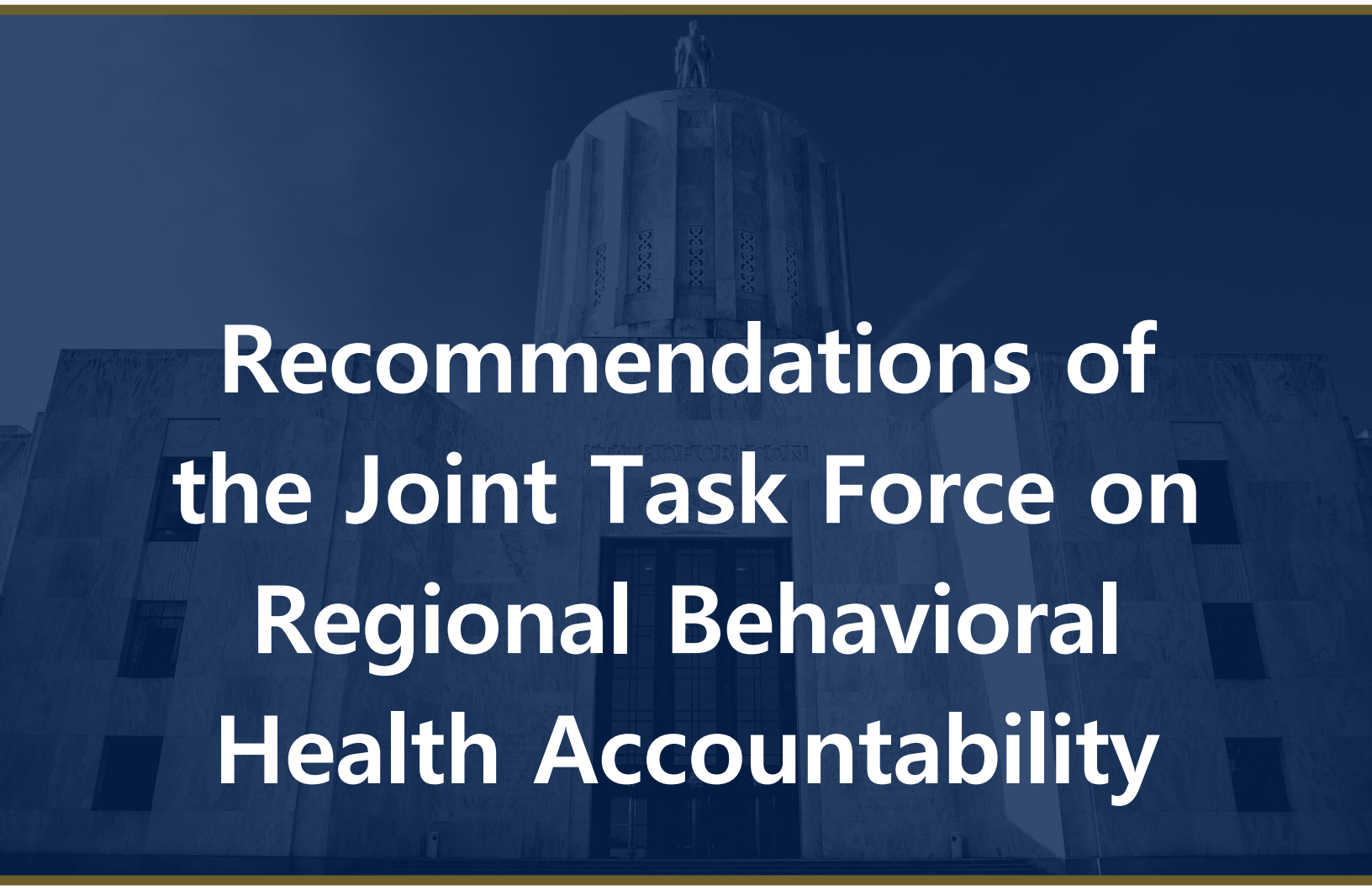


Recommendations of the Joint Task Force on Regional Behavioral Health Accountability

Letter From the Co-Chairs

To the Oregon Legislative Assembly:

In 2024, Oregon legislators created the Joint Task Force on Regional Behavioral Health Accountability to explore options for regionalizing Oregon's behavioral health system. Included in House Bill 4002, which recriminalized drug possession, the Task Force was charged with developing recommendations to improve collaboration, accountability, funding efficiencies, and equity of treatment across Oregon's behavioral health system. This charge recognized HB 4002's emphasis on treatment over criminality and asked the Task Force to investigate potential efficiencies to help meet the increasing behavioral health needs of Oregonians.

The Task Force's charge was challenging from the outset, given the complexity of funding for Oregon's behavioral health system and the broad scope within which the Task Force was directed to develop recommendations. In addition, several external events, including the delayed implementation of changes to the County Financial Assistance Agreements (CFAAs) and the federal passage of H.R. 1, are anticipated to redirect health care system capacity in the near term and impacted how the Task Force developed and considered recommendations.

In light of these challenges, the Task Force has chosen to offer recommendations that blend opportunities to align work already in progress with longer term recommendations that aim to improve system transparency and accountability over time. The Task Force advances these recommendations with full recognition of the challenging time ahead the state's behavioral health system. It is our hope that these near and longer term recommendations offer meaningful suggestions for how recent investments in its behavioral health system can be further leveraged to improve efficiency, transparency, and accountability, even in a period of uncertainty.

We sincerely thank the members of the Task Force for their dedication to both the Task Force and the state's behavioral health system. Each member brought unique insights that contributed to robust and well-informed discussion. We also thank staff from Arizona, Colorado, and Minnesota for their time and insight into their systems.

Respectfully submitted,

[Signatures forthcoming]

Senator Kate Lieber, Co-Chair

Senator Dick Anderson, Co-Chair

Task Force Members

Legislative Members (Non-voting):

Senator Kate Lieber, Co-Chair
Senator Dick Anderson, Co-Chair
Representative Darcey Edwards
Representative Rob Nosse

Non-Legislative Members (Voting):

Marris Alden
Dee Butler
Andrew Cherry
Ebony Clarke
Annaliese Dolph
Melissa Eckstein
Ann Ford
Bennett Garner
Ana Gonzalez
Amanda Gray
Holly Harris
Mahad Hassan
Heather Jefferis
Kimberly Lindsay
Alison Noice
Korin Richardson
Jennifer Sewitsky
John Shafer
Michele Vowell
Nan Waller
Scott Winkels
Lamar Wise

Task Force Member Vote

Task Force members adopted this report on [DATE] and affirmed that its contents reflect the findings and recommendations of members.

Staff

Alexandra Kihn-Stang, Legislative Analyst | alexandra.kihnstang@oregonlegislature.gov

Brian Nieubuurt, Legislative Analyst | brian.nieubuurt@oregonlegislature.gov

Timothy Merrill, Committee Assistant | timothy.merrill@oregonlegislature.gov

Oregon State Legislature

Oregon State Capitol | (503) 986-1813 | www.oregonlegislature.gov

Executive Summary

Recommendations of the Joint Task Force on Regional Behavioral Health Accountability

November 3, 2025

The Joint Task Force on Regional Behavioral Health Accountability was established through House Bill 4002 (2024) to develop recommendations to improve governance and evidence-based funding decisions for Oregon's behavioral health system. The 26-member legislative Task Force convened between November 2024 and November 2025 and included a wide range of stakeholders from across Oregon's behavioral health system.

The timeline for the Task Force overlapped with the 2025 legislative session as well as notable revisions to state administrative processes and federal policy changes. These events impacted the scope of Task Force recommendations.

This Final Report offers recommendations in two primary categories, near term recommendations to build on existing efforts to improve behavioral health system coordination and accountability, and longer term recommendations intended to build a vision for Oregon's behavioral health system, particularly around system transparency and accountability.

Near Term Recommendations

- **Recommendation 1: Oregon Health Authority (OHA) rulemaking and decision-making around the Residential Behavioral Health Capacity Program should incorporate relevant information from the County Financial Assistance Agreement (CFAA) local plan.**
- **Recommendation 2: As part of their work related to investigating certain flexibilities for residential treatment services, the House Bill 2015 (2025) work group should look at how to minimize administrative burden and other barriers, including screening requirements, for people to move efficiently to the appropriate level of treatment.**
- **Recommendation 3: OHA should utilize Coordinated Care Organization (CCO) Community Health Improvement Plan (CHIP) information to inform other grant appropriations related to behavioral health funding conduits not already included in the CCO global budget or CFAA.**

- **Recommendation 4: OHA should include information in the report required by House Bill 2015 (2025) detailing how options identified would impact regional equity of service availability.**
- **Recommendation 5: OHA should provide regular reporting on implementation of new CFAA agreements during the initial term (anticipated to be six years). Reporting should include information on how community mental health programs (CMHPs) are complying with Resilience Outcomes Analysis and Data Submission (ROADS) reporting requirements.**
- **Recommendation 6: OHA should align performance metrics across CHIP behavioral health plan requirements and ROADS reporting requirements for county mental health programs, with specific attention to the coordination of services for members with an SMI diagnosis or with a history of court-ordered behavioral health treatment.**

Long Term Recommendations

- **Long Term Recommendation 1: OHA should leverage reporting required by the updated CFAA to create transparency into behavioral health system expenditures.**
- **Long Term Recommendation 2: OHA should use updated reporting to both efficiently track the financial health of the behavioral health system and hold partners accountable for achieving desired outcomes.**

The full report can be found on the Oregon Legislative Information system at: [ADD URL HERE]

Table of Contents

Introduction

The Joint Task Force on Regional Behavioral Health Accountability (the "Task Force") was established through House Bill 4002 (2024) to develop recommendations to improve governance and evidence-based funding decisions for Oregon's behavioral health system. Between November 2024 and November 2025, the 26-member legislative Task Force was directed to develop recommendations in several broad areas relating to accountability of funding and services across Oregon's behavioral health system.

