Oregon Adult Mental Health Statewide Reform Strategy

A Briefing for the Governor

1. Executive Summary

Oregon spends comparatively heavily on behavioral health yet ranks near the bottom nationally (roughly **42nd**)[1] on overall system performance. The problem is **structural**, not a deficit of knowledge or money: fragmented services, diffuse governance, chronic undercapacity, legal constraints on the state hospital, workforce shortages, gaps in substance use policy, and an affordable-housing system in crisis.

Reform is organized into five workstreams — **Governance, Capacity & Workforce, Behavioral Health Housing, Forensic & Legal System, Prevention & Social Determinants** — sequenced across three two-year phases aligned to legislative sessions. The priority population is people with **high acuity behavioral health** conditions (HABH), with explicit recognition of substance use comorbidity.

These workstreams describe one system, not five. The people this strategy is written for move continuously between health care, the criminal justice system, and housing. The person in a jail cell awaiting an aid-and-assist evaluation and the person boarding in an emergency department are very often the same person at different points in the same untreated illness. Oregon's failure is not that any one of these systems performs badly in isolation, but that no one is accountable for a person's path across all three. Reform therefore requires a connected continuum: prevention, outreach, crisis response, treatment, housing, and long-term management and recovery under a single, empowered statewide system leader who is directly accountable for outcomes across it.

Timing is the strategy. An estimated **$11.6 billion in federal health-care funding losses over three biennia** will otherwise force reactive cuts rather than redesign.[2] The aim is to secure decisive budget and policy commitments in the **2027 session** — a "wedge" that locks in a longer-term rebuild — and to size those commitments from system-demand modeling rather than national per-capita benchmarks.

High level recommendations

- Fixing the broken behavioral health system must start with **addressing the fragmented governance model,** empowering a single statewide system leader, a regionalized model and clarifying accountabilities of entities within the current system while reducing complexity and duplication.
- **People who enter the system through the aid-and-assist process have serious mental illness and need treatment**; for many, that need went unmet long before a criminal charge existed. Building treatment capacity for this population in the community and in settings other than the State Hospital is part of the same continuum as civil care, and will in turn release State Hospital capacity for people requiring civil commitment.
- **Primary Care and behavioral health integration** are crucial to maximize capacity, continuity and effective hand-offs between the systems. Integration will require incentives for primary care

practices, continuation and expansion of programs for behavioral health in primary care and pathways for people to move between systems as needed, including as part of a person's recovery path.

- **Incentives must be aligned across the system**, including for behavioral health housing providers, so all parts of the systems are integrated and working to achieve the same outcomes for Oregonians. Aligned incentives are necessary but not sufficient: they work where a single accountable leader can also direct action across the systems concerned.
- **Reduce Administrative Burden.** Direct the Oregon Health Authority to eliminate duplicative administrative requirements, standardize behavioral health program and reporting requirements, and streamline contracting, licensing, and data-sharing. Reducing unnecessary bureaucracy will increase provider capacity, improve access to care, and lower system costs.

Report scope

In scope for this strategy are:

- Community hospitals and community mental health centers
- Residential treatment (mental health and SUD) and withdrawal management centers
- Crisis and acute services (e.g., drop-in and 23-hour models)
- Secure and non-secure 24-hour facilities
- Behavioral Health Housing, including permanent supportive housing (PSH) designed for this population
- Behavioral health outpatient care, including intensive outpatient services such as Assertive Community Treatment (ACT) and Intensive Case Management (ICM)
- Behavioral health delivered in primary care

The population in-scope for this strategy is **adults with high acuity behavioral health (HABH) conditions**, specifically psychotic disorders, stimulant use disorder and opioid use disorder**.** Substance use disorder is scoped as a comorbidity rather than a stand-alone primary diagnosis for this strategy, both to avoid scope drift and because, clinically, near-universal trauma and comorbidity make "SUD-only" a difficult category. However, people with a stimulant use disorder (StUD) should be noted as a population with significant behavioral health needs who are often under-served by the current system, are associated with significant system disruption and experience poor outcomes.

This strategy focuses on the **adult population** but recognizes the need for a dedicated piece of work to also evaluate the **children's behavioral health system** and make appropriate recommendations for improvement. This work could be carried out by the System of Care Advisory Council (SOCAC).

2. Our system today is broken

Oregon has one of the highest per-capita rates of state mental health spending in the country.[3] Even still, Oregon ranks 51st of 51 (50 states and DC) on MHA's prevalence of mental illness measure, while ranking 42nd for overall system performance, even as recent investment has driven a marked improvement in access rankings relative to other states.[4] Oregon has a system that struggles to deliver timely, coordinated, effective care, especially for people with severe mental illness and substance use disorders.

Capacity snapshot

Oregon is materially under-bedded relative to need, and usable capacity is lower still because of workforce shortages and programs operating below their intended purpose.

> **Inpatient psychiatric capacity crisis: in recent weeks, patients in Oregon have lost access to 114 inpatient psychiatric beds.** This includes Cedar Hills (34 beds closed), OHSU Hillsboro Medical Center (21 geriatric psychiatric beds closed) and Rainier Springs, Vancouver WA (59 beds closed). All of these cuts put increasing pressure on remaining inpatient capacity in the Portland Metro region and statewide. Urgent action is needed to prevent further closures and re-establish the capacity needed to meet community needs.

Comparison metrics	Oregon	U.S. Average
Community hospital beds, 2024[5]	1.44 / 1,000	1.96 / 1,000
Mental Health Treatment Facility Beds, 2024[6]	16 / 100,000	30 / 100,000
Civil occupancy of state psychiatric beds, % of total, 2023[7]	7%	48%

The current working estimate is a statewide gap of approximately **486 inpatient psychiatric beds.**[8] Investments to date have only minimally expanded inpatient psychiatric or comparable capacity (including Class I non-hospital facilities), and the focus on forensic demand has left significant gaps for people outside the forensic system.

The current base capacity artifact, the **Public Consulting Group (PCG) report** of August–September 2024, has acknowledged gaps: it contains no distinct lane for ambulatory behavioral health capacity, and none for respite / sub-acute acute care (only hospital vs. secure residential) or permanent supportive housing and community-based clinical and housing support services, and its recommendations may now be stale. An updated PCG report is expected summer 2026, and the OHSU system-demand model in roughly six months.

3. Root causes for our broken system

Oregon's performance reflects interacting structural failures, not a single cause. They compound because they sit in different systems. Each failure below is individually well understood within health care, criminal justice, or housing but no entity is responsible for the points at which they meet, which is where care is lost.

1. **Fragmentation and lack of system coordination.** There is not an established statewide infrastructure needed to clearly define care coordination responsibilities, manage capacity and patient flow, or ensure effective transitions across Oregon's behavioral health system. The combination of direct responsibilities of OHA and ODHS and delegated responsibilities across CCOs, CMHPs, hospitals, and other providers lacks sufficient role clarity and accountability, resulting in fragmented referrals, limited visibility into available capacity, bottlenecks, and discharge delays. While service shortages contribute to system strain, the lack of a statewide infrastructure, including a coordinated framework for care management and system navigation, has compounded these gaps and contributed to ongoing access and flow failures.
2. **Diffuse governance and accountability.** Authority is split across OHA, ODHS, Counties, and CCOs; even well-funded, inclusive planning has failed to produce results. The lived expression of this is that when a person reaches the hospital, no single entity is clearly responsible for finding placement.
3. **Insufficient capacity across levels of care.** Too few inpatient psychiatric beds (especially civil/non-forensic), inadequate intermediate and community options, and limited crisis stabilization — driving ED boarding and crisis cycling. The recent loss of COVID-era hospital-bed flexibilities removed capacity at major hospitals, and further capacity has since been withdrawn: Hillsboro Medical Center is closing its 21-bed geriatric psychiatric unit in September 2026 and Cedar Hills Hospital is cutting 34 behavioral health beds. Both closures were attributed to staffing shortages and unsustainable volumes rather than to the loss of pandemic-era flexibilities, compounding the workforce and financing failures set out below.
4. **Legal constraints on state hospital use.** The 2002 *Oregon Advocacy Center v. Mink* ruling prioritized competency restoration, leaving the Oregon State Hospital largely dedicated to people in the forensic system rather than civil psychiatric care.
5. **Workforce shortages and maldistribution.** Too few prescribers and clinicians, an aging workforce, and concentration in private practice over public safety-net settings — worst in rural areas, where the binding constraints include housing for staff, licensure reciprocity, student-loan limits, and burnout / moral injury when the surrounding system does not function.
6. **Substance use crisis and policy limitations.** Fentanyl and methamphetamine have driven overdose mortality and significant psychiatric comorbidity; Oregon does not allow civil commitment for substance use disorder, and Measure 110 reduced penalties without sufficient treatment infrastructure (its revision/repeal was a positive step).
7. **Housing instability and an affordable-housing system in crisis.** The affordable-housing continuum can no longer absorb unmanaged behavioral-health acuity; eviction-standard liberalization is expected to be lobbied in the next long session, and nonprofit affordable-housing providers are divesting portfolios to commercial owners who manage these tenancies very differently — accelerating downstream acute-care pressure.

8. **Disconnect between spending and outcomes.** Oregon spends more per capita than most states yet ranks near the bottom nationally — reflecting fragmentation, misaligned funding, and weak accountability and performance tracking.
9. **Administrative complexity has become a barrier to care.** Oregon's fragmented governance structure has created a parallel administrative system requiring providers to navigate multiple contracts, funding streams, data systems, reporting requirements, and approval processes. Administrative inefficiency and lack of system alignment are limiting transformation efforts. The cumulative burden reduces the behavioral health workforce's ability to serve patients, increases costs, discourages innovation, and obscures accountability for outcomes.
10. **Commercial health plans and Medicare both underfund behavioral health**. Commercial plans in Oregon do not adequately cover behavioral health services relative to their enrollee base, resulting in a disproportionate reliance on Medicaid to finance mental health care. This coverage gap, rather than a failure of the public system alone, is a structural driver of the behavioral health system's capacity and funding strain. Medicare is the larger blind spot. It is a principal payer for adults with serious mental illness, many of whom qualify through disability rather than age, and both Medicare and Medicare Advantage reimburse well below the cost of delivering care in Oregon.

