494 related to Attorney General oversight of TMSA
Tobacco taxes are transferred to OHA to fund the Tobacco Prevention Education Program (TPEP). Most funds are used for grants to counties and community-based organizations. OHA administers: 1) a tiered TPEP grant program for County Health Departments' tobacco prevention efforts that includes Clean Air Act enforcement and may include other system and policy change. Counties opt in to their desired level of participation; 2) public health equity grants for commercial tobacco prevention education; and 3) Regional Health Equity Council grants for regional prevention efforts.	OHA is required to consult with certain parties in developing its RFP for TPEP grants. See OAR 333-010-0330(2). Applications must list partners and their roles.	Measure 44 (1996) established tobacco taxes and smoking cessation programs Measure 108 (2020) increased taxes ORS Chapter 323 related to tax provisions ORS 431A.150 and OAR 333-010-0300 to 333-010-0370 related to OHA grants from tobacco funds

Funding Conduit – Tribal Behavioral Health

Description	Requirement to Collaborate	Relevant Policies
Tribal Councils may elect to contract with OHA to fund community mental health programs (CMHP) (see ORS 430.640(1)(d)). **Tribal behavioral health contracts** bundle state and federal funds for multiple programs such as outpatient mental health, mobile crisis, substance use disorder treatment, residential and transitional living centers. To develop the contract, OHA outlines available funding and suggested focus areas. Each Tribe submits a proposed workplan and budget. The specific process varies among Tribes. For example, the Siletz Tribe employes a behavioral health director who develops the workplan; Siletz Tribal Council approves any major changes to the workplan prior to the contract being finalized with OHA. Tribes draw from a variety of information sources in developing work plans, which can include information gathering with partners. For example, the Siletz Tribe consults a group of community advisors that includes the fire department, police department, and schools. They also receive county data on overdoses to inform program planning.	Oregon agencies are required to consult with Tribes on a range of issues. For example, state law requires the following groups to include Tribal representatives: • The Alcohol and Drug Policy Commission (see ORS 430.221) • The Criminal Justice Commission's grant review committee (see ORS 430.234) Coordinated Care Organizations are required to have a Tribal liaison (see ORS 414.572 (2)(r)). CCOs are required to consult with a Tribal Advisory Council appointed by Tribes that oversees Tribal CCO liaisons and represents Urban Indian Health Programs in Oregon (see ORS 414.581).	ORS 430.630 - 430.640 related to Tribal CMHPs ORS 414.572 – 414.581 related to CCO consultation with Tribes OAR Chapter 309 Div 14 related to CMHP regulations
Oregon's nine federally recognized Tribes are eligible to participate in multiple **national Tribal opioid settlements** that are separate from state settlements. The settlements outline approved uses of funds. Each Tribe retains the right to determine how funds will be used among the list of approved uses. Oregon's opioid settlement board has also set aside 30% of **state opioid settlement funds** per year, beginning in 2024, specifically for Tribes.	There are no specific collaboration requirements. Coordination activities are an approved use of funds.	National Tribal Opioid Settlement Agreements

Highlights from Stakeholder Interviews

Recap of Findings from May + Additional Info

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Recap of Findings Presented in May 2025

(full slides here)

- Oregon “braids and blends” funds from many sources to deliver behavioral health services
- There was agreement that the funding system *as a whole* is not functioning as it should even when individual funding conduits are perceived as well managed
- Funders commonly describe their approach as aiming to “fill gaps” in services
- Across the system, key information and communication tools are missing for this type of gap-based funding allocation process

Recap of Findings Presented in May (slides here)

"Backbone" funding conduits
- Medicaid
- County Financial Assistance Agreements
- Other public or private payers

+

Other funding conduits (often grants)
- Direct legislative investments
- Other federal grants
- State and local taxes
- Legal settlements

Tools or information that could support "gap analysis" as a lens for planning and decision-making about behavioral health investments across funding conduits:
- Shared understanding of which core services ought to be maintained as part of the delivery system
- Tools to monitor ongoing existing capacity and forecast future demands/gaps for those services
- Clarification on who pays first, last, etc. when services require braided or blended funds
- A clearinghouse for information about entities receiving public funds from various conduits