The Task Force's work was interrupted by several key events, including the 2025 legislative session, administrative delays, and the federal passage of H.R. 1. The Task Force developed its recommendations to be responsive to these events, focusing on aligning state efforts already in progress and establishing a vision for how future efforts around increasing transparency and accountability could bring meaningful improvement to the state's behavioral health system.

Task Force Process

Charge and Background: House Bill 4002 (2024)

House Bill 4002, enacted during the 2024 legislative session, established the Joint Task Force on Regional Behavioral Accountability. The primary focus of HB 4002 was the reintroduction of potential criminal penalties for the possession of controlled substances, decriminalized via Ballot Measure 110 (the "Drug Addiction Treatment and Recovery Act") in November 2020. HB 4002 created pathways for individuals cited for drug possession to avoid criminal penalties through the successful completion of diversion or deflection.

Recognizing the additional strain that new treatment pathways could put on the state's behavioral health system, provisions aimed at mitigating these impacts were included in HB 4002, including establishment of the Joint Task Force on Regional Behavioral Health Accountability, to develop recommendations to improve governance and evidence-based funding decisions.

The Task Force was directed to develop recommendations to

a. improve collaboration and accountability across federal, state and local behavioral health and substance use disorder treatment programs and funding;

b. ensure equitable outcomes in publicly supported treatment settings across Oregon communities;
c. provide greater cost efficiencies in the continuum of care of Oregon's behavioral health system; and
d. establish broad access to methadone and other opioid use disorder medications through mobile devices, telehealth, and pharmacy-based services to measurably increase the engagement statewide of individuals with opioid use disorder in opioid use disorder treatment.

The 26-member Task Force included four non-voting legislative members (two Senators and two Representatives) and 22 voting members, one Oregon Judicial Department representative appointed by the Chief Justice of the Supreme Court and 21 members appointed by the Governor. The 21 gubernatorial appointees representing a wide range of stakeholders from across Oregon's behavioral health system:

- Oregon Health Authority (OHA) and Department of Human Services (OHDS),
- Alcohol and Drug Policy Commission (ADPC),
- coordinated care organizations (CCOs),
- hospitals,
- pharmacists,
- the insurance industry,
- behavioral health workers and providers, including county mental health providers,
- cities,
- counties, and
- Tribal populations.

With support from the Legislative Policy and Research Office (LPRO), the Task Force began its work by assessing needs and opportunities within the four recommendation areas (see Appendix A). Task Force members completed a Needs Assessment that included questions about member goals, priorities for the Task Force's work, and initial information requests. LPRO utilized the information to assist in the drafting of a Task Force workplan, setting goals for the work, establishing policy needs and opportunities, and identifying tools and resources needed to help the Task Force develop recommendations.

Needs Assessment

Task Force members were invited to complete a Needs Assessment survey following the Task Force's initial organizational meeting held in November 2024. Results were presented to the Task Force at the following meeting on December 9. The survey found that Task Force members shared three initial overarching priority areas for developing Task Force recommendations. These high-level themes are expanded upon in the Needs Assessment Summary (see Appendix A) and included

- achieving a statewide behavioral health system,
- aligning governance and funding structures, and
- increasing system transparency, particularly regarding performance and funding investment.

Task Force members identified both process and outcome-specific goals for their work. Outcome goals included

- concrete recommendations with measurable outcomes;
- measurable improvements across Oregon's public behavioral health system with priorities for the client/patient, organizational, provider, payer, and governance levels; and
- an overarching vision for Oregon's public behavioral health system.

Members identified several process goals to consider when approaching their work

- defining the problem and operationalizing key terms,
- agreeing to goals that are realistic given the timeline,
- understanding the current landscape of behavioral health care in Oregon, and
- balancing information gathering with engaging in meaningful discussion.

Initial member priorities and goals were discussed by the Task Force during the December 9 meeting and used to inform the development of a Task Force problem statement to focus future meetings and conversations around developing the final report and recommendations to the legislature. A reoccurring point raised by Task Force members, both in the Needs Assessment Survey and during discussion, was the need for the Task Force to avoid duplication of other ongoing state efforts. Task Force members highlighted an interest in considering other relevant legislation enacted during the 2025 session, as well as the work of other non-legislative workgroups.

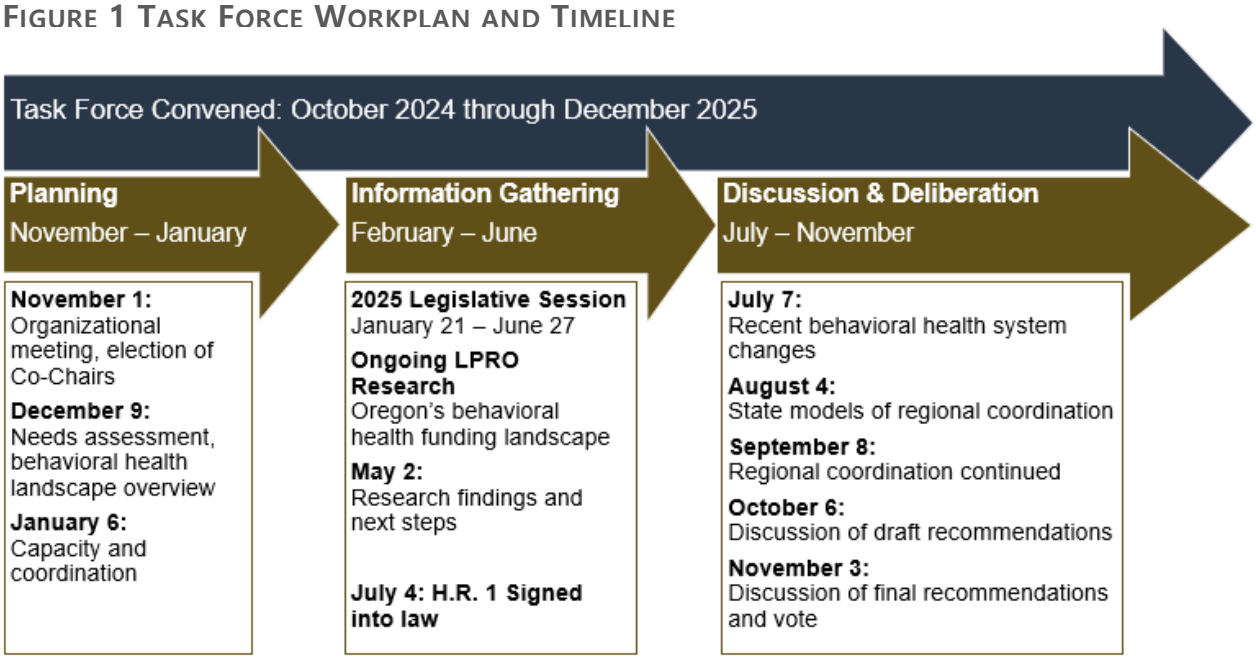
Workplan and Meeting Materials

The Task Force was appointed between May and September of 2024 and held three meetings prior to the start of the 2025 legislative long session. Task Forces typically pause during the legislative session due to limitations in scheduling and Capitol capacity, but this Task Force included a mid-session meeting on May 2, 2025, among the nine meetings held between November 2024 and November 2025. Task Force meetings occurred in three phases: planning, information gathering, and discussion/deliberation.

HB 4002 (2024) included a provision (Section 16, Subsection 12) for LPRO to conduct research activities to support the work of the Task Force. Findings from the Needs Assessment survey, Task Force discussion, and direction from the Co-Chairs informed development of meeting agendas prior to the start of the 2025 legislative session and the development of an LPRO research proposal. LPRO research activities were completed during the 2025 legislative session and presented to the Task Force during the May and August 2025 meetings. LPRO completed an initial comparative analysis looking at Oregon's behavioral health system performance through national data from the Substance Abuse and Mental Health Services Administration (SAMHSA) and presented findings during the December 2024 meeting.

Figure 1 shows the Task Force timeline, phases, meeting dates and topics, and intervening events that impacted Task Force direction and recommendation development. A detailed list of meeting presentations and materials is available in Appendix B. Intervening events are discussed in detail in a subsequent section of this report.

FIGURE 1 TASK FORCE WORKPLAN AND TIMELINE



Preliminary Report on September 12, 2025

House Bill 4002 (2024) directed the Task Force to submit preliminary recommendations to the Interim Committees related to health by September 15, 2025. The preliminary report was prepared by staff from the Legislative Policy and Research Office and approved by the Task Force during its September 8, 2025 meeting. The preliminary report included the following:

- background on the Task Force charge outlined in HB 4002,
- an overview of Task Force membership and leadership,
- a description of the initial assessment and planning work completed,
- upcoming Task Force meetings, and
- plans for development of forthcoming recommendations.