4. Our proposed future state for behavioral health in Oregon

Oregonians have rapid access to the care they need, when they need it

- **Access to behavioral health care** to treat people early rather than letting them deteriorate, with effective early intervention. *Success will be shown by measured improvement in time to service and reduced psychiatric boarding at all levels of care.*

Care which focuses on achieving and maintaining stability

- **Supportive behavioral health housing** to provide a long-term, stable environment for people with high acuity behavioral health needs and end the cycle of homelessness, victimization, injury and cycling through hospitals. *Success will be shown by a decreased rate of homelessness among this population and improved long-term retention in permanent supportive housing with behavioral health service engagement.*
- **Sustained engagement in clinical care**, especially consistent medication adherence, as a primary driver of stability. This applies broadly to the target population and when this breaks down, behaviors can escalate, leading to higher-acuity care needs and increased housing risk. *Success will be measured through sustained medication possession ratio (MPR) for antipsychotics and medications for opioid use disorder (MOUD), where appropriate.*
- **Reduced crisis cycling and decompensation**. *Success will be shown by reductions in avoidable inpatient admissions, decreased frequency of emergency department use and reduced recidivism rates.*

High-quality clinical care provided in line with evidence-based practice

- **Closing well-documented evidence-to-practice gaps**. For example, roughly 30% of people with schizophrenia have treatment-resistant illness, yet only about 1 in 20 is on clozapine; long-acting injectable antipsychotics are similarly underused. [9]*Success will be shown by closing this gap in medication underutilization resulting in reduced hospitalization, improved housing retention and reduced mortality from suicide.*
- **Fidelity standards with a defined rural-adaptation allowance**, so programs like ACT are not rendered unworkable in low-density counties (e.g. a fidelity team cannot sit idle awaiting a qualifying ACT referral in a frontier county). *Success will be shown by true statewide access to high-intensity programs such as ACT with prioritized permanent housing resources (units/vouchers) for each person supported in the community.*

A behavioral health system that works equitably across the state and for all communities

- **Uniform standards and a guaranteed minimum response everywhere**, even where immediate hospital access differs. A person who would be civilly committed in Portland should be committed under the same standard in Lake County. *Success will be shown by reduced county-level variation at the pre-court stage — the proportion of notices of mental illness that proceed to a commitment hearing, and investigator decision rates by county — rather than by commitment rates alone, which track local hospital availability as much as they track legal standards.*
- **A behavioral health regulatory and operational framework that works for rural communities**, one which recognizes the realities of delivering care across large geographic areas with smaller populations, limited workforce, and fewer available services. Rules designed around urban

systems can unintentionally create barriers in rural areas by requiring staffing models, physical infrastructure, administrative processes, or service volumes that are simply not feasible or sustainable in smaller communities. Rural behavioral health providers should have the flexibility to adapt how services are delivered while maintaining appropriate standards for quality, safety, and accountability. This includes greater flexibility in staffing, facility models, telehealth and mobile services, partnerships across organizations, and the use of regional or shared resources. The goal should not be lower standards for rural Oregon, but different and more flexible pathways to achieve the same outcomes. A one-size-fits-all regulatory approach can ultimately reduce access, undermine workforce stability, and force rural providers to spend scarce resources complying with requirements that do not improve care. Success will be shown by the number of administrative rules given a defined rural-adaptation pathway, a measured reduction in reporting burden for rural providers, and access to high-intensity programs such as ACT in frontier counties under adapted fidelity standards.

- **Culturally specific programming available** so communities across Oregon can reach care that fits their language, culture, and context. This requires considered work and effort to effectively design and implement such programs. *Success will be shown by access to culturally appropriate services with funding that is determined by the population size and psychiatric morbidity present in the different cultural groups in Oregon.*

5. Near Term Priorities

The strategic logic is to "get a wedge in" during the 2027 session, concrete budget and policy commitments that make a longer-term rebuild hard to reverse and before federal funding losses force pure cost-cutting. Priorities fall into two groups: actions the Governor can direct immediately at little or no new cost, which build momentum and credibility ahead of the session; and the capital and policy asks that must be secured in the 2027 session itself.

Direct now — executive actions requiring no new appropriation or legislation

1. **The Governor should establish a group of subject matter experts, led by the Governor, to determine the appropriate system leader and assess governance accountabilities and fragmentation across the system to arrive at a simplified, regional governance model.** Decide the system-leader vehicle (considering a restructured OHA, a new cabinet-level authority and a cross-system leader within Governor's office) and codify the payer-anchored accountability map. Include distinct roles, funding, deliverables, populations served, and performance expectations in county agreements and CCO contracts as they come up for renewal.
2. **The Governor should direct OHA to adopt the OHSU system-demand model as the official basis for capacity and housing targets.** Direct OHA to work with OHSU to size every bed and housing commitment from the model and continue developing it to be statewide and to cover all care settings and behavioral health housing. This is the analytic foundation the capital asks depend on.
3. **The Governor should direct OHA to modernize its interpretation of the federal IMD exclusion consistent with current federal guidance.** Specifically, OHA should cease aggregating separately licensed facilities of 16 or fewer beds under common ownership when determining whether a facility exceeds the 16-bed limit. This aggregation practice is inconsistent with the plain language of the Medicaid Act (42 USC § 1396d(i)), CMS's regulatory definition of an IMD (42 CFR § 435.1010), and CMS's guidance in the State Medicaid Manual (SMM § 4390), under which a separately licensed component of 16 or fewer beds qualifies as an independent facility. Alternatively, to the extent OHA believes federal constraints prevent it from reimbursing these campus-based models, OHA should pursue the necessary CMS waivers to maximize Medicaid reimbursement for behavioral health treatment. Oregon should not maintain an interpretation more restrictive than federal law requires when doing so blocks state-funded projects, limits residential and crisis respite bed capacity, and restricts access to care.
4. **The Governor should direct OHA to review and modernize its implementation of HCBS requirements for licensed residential behavioral health treatment settings.** OHA should identify areas where state policy, guidance, or oversight practices apply housing-oriented standards more broadly than federal law requires and modify those interpretations to better reflect the purpose of residential treatment. This review should include policies related to residency agreements, individually based limitations, discharge and transition processes, and other HCBS compliance requirements that affect the operation of residential treatment programs. The goal should be to preserve the rights and autonomy of people receiving services while recognizing that residential treatment settings serve a clinical function distinct from independent supported housing. Oregon should not maintain interpretations that unnecessarily constrain providers' ability to deliver treatment, limit residential capacity, or create barriers to access when federal guidance permits a

more balanced approach, an effect concentrated in rural and frontier communities, where these restrictions have had the greatest impact.

5. **The Governor should direct OHA to implement incentives for establishing collaborative and integrated behavioral health care through primary care homes and CCBHCs.** Leverage existing payment models and address current barriers to implementation. In Medicaid, this could be established through CCO rate setting or through restoration of the Quality Pool.
6. **The Governor should direct OHA to require that insurance companies offering coverage in Oregon be required to reimburse clinics, primary care providers and psychiatric providers** for the provision of collaborative behavioral health care services.
7. **The Governor should commission a pediatric system redesign**, under the direction of the System of Care Advisory Council (SOCAC), to assess the current pediatric mental health system and develop recommendations specific to the pediatric system in addition to this report.
8. **The Governor should establish a Governing Board for the Oregon State Hospital that is responsible for overseeing operations of the State Hospital.** All of Oregon's community hospitals operate with a Board of Trustees, and OSH should be the same. The Medicare Conditions of Participation require every participating hospital to have an effective governing body legally responsible for the conduct of the hospital (42 CFR § 482.12); at OSH that function currently rests with the OHA Director alone. The Board needs representatives from hospitals (with and without psychiatric units), psychiatrists, forensic psychologists, nursing, Counties, District Attorneys, Judiciary, and include former patients and family members. This is a shift from the current "Advisory Board" that has no ability to actually govern. This will provide transparency and accountability to the State Hospital.

Secure in the 2027 session — the budget and policy asks

9. **The Governor should secure capital commitment for a balanced bed portfolio for civil and voluntary populations.** Make a binding, bond-financed commitment to a multi-level portfolio (inpatient, step-down, respite, and sub-acute) sized from the OHSU model, with a cost-based rate floor so new capacity does not collapse and dedicated carve-outs for people who are civilly committed and for voluntary admissions. This is a commitment of state capital and a rate floor, not a commitment to state operation: beds funded through this portfolio should be built and operated by community hospitals, CMHPs and licensed providers, with the state's role limited to financing, standards and accountability.
10. **The Governor should secure funding for a cost-based add-on rate for civil commitment and guardianship admissions.** Psychiatric units are currently paid a standard per-diem for the highest-cost admissions in the system, which is a direct disincentive to maintaining the civil capacity this strategy depends on. Fund an add-on payment that reflects the true cost of these admissions, including a defined rate for patients who are medically ready but awaiting placement, implemented in Medicaid through CCO directed payments or the fee schedule.
11. **The Governor should secure a capital commitment for dedicated behavioral health housing, with support and funding standards.** Fund permanent-supportive and transitional Behavioral Health Housing, sized from the model, and adopt the two standards that prevent failure: a post-placement support standard (ACT plus onsite services) and a single funder-of-record per housing level. Launch the statewide value-stream-mapping effort. The Governor, OHA and OHCS should create flexibility for the expansion of both Transitional Behavioral Health Housing and augmented

PSH with support for participant service engagement requirements which are unobstructed within TH programs and may have up to a 24-month duration.

12. **The Governor should ensure people don't have to enter the forensic system in order to receive appropriate care by securing funding and legislation to make treatment available in every setting and accessible at the point of need**. Fund the Phase 1 forensic package set out in section 6.4 — a mental health resource attorney at DOJ, enhanced behavioral health services for people in custody in dedicated treatment settings, pilot outpatient treatment courts, a coordinating function for forensic patient care, and a $2 million increase for the Oregon Public Guardian and Conservator — and pair it with the two legislative fixes that package depends on: revision of the assisted outpatient treatment statute (ORS 426.133) and a new "magistrate's hold" process. Together, these investments will ensure that people have access to appropriate care in all settings and all acuity levels as soon as possible to avoid needing to go to the State Hospital, enabling the Hospital to focus resources on individuals who need the highest level of care.