Cross-Cutting Themes: Information and Planning

- Despite jurisdictional tensions between state and local governments, there is agreement on the need for better information sharing about who and what is being funded
- The more organizational “layers” a funding source passes through, the more difficult it can be to track use of funds or outcomes over time
- Ideally, data collection and reporting would be designed to:
    - fill needs for BOTH health care and justice system partners, regardless of where funds are spent
    - support BOTH future planning and oversight/compliance needs

Cross-Cutting Themes: Decision-Making Processes

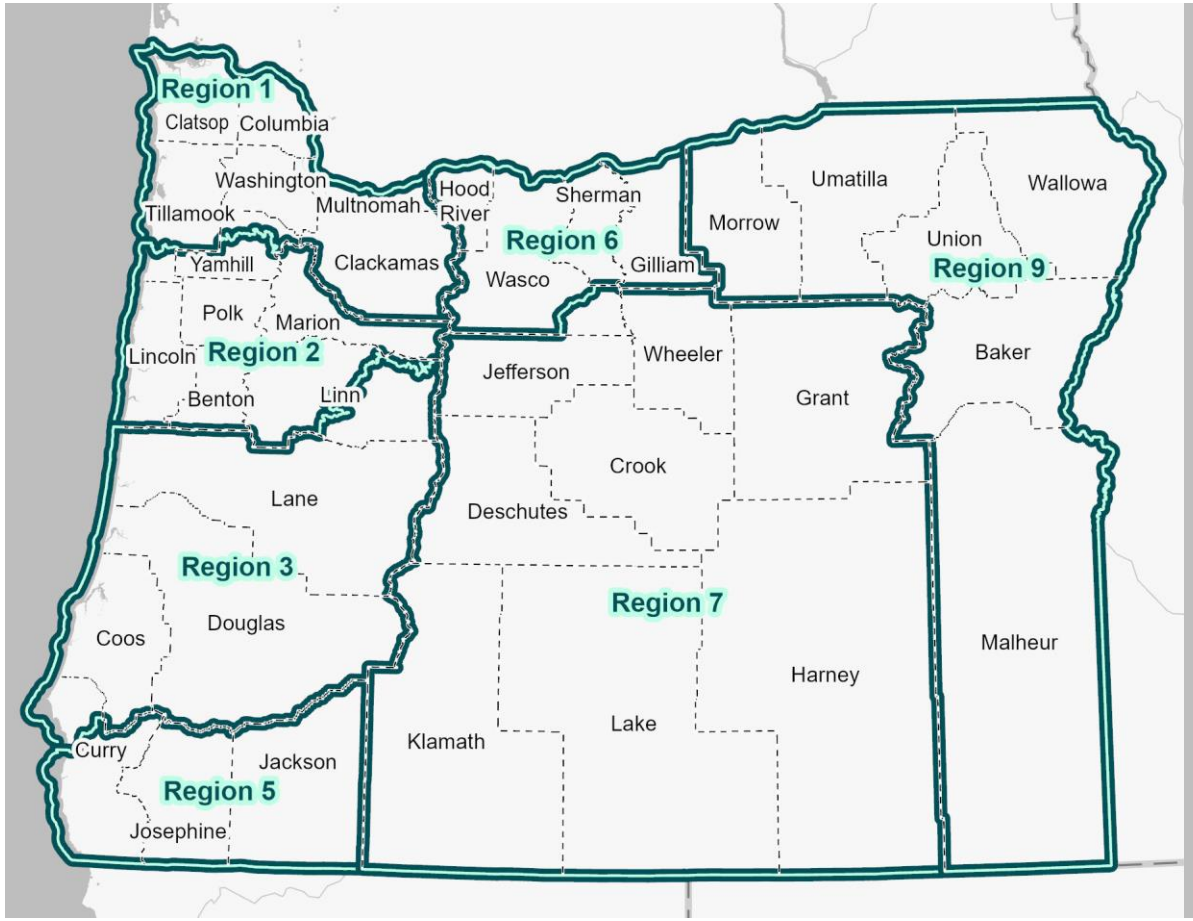
- Questions or uncertainty exist among partners about:
    - the relationship between current efforts related to caseload forecasting, system capacity planning, and grant decision-making processes
    - how successful pilots or innovations should be transitioned from one-time/startup funding sources to sustained funding or billing
- Grant decisions benefit from both content expertise from agency staff and community representation on Boards
- Some funders report they need more and better information, but also report not having sufficient time to review the information they already have