The preliminary report was adopted unanimously by the Task Force on September 8, 2025 and presented to the Legislative Assembly on September 12, 2025.

Task Force Framing

As described in the Needs Assessment section, the Needs Assessment survey helped the Task Force identify several process goals for its work:

- defining the problem and operationalizing key terms,
- agreeing to goals that are realistic given the timeline,

- understanding the current landscape of behavioral health care in Oregon, and
- balancing information gathering with engaging in meaningful discussion in developing its recommendations.

As part of its effort to achieve these goals, the Task Force sought to develop a Problem Statement based on member and Co-Chair priorities from the Task Force's charge that would be used to develop meeting agendas, orient discussions, and guide the development of Task Force recommendations.

Task Force Problem Statement

The goals identified in the Needs Assessment survey helped inform the development of a Problem Statement that was affirmed by the Task Force at its meeting on January 6, 2025:

> 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.

In developing this Problem Statement with staff, the Co-Chairs specifically emphasized transparency and collaboration as focus points for potential Task Force recommendations.

Acknowledging discussions to date, the Task Force's timeline, and the recent passage of H.R. 1 at the federal level, the Task Force returned to the Problem Statement at the September 8, 2025, meeting. At this meeting the Task Force updated the Problem Statement to include a focus on specific populations in the development of potential recommendations:

> 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, *particularly in coordinating for individuals with severe mental illness or subject to court-ordered treatment.*

Oregon's Behavioral Health Funding Conduits

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 staff presented inventory and interview findings to the Task Force during the May and August meetings. In these presentations to the Task Force, staff used the term "funding conduit" to capture the pathway that dollars flow along from original source to the point of care/service.

Many Funding Sources and Gaps in Services

The presentation on May 2 included preliminary thematic analysis of system-level themes that arose during the stakeholder interviews. Key themes included that Oregon "braids and blends" funds from many sources to deliver behavioral health services, along with 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 described their approach trying to "fill gaps" in services. However, across the system, key information and communication tools for supporting this type of gap-based funding allocation process were missing.

Three Funding Conduits

The analysis indicated that some of the perceived lack of collaboration within Oregon's behavioral health system is due to limitations related to the braiding and blending of funds where each funding stream has its own permitted uses or limitations, decision makers and processes, and reporting obligations. While this entire system of funding conduits is required to support a continuum of care, stakeholder interviews revealed that the "backbone" of Oregon's behavioral health system is comprised of three primary funding conduits: the state Medicaid program, the CFAA, and coverage offered by other public payers and commercial insurance plans.

Challenges to Collaboration

Interviews highlighted that the relationship between Medicaid and CFAA-funded services can be challenging as individuals can "churn" through the systems supported by those funds depending on their service needs. The entities responsible for coordinating service delivery for the Medicaid and CFAA conduits, coordinated care organizations (CCOs) and community mental health programs (CMHPs), also have various funding structures, geographic service areas, and service delivery

requirements. Interviewees agreed that Oregon's behavioral health system is chronically underfunded and that collaboration to fill gaps in the system can be hindered by variable decision-making processes and missing information regarding system capacity and the flow of existing funds.

Additional information on funding conduits, including statutory and other requirements for collaboration placed upon each funding conduit, was presented to the Task Force at the August 4 meeting. A complete list of funding conduits reviewed is available in Appendix C, including a description of the conduit, any known requirements for collaboration with other entities, and any relevant policies directing collaboration.

Oregon statute does require coordination between CCOs and local mental health authorities (LMHAs), whereas many other funding conduits included in the analysis lacked requirements for collaboration. Coordination is encouraged among some other funding conduits, including those typically intended to fill gaps in the care continuum, such as certain funds for substance use disorder (SUD) treatment and Behavioral Health Resource Networks (BHRNs).

State Examples of Regional Behavioral Health Coordination

Acknowledging the charge from HB 4002 to investigate governance changes that could facilitate better alignment of spending decisions, the Task Force also sought to hear from states that had implemented some measure of regional coordination for their behavioral health system. In interim Informational Meetings prior to the 2024 Session that informed the development of HB 4002, the Joint Committee on Addiction and Community Safety Response heard about the establishment of deflection programs – initiatives that give people facing drug-related criminal charges the opportunity to choose treatment in lieu entering the criminal justice system. Among the presenters were individuals who helped established the deflection system in Arizona, a state with a history in regionalizing the coordination of behavioral health services. The Task Force also heard from staff from Colorado and Minnesota, states whose regional approaches to behavioral health offered additional insights.

Arizona

At its August 2025 meeting, the Task Force received a presentation from staff at the Arizona Health Care Cost Containment System (AHCCCS) about that state's Regional Behavioral Health Authority (RBHA) system. Similar to OHA's role in Oregon,

AHCCCS is the state agency for both Medicaid and behavioral health. Like Oregon, Arizona endeavors to have the majority of its Medicaid recipients enrolled in a managed care organization. Arizona's managed care organizations combine the coordination of both physical and behavioral health services into one plan, called AHCCCS Complete Care, instead of separate plans for physical and behavioral health. As the state agency for both Medicaid and behavioral health, AHCCCS can braid and blend Medicaid funds with other funds used to help support the state's behavioral health system.

Arizona has established RBHA as a subset of its AHCCCS Complete Care plans to help provide behavioral health crisis services, as well as manage the coordination of services for individuals determined to have a serious mental illness (SMI). Originally implemented only for the state's most populous county, Arizona now has three RBHA for different geographic service areas as well as seven RBHA for Tribal members.

Colorado

At the August meeting, the Task Force also received a presentation from staff at Colorado's Behavioral Health Administration about that state's 2025 effort to implement Behavioral Health Administrative Service Organizations (BHASOs). The BHASO model originated out of a 2020 task force established by Governor Polis that resulted in 2022 legislation which established the Behavioral Health Administration (BHA). The BHA was directed to create a coordinated, cohesive, and effective behavioral health system that included regionally-based BHASOs.

Colorado's BHASOs are responsible for services paid for with federal and state mental health and substance use disorder (SUD) funds, making them responsible for service coordination for crisis services and services for the uninsured and underinsured. Unlike Arizona's RHBA, Colorado's BHASOs are not responsible for coordinating Medicaid-funded services. Like Oregon and Arizona, Colorado has a managed Medicaid system, although it is administered by a separate state agency. However, BHASOs have been designed to align the four regional service areas with the service areas for the state's Medicaid managed care entities, known as Regional Accountable Entities (RAEs).

Minnesota

At the September 2025 meeting, the Task Force received a presentation from staff at Minnesota's Department of Human Services about the state's Adult Mental Health

Initiative (AMHI) model. As an evolution of the national movement to transition people with mental illness from institutions to the community, the AMHI team gave the Task Force insight into regional collaboration for the provision of local mental health services and supports. Like Colorado's BHASO model, AMHIs provide services not already covered by the state Medicaid program. Similar to Arizona's RBHAs, current AMHI eligibility requires diagnosis with serious and persistent mental illness (SPMI).

Minnesota currently has 19 AMHIs, including 11 multi-county regional partners, seven single county partners, and one Tribal partner. For regional partnerships, a single county acts as the fiscal agent for a region. AMHIs serve as community mental health authorities, responsible for identifying and responding to local community needs. The state-funded program implemented a revised funding formula in early 2025 to support equitable distribution across AMHIs.

Intervening Events

The Task Force's timeline through the 2025 calendar year meant that deliberations were impacted by activities from the 2025 Legislative Session. In addition to these state legislative changes, state administrative delays and federal policy changes impacted the Task Force's discussions and Final Recommendations.

2025 Legislative Session

As a "long" session, the 2025 Legislative Session resulted in the passage of measures establishing or shifting policy, as well as use of the biennial budget to continue system investments initiated during earlier sessions. These events impacted Oregon's behavioral health system and had implications for the work of the Task Force.

The 83rd Legislative Assembly passed several measures aimed at improving collaboration consistent with the Task Force's Problem Statement.

House Bill 2208: Coordination in Behavioral Health Planning

House Bill 2208 expanded and clarified the collaboration already required to inform coordinated care organization (CCO) development of its community health improvement plans (CHIPs) by specifically adding community mental health programs (CMHPs) and local planning committees to the list of entities that CCOs must collaborate with when developing a CHIP. The measure also requires the CHIP to include any other behavioral health plans required by law or OHA, including the

local plan required for CFAA planning (see Updated County Financial Assistance Agreement section). A CCO's CHIP offers a long-term, strategic plan to address a community's health issues, needs, and priorities. By requiring CCOs to be more collaborative and inclusive in developing their CHIP, the requirements of HB 2208 offer opportunity for better identification and collaboration of local communities' health needs, especially around behavioral health.

HB 2208 also requires OHA to investigate whether residential behavioral health services to Medicaid recipients can be provided through options other than the state's Home and Community-Based Services (HCBS) waiver. Offered through Section 1915 of the Social Security Act, HCBS waivers offer states a pathway to offer long-term care services and support in a person's home or community, rather than in an institutional setting. Oregon's HCBS waiver currently supports the provision of community-based integrated supports, psychosocial rehabilitation, in-home personal care, and residential habilitation services. HB 2208 requires OHA to deliver a report on the findings of its flexibilities study to the Legislative Assembly by September 15, 2026.