6. The Strategy: How we achieve our proposed future state

The recommendations in this strategy are broken down across five swim lanes of activity. Within each, required actions are phased across three two-year horizons aligned to legislative sessions with the goal of delivering impact rapidly and building to the overall future state through these incremental steps. The five lanes organize delivery; they do not describe five separate systems. Governance sets who is accountable, and the other four describe successive points on one continuum that the same people travel. The actions should therefore be read across the lanes as well as down them — in particular, the housing and forensic actions in 6.3 and 6.4 are part of the behavioral health continuum, not adjacent to it. This strategy should be implemented in conjunction with the wider package of reforms recommended by the Health System Sustainability Group, including the reforms needed to enable primary care capacity to support behavioral health.

6.1 Governance

The problem. Authority is fractured across Counties, CCOs, OHA, and ODHS — CCOs cover most mental health but not residential; ODHS holds foster care, APD, and the statutorily carved-out long-term services and supports (LTSS) that are roughly a third of Medicaid spend — so responsibility and authority never sit in the same hands. Coordination runs on contract and MOU (CMHP–CCO, CCO–APD) rather than structure, and no entity clearly owns building capacity where it is short. The system is also built around Medicaid, which is only about 60% of behavioral-health financing, leaving people covered by Medicare or commercial insurance an afterthought — Medicare most of all, since it is a principal payer for adults with serious mental illness and reimburses well below the cost of care in Oregon — and does not allow providers a margin to build capacity themselves.

> **Keystone recommendation.** Establish a Governor-led group of subject matter experts to develop a Regional Accountability Model for Behavioral Health and **a clear, accountable system leader** (a reformed OHA or a new cabinet-level entity) vested with statewide standards, enforcement, and capacity. Establish clear accountability for each person's care, centered on the payer (the CCO for Medicaid members) so responsibility for every individual is unambiguous.

Phase 1 — Years 1–2 *2027 / 2028 sessions*

- **Decide the vehicle for the system leader:** a new cabinet-level authority or a restructured OHA (form follows function; don't just move boxes) — a regional authority leading the system, not a payer that displaces the CCOs. If OHA, that requires leadership and structural transformation, integration with Medicaid leadership, and the defined "five things that must happen at OHA."
- **Establish a Governor-led group of subject matter experts to develop a Regional Accountability Model for Behavioral Health.** The model should align funding approaches from across existing efforts (e.g., BHRNs, Measure 110, etc.) and include distinct roles, funding, deliverables, populations served, and performance expectations in OHA authority and County agreements and CCO contracts as they come up for renewal. Serious consideration should be given to where structures can be integrated or consolidated, for example integrating Adult Residential into the CCO Benefit.

- **Codify the payer-anchored accountability and authority**: the CCO as accountable entity for Medicaid members, the commercial insurer for people with commercial insurance, the county/CMHP as safety-net backstop for people who are uninsured, and, for people enrolled in Medicare, the aligned Dual Eligible Special Needs Plan for full-benefit dual eligibles and a designated accountable entity for people with Medicare only, with explicit handoffs at coverage changes and for justice-, child-welfare-, and APD-involved cases.
- **Use the newly executed 18-month CFAA, aligned CMHP–CCO MOUs, and CCO 2.0 contracts as the near-term levers**, with an analysis of county financial-services agreements, CCO contracts and legislation/OAR to map duplication and fractured accountability, then redraft to assign distinct roles, funding sources, deliverables, populations served, and performance expectations across OHA, ODHS, counties, and CCOs, and to fix that no entity now owns building capacity where it is short.
- **Review processes, barriers to accessing care for people, and administrative reporting burden for providers to identify opportunities for streamlining processes.** For example, aligning CCO BH metrics with CCBHC metrics given the topics and ideas they are measuring are in alignment, but the technical specifications are different. This leads to providers hand-pulling data for similar topics/reports.
- **Build buy-in with the right players:** the fiscal-crisis window leaves little time for full consensus, so lead with a straw-person proposal vetted by a limited group (e.g., the HB 4092 work group — hospitals, NAMI, CMHPs, CCOs), learning from the stalled regional-accountability effort.
- **Establish a Governing Board for the Oregon State Hospital that is responsible for overseeing operations of the State Hospital.** All of Oregon's community hospitals operate with a Board of Trustees, and OSH should be the same. The Medicare Conditions of Participation require every participating hospital to have an effective governing body legally responsible for the conduct of the hospital (42 CFR § 482.12); at OSH that function currently rests with the OHA Director alone. The Board needs representatives from hospitals (with and without psychiatric units), psychiatrists, forensic psychologists, nursing, Counties, District Attorneys, Judiciary, and include former patients and family members. This is a shift from the current "Advisory Board" that has no ability to actually govern. This will provide transparency and accountability to the State Hospital.
- **Direct OHA to undertake a review** to ensure statewide fee schedules, rate development, and policy development do not disproportionately harm safety net behavioral health services.

Phase 2 — Years 3–4 *2029 / 2030*

- **Implement the accountability structure and per-entity performance tracking**; remove the duplication surfaced by the contract analysis; execute the organizational transformation.
- **Stand up a public statewide behavioral-health outcomes dashboard** (a CHIA-style mechanism), reporting access, equity, ED and criminal-legal diversion, and overdose and suicide outcomes by entity. This dashboard should also include Continuum of Care (CoC) based housing program completion and tenancy continuity outcomes as essential KPIs for this population.
- **Restructure Measure 110 Behavioral Health Resource Network funding (~$100M/yr)** toward measurable behavioral-health outcomes and integrate with CCO and CMHP systems (converting low-barrier contact into treatment engagement) and shift funding into the new regionalized governance structure for distribution.

Phase 3 — Years 5–6 *2031 / 2032*

- **A coordinated system with consistent statewide rules and measurable outcomes by entity**, capturing savings from administrative efficiency and reduced avoidable utilization.
- **Extend the system beyond Medicaid and resolve the LTSS carve-out: pursue whole-population scope** — including, as in high-performing states, commercial-insurance regulation and parity enforcement — and either integrate LTSS with behavioral health or appropriately fund and deepen CCO–APD/AAA coordination so that older adults with serious mental illness are not stranded in behavioral-health residential.

6.2 Capacity & Workforce

The problem. Oregon is under-bedded across inpatient, intermediate, respite, and crisis levels, and could not staff even a well-designed system. State Medicaid fee schedules put at risk the current operations and capacity within the system and do not support any margin so that providers would be able to build the capacity themselves and therefore must rely on government investment to build new capacity. The OHSU simulation model shows the shortage is also structural: bottlenecks cascade from residential to inpatient to ED/PES boarding, so no single facility type, added on its own, meaningfully relieves the system and even a perfectly designed system fails without the workforce to run it.

> **Keystone recommendation.** Adopt the **OHSU behavioral health system-demand model** as the official basis for capacity targets, and invest in a **coordinated, balanced portfolio across levels of care** rather than any single bed type. **Develop the model further to be statewide, include all behavioral health care settings and behavioral health housing.**

Phase 1 — Years 1–2 *2027 / 2028 sessions*

Capacity

- **Require that insurance companies offering coverage in Oregon be required to reimburse clinics, primary care providers and psychiatric providers for the provision of collaborative behavioral health care services.** For Medicaid, ensure that this is funded through rate setting or restoration of the quality pool.
- **Make a binding 2027-session capital commitment** to a balanced, multi-level bed portfolio (inpatient, step-down, respite, and sub-acute), financed through bonding and sized from the model. The model's "moderate bundle" — targeted capacity plus length-of-stay reduction — projects roughly an 80% cut in ED/PES boarding (from ~16 to ~2.9 patients at any given time).
- **Size the portfolio to the model's balanced ratio.** An illustrative 100-bed-equivalent mix is ~25% RTF, 50% respite, 25% sub-acute. The model projects that SRTF demand will likely be met as capacity from previous appropriations comes online. These ratios are directional model output to be finalized against the updated model and PCG report, not fixed targets.[10]
- **Direct OHA to modernize its interpretation of the federal IMD exclusion consistent with current federal guidance.** Specifically, OHA should cease aggregating separately licensed facilities of 16 or fewer beds under common ownership when determining whether a facility exceeds the 16-bed limit. This aggregation practice is inconsistent with the plain language of the Medicaid Act (42 USC § 1396d(i)), CMS's regulatory definition of an IMD (42 CFR § 435.1010), and CMS's guidance in the State Medicaid Manual (SMM § 4390), under which a separately licensed component of 16 or fewer beds qualifies as an independent facility. Alternatively, to the extent OHA believes federal constraints prevent it from reimbursing these campus-based models, OHA should pursue the necessary CMS waivers to maximize Medicaid reimbursement for behavioral health treatment. Oregon should not maintain an interpretation more restrictive than federal law requires when doing so blocks state-funded projects, limits residential and crisis respite bed capacity, and restricts access to care.
- **Direct OHA to review and modernize its implementation of HCBS requirements for licensed residential behavioral health treatment settings.** OHA should identify areas where state policy, guidance, or oversight practices apply housing-oriented standards more broadly than federal law

requires and modify those interpretations to better reflect the purpose of residential treatment. This review should include policies related to residency agreements, individually based limitations, discharge and transition processes, and other HCBS compliance requirements that affect the operation of residential treatment programs. The goal should be to preserve the rights and autonomy of people receiving services while recognizing that residential treatment settings serve a clinical function distinct from independent supported housing. Oregon should not maintain interpretations that unnecessarily constrain providers' ability to deliver treatment, limit residential capacity, or create barriers to access when federal guidance permits a more balanced approach, an effect concentrated in rural and frontier communities, where these restrictions have had the greatest impact.