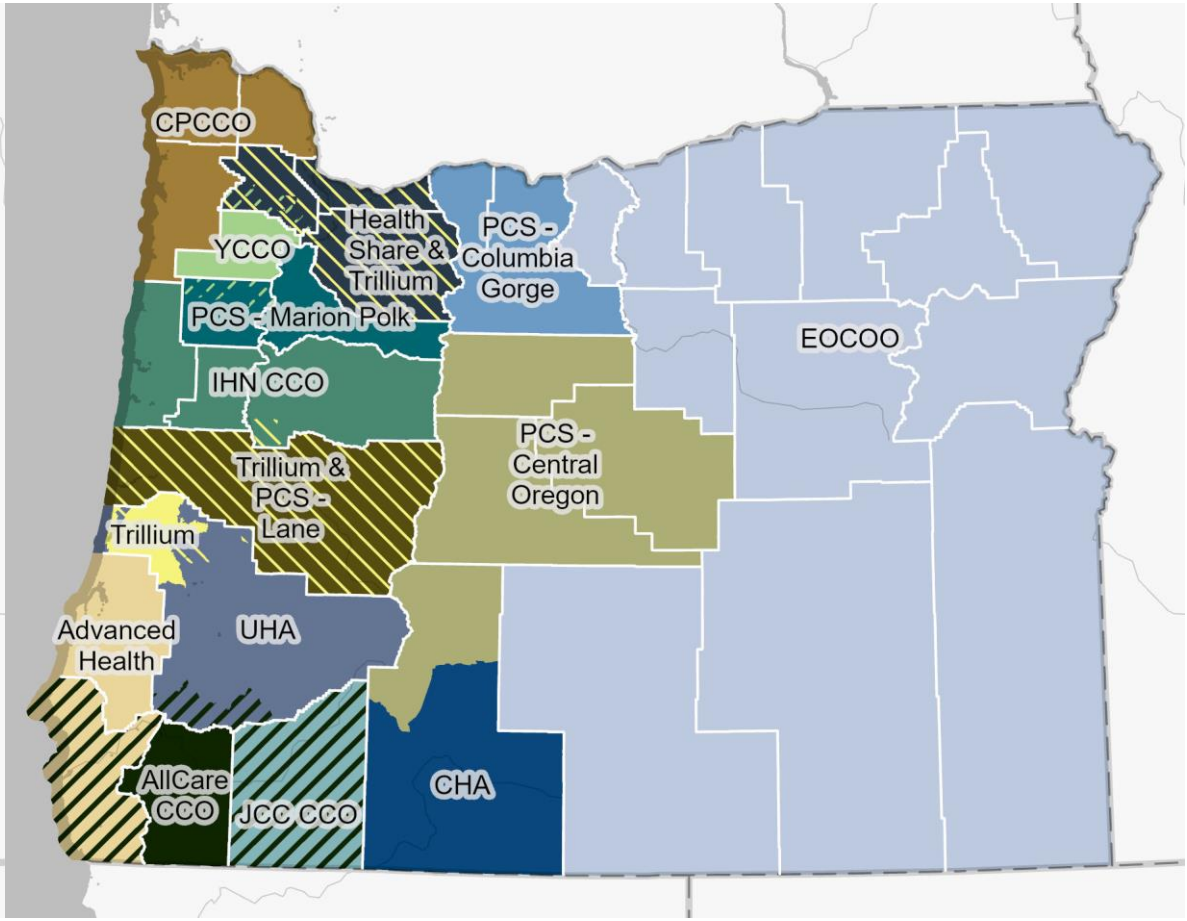
Many Stakeholders Named in BH Funding Decisions