House Bill 2015: Flexibilities for Residential Treatment Services

House Bill 2015, like HB 2208, looked to opportunities for administrative simplification to improve access to services. Specifically, HB 2015 requires OHA to study potential flexibilities for administering residential behavioral health services. The measure requires OHA to study flexibilities in several potential areas, including nurse staffing requirements, reimbursement methodologies, direct discharge opportunities, and capacity payment options.

Other Measures Enacted: Behavioral Health System Investments

Other policy-related activity from the 2025 session focused on further clarification of measures related to HB 4002 and the 2024 "short" session. This included the passage of House Bill 2005, which modifies processes and timelines for the aid & assist and civil commitment processes in an effort to remove barriers to competency restoration via the Oregon State Hospital (OSH) and community settings. Changes to the funding of deflection programs were also made in 2025 via Senate Bill 610 (making the Oversight and Accountability Council an advisory body to OHA) and House Bill 3069 (establishing the deflection program funding formula going forward).

In addition to these policy efforts, the Legislative Assembly also continued making financial investments in the state's behavioral health system that were relevant to the Task Force's charge during the 2025 session. This included appropriating $65 million to the Residential Behavioral Health Capacity Program created within OHA by House Bill 2059. This new program is intended to identify and fund behavioral health programs that can increase communities' facility capacity for withdrawal management, residential treatment, and psychiatric inpatient treatment. The investments are also intended to target the needs identified in the Behavioral Health Residential+ Facility Study done by the Public Consulting Group (PCG) for OHA at the direction of Governor Kotek and finalized in June 2024. The PCG Study assed the state's capacity and unmet need for mental health residential, substance use residential, and withdrawal management facilities.

Additional financial investments in the 2025 session similarly focused on building or supporting capacity in key areas of the behavioral health continuum. Highlights included

- $14.1 million to help expand the Certified Community Behavioral Health Clinic (CCBHC) system statewide through the integration of 15 additional clinics;
- $13.2 million to continue CMHP deflection and diversion program funding;
- $9.6 million to increase reimbursement rates for adult mental health residential services;
- $55.5 million to help establish and hire over 200 positions at the OSH;
- $2.4 million to help fund navigator positions to assist people on Aid and Assist orders at OSH transition back to the community;
- $1.5 million to help fund coordinator positions to assist people going through the civil commitment process; and
- $13.2 million to continue diversion and deflection program funding, including $9.8 million for distribution to CMHPs for deflection.

Together, the policy changes and financial investments made during the 2025 Legislative Session offer opportunities to improve behavioral health service availability and coordination in line with the Task Force's Problem Statement. By promoting a reduction in administrative burden, the consolidated planning required by HB 2208 and administrative flexibilities potentially discovered through the HB

2059 study may strengthen the impact of the additional capacity investments made during the Legislative Session.

Updated County Financial Assistance Agreements

The Oregon Health Authority's (OHA) planned updates to County Financial Assistance Agreements (CFAA) offered additional opportunity to improve both collaboration and accountability in line with the Task Force's Problem Statement.

Definition of County Financial Assistance Agreements

CFAAs are agreements between OHA and local mental health authorities (LMHAs) that provide financial assistance to the LMHA to establish and operate a Community Mental Health Program (CMHP). Funding provided by the CFAA is primarily comprised of General Fund dollars but also includes certain tax revenues and block grant funds. This funding is designed to help pay for non-Medicaid eligible services and supports, particularly in those areas in which CMHPs are statutorily required to provide services, including mobile crisis and services for the civilly committed and forensic populations.

Increased Flexibility for County Planning

Simultaneous to the Task Force's timeline, OHA was working with CMHP directors on revisions to the CFAA. In addition to extending the length of the agreements from two to six years, updates are intended to give counties more flexibility in using some funding. Rather than the historical focus on service elements that all counties were required to provide, the updated CFAA will leverage the local plan and budget that LMHAs are statutorily required to adopt. (See ORS 430.630(b) (2023)). Counties are required to prioritize the availability of services around four population categories:

(1) court ordered and civilly committed individuals;
(2) individuals eligible for diversion from the legal system because of a behavioral health disorder;
(3) individuals under the age of 18 year who are at risk of hospitalization or home removal and individuals who require treatment other than hospitalization; and
(4) all other individuals who have or are at risk of developing a behavioral health disorder.

With counties responsible for the same outcome metrics, the updated CFAA may provide more flexibility for counties to articulate their plans for meeting outcomes while reflecting local needs and resources. As noted above, HB 2208 requires that

local plans be reflected in applicable CCOs' CHIPs, thereby promoting increased coordination and collaboration between counties and CCOs.

Consolidated Reporting Through ROADS System

Another component of the revised CFAA was streamlining and improving reporting while reducing administrative burden on counties and providers. The move away from service elements should help reduce counties' reporting burden. OHA indicated that it anticipates consolidation of most behavioral health reporting through the newly established Resilience in Outcomes Analysis and Data Submission (ROADS) system. The updated CFAA will also require regular financial reporting, reporting which has not historically been required. The updated reporting structure and requirements should provide better information, particularly around outcomes and financing, for the state and system partners to utilize to inform decision-making. It also aims to reduce the administrative burden of reporting which, when paired with the funding flexibilities provided by the update, may improve CMHP service capacity.

CFAA Implementation

Updates to the CFAA were initially anticipated to be in place for the fiscal year beginning July 1, 2025, potentially offering the Task Force an opportunity to learn from its implementation. However, OHA and CMHP directors agreed to postpone this implementation until January 2026 to allow counties to develop their local plans in collaboration with OHA and informed by the counties' prospective budgets.

H.R. 1

While the 2025 Legislative Session and anticipated updates to the CFAA offered changes that are consistent with addressing some of the issues identified by the Task Force's Problem Statement, federal policy changes signed into law as the Task Force returned after the Legislative Session challenged the Task Force's ability to consider broader system changes. Signed into law on July 4, 2025, H.R.1 (a.k.a. the "One Big Beautiful Bill Act") brings significant changes to a number of federal programs, including Medicaid. Scheduled to take effect in 2026, the changes to Medicaid in H.R. 1 will impact both who is eligible for OHP, as well as how that coverage can be funded.

Changes to Eligibility Criteria

H.R. 1 makes changes to both eligibility criteria and the frequency that eligibility will need to be determined. First, H.R. 1 eliminates Medicaid eligibility for certain non-

U.S. citizens, including asylees, refugees, and victims of human trafficking. Beginning January 1, 2027, H.R. 1 also requires states to begin verifying eligibility for all enrollees every 6 months. This change is especially dramatic for Oregon as the state had negotiated two years of continuous eligibility through its most recent Section 1115 Demonstration Waiver.

Reductions in State-Directed Payments and Provider Taxes

Financing changes included in H.R. 1 will also have significant impacts for Oregon. First, H.R 1 reduced the maximum allowable value for state-directed payments (SDPs). SDPs are mechanisms that allow states to supplement base Medicaid payments by directing managed care plans to pay providers specific amounts. Used to improve care and reduce disparities, Oregon has recently used SDPs to supplement the reimbursement of behavioral health providers. The legislation also significantly limits the use of provider taxes that are levied by most states, including Oregon, to help finance their portion of the Medicaid program. H.R. 1 reduces the provider tax threshold over the next several years for states like Oregon that have established provider taxes at the current threshold. H.R. 1 also imposes a moratorium on the imposition of any new provider taxes.

Preliminary Estimates

On August 11, 2025, Oregon's Department of Administrative Services (DAS) issued a preliminary estimate of the impacts of H.R. 1 to various state agencies and programs, including OHA and OHP. The document outlines the significant fiscal challenges H.R. 1 compliance presents for publicly-financed health care in the state, beginning with an estimated impact of nearly $500 million for the 2025-2027 biennium, which expands to nearly $7 billion by the 2029-2031 biennium. In addition to the loss of federal funds supporting its Medicaid program, Oregon will need to update eligibility systems to support changes in H.R. 1

Collectively, the changes in H.R. 1 are expected to reduce the number of people who have health coverage in Oregon and how that coverage is paid for. Bringing the state into compliance with H.R. 1 will likely be near-term the priority of OHA, legislators, and the health care system given the current timeline of those changes.

Recommendations

In developing these recommendations, the Task Force sought to balance the process and outcome goals established through the Needs Assessment survey with the

impact of intervening events, including the delayed implementation of revisions to the County Financial Assistance Agreements (CFAAs) and federal passage of H.R. 1.

Impacts of Delay in Updated CFAA Implementation

A process goal for the Task Force was to avoid duplication of other active efforts to improve the state's behavioral health system. The delay in updated CFAA implementation had implications for this goal, as the new CFAAs are anticipated to improve funding flexibilities and reporting requirements. For example, Task Force members identified that increased transparency into how behavioral health funds were used could improve collaboration and efficacy of behavioral health spending, while revised CFAA reporting requirements could further improve transparency.