- **Add the missing levels of care to both the plan and the model and sustainable billable pathway** — ambulatory behavioral health, respite/sub-acute, and 23-hour "recliner"/drop-in crisis stabilization centers (CMHP-run; operating or in development in Deschutes, Malheur, Clackamas, Benton, and Klamath counties) and add in both the permanent and transitional housing capacity needed to support this population. Add in geriatric psychiatric capacity, and long-term care options with mental health supports, to the model specifically, as a share of the overall system capacity needed.
- **Set a rate floor tied to the actual cost of stable delivery** so existing and newly created capacity does not collapse; pair each bed/service with a sustainable rate and evaluate a cost-based daily rate to stabilize safety-net CMHPs. Evaluate the actual cost of care for BH services for each level of care, including acute psychiatric care, utilizing existing data gathered through the pricing process.
- **Protect non-forensic access** with dedicated capacity and financing carve-outs for people who are civilly committed and for voluntary admissions, not only for forensic demand.
- **Establish a cost-based add-on rate for civil commitment and guardianship admissions.** Direct OHA to develop an add-on payment that makes a psychiatric unit whole for admissions of people who are civilly committed or under guardianship, set from the actual cost of delivering that care — court process, enhanced staffing, and lengths of stay driven by placement availability rather than clinical need. In Medicaid this can be implemented through CCO directed payments or the fee schedule and should include a defined rate for medically ready patients awaiting placement, so that discharge delay is not absorbed by the unit. Because Medicare rates are set federally and cannot be supplemented on the claim, OHA should pursue the equivalent effect for Medicare and dual-eligible patients through the contracts every Dual Eligible Special Needs Plan holds with the state, and quantify the residual shortfall as part of the Medicare strategy. In addition, Oregon should explore options to engage the Federal government on Medicare rate setting to ensure system sustainability.
- **Reduce lengths of stay in RTF with investments in housing and outpatient capacity.** LOS reduction is the model's highest-leverage lever but requires permanent supportive housing and outpatient services to step patients down into. Without them, capacity investments will not achieve modeled outcomes and people are pushed back into crisis cycling.
- **Stand up under-resourced services** via existing CCO workgroups, with standard capitation-backed payments: Addiction Consult Service (inpatient), wound care, Mobile Crisis.
- **Direct OHA to implement incentives for establishing collaborative and integrated behavioral health care through primary care homes and CCBHCs.** Leverage existing payment models and

address current barriers to implementation. In Medicaid, this could be established through CCO rate setting or through restoration of the Quality Pool. Integration will require incentives for primary care practices, continuation and expansion of programs for behavioral health in primary care and pathways for people to move between systems as needed, including as part of a person's recovery path.

- **Support consultative models for psychiatry in primary care** including OPAL and ECHO.
- **Prioritize integrating and expediting Medicaid eligibility and functional assessments, APD evaluations and placements, child-welfare transitions, and the crisis system** through increasing speed and throughput and/or allowing providers to do their own evaluations for access to enhanced rates and placement. Implement a system of presumptive eligibility for people in acute care and a presumptive or provisional enhanced-rate, so they can move quickly to lower levels of care while the evaluations/approvals take place (and they are cared for in a much less expensive care setting).
- **Require and fund CMHPs and Exceptional Needs Care Coordinators (ENCCs) to initiate placement referrals within a defined timeframe** once an individual is identified as no longer requiring acute psychiatric care.
- **Establish a fund for guardianships** that allows families to access private guardianship processes and speed time to establishment without having to wait for county/state processes.
- **Enforce existing OARs that require Skilled Nursing Facilities (SNFs) to accept someone returning to care within 30 days** without requiring rescreening by APD.
- **Establish a cross-agency process for discharge escalation and resolution**, including OHA, APD, CMHPs, CCOs, hospitals, and placement partners, to resolve complex discharge barriers in real time.
- **OHA should establish the policies, procedures, and reimbursement mechanisms necessary to make Contingency Management available statewide** for people with a stimulant use disorder (StUD) and for those with co-occurring conditions, given StUD can be a major co-occurring condition with psychosis and the need to treat both StUD and psychosis in a coordinated way.

Workforce

- **Short-term workforce:** national recruitment with competitive pay; interstate licensure reciprocity; and workforce housing in rural areas.

Phase 2 — Years 3–4 *2029 / 2030*

Capacity

- **Bring financed capacity online** across inpatient, step-down, respite, and sub-acute; build the ambulatory and respite/sub-acute levels.
- **Move from the moderate bundle toward the full bundle** as housing and outpatient capacity mature — deepen RTF length-of-stay reduction (the model lowers new-resident average LOS from ~1,957 days toward 900–1,300, plus a ~30% reduction in existing stays) and add community-restoration and OSH civil-commitment levers (coordinated with 6.4). The full bundle approaches near-elimination of boarding (~0.6 patients, a >93% reduction).

Workforce

- **Expand the in-state training pipeline** in critical prescriber/clinician roles; restructure loan repayment to offset reduced federal student-loan limits; act on retention, not just recruitment.

- **Establish up-front funding of education as an alternative to loan-repayment schemes.** As an option to expand access to education and build a workforce pipeline.

Phase 3 — Years 5–6 *2031 / 2032*

Capacity

- **Sustain capacity at model-derived targets** with stable financing, holding the system at full-bundle performance (near-elimination of ED/PES boarding).

Workforce

- **Maintain a self-renewing in-state workforce pipeline** sized to staffed capacity.

6.3 Behavioral Health Housing

The problem. This strategy treats Behavioral Health Housing as a distinct domain, designed around the population served. The term behavioral health housing is a re-cast of Permanent Supportive Housing and is rooted within the truth our State does not consistently or effectively deliver PSH to fidelity of evidence-based models of services. Behavioral Health Housing may also be configured to include Transitional Housing as a model which can require service engagement as part of a tenancy agreement for up to 24 months. High acuity behavioral health conditions are chronic conditions requiring long-term disease management, and the housing crisis is amplified by an under-resourced acute behavioral-health system. The affordable-housing continuum can no longer absorb unmanaged behavioral-health acuity, with eviction-standard liberalization expected next long session and nonprofits divesting housing to commercial owners. The result is a persistent housing/service mismatch: supportive services are disconnected from housing pathways, the psychiatric-inpatient-to-permanent-supportive-housing transition is not prioritized, and residential entry (RTF/RTH) is available only through voluntary admission or civil-commitment/forensic conditions. Cross-system handoffs and accountability remain unclear.

> **Keystone recommendation.** Pursue a **both-and strategy**: preserve and improve the existing affordable housing ecosystem now while pursuing person-centered redesign, organized as concentric levels of support around the most acute population. Pair a binding **2027-session capital commitment to build permanent-supportive and transitional Behavioral Health Housing** (sized from the model) with two standards that prevent failure: a **defined post-placement support standard** (ACT/ICM plus onsite services) and a **single funder-of-record per housing level**. Coordinate the **five levers — treatment, housing capacity, service, workforce, and prevention** — and hold scope to **people with high acuity behavioral health conditions, delivered with fidelity**, excluding people whose primary diagnosis is a substance use disorder to prevent drift.

Phase 1 — Years 1–2 *2027 / 2028 sessions*

- **Secure the 2027 capital commitment** (bonding) for permanent-supportive and transitional Behavioral Health Housing capacity, sized from the OHSU model.
- **Run the statewide value-stream-mapping effort** with CCOs, hospital systems, key providers, OHA/OHCS, the Housing Authority, ODHS, and counties/HUD CoCs to map the idealized state — what guaranteed placement and long-term housing voucher funding is required at-scale for the population — locate where the system breaks down, and identify who has authority to act.
- **Define the post-placement support standard** (ACT + onsite services) and the funder-of-record for each housing level, to cut placement in shelter, failed housing placements, cycling, and rehospitalization.
- **Set acute-care-to-housing pathway standards** that prioritize the psychiatric-inpatient-to-permanent-supportive-housing transition — eligibility, timing, funding responsibility, and referral/information-sharing handoffs, while accountable for scale to population need.
- **Design the approach to service engagement** — including how it is mandated and the use of contingency management for SUD abstinence and for medication adherence.
- **Launch a housing-preservation package** to keep people in their existing units: debt buy-down, an insurance pool, safety-and-security support grants, funded tenancy-support coordination teams,

an eviction/lease-violation modification policy that ensures timely unit turn, a rent-cap-and-voucher strategy, and cross-provider response teams.

- **Engage proactively on the coming eviction-standard debate** and on nonprofit housing-portfolio divestment.

Phase 2 — Years 3–4 *2029 / 2030*

- **Assign funding responsibility by housing level** and define the role of Coordinated Access in triaging to available capacity; expand supported housing with onsite services for people with high acuity behavioral health conditions.
- **Complete a total cost-outcome analysis** across SRTF, RTF, group home, and PSH — including the cost of returns to homelessness — to guide investment, and resolve OHA's responsibility for PSH and the associated waiver.

Phase 3 — Years 5–6 *2031 / 2032*

- **A coupled behavioral-health-and-housing system** — person-centered and organized in concentric levels of support — with reliable throughput from treatment and respite to transitional and permanent supportive housing.

6.4 Forensic & Legal System

The problem. The people described in this section are not a separate population. They are the people described in 6.2 and 6.3, encountered later and more expensively, after the civil system failed to reach them. The Oregon State Hospital is largely consumed by forensic demand. As of June 15, 2026, 374 of the State Hospital's 704 staffed beds were occupied by people undergoing competency restoration, 82% of whom were charged with felony crimes and 18% with misdemeanor crimes.[11] Another 280 beds are occupied by people found guilty except for insanity (GEI).[12] As of 2023, Oregon ranked 45th for the percentage of state hospital beds occupied by civil patients.[13]

Over the past decade, judicial orders have restricted access to Oregon's highest acuity settings to ensure timely access for people unable to aid and assist in their legal defense to stand trial. The judicial orders have worked: the wait times for people undergoing aid-and-assist evaluation have fallen from over 40 days in 2022 to an average of 4.4 days in July of 2026.[14] This progress has come at the expense of access to services for the civil commitment population, which used to represent 54% of the State Hospital's population and today represents less than 8%.[15] While the State Hospital is now admitting people undergoing aid-and-assist evaluation in fewer than seven days, it remains a forensic facility, preventing people from getting the care they need and allowing them to further decompensate. Even with additional flexibility at the State Hospital, demand from the forensic system for this capacity is artificially lowered by federal court orders. Without the federal court order, the forensic demand will return.