Local Mental Health Authorities and CMHPs	Oregon Legislative Assembly	M110 Oversight Accountability Council (OAC) and subcommittees	Tribal BH Programs and Urban Indian Health Programs	Oregon Office of Economic Analysis	Tobacco Reduction Advisory Committee (TREC, BM44)
Coordinated Care Organization (Board or Administration)	Oregon Department of Justice	BH Resource Networks	Oregon Liquor and Cannabis Commission	Oregon Department of Revenue	BM108 CBO Advisory Committee ("TPEP Council")
Oregon Health Authority (Finance, BH Division, Health Policy & Analytics, Public Health Division, Medicaid Division)	CCO Community Advisory Council (CAC)	Addictions and Mental Health Planning and Advisory Council (AMHPAC)	HB 4092 Workgroup (Tackling Admin Burden)	BH Providers and Community-Based Organizations	Coalition of Local Health Officials
	Oregon Department of Administrative Services	Federal Government (CMS and SAMHSA)	HB 3610 Task Force on Alcohol Pricing & Addiction Services	Regional Health Equity Coalitions (RHEC)	Oregon Partnership for Tobacco Prevention
Associations (AOCMHP, OCBH)	Child Welfare System	Opioid Settlement Board	Alcohol and Drug Policy Commission	Legislative Revenue Office	Public Health Advisory Board
Oregon State Hospital	Hospitals	Governors Office	Courts	Criminal Justice Commission	Schools & Districts

Oregon Counties, CCO, and ATAB Region Map

Use the interactive mapping tool to explore the data:
https://orleg.maps.arcgis.com/apps/instant/compare/index.html?appid=01adc1f2d6ef44039701f4bd43d19066





Discussion

What questions do you still have about Oregon's funding conduits?

Initial reflections or reactions to share at this point?

Other State Models

Presentations from Colorado and Arizona

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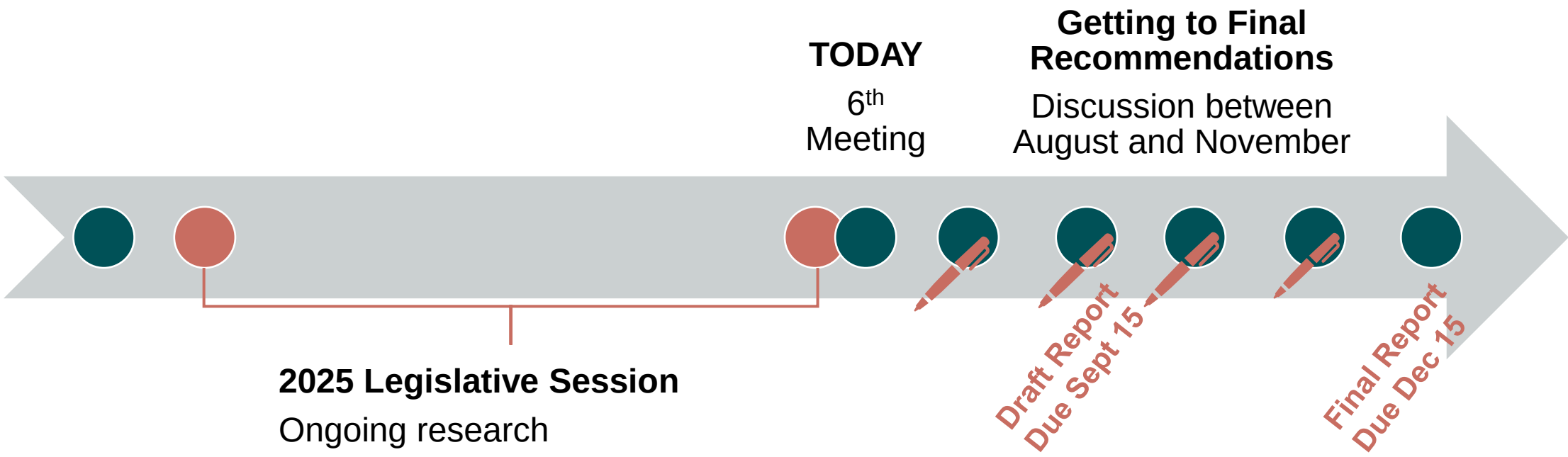
Task Force in 2025



Discussion

What information on other state models would be helpful at your next meeting?

If Oregon moved to a regional model for BH decision-making:

- Which funding streams should be included, and not?
- How formal should it be? In statute? Voluntary?
- How should partners be incentivized to participate? What benefits in participating?

Upcoming Task Force Meetings

Next meeting is **Monday*, September 8th**

<u>Remaining Meetings</u>

Oct. 6, Nov. 3, Dec. 8*

*Meeting not held on the first Monday

Thank you!

Please contact LPRO Staff with questions or for additional information

Brian Nieubuurt brian.nieubuurt@oregonlegislature.gov

Alexandra Kihn-Stang alexandra.kihnstang@oregonlegislature.gov

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