Implications of H.R. 1

The federal passage of H.R. 1 impacted the scope of Task Force recommendations, particularly those related to the state Medicaid program, known as the Oregon Health Plan (OHP). H.R. 1 presents potentially significant implications for the financing of, and eligibility for, state Medicaid programs. Many of the Medicaid changes in H.R. 1 are scheduled to take effect in 2026, presenting two main challenges for the Task Force. First, what and who OHP covers going forward is likely to change as a result of bringing the program into compliance with H.R. 1. Second, in its role as the state agency for both Medicaid and behavioral health, the Oregon Health Authority (OHA) will be focused on H.R. 1 compliance in the near term, significantly limiting its capacity to act upon Task Force recommendations.

Drafting Process

Draft recommendations were initially presented to Task Force members in a draft memorandum and discussed during the October 6 meeting. The recommendations were revised to incorporate feedback from Task Force discussion, individual member feedback submitted to staff via email in the week after the meeting, and directions from the Co-Chairs.

Near Term Recommendations

Near term recommendations put forth by the Task Force were developed to complement existing efforts to improve Oregon's behavioral health system through additional financial investments, clarified planning and reporting processes, and streamlined collaboration and accountability requirements.

Recommendations Related to 2025 Legislation

- **Recommendation 1: Oregon Health Authority (OHA) rulemaking and decision-making around the Residential Behavioral Health Capacity Program should incorporate relevant information from the County Financial Assistance Agreement (CFAA) local plan.**
- **Recommendation 2: As part of their work related to investigating certain flexibilities for residential treatment services, the House Bill 2015 (2025) work group should look at how to minimize administrative burden and other barriers, including screening requirements, for people to move efficiently to the appropriate level of treatment.**
- **Recommendation 3: OHA should utilize Coordinated Care Organization (CCO) Community Health Improvement Plan (CHIP) information to inform other grant appropriations related to behavioral health funding conduits not already included in the CCO global budget or CFAA.**
- **Recommendation 4: OHA should include information in the report required by House Bill 2015 (2025) detailing how options identified would impact regional equity of service availability.**
- **Recommendation 5: OHA should provide regular reporting on implementation of new CFAA agreements during the initial term (anticipated to be six years). Reporting should include information on how community mental health programs (CMHPs) are complying with Resilience Outcomes Analysis and Data Submission (ROADS) reporting requirements.**
- **Recommendation 6: OHA should align performance metrics across CHIP behavioral health plan requirements and ROADS reporting requirements for county mental health programs, with specific attention to the coordination of services for members with an SMI diagnosis or with a history of court-ordered behavioral health treatment.**

Long Term Recommendations

With near term goals focused on existing efforts, the Task Force turned to the outcome goal of defining a vision for the state's behavioral health system to guide additional recommendations with a longer time horizon. These recommendations acknowledge both the urgency of H.R. 1 compliance and expectations for changes to the CFAA. These recommendations seek to ensure that the improvements

anticipated by changes in the CFAA are implemented in a way that benefits transparency and accountability of funding within the system.

Transparency

Long Term Recommendation 1: OHA should leverage reporting required by the updated CFAA to create transparency into behavioral health system expenditures.

Oregon's behavioral health system is supported by many funding conduits, requiring that funds be braided and blended together to provide a continuum of care. Task Force members identified a need to improve insight into how behavioral health funding conduits are appropriated and utilized across the system. Task Force members assert that greater transparency into the flow of funds could improve both coordination among system partners, as well as the efficacious use of funds and other resources within the state's behavioral health system. Better insight into how funds are spent could improve the ability to identify gaps in the care continuum and allow for more informed prioritization of resources.

OHA has begun to provide some of this insight via the Behavioral Health Housing and Licensing Capacity Investments Dashboard ("Dashboard"). The Dashboard is intended to provide insight into how investments are increasing capacity to behavioral health housing in Oregon communities. The Dashboard currently provides capacity information that may be viewed by county, trauma region, and facility type, including projected capacity through 2026. By offering this level of detail into projected behavioral health capacity, future investments may be better informed about specific areas of outstanding need.

Task Force members expressed optimism that the updated planning and reporting anticipated to be included among the changes to the CFAA would allow additional detailed reporting on behavioral health investments and system capacity. As counties braid and blend funds, including General Fund dollars through the CFAA, Medicaid funds (both direct and indirect), and grant funds, Task Force members were hopeful that the reporting included in the updated CFAA could be captured in a funding-focused dashboard to allow for greater financial transparency into behavioral health expenditures. The Task Force believes that expanding transparency into the utilization of behavioral health funds could enable better informed investments and resource allocation within Oregon's behavioral health system.

Accountability

Long Term Recommendation 2: OHA should use updated reporting to both efficiently track the financial health of the behavioral health system and hold partners accountable for achieving desired outcomes.

Updates to CFAA reporting are intended to focus on achieving desired outcomes. This should allow for better accountability among behavioral health system partners, allowing OHA to monitor attainment of desired outcomes. Increased emphasis on the local plan and financial reporting through the updated CFAA should enable system partners to be more accountable for achieving the priorities articulated in the local plan. This reporting shift should also enable more flexible and efficacious resource allocation as expenditures are less activity-driven and more outcome-based.

Task Force members viewed updated CFAA reporting favorably and saw the potential for changes to complement consolidated planning requirements in a way that could create useful information and data. Task Force members expressed hope that the consolidated planning required by updated CFAA local plans and through House Bill 2208 (2025) could be used to ensure that systems and providers are held accountable for achieving desired outcomes while reporting only necessary, nonduplicative data. Through improved reporting, available data may be used to efficiently monitor the health of the system and hold partners accountable for achieving desired outcomes. As such, the Task Force advocated that OHA be sufficiently resourced so that reported data may be efficiently and effectively utilized within the system.

Conclusion

The Joint Task Force on Regional Behavioral Health Accountability respectfully submits this report and recommendations therein to the interim committees of the Legislative Assembly related to health. The Task Force requests that the Legislative Assembly and affected agencies consider these concepts, to the extent practicable, in the upcoming 2026 legislative session and beyond.

Appendix A: Needs Assessment

See next page.

Memorandum

PREPARED FOR: Co-Chairs Lieber and Anderson and Members of the Joint Task Force on Regional Behavioral Health Accountability
DATE: December 9, 2024
BY: LPRO Staff
RE: Needs Assessment – Results Summary

The Joint Task Force on Regional Behavioral Health Accountability (JTFBHA) was established through House Bill 4002 (2024) to develop legislative recommendations for improving various aspects of Oregon's behavioral health system. JTFBHA members were surveyed to gather preliminary information regarding member perspectives on key components of HB 4002 as they pertain to the work of the Task Force. This memorandum contains a qualitative summary of member responses to inform initial planning and scoping conversations.

This summary document provides a snapshot of *individual* ideas, priorities, and needs identified by members of the Task Force. Views conveyed in this document have not yet been discussed among the group and therefore do not reflect consensus. Official Task Force recommendations will be developed at a later date.

Vision and Goals for the Task Force

Task Force members shared a wide range of perspectives regarding their vision for success and priorities for the work of the group. These fell into several categories:

- outcomes that members would like to see as a result of their work,
- process goals for the Task Force, and
- initial priorities to explore when developing recommendations.

Outcomes Goals for the Task Force

Members indicated the following outcomes that they would like to see the group achieve through their work together.

- **Concrete recommendations with measurable outcomes.** Members described a shared goal of collaboratively reaching agreement on a set of **evidence-based** recommendations to the legislature informed by relevant data and research. Task Force recommendations should include an **appropriate level of detail** and a plan for evaluation through identifying **measurable outcomes**, including clear processes to measure outcomes and evaluate success. The recommendations should also consider implications and consequences for stakeholders at different levels of the behavioral health system and include a plan and/or resources to support implementation.
- **Measurable improvements across Oregon's behavioral health system,** including increased accessibility, availability, and timeliness of statewide behavioral health services. Improvements should move toward a statewide

behavioral health system that is responsive to local and regional needs. Several priority areas for improvement were identified:
    - *Client/patient*. Including barriers and time to care, client engagement and retention within the system, supporting clients in moving between levels of care, and clients within the criminal justice system.
    - *Organization and provider*. Including pathways to increase capacity and sustainably scale care, redundancies and administrative burden, as well as accountability for providing services.
    - *Payor and governance.* Including transparency around funding and system performance, defining scope and responsibilities for payors and oversight entities within funding resources, as well as public data reporting through dashboards.
- **A vision for Oregon's behavioral health system.** Creating an overarching vision or roadmap for Oregon's behavioral health system to guide the work of the Task Force.

Process Goals

Members identified several goals for the group to consider when approaching their work.

- **Defining the problem and operationalizing key terms.** Establishing a shared understanding of the problem to be solved by the Task Force, agreeing upon definitions for key terms (e.g. accountability, collaboration) and operationalizing those terms for shared use.
- **Agreeing to realistic goals.** Breaking the work into manageable steps with timelines that account for process steps, tracking progress, identifying "low-hanging fruit" that can be easily addressed through recommendations, and focusing on what is necessary and achievable within the timeline.
- **Understanding the current landscape** of behavioral health funding and governance. Prioritizing decision making based available information.
- **Balancing information gathering with meaningful discussion**. Members expressed the need to inform their work by learning from relevant experts and organizations, while also noting the need to move quickly into focused discussion to make progress on developing recommendations within the timeline.

Initial Member Priorities

Members were asked for their priorities for the Task Force. One or more members identified the following topics as priorities.