People undergoing aid-and-assist evaluation face a structural lack of anywhere to go. Even when a person achieves competency restoration,[16] the goal of that process is fitness to stand trial, not long-term stability. The person is returned to jail, tried, sentenced, and eventually released in the same if not worse condition than when they entered. Without treatment aimed at sustained recovery, many cycle back through crisis, re-arrest, and the aid-and-assist queue.[17]

The result is a self-reinforcing spiral: the absence of civil treatment capacity pushes more people into the forensic track, and the forensic track returns them to the community without treatment, where they deteriorate and return.[18] This cycle cannot be broken without alternative treatment modalities and additional treatment capacity for people undergoing aid-and-assist evaluation, dedicated not just to achieving long-term stability for that population but also to freeing up hospital capacity for those who need it today.

> **Keystone recommendation.** Reduce the aid-and-assist inflow into the State Hospital by making treatment-focused care available earlier and closer to home building community-based alternatives for competency restoration treatment, including appropriate housing so that people receive care at the point of need and OSH admission is reserved for those who genuinely require hospital-level restoration.

Phase 1 — Years 1–2 *2027 / 2028 sessions*

- **Coordinate with the Department of Justice on a preliminary legal review** of whether the Mink/Bowman seven-day admission standard could be challenged and aligned to timelines in peer states.

- **Improve the effectiveness of magistrate holds** as a tool for diverting someone out of the forensic system and into the civil commitment process **by increasing mental health evaluations prior to a hold's issuance, encouraging coordination between judges and hospitals, and bolstering funding for hospitals and CMHPs to care for these individuals.** Judges can initiate a hold on someone for civil commitment and may do so in an ongoing criminal proceeding. However, these types of holds are used inconsistently. At the same time, the existing statute on magistrate holds is unclear about the process and who is responsible for what.
  - **Direct OHA to investigate licensing, rate-setting, and directed payment mechanisms** it can leverage to ensure that every hospital in the state has evaluation, observation, and treatment facilities for people in acute psychiatric crises in the criminal justice system.
  - **Work with OJD, hospitals, CMHPs, tribal courts, and the Legislature to craft a new "magistrate's hold" process** in statute for the removal of a person in acute psychiatric crisis in the criminal justice system from a custodial setting and to a hospital, and clarify the roles and responsibilities of each entity in any subsequent civil commitment process.
- **Increase funding for the Oregon Public Guardian and Conservator** by $2 million to establish dedicated staff to investigate people undergoing aid-and-assist evaluation whose charges are dismissed or who are deemed "never able."
- **Establish an agency to act as "air traffic control" for forensic patient care.** This function could build off existing efforts to create a centralized forensic evaluation system, which would consolidate all forensic evaluation services into a single entity to coordinate and perform. The next iteration of a centralized forensic evaluation service should include decision-making over placements, coordination of services and treatment in community restoration, and some level of post-discharge supervision to ensure people are receiving what they need (services, housing) to be successful.
- **Secure pilot funding for enhanced behavioral health services for people in custody in dedicated treatment settings.** After a person is arrested and booked into jail, they may wait months for a competency evaluation, time that falls entirely before the seven-day Mink/Bowman admission timeline even begins. In the meantime, they remain untreated in the jail general population. Similarly, people restored to competency are returned to jail, where they are often unable to continue their treatment. State funding should be set aside to develop dedicated treatment settings and to offset operating costs for voluntary services that stabilize people and maintain restoration.
- **Direct OHA to develop a single formulary across treatment settings** to ensure that medication regimens do not need to change every time a person's placement does, ranging from behavioral health services received in jail custody to the state hospital to community restoration.
- **Revise Oregon's existing assisted outpatient treatment (AOT) statute (ORS 426.133)** to increase utilization of lower levels of care for people who do not meet civil commitment criteria. Require court programs operating under these statutes to include an explanation of the proposed treatment plan (including services) to be presented to and approved by the court, and ongoing reporting to the court on adherence to the treatment plan by the person as well as by the services provider. Adopt a remedy structure for non-adherence to the treatment plan, including court re-evaluation of the treatment plan or initiation of commitment procedures (under ORS 426.070).

  - **Fund pilot programs that include a robust outpatient treatment court**, including an independent treatment monitor, who will report to the court and parties on the adherence of the person and service providers (including the CMHP) to their obligations under the court-ordered treatment plan.
  - **To achieve these goals, the Governor should direct OHA to work with OJD to develop technical guidance on implementing AOT.**
- **Direct OHA to evaluate how other states that authorize up to 90 days of pre-release behavioral health services for people in custody are navigating CMS guidance on designated state health programs.** If possible, direct the agency to resume implementation and seek renewal.
- **Direct OHA to implement Medicaid presumptive eligibility for people under Aid and Assist or GEI orders** immediately upon discharge from jail, prison, OSH, or an RTF and require discharge protocols that restart enrollment in their prior CCO, all to the fullest extent possible using medical frailty and inability to work criteria to most efficiently meet H.R. 1's work requirements (Pinals, 11th Report).
- **Direct OHA to build a tracking system** that identifies current funding sources for people under Aid and Assist or GEI orders and monitors outcomes after they leave jail, OSH, or an RTF, including Medicaid enrollment status, enrollment lag time, emergency department utilization, and criminal justice reentry (Pinals, 11th Report).
- **Amend ORS 161.372, or create a new statutory structure, to expand the eligible treatment settings allowed to involuntarily medicate those undergoing competency restoration and indemnify these facilities.** Under current statute, only the superintendent of the state mental hospital can pursue a Sell order to medicate someone undergoing competency restoration in their custody. SRTFs will not be able to fully supplement the State Hospital without this change, and without indemnity to lower their risk, the facilities will not offer this service to the state.
- **Establish a resource prosecutor position within the DOJ dedicated to mental health cases**, to advise county prosecutors on how to charge, divert, and resolve these cases.
- **Direct OCJ to develop a central, searchable repository of court-ordered mental health evaluations** and require the courts to submit each mental health evaluation to this central repository. HB 2005 (2025) allowed courts to consider prior mental health evaluations, but previous evaluations are rarely considered because they are too difficult to find. Greater access to prior evaluations would help the courts make more informed decisions about a person's treatment and placement needs.
- **Amend ORS 426.228(2) to delete the word "imminent" from the standard for a hold initiated by a community mental health program (CMHP) director** to address inconsistencies in legislation as a result of HB 2005 (2025). The same bill should confirm that those definitions apply to the hold statutes (ORS 426.228, 426.232 and 426.233), and should leave the existing requirement for immediate or emergency care untouched.

Phase 2 — Years 3–4 *2029 / 2030*

- **Build aid-and-assist-specific treatment capacity outside of the Oregon State Hospital and in regional areas.** Jackson House had proposed a 72-bed, aid-and-assist-dedicated campus model, with three 16-bed RTFs and one 24-bed SRTF. This proposal was scaled down to the 24-bed SRTF due to licensing challenges at OHA. Direct OHA to partner with project sponsors on licensing population-specific, community-based residential treatment models and to work with OHSU to

estimate how many similar sites are needed to decrease the forensic share of the Oregon State Hospital census (aid and assist and GEI) to 2000 levels (from 94% to 46%).

- **Scale AOT by expanding resources for outpatient treatment courts and enhanced jail behavioral health services (OHA) programs across the state.** Direct agencies to develop best practices and accountability structures for implementation.
- **Establish state grant funding for counties to support county pilot programs** to identify and transition eligible people out of the forensic system into the civil treatment system, leaving program design flexible to local approach. The grant funding should be followed by a review of what models proved effective.
- **Clarify how a court should contemplate the reasonable foreseeability of harm after release from care** currently being received within ORS 426.005(1)(f), which has reportedly been inconsistently interpreted by the courts since the passage of HB 2005 (2025).
- **Convene an expert panel to evaluate whether and how Oregon could expand civil commitment eligibility** to people unable to meet basic needs due to a severe substance use disorder, and to design a corresponding treatment continuum.
- **Evaluate, once dedicated capacity is in place within the Oregon Public Guardian and Conservator, whether Oregon's protective-proceedings framework gives OPGC adequate tools**, including dangerousness-specific criteria and secure-placement authority, to serve people found "never able" under ORS 161.371 who are charged with violent offenses, drawing on models like California's Murphy Conservatorship (Welf. & Inst. Code § 5008(h)(1)(B)). Separately assess whether the same framework adequately serves people who are repeatedly found "never able" on lower-level charges, since that population's needs may differ from the violent-charge cohort.

Phase 3 — Years 5–6 *2031 / 2032*

- **Continue to support statewide access to AOT and enhanced behavioral health services for people in custody** through requirements, incentives and/or funding.
- **Direct OHA to develop a grant or reimbursement scheme** to encourage CMHPs and hospitals, in regions where AOT is available, to evaluate people who are exiting a 180-day commitment or are under 14-day diversion for AOT before the commitment expires or the hold ends.
- **Direct OHA to publicly report on equitable access to the civil treatment system**, including the consistency in how civil commitment cases are pursued as well as placement availability and wait times for different facilities.

6.5 Prevention & Social Determinants

The problem. Prevention is essential but must be scoped to stay actionable rather than "fixing the world." The highest return on preventing adult mental illness is in the **first 1,000 days of life** — from conception to a child's second birthday — when maternal stress, adverse childhood experiences (ACEs), parental substance use, and compromised early relational health set durable trajectories for later adult mental health and substance use disorders. Most current spending is reactive, reaching families only after needs surface; Oregon ranks high on addiction prevalence but low on treatment access, the pattern upstream investment is meant to reverse.

> **Keystone recommendation.** Adopt a **narrow, named prevention portfolio** — anchored in (a) a first-1,000-days bundle and (b) treatment foster care — rather than an open-ended prevention agenda, with each element tied to a system goal it serves. Operationalize the bundle through **five policy levers** drawn from Oregon's Upstream Initiative and the proposed Child Success Act (SB 1167) model: (1) build local "Child Success" infrastructure; (2) guarantee universal family navigation and evidence-based home visiting; (3) consider the role of Medicaid to finance prevention; (4) stabilize families through housing, food, child care, and flexible cash; and (5) embed infant and early childhood behavioral health across the systems families already touch. Hold the portfolio to prevention that demonstrably reduces downstream acute demand and reinvest the savings upstream.

Phase 1 — Years 1–2 *2027 / 2028 sessions*

- **Fund the first-1,000-days bundle:** prenatal and maternal care, postnatal parenting support, and parental SUD treatment (parental use in early childhood is a primary driver of downstream harm).
- **Expand evidence-based home visiting** and determine responsibility for these between the public health system, family medicine and the medical pediatric system. Increase state and Medicaid funding for voluntary, prenatally initiated home-visiting models (e.g., MIECHV-supported programs), prioritizing families experiencing housing instability, maternal depression, substance use, intimate partner violence, poverty, or child-welfare involvement.
- **Guarantee universal prenatal-to-age-3 navigation.** Establish a "no wrong door" family navigation system that connects families to OHP/Medicaid, WIC, housing, food, child care, home visiting, developmental screening, and behavioral health and substance use treatment — replacing fragmented referrals with a single accountable access pathway.
- **Integrate maternal behavioral health into prenatal, postpartum, and pediatric care.** Require routine screening and warm handoffs for depression, anxiety, substance use, intimate partner violence, and social needs across pregnancy, postpartum, and well-child visits; reimburse dyadic (parent-and-child) treatment; and extend postpartum behavioral health supports beyond the traditional window.
- **Establish a sustainable funding model for dedicated maternal SUD treatment**, given a key driver of adult psychiatric morbidity is parental SUD.
- **Fund infant and early childhood mental health (IECMH) consultation** in pediatric primary care, child care, early learning, home visiting, and family-serving CBOs, to help providers identify trauma, attachment concerns, maternal depression, developmental delay, and early signs of behavioral health need.

- **Expand treatment foster care** as a concrete, in-scope youth intervention and expand funding for this outside of the ODHS system.
- **Stand up local "Child Success" pilots.** Fund regional pilots led by Early Learning Hubs, CCOs, public health, behavioral health, housing, food, and community-based organizations, each building a local model with shared governance, braided funding, and measurable outcomes (aligned to Oregon's Upstream Initiative and the proposed Child Success Act).

Phase 2 — Years 3–4 *2029 / 2030*

- **Create and fund Medicaid/CCO incentives for upstream child and family outcomes** — quality metrics tied to prenatal care access, postpartum depression screening and treatment, developmental and social-emotional screening, connection to home visiting, housing stability, food security, and early relational health and allow CCOs to deploy funding for prevention.
- **Stabilize families during the first 1,000 days** through housing (priority access to rental assistance, eviction prevention, rapid rehousing, and supportive housing), food security, child care, and time-limited, low-barrier flexible cash paired with voluntary navigation rather than compliance-heavy case management — treating family stability as a behavioral health prevention strategy.
- **Fund and reimburse standardized developmental, autism, social-emotional, and caregiver-depression screening** in pediatric and early-learning settings, ensuring positive screens trigger timely evaluation, follow-up evaluation and coordination, early intervention, IECMH, and family supports.
- **Expand culturally specific perinatal and early childhood supports** — doulas, peer supports, community health workers, Tribal programs, and language access — and require regional models to include community-based organizations in governance and funding decisions.
- **Build shared data and referral infrastructure** with interoperable, HIPAA-compliant closed-loop tracking across CCOs, Early Learning Hubs, public health, behavioral health, housing, food, and child care, so the system tracks whether families receive services, not just whether referrals were made.
- **Scale interventions that demonstrate impact**; fix the misaligned pediatric regulatory and payment schema; reinvest total-cost-of-care savings upstream.

Phase 3 — Years 5–6 *2031 / 2032*

- **Authorize braided funding across health, early learning, housing, and human services** — letting state agencies and regional partners pool Medicaid, public health, early learning, child-welfare prevention, housing, and philanthropic funds against shared accountability for child and family outcomes rather than program-specific outputs.
- **Sustained upstream investment** that measurably reduces downstream acute demand.

Appendix A — Budget items requiring costing

The items below are the budget requests arising from this strategy that require costing by the Governor's Office and the Oregon Health Authority ahead of the 2027–29 Governor's Budget. They are listed as requests to be costed; no figures are attached at this stage. Items are grouped by the section of this report in which the underlying recommendation sits. Section 6.1 Governance generates no direct budget request.

A.1 Capacity & Workforce (section 6.2)

#	Budget item requiring costing
1	Capital: a binding, bond-financed 2027-session commitment to a balanced, multi-level bed portfolio — inpatient, step-down, respite and sub-acute — sized from the OHSU model.
2	Dedicated capacity and financing carve-outs for people who are civilly committed and for voluntary admissions, not only for forensic demand.
3	A rate floor tied to the actual cost of stable delivery, pairing each bed and service with a sustainable rate, with a cost-based daily rate evaluated to stabilize safety-net CMHPs — informed by an evaluation of the actual cost of care for each level of care, including acute psychiatric care, using data already gathered through the pricing process.
4	Establish a fund for guardianships that allows families to access private guardianship processes and speeds time to establishment without waiting for county or state processes.
5	Workforce: national recruitment funding with competitive pay.
6	Workforce: housing for behavioral health staff in rural areas.
7	Fund the placement-referral requirement placed on CMHPs and Exceptional Needs Care Coordinators under the timely-placement-referral directive (Appendix B, Draft Order B, Section 10) — the capacity to initiate referrals within the defined timeframe and to report against it.
8	Secure funding for the cost-based add-on rate for civil commitment and guardianship admissions, including the defined rate for people who are medically ready but awaiting placement.

A.2 Behavioral Health Housing (section 6.3)

#	Budget item requiring costing
9	Capital: a bond-financed 2027-session commitment to permanent-supportive and transitional Behavioral Health Housing capacity, sized from the OHSU model.
10	Launch a housing-preservation package to keep people in their existing units: debt buy-down, an insurance pool, safety-and-security support grants, funded tenancy-support coordination teams, an eviction/lease-violation modification policy that ensures timely unit turn, a rent-cap-and-voucher strategy, and cross-provider response teams.

A.3 Forensic & Legal System (section 6.4)

#	Budget item requiring costing
11	Stand-up and operating funding for the forensic patient care coordination function established under Appendix B, Draft Order D, Section 3 — centralized forensic evaluation, decision-making over placements, coordination of services and treatment in community restoration, and post-discharge supervision.
12	Pilot funding for enhanced behavioral health services for people in custody, in dedicated treatment settings, offsetting the operating costs of voluntary services that stabilize people and maintain restoration.
13	Increase funding for the Oregon Public Guardian and Conservator by $2 million to establish dedicated staff to investigate people undergoing aid-and-assist evaluation whose charges are dismissed or who are deemed “never able.”
14	Fund pilot programs for a robust outpatient treatment court, including an independent treatment monitor who reports to the court and the parties on adherence by the person and by the service providers (including the CMHP) to their obligations under the court-ordered treatment plan.
15	Funding for hospitals and CMHPs to care for people diverted into the civil system on a magistrate hold, and for the mental health evaluations conducted before a hold is issued.
16	Establish and fund a resource prosecutor position within the Department of Justice dedicated to mental health cases, to advise county prosecutors on how to charge, divert and resolve those cases.

A.4 Prevention & Social Determinants (section 6.5)

#	Budget item requiring costing
17	Fund the first-1,000-days bundle: prenatal and maternal care, postnatal parenting support, and parental substance use disorder treatment.
18	Expand evidence-based home visiting — increasing state and Medicaid funding for voluntary, prenatally initiated models (e.g. MIECHV-supported programs) — and determine responsibility for it across the public health system, family medicine and pediatrics.
19	Guarantee universal prenatal-to-age-3 family navigation: a “no wrong door” system connecting families to OHP/Medicaid, WIC, housing, food, child care, home visiting, developmental screening and behavioral health and substance use treatment.
20	Integrate maternal behavioral health into prenatal, postpartum and pediatric care: routine screening and warm handoffs across pregnancy, postpartum and well-child visits; reimbursement for dyadic (parent-and-child) treatment; and postpartum behavioral health supports extended beyond the traditional window.
21	Establish a sustainable funding model for dedicated maternal substance use disorder treatment.
22	Fund infant and early childhood mental health (IECMH) consultation in pediatric primary care, child care, early learning, home visiting and family-serving community-based organizations.
23	Expand treatment foster care as a concrete, in-scope youth intervention, with funding expanded outside the ODHS system.

#	Budget item requiring costing
24	Stand up local “Child Success” regional pilots led by Early Learning Hubs, CCOs, public health, behavioral health, housing, food and community-based organizations, each building a local model with shared governance, braided funding and measurable outcomes.

Appendix B — Draft Executive Order wording

The wording below is provided for the Governor's Office to use or adapt. The recommendations of this strategy that can be carried by executive action are consolidated into four orders, grouped by theme. Dates, order numbers, and signature elements are shown as placeholders marked [X].