Exhibit 1. Initial Member Priorities for Task Force Work

Priority Areas	
Achieving a statewide behavioral health system	• Develop robust service delivery models and ensure the full spectrum of services is available to all clients in the community regardless of location • Address barriers to care and service gaps in regionally appropriate ways • Reduce silos across the continuum to support collaboration • Consider regional needs, including those of specific population groups, to improve accessibility and equity • Expand awareness and availability of medications for opioid use disorder (MOUD) to reduce stigma and increase access
Aligning governance and funding structures	• Align local, regional, and state governance structures to enhance collaboration • Enhance regulatory oversight and accountability for how providers and organizations use resources • Streamline funding sources and processes where possible and reduce administrative burden on providers • Create system transparency around funding and oversight
Increasing system transparency	• Map the current system(s) and investments • Identify meaningful and measurable outcome measures to evaluate system performance improvements • Ensure robust and transparent data collection and analysis to promote accountability • Create publicly facing data dashboards and centralized resources to support clients and providers

Scoping the Work of the Task Force

Task Force members were asked to define key terms and identify needs and opportunities for the four major focus areas for their work: collaboration and accountability, equitable outcomes, cost efficiencies, and expanding access to medications for opioid use disorder (MOUD).

Collaboration and Accountability

Defining Collaboration

Task Force members generally agreed that collaboration meant all parties within and across each level of the behavioral health system working together toward **shared goals**, facilitated by **communication** and **clearly defined roles** for each party. Members identified potential shared goals, including improving care quality, access, and client outcomes, and increasing accessibility. It was also noted that increasing

collaboration should benefit all parties without adding unnecessary burden to any level of the system.

Some members noted the importance of including outside sectors in system collaboration, including social services such as housing and employment services, to support care transitions within and out of the system.

Defining Accountability

Members had similar perspectives on how to define accountability for the work of the Task Force, generally describing accountability as it relates to the effective and efficient use of public funds. However, members differed in their ideas of how and where to apply the concept of accountability across levels of the system.

Some members described the need for accountability to **clients**, for the provision of services, process of receiving care, and associated outcomes. Some members described the need for accountability to fall at the **provider or organizational** level, with providers being accountable for providing care that achieves intended outcomes. Several members described accountability as applying to the **regulatory or governance** level, where oversight entities such as OHA are responsible for justifying process changes, avoiding adding burden for other parts of the system, and providing funding in a strategic and timely manner. Some members identified a combination of these perspectives, describing accountability as being necessary at all levels.

Needs and Opportunities Related to Collaboration and Accountability

Members were asked to identify specific needs and opportunities related to improving collaboration and accountability across programs and funding within Oregon's behavioral health system.

Members expressed a wide range of needs and opportunities to improve collaboration and accountability, falling into several categories, including **understanding the system and identifying gaps**, **aligning system components, improving coordination and communication, increasing transparency**, and **balancing requirements with burden.** These ideas are explored in Exhibit 2.

Exhibit 2. Needs and Opportunities Related to Improving Collaboration and Accountability

Element	Needs and Opportunities to Improve Collaboration and Accountability
Understanding the system and identifying gaps	• Map the current behavioral health system (including flow of resources and services), use data to target areas for improvement • Identify where services are available and reasons for remaining capacity • Establish plans for accountability and consider how to allocate accountability across the system
Aligning system components	• Consider how to align regulatory agencies, services (such as crisis, involuntary, and forensic), agency policies and outcomes, behavioral health and CCOs, reporting requirements, as well as payors and payment mechanisms • Build consensus around shared goals and operational strategies to achieve those goals, consider aligning behavioral health system activities with OHA strategic goals • Create regional continuums of care, utilize peer services as appropriate to fill gaps
Improving coordination and communication	• Create opportunities for relationship building and improved communication between counties, as well as between counties and system partners • Create educational opportunities to raise awareness of what successful programs are doing • Create a central hub of information on programs, requirements, and referral processes • Clarify processes so that compliance can be maintained in the event of staff turnover
Increasing transparency	• Identify how public funds are used across the behavioral health system and what oversight exists • Create transparency in programming and spending, including program successes and failures • Explore statewide data reporting infrastructure and dashboards • Create transparency around funding and limit competition among system members
Balancing requirements with burden	• Prioritize regulatory decisions that are practicable at the service level without adding undue administrative burden • Address staffing capacity to support care coordination, data tracking and reporting, and increasing timely access to care • Establish appropriate metrics and reporting processes that avoid duplication

Equitable Outcomes

Members defined equitable outcomes in similar ways, noting the need for all Oregonians to have access to the full continuum of behavioral health services and for the system to actively work to eliminate disparities across population groups.

Several members noted that the process for obtaining treatment may need to adapt to serve the unique needs of the clients, offering flexibility to meet clients where they are. Several members noted that achieving equitable outcomes will require strategic allocation of resources to ensure that all populations in a given region are able to access care.

Members identified a wide array of potential population groups and treatment outcomes for the Task Force to consider when developing recommendations about achieving equitable outcomes; these are listed in Exhibit 3, below, in no specific order.

Exhibit 3. Potential Populations and Treatment Outcomes

Population considerations	Older adults, youth/teens, individuals with physical disabilities, individuals with intellectual and developmental disabilities (IDD), racial and ethnic minorities, LGBTQ+ populations, urban/rural/remote residents, dually diagnosed and those with serious and persistent mental illness (SPMI), forensic populations
Treatment outcomes	Outcomes from statewide treatment centers, rating scales (Acorn, FIT), symptoms and symptom rating scales, quality of life scales, emergency department visits, crisis team encounters, hospitalizations, arrests, medical costs, education, employment, housing status, drug testing (for abstinence-focused programs), treatment engagement (attendance), time to access care, achieving projected network adequacy, infrastructure development, treatment completion, overdose rates, suicide rates, health coverage continuity and change, health outcomes, access to primary care, transition to lower acuity levels of care, length of stay in higher acuity levels of care, interactions with law enforcement, incarceration, recidivism, outpatient services utilization, peer support utilization

Needs and Opportunities Related to Equitable Outcomes

Members were asked to identify specific needs and opportunities related to ensuring equitable health outcomes within Oregon's behavioral health system. Members expressed a wide range of needs and opportunities for ensuring equitable outcomes that could be grouped into two overarching categories, **considerations for services** and **considerations for data**.

Exhibit 4. Needs and Opportunities Related to Ensuring Equitable Outcomes

Element	Needs and Opportunities Related to Ensuring Equitable Outcomes
Considerations for services	• Educate to promote a culture of equity from leadership, create a foundation of culturally-competent and trauma-informed care • Adapt one-size-fits-all service approaches where possible, ensure that processes and requirements can be flexible to meet the needs of the client • Consider that not all populations respond to treatment in the same way, explore culturally-specific approaches • Alternate payment models, pilot programs, and innovative care models to support services • Update OARs to account for small business nature of providers • Allocate sufficient resources to programs that serve diverse communities, provide adequate funding to support programs engaged in this work • Ensure access to the full spectrum of behavioral health services across geographic areas and for all populations (regardless of acuity), identify alternate pathways to care if service cannot be accessed in the community • Address staff capacity to support care coordination and navigation services
Considerations for data	• Meaningful disaggregation of data for analysis of outcomes; tracking data at a granular level can contribute to administrative burden • Consider a statewide, public-facing reporting system for outcomes measurement • Address staff capacity to support data collection and tracking • Understand currently available data and what is needed for tracking • Avoid duplication of prior work

Cost Efficiencies

Members were asked to define cost efficiencies within the context of the Task Force's work. Most members shared a similar understanding of cost efficiencies as using public funds in ways that are **strategic**, **efficient**, and **effective** toward desired outcomes, while **reducing unnecessary costs** and working toward sustainability and economies of scale in the longer term.

One member noted that cost efficiencies would come from an environment that incentivizes a network mentality; another identified the importance of having sufficient resources to prevent clients from future avoidable care. Two members specified the importance of alternate payment models in achieving cost efficiencies. One member noted that achieving cost efficiencies might require offsetting higher costs in some parts of the system against lower costs in others; another noted that due to historic underfunding, scaling services to the level needed will take time to result in obvious cost savings.

Members were asked to identify whose costs and what costs should be considered by the Task Force, as well as what the Task Force might consider for measuring cost efficiencies. Their initial ideas are summarized in Exhibit 5 below.