Draft Order A — Governance and Accountability

OFFICE OF THE GOVERNOR
STATE OF OREGON
EXECUTIVE ORDER NO. 26-[X]
STRENGTHENING GOVERNANCE AND ACCOUNTABILITY IN OREGON'S BEHAVIORAL HEALTH SYSTEM

WHEREAS, Oregon maintains one of the highest per-capita rates of state mental health spending in the country, yet ranks near the bottom of national assessments of behavioral health system performance, indicating that the system's challenges are structural rather than a deficit of resources or knowledge;

WHEREAS, authority and responsibility for behavioral health services are divided among the Oregon Health Authority ("OHA"), the Oregon Department of Human Services ("ODHS"), counties and their community mental health programs ("CMHPs"), and coordinated care organizations ("CCOs") — with CCOs covering most mental health services but not residential care, and ODHS holding foster care, Aging and People with Disabilities programs, and the statutorily carved-out long-term services and supports that represent roughly one third of Medicaid spending — such that responsibility and authority for an individual's care do not consistently sit in the same hands, and no entity clearly owns the responsibility for building capacity where it is short;

WHEREAS, coordination across the behavioral health system currently operates primarily through contracts and memoranda of understanding rather than through clear structural accountability, and the system is built around Medicaid — approximately 60 percent of behavioral health financing — leaving people covered by Medicare or commercial insurance without a clearly accountable entity;

WHEREAS, Medicare is a principal payer for adults with serious mental illness, many of whom qualify through disability, yet Medicare reimburses well below the cost of care in Oregon and no entity in the current system is accountable for the care of people whose coverage is Medicare;

WHEREAS, administrative complexity has become a barrier to care: providers must navigate multiple contracts, funding streams, data systems, reporting requirements, and approval processes, and this cumulative burden reduces the workforce's ability to serve patients, increases costs, discourages innovation, and obscures accountability for outcomes;

WHEREAS, statewide fee schedules, rate development, and policy development can bear disproportionately on safety-net behavioral health services, placing existing capacity at risk;

WHEREAS, the Medicare Conditions of Participation require every participating hospital to have an effective governing body legally responsible for the conduct of the hospital, 42 C.F.R. § 482.12; the Oregon State Hospital's current statutory Advisory Board has no authority to govern the institution, and that governing function currently rests with the OHA Director alone, while every community hospital in Oregon operates under the oversight of a board of trustees;

WHEREAS, Oregon faces an estimated $11.6 billion in federal health-care funding losses over the next three biennia, and decisive commitments in advance of and during the 2027 legislative session are necessary to enable deliberate system redesign rather than reactive reductions;
WHEREAS, the Oregon Adult Mental Health Statewide Reform Strategy (the "Strategy") recommends that reform begin with governance: establishing a clear, accountable statewide system leader, a Regional Accountability Model for Behavioral Health, and clear accountability for each patient's care, centered on the payer; and
WHEREAS, the Strategy focuses on adults with high acuity behavioral health conditions, while recognizing the need for a dedicated assessment of the children's behavioral health system;
NOW, THEREFORE, I, TINA KOTEK, Governor of the State of Oregon, by virtue of the power and authority vested in me by the Constitution and statutes of the State of Oregon, do hereby order and direct as follows:

1. Governor-Led Expert Group on System Governance.

(a) There is established a group of subject-matter experts, convened and led by the Governor, to determine the appropriate statewide behavioral health system leader and to assess governance accountabilities and fragmentation across the system, working toward a simplified, regional governance model in which a single leader is responsible for the system.
(b) The group shall be constituted no later than [X]. Its determinations under this Section and its work under Sections 2 and 3 shall be delivered to the Governor in time to inform the Governor's 2027 legislative and budget program.

2. Decision on the System-Leader Vehicle.

(a) The group established in Section 1 shall recommend, and the Governor will decide, the vehicle for the statewide system leader: a restructured Oregon Health Authority, a new cabinet-level authority, or a cross-system leader established within the Governor's Office. The system leader shall be established as a regional authority leading the system, not a payer that displaces the CCOs.
(b) The recommendation shall proceed from function rather than organizational form. If a restructured OHA is recommended, the recommendation shall specify the leadership and structural transformation required, including integration with Medicaid leadership and the defined conditions that must be met at OHA.
(c) The recommendation shall be delivered to the Governor no later than [X], ahead of the 2027 legislative session.

3. Regional Accountability Model for Behavioral Health.

(a) The group established in Section 1 shall develop a Regional Accountability Model for Behavioral Health. The model shall align funding approaches from across existing efforts — including Behavioral Health Resource Networks and Measure 110 investments — and shall define distinct roles, funding, deliverables, populations served, and performance expectations in OHA authority, county agreements, and CCO contracts as they come up for renewal.
(b) In developing the model, serious consideration shall be given to where structures can be integrated or consolidated, including integrating adult residential care into the CCO benefit.
(c) The model shall be delivered to the Governor no later than [X].

4. Straw-Person Governance Proposal.

(a) The Governor's Office, supported by the group established in Section 1, shall develop a straw-person governance proposal and vet that proposal with a limited group of system stakeholders, such as the members of the HB 4092 work group, including hospitals, the National Alliance on Mental Illness, CMHPs, and CCOs.

(b) The vetted proposal shall be completed no later than [X], in time to inform the Governor's 2027 legislative and budget program.

5. Analysis of Agreements, Contracts, and Regulatory Requirements.

(a) OHA is directed to commission an analysis of county financial-services agreements, CCO contracts, and applicable legislation and Oregon Administrative Rules to map duplication and fractured accountability across the behavioral health system.

(b) The analysis shall identify the redrafting needed to assign distinct roles, funding sources, deliverables, populations served, and performance expectations across OHA, ODHS, counties, and CCOs, and to establish clear ownership of the responsibility to build capacity where it is short.

(c) OHA shall use the newly executed 18-month county financial assistance agreement, aligned CMHP–CCO memoranda of understanding, and CCO 2.0 contracts as near-term levers for implementing the findings of this analysis.

(d) OHA shall deliver the completed analysis to the Governor no later than [X].

6. Payer-Anchored Accountability.

(a) OHA is directed to codify payer-anchored accountability and authority, such that a single accountable entity is identified for every individual: the CCO for Medicaid members; the commercial insurer for individuals with commercial insurance; the county or CMHP as the safety-net backstop for individuals who are uninsured; and, for individuals enrolled in Medicare, the aligned Dual Eligible Special Needs Plan for full-benefit dual eligibles and a designated accountable entity for individuals whose only coverage is Medicare.

(b) For the Medicaid, commercial, and safety-net lanes, this accountability shall be codified in county agreements and CCO contracts as those agreements and contracts come up for renewal. For the Medicare lanes, OHA shall implement accountability through the levers available to the State — the aligned Dual Eligible Special Needs Plan contract and alignment on the Medicaid side of dual coverage — and shall recommend to the Governor, no later than [X], the entity to be designated as accountable for individuals whose only coverage is Medicare.

(c) Contract and agreement language shall include explicit handoff protocols governing changes in coverage and cases involving individuals engaged with the justice system, the child-welfare system, or Aging and People with Disabilities programs.

7. Reduction of Administrative Burden.

(a) OHA is directed to reduce administrative burden across the behavioral health system by eliminating duplicative administrative requirements, standardizing behavioral health program and reporting requirements, and streamlining contracting, licensing, and data-sharing.

(b) OHA shall review processes, barriers to accessing care for patients, and administrative reporting burden for providers to identify opportunities for streamlining, including aligning CCO behavioral health metrics with Certified Community Behavioral Health Clinic metrics so that measures addressing the same topics use consistent technical specifications and providers are not required to manually compile similar data for separate reports.

(c) OHA shall report to the Governor no later than [X] on actions taken and planned under this Section, including measurable reductions in reporting requirements.

8. Review of Fee Schedules, Rate Development, and Policy Development.

(a) OHA is directed to undertake a review to ensure that statewide fee schedules, rate development, and policy development do not disproportionately harm safety-net behavioral health services.

(b) OHA shall deliver the completed review to the Governor no later than [X], together with the corrective actions OHA will take where disproportionate harm is identified, so that the findings can inform rate and budget development for the 2027–29 biennium.

9. Oregon State Hospital Governing Board.

(a) There shall be established a Governing Board for the Oregon State Hospital, responsible for overseeing the operations of the State Hospital. This is a shift from the current Advisory Board, which has no authority to govern, and reflects that every community hospital in Oregon operates with a board of trustees.

(b) The Governing Board shall include representatives from hospitals with and without psychiatric units, psychiatrists, forensic psychologists, nursing, counties, district attorneys, and the judiciary, and shall include former patients and family members.

(c) OHA, in coordination with the Governor's Office and the Office of General Counsel, shall determine the actions — executive, administrative, or legislative — required to establish the Governing Board and transition from the existing Advisory Board, and shall report those actions to the Governor no later than [X]. Where establishment can proceed under existing authority, it shall proceed without delay; where legislation is required, proposed legislation shall be prepared for the 2027 session.

10. Pediatric Behavioral Health System Redesign.

(a) OHA is directed to commission a pediatric behavioral health system redesign, under the direction of the System of Care Advisory Council ("SOCAC") — an assessment of the current children's mental health system with recommendations specific to that system — complementing the adult-focused Strategy.

(b) The assessment shall be delivered to the Governor no later than [X].

11. General Provisions.

(a) All agencies subject to the authority of the Governor shall cooperate with the implementation of this Executive Order and shall provide such information and assistance as the Governor's Office may request.

(b) Nothing in this Executive Order shall be construed to require the appropriation of funds not otherwise available, or to create any right or benefit, substantive or procedural, enforceable at law by any party against the State of Oregon, its agencies, officers, or employees.

(c) This Executive Order is effective immediately and remains in effect until amended or rescinded.

Done at Salem, Oregon, this [X] day of [X], 2026.

/s/ [X]

TINA KOTEK

GOVERNOR

ATTEST:

/s/ [X]

SECRETARY OF STATE

Draft Order B — Capacity and Workforce

OFFICE OF THE GOVERNOR
STATE OF OREGON
EXECUTIVE ORDER NO. 26-[X]
EXPANDING BEHAVIORAL HEALTH TREATMENT CAPACITY AND STRENGTHENING THE BEHAVIORAL HEALTH WORKFORCE

WHEREAS, Oregon is under-bedded across inpatient, intermediate, respite, and crisis levels of care, and the current working estimate is a statewide gap of approximately 486 inpatient psychiatric beds;

WHEREAS, capacity shortages compound across levels of care: bottlenecks cascade from residential settings to inpatient units to emergency department and psychiatric emergency service boarding, so that no single facility type, added on its own, meaningfully relieves the system;

WHEREAS, the behavioral health system-demand model developed by Oregon Health & Science University ("OHSU") provides a quantitative, Oregon-specific basis for sizing capacity investments, and its "moderate bundle" of targeted capacity and length-of-stay reduction projects a reduction in emergency department and psychiatric emergency service boarding of approximately 80 percent;

WHEREAS, state Medicaid fee schedules place existing operations and capacity at risk and do not support a margin sufficient for providers to build capacity themselves, making the analytic soundness of state capacity investments essential;

WHEREAS, psychiatric units are paid a standard per-diem for admissions of patients who are civilly committed or under guardianship — among the highest-cost admissions in the system, involving court process, enhanced staffing, and lengths of stay driven by placement availability rather than clinical need — which is a direct disincentive to maintaining the civil capacity on which the Strategy depends;