Exhibit 5. Identifying and Measuring Costs

Whose costs	OHA, CMHPs, providers, healthcare system partners, clients, governance (city, county, state), the criminal justice system
What costs	Program costs (operational, service provision), Medicaid costs (operating OHP, social service costs of related interventions such as housing, education), costs to the health system (emergency department visits), costs to the criminal justice system, costs by geographic area
Considerations for measuring costs	• Measuring cost efficiency in behavioral health is challenging and may require a unique approach • The true cost of providing services at the level required to meet statewide needs is unknown, making it challenging to identify cost inefficiencies • Costs need to account for client movement between levels of care • Consider measuring returns on investments in evidence-based programs • Consider identifying regional benchmarks based on service gaps and community needs, scale continuum of care based on regional needs • Consider measuring service costs by groups to identify average costs • Need to consider the availability of data, means of collection and analysis

Establishing Broad Access to MOUD

Task Force members shared similar ideas when asked to identify factors that are currently limiting access MOUD across Oregon. Several key themes emerged across responses:

- **Stigma and education** was identified by multiple members as a prominent barrier to MOUD access. A lack of education around the use of MOUD was also noted as contributing to ongoing stigma and other barriers.
- **Limited access to MOUD** was highlighted by multiple members, including myriad factors contributing to limited access: a lack of prescribing providers, limited capacity of existing providers, restrictions on dispensing locations, and challenges with referral to care and obtaining an order for medications. Access to MOUD was also described as limited within certain settings, including jails and prisons, as well as in rural locations.
- **Insufficient coverage and reimbursement** was indicated as another barrier that kept potential providers from prescribing MOUD. A payor may only cover some types of MOUD or may decline to cover medication as a standalone treatment; this can complicate prescribing practices and further limit client access.

- **Regulatory restrictions** at the federal level were noted as a barrier to expanding access across Oregon.
- **Other barriers** that did not align with other factors included challenges with medication effectiveness due to the existence of more potent opioids and polysubstance use, a lack of programs that offer MOUD in combination with therapy, and limited availability of MOUD offered as a standard of care or as a part of harm reduction services.

Needs and Opportunities for Improving Access to MOUD

Task Force members were asked to identify specific needs and opportunities related to expanding broad access to MOUD. Responses have been organized in Exhibit 7 below by type of barrier.

Exhibit 7. Needs and Opportunities Related to Improving Access to MOUD

Barrier	Needs and Opportunities for Expanding Access to MOUD
Stigma and education	• Expand education on MOUD and support for prescribers • Target MOUD-specific training and education to geographic areas currently resistant to offering medication services • Increase education in primary care settings with pharmacy dispensing
Limited access to MOUD	• Increase supplies at prescribing locations, maximize federal allowances • Improve the client referral process • Consider CCO engagement and state licensing • Tailor education efforts to primary care and other providers • Integrate MOUD into standard of care practices • Expand mobile distribution and access points, increase workforce with prescribing power
Insufficient coverage and reimbursement	• Identify ways to offset startup costs for dispensing, expand services through grant programs • Explore Opioid Settlement Board funding as a sustainable source for providers without needing to increase client volumes • Consider financial viability for CMHPs to dispense medications independently from other services • Expand coverage and reimbursement for the full range of MOUD products • Consider alternate payment models
Regulatory restrictions	• Support federal rule modernization and reforms to allow access through Medicaid
Other barriers	• Identify community-specific needs and develop strategies to address them • Explore ways to increase client affordability by offsetting over-the-counter costs

Task Force Needs and Resources

When asked what would help the group develop recommendations in each of the four focus areas, Task Force members identified several types of information that would be helpful to their work:

- **Expert recommendations**. Members suggested they learn various topics from groups and subject matter experts. These included presentations on MOUD access and considerations.
- **Data sources and availability**. Members identified potential data sources to inform discussions and decision making: OHA providers, CCOs, hospitals, law enforcement
- **Hearing perspectives from the behavioral health system**. These included organizations, providers, clients, agencies, and governance entities.

Members identified types of information that would be helpful and provided resources that they wanted to share with the group; resources are listed by topic in Exhibit 8 below.

Exhibit 8. Member Suggested Resources by Topic

Resource Type	Details
Collaboration and Accountability	
Groups	• Local Alcohol and Drug Planning Committee (LAPDC) of Jackson County • GAINS Regional Behavioral Health Resource Centers Workgroup (report forthcoming, TBD) • American Society of Addiction Medicine (ASAM) • CARF International
Reports and Data	• HHS Roadmap for Behavioral Health Integration • Oregon Heath Authority Behavioral Health Residential+ Facility Study • System of Care Advisory Council Report (2023 and 2024) • Protecting the Nation's Mental Health (CDC) • Community Information Exchange to Support Oregon's 1115 Medicaid Waiver (OHA) • Commitment to Change Workgroup Final Report (OJD) • 2021 Multnomah County Corrections Grand Jury Report • Ombudsman reports • CMHP analyses: core services study, workforce vacancy analysis, budget trends)
Equitable Outcomes	
Groups	• Oregon Council for Behavioral Health (OCBH) • National Alliance on Mental Illness (NAMI) • Oregon Tribes • Treatment organizations and providers, clients and peers • Public testimony on accessibility and awareness of treatment programs • Other health equity focused groups

Reports and Data	• Oregon Substance Use Disorder Services Inventory and Gap Analysis (ADPC) • Existing population/demographic and treatment outcome data from various sources: County Financial Assistance Award (CFAA), CCOs, CCBHCs
Cost Efficiencies	

Groups	• Milliman Reports
	  ○ Behavioral Health Conditions and Healthcare Spending (2020)
	  ○ Potential Economic Impact of Integrated Care (2018)

Reports and Data	• Care utilization reports, referral metrics, OHA data, treatment organizational data, public insurance spending and participation
Expanding Access to MOUD	
Groups	• The Oregon Psychiatric Access Line (OPAL) • Oregon AIDS Education and Training Center (AETC; for best practices, lessons learned) • Regence Blue Cross Blue Shield Behavioral Health Toolkit • Oregon State Pharmacy Association

Reports and Data	• American Association of Psychiatric Pharmacists (AAPP)
	  ○ 2025 Health Policy Agenda
	  ○ AAPP Response to Tonko and Turner on MOUD Access Post MAT Act (November 2024)
	• Recidivism rates, hospital and emergency admissions, MOUD utilization rates

About this Document

This document was prepared by the Legislative Policy and Research Office (LPRO). LPRO provides centralized, nonpartisan research and issue analysis for Oregon's legislative branch. LPRO does not provide legal advice. LPRO publications contain general information that is current as of the date of publication. Subsequent action by the Task Force may affect accuracy.

LPRO surveyed members in November 2024 using a written questionnaire. Fourteen members responded. LPRO analyzed responses using an inductive qualitative coding approach. Content was thematically organized to highlight areas of agreement or disagreement in the group. This analysis summarized content for brevity but did not rank or prioritize content for inclusion and aimed to reflect the full range of responses.

LPRO has not independently verified the accuracy of any claims in this document and as a nonpartisan agency has no position on the merits, appropriateness, feasibility, or potential impact of any ideas expressed herein.

Appendix B: Task Force Workplan, Presentations, and Materials

TABLE 1 TASK FORCE WORKPLAN, PRESENTATIONS, AND MATERIALS

Meeting Date	Topics Discussed (Hyperlinks to Materials)
November 1, 2024 Planning	**Organizational Meeting** o Adoption of Committee Rules, Review of Operating Procedures, Selection of Chair(s) **Informational Meeting** • **Public Meeting and Records Review** Erin Jansen, Legislative Counsel (*pre-recorded*) • **Review of HB 4002 Requirements and Timeline** Legislative Policy and Research Office • **Preview of Needs Assessment** Legislative Policy and Research Office **Meeting Materials** • 2023-24 Interim JTFRBHA Task Force Operating Procedures • 2023-24 Interim JTFRBHA Task Force Rules (proposed) • Joint Task Force on Regional Behavioral Health Accountability - LPRO (presentation) • JTFRBHA Needs and Opportunities Survey (final) • Overview of Public Records Requirements - Erin Jansen (video) • Public Records and Meetings training 2024 Task Forces - Legislative Counsel (presentation)
December 9, 2024 Planning	**Informational Meeting** • **Needs Assessment Results and Discussion** LPRO Staff

	• **Oregon Behavioral Health Landscape Overview** Ebony Clarke, Director, Behavioral Health Division, Oregon Health Authority • **Overview of SAMHSA Data on Behavioral Health Care** LPRO Staff • **Task Force Discussion** Co-Chairs Lieber and Anderson **Meeting Materials** • 11-1-24 JTFBHA Meeting Summary • Joint Task Force on Regional Behavioral Health Accountability - staff (presentation) • Needs Assessment Results and Discussion - staff (memo) • Oregon Behavioral Health Landscape Overview - Ebony Clarke (presentation) • Oregon Behavioral Health Landscape Overview - Ebony Clarke (Update on Recommendations) • Overview of SAMHSA Data on Behavioral Health Care - staff (presentation)
January 6, 2025 Planning, Information Gathering	**Informational Meeting** • **Oregon Behavioral Health Coordination Center** Matthias Merkel, Senior Associate Chief Medical Officer, Capacity Management and Patient Flow OHSU Health Stephanie Gilliam, Director of OHSU Mission Control • **Mental Health Treatment Capacity Model** Alexandra Nielsen, Modeling and Simulation Engineer Peter Graven, Director of the OHSU Office of Advanced Analytics • **Task Force Workplan and Discussion** Co-Chair Anderson and Task Force Members **Meeting Materials** • 12-9-24 JTFBHA Meeting Summary

	• Joint Task Force on Regional Behavioral Health Accountability - staff (presentation) • Mental Health Treatment Capacity Model - Nielsen (presentation) • Oregon Behavioral Health Coordination Center - Merkel (presentation) • Overview of SAMHSA Data on Behavioral Health Care - staff (memo)
May 2, 2025 Planning, Information Gathering	**Informational Meeting** • **Perspectives on Oregon's Health Funding Landscape** LPRO Staff • **Discussion: Behavioral Health System Funding** Task Force • **Task Force Goals and Next Steps** Co-Chairs Lieber and Anderson **Meeting Materials** • Joint Task Force on Regional Behavioral Health Accountability - staff (presentation)
July 7, 2025 Information Gathering	**Informational Meeting** • **Governor's Office Regional Behavioral Health Tables** Amy Baker, Behavioral Health Initiative Director, Office of Governor Tina Kotek • **Task Force Discussion** Co-Chairs & Task Force • **County Financial Assistance Agreement (CFAA) Updates** Jon Collins, Behavioral Health Deputy Director, Operations and Strategy, Oregon Health Authority Christa Jones, Behavioral Health Deputy Director, Service Delivery, Oregon Health Authority • **Task Force Discussion and Work Plan** Co-Chairs & Task Force

	• **2025 Legislative Session Highlights** LPRO Staff **Meeting Materials** • 11-1-24 JTFBHA Meeting Summary • 12-9-24 JTFBHA Meeting Summary • 1-6-25 JTFBHA Meeting Summary • 5-2-25 JTFBHA Meeting Summary • 7-7-25 JTFBHA Staff Presentation • County Financial Assistance Agreement (CFAA) Updates - Jon Collins (presentation) • Governor's Office Regional Behavioral Health Tables - Amy Baker (presentation)
August 4, 2025 Information Gathering	**Informational Meeting** • **Perspectives on Oregon's Behavioral Health Funding Landscape** LPRO Staff • **Colorado's Behavioral Health Administrative Service Organization (BHASO) Model** Kelly Causey, Deputy Commissioner, Colorado Behavioral Health Administration (BHA) Alyssa Hetshel, BHASO Division Director, Colorado BHA Keyla Martin, BHASO Administrative Unit Manager, Colorado BHA Joseph (Joey) Pachta, BHASO Service Unit Manager, Colorado BHA George Laumeyer, Public Information Officer, Colorado BHA Meg Taylor, Chief Behavioral Health Officer, Rocky Mountain Health Plans • **Arizona's Health Care Cost Containment System (AHCCCS) Regional Behavioral Health Authority (RBHA) Model** Dr. Theresa Costales, Chief Medical Officer, AHCCCS CJ Loiselle, Assistant Director, Division of Behavioral Health and Housing, AHCCCS

	Meeting Materials • 8-4-25 JTFBHA Staff Presentation • Arizona AHCCCS ACC-RBHA system and funding 8-4-2025 • FINAL BHASO Oregon BH Task Force Presentation 8.4.25
September 8, 2025 Information Gathering	**Informational Meeting** • **Revised Task Force Problem Statement** LPRO Staff • **Minnesota's Adult Mental Health Initiative (AMHI) and Community Support Program (CSP) Model** Pam Sanchez, Supervisor, Behavioral Health Administration (BHA), Minnesota Department of Human Services (MDHS) Breanna Bertozzi, AMHI & CSP Program, Policy & Grant Management Lead, BHA, MDHS Chris Ederer, AMHI & CSP Program, Policy & Grant Management Lead, BHA, MDHS • **Other Regionalized/Coordinated Models** LPRO Staff • **Task Force Discussion** Co-Chairs LPRO Staff **Work Session** • **Review and Approval of the Preliminary Report** **Meeting Materials** • 9-8-25 JTFBHA Staff Presentation • Minnesota's (AMHI) and (CSP) Model - Pam Sanchez (presentation) • JTFBHA Interim Status Update September 2025 Final Draft • JTFBHA Interim Status Update September 2025 FINAL
October 6, 2025	**Informational Meeting**

Discussion and Deliberation	• **Task Force Recommendations Discussion** LPRO Staff Co-Chairs Task Force Members **Meeting Materials** • JTFBHA Draft Recommendations Proposal • JTFBHA LPRO Slides 10.6.25
November 3, 2025 Discussion and Deliberation	**Work Session** • **Adoption of Task Force Recommendations, Submission of Final Report** **Meeting Materials** • JTFBHA Final Report November 2025 Draft • JTFBHA Final Report November 2025 Final TO BE UPDATED FOLLOWING 11/3 MEETING

Appendix C: Oregon's Behavioral Health Funding Conduits

The table presented in Appendix C (see next page) presents information about notable funding conduits within Oregon's public behavioral health system identified by the LPRO research team. The term "funding conduit" aims to capture the pathway that dollars flow along from original source to the point of care/service.

Conduits were identified for inclusion by first scanning all references to behavioral health funding included in the Governor's budget, before narrowing the list through discussion with Task Force members and Co-Chairs. Stakeholder interviews were conducted for each conduit. Additional details regarding requirements for collaboration were compiled through review of statute and any other existing regulations.

Labels can describe various elements of a conduit, including funding sources (e.g. alcohol sales tax); the agency, program or trust receiving the funds (e.g. Tobacco Prevention Education Program); and the funding purpose or allocation (e.g. "OHP open card"). Labels were selected for clarity and familiarity, rather than a consistent unit of analysis. Some dollars pass through multiple entities; get divided and apportioned out and labels may change along the way. Additionally, the idea of "revenue" versus "expense" is a matter of one's position within the BH funding system.

Funding 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

Oregon's Behavioral Health Funding Conduits, Statutory and Other Collaboration Requirements (Table created August of 2025)		
Description	**Requirement to Collaborate**	**Relevant Policies**
Funding Conduit: Oregon Health Plan Coordinated Care Organization Contracts		
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)

Description	Requirement to Collaborate	Relevant Policies
Funding Conduit: Oregon Health Plan Coordinated Care Organization Contracts		
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"

Description	Requirement to Collaborate	Relevant Policies
Funding Conduit: County Mental Health		
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 (OHP; including CCOs and 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)

Description	Requirement to Collaborate	Relevant Policies
Funding Conduit: County Mental Health		
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)

Description	Requirement to Collaborate	Relevant Policies
Funding Conduit: Measure 110 Grants		
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

Description	Requirement to Collaborate	Relevant Policies
Funding Conduit: Oregon Health Plan Long Term Services and Supports (1915i) and Substance Use Disorder (SUD) Waiver Services (1115)		
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)

Description	Requirement to Collaborate	Relevant Policies
Funding Conduit: Oregon Health Authority Directed Payments		
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. See 42 CFR Parts 438 and 457. CCO Contract Exhibit C relates to directed payment authorities and requirements and cites related ORAs. The 2025 Federal Budget Reconciliation Bill limit states' ability to implement new directed payments and will phase in reductions in existing state directed payments that exceed published Medicare payment rates.

Description	Requirement to Collaborate	Relevant Policies
Funding Conduit: Alcohol and Sales Taxes		
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).	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).
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)

Description	Requirement to Collaborate	Relevant Policies
Funding Conduit: Opioid Settlement Grants		
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 its 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.

Description	Requirement to Collaborate	Relevant Policies
Funding Conduit: Oregon State Hospital Funding		
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)

Description	Requirement to Collaborate	Relevant Policies
Funding Conduit: SAMHSA Block Grants		
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

Description	Requirement to Collaborate	Relevant Policies
Funding Conduit: State Opioid Response Grant		
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)

Description	Requirement to Collaborate	Relevant Policies
Funding Conduit: Tobacco Prevention Education Fund Grants (Tobacco Tax Revenues, Settlement)		
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: 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; public health equity grants for commercial tobacco prevention education; and Regional Health Equity Council grants for regional prevention work.	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

Description	Requirement to Collaborate	Relevant Policies
Funding Conduit: Tribal Behavioral Health		
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	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

department, and schools. They also receive county data on overdoses to inform program planning.		
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

Appendix D: Acronyms Used in This Report

AHCCCS – Arizona Health Care Cost Containment System

ADPC – Alcohol and Drug Policy Commission

AMHI – Adult Mental Health Initiative (Minnesota)

AMPHAC – Addictions and Mental Health Planning and Advisory Council

BHASO – Behavioral Health Administrative Service Organization (Colorado)

BHRN – Behavioral Health Resource Network

CCO – Coordinated Care Organization

CFAA – County Financial Assistance Agreement

CHIP – Community Health Improvement Plan

CMHP – Community Mental Health Program

DAS – Department of Administrative Services

DTRSF – Drug Treatment and Recovery Services Fund

HCBS – Home and Community-Based Services

HRS – Health-Related Services

LMHA – Local Mental Health Authority

LPRO – Legislative Policy & Research Office

MHADS – Mental Health Alcoholism and Drug Services Account

ODHS – Oregon Department of Human Services

OHA – Oregon Health Authority

OHP – Oregon Health Plan

OLCC – Oregon Liquor Control Commission

OSH – Oregon State Hospital

PCG – Public Consulting Group, LLC

RAE – Regional Accountable Entities (Colorado)

RBHA – Regional Behavioral Health Authority (Arizona)

ROADS – Resilience Outcomes Analysis and Data Submission

SAMHSA – Substance Abuse and Mental Health Services Administration

SDP – State-Directed Payment

SMI/SPMI – Serious Mental Illness/Serious and Persistent Mental Illness

SOR – State Opioid Response Grant Program

SUD – Substance Use Disorder

TMSA – Tobacco Master Settlement Agreement

TPEP – Tobacco Prevention Education Program