WHEREAS, administrative interpretations of federal Medicaid requirements — including the exclusion applicable to institutions for mental diseases ("IMD") and requirements applicable to home and community-based services ("HCBS") — affect the availability of residential and crisis capacity, and the State should not maintain interpretations more restrictive than federal law requires when doing so limits access to care;

WHEREAS, integration of behavioral health with primary care is crucial to maximizing capacity, ensuring continuity, and enabling effective handoffs between systems, and requires incentives for primary care practices, continuation and expansion of programs for behavioral health in primary care, and pathways for patients to move between systems as part of a recovery path;

WHEREAS, patients who no longer require acute psychiatric care frequently remain in acute settings because eligibility determinations, evaluations, placement referrals, and discharge processes are slow or contested, occupying the system's scarcest capacity while the patient waits in the most expensive care setting;

WHEREAS, stimulant use disorder is a major co-occurring condition with psychosis, and both conditions must be treated in a coordinated way;

WHEREAS, workforce shortages and maldistribution — including too few prescribers and clinicians, an aging workforce, and concentration away from public safety-net settings, with rural areas most affected — limit the capacity of even well-designed systems; and

WHEREAS, the Oregon Adult Mental Health Statewide Reform Strategy (the "Strategy") recommends adopting the OHSU system-demand model as the official basis for capacity targets and investing in a coordinated, balanced portfolio across levels of care rather than any single bed type;

NOW, THEREFORE, I, TINA KOTEK, Governor of the State of Oregon, by virtue of the power and authority vested in me by the Constitution and statutes of the State of Oregon, do hereby order and direct as follows:

1. Adoption of the OHSU System-Demand Model.

(a) OHA is directed to adopt the OHSU behavioral health system-demand model as the official basis for statewide behavioral health capacity and housing targets, and to size every bed and housing commitment proposed for the 2027–29 biennium from the model.

(b) OHA shall work with OHSU to continue developing the model so that it is statewide in scope and covers all behavioral health care settings and behavioral health housing.

(c) OHA shall reconcile model outputs with the updated Public Consulting Group capacity report upon its publication, and shall report to the Governor no later than [X] on the resulting capacity and housing targets.

2. Modernization of the State's Interpretation of the Federal IMD Exclusion.

(a) OHA is directed to modernize its interpretation of the federal IMD exclusion consistent with current federal guidance. Specifically, OHA shall cease aggregating separately licensed facilities of 16 or fewer beds under common ownership when determining whether a facility exceeds the 16-bed limit.

(b) This directive reflects that the aggregation practice is inconsistent with the plain language of the Medicaid Act, 42 U.S.C. § 1396d(i), the regulatory definition of an institution for mental diseases at 42 C.F.R. § 435.1010, and the guidance in the State Medicaid Manual § 4390, under which a separately licensed component of 16 or fewer beds qualifies as an independent facility.

(c) To the extent OHA concludes that federal constraints prevent reimbursement of campus-based models notwithstanding subsection (b), OHA shall pursue the federal waivers necessary to maximize Medicaid reimbursement for behavioral health treatment.

(d) OHA shall report to the Governor no later than [X] on the implementation of this Section, including any conforming changes to rule, guidance, or licensing practice.

3. Review and Modernization of HCBS Implementation for Residential Treatment.

(a) OHA is directed to review and modernize its implementation of HCBS requirements for licensed residential behavioral health treatment settings, identifying areas where state policy, guidance, or oversight practices apply housing-oriented standards more broadly than federal law requires, and modifying those interpretations to better reflect the purpose of residential treatment.

(b) The review shall include policies related to residency agreements, individually based limitations, discharge and transition processes, and other HCBS compliance requirements that affect the operation of residential treatment programs, and shall give particular attention to rural and frontier communities, where the effect of these restrictions has been concentrated and greatest.

(c) The review shall preserve the rights and autonomy of individuals receiving services while recognizing that residential treatment settings serve a clinical function distinct from independent supported housing.

(d) OHA shall deliver the completed review, with implementing actions, to the Governor no later than [X].

4. Incentives for Collaborative and Integrated Behavioral Health Care.

(a) OHA is directed to implement incentives for establishing collaborative and integrated behavioral health care through primary care homes and Certified Community Behavioral Health Clinics, leveraging existing payment models and addressing current barriers to implementation.

(b) The incentives shall include incentives for primary care practices, support for the continuation and expansion of programs for behavioral health in primary care, and pathways for patients to move between the primary care and behavioral health systems as needed, including as part of a patient's recovery path.

(c) In Medicaid, OHA shall evaluate establishing these incentives through CCO rate setting or through restoration of the Quality Pool, and shall report its selected mechanism to the Governor no later than [X].

5. Reimbursement of Collaborative Behavioral Health Care by Insurers.

(a) OHA, in coordination with the Department of Consumer and Business Services, is directed to take all steps within existing statutory and regulatory authority to require that insurers offering health benefit plan coverage in Oregon reimburse clinics, primary care providers, and psychiatric providers for the provision of collaborative behavioral health care services.

(b) For Medicaid, this reimbursement shall be funded through rate setting or through restoration of the Quality Pool, consistent with the mechanism selected under Section 4.

(c) If OHA and the Department of Consumer and Business Services determine that elements of this directive cannot be achieved under existing authority, they shall report that determination to the Governor no later than [X], together with recommended legislation for the 2027 session.

6. Completing the Continuum of Care.

(a) OHA is directed to add the missing levels of care to the statewide capacity plan, to the system-demand model, and to a sustainable billable pathway: ambulatory behavioral health; respite and sub-acute care; and 23-hour crisis stabilization centers, including the CMHP-operated centers operating or in development in Deschutes, Malheur, Clackamas, Benton, and Klamath Counties.

(b) OHA shall likewise incorporate into the plan and model the permanent and transitional housing capacity needed to support this population, and — as a share of the overall system capacity needed — geriatric psychiatric capacity together with long-term care options with mental health supports.

7. Standing Up Under-Resourced Services.

OHA is directed to stand up under-resourced services through existing CCO workgroups, with standard capitation-backed payments, including: addiction consult services in inpatient settings; wound care; and mobile crisis services.

8. Consultative Psychiatry in Primary Care.

OHA is directed to support consultative models for psychiatry in primary care, including the Oregon Psychiatric Access Line ("OPAL") and Project ECHO, and to report to the Governor no later than [X] on whether continuation and expansion of these programs requires incremental funding in the 2027–29 budget.

9. Expedited Eligibility, Evaluations, Placements, and Transitions.

(a) OHA and ODHS are directed to prioritize integrating and expediting Medicaid eligibility and functional assessments, Aging and People with Disabilities ("APD") evaluations and placements, child-welfare transitions, and the crisis system, by increasing the speed and throughput of evaluations and placements and by evaluating mechanisms to allow qualified providers to conduct their own evaluations in exchange for access to enhanced rates and placement.

(b) OHA shall implement a system of presumptive eligibility for patients in acute care, together with a presumptive or provisional enhanced rate, so that patients can move quickly to lower levels of care while evaluations and approvals take place and are cared for in a less expensive care setting.

10. Timely Placement Referrals.

(a) CMHPs and Exceptional Needs Care Coordinators ("ENCCs") shall initiate placement referrals within a defined timeframe once a patient is identified as no longer requiring acute psychiatric care. OHA is directed to define that timeframe, and the mechanism through which it will be applied and monitored, no later than [X].

(b) Because this is a new requirement on CMHPs, it shall be funded: OHA is directed to identify the funding required for CMHPs and ENCCs to meet and report against the requirement, and the route through which that funding will be provided, for inclusion in the 2027–29 budget development. The requirement shall not take effect before its funding is in place.

11. Enforcement of Skilled Nursing Facility Return Requirements.

OHA and ODHS are directed to enforce existing Oregon Administrative Rules requiring skilled nursing facilities to accept a patient returning to care within 30 days without requiring rescreening by APD, and to report to the Governor no later than [X] on the enforcement actions available and taken.

12. Cross-Agency Discharge Escalation and Resolution.

OHA and ODHS are directed to establish a cross-agency process for discharge escalation and resolution — including OHA, APD, CMHPs, CCOs, hospitals, and placement partners — to resolve complex discharge barriers in real time. The process shall be operational no later than [X].

13. Statewide Contingency Management.

OHA is directed to establish the policies, procedures, and reimbursement mechanisms necessary to make contingency management available statewide for patients with a stimulant use disorder and for those with co-occurring conditions, so that stimulant use disorder and psychosis can be treated in a coordinated way.

14. Reducing Residential Lengths of Stay.

OHA is directed to reduce lengths of stay in residential treatment facilities by directing investment toward the permanent supportive housing and outpatient capacity needed to step patients down into, recognizing that length-of-stay reduction is the system-demand model's highest-leverage lever and that, without housing and outpatient capacity, bed investments will not achieve modeled outcomes.

15. Cost-Based Add-On Rate for Civil Commitment and Guardianship Admissions.

(a) OHA is directed to develop an add-on payment that makes a psychiatric unit whole for admissions of patients who are civilly committed or under guardianship, set from the actual cost of delivering that care — including court process, enhanced staffing, and lengths of stay driven by placement availability rather than clinical need.

(b) In Medicaid, the add-on payment may be implemented through CCO directed payments or the fee schedule, and shall include a defined rate for patients who are medically ready but awaiting placement, so that discharge delay is not absorbed by the unit.

(c) Because Medicare rates are set federally and cannot be supplemented on the claim, OHA shall pursue the equivalent effect for Medicare and dual-eligible patients through the contracts each Dual Eligible Special Needs Plan holds with the State, and shall quantify the residual shortfall as part of the State's Medicare strategy. OHA and the Governor's Office shall in addition explore options to engage the federal government on Medicare rate setting, so that the residual shortfall is addressed at its source rather than absorbed by Oregon providers.

(d) OHA shall deliver the rate design to the Governor no later than [X], in time to inform the 2027–29 budget development.

16. General Provisions.

(a) All agencies subject to the authority of the Governor shall cooperate with the implementation of this Executive Order and shall provide such information and assistance as the Governor's Office may request.

(b) Nothing in this Executive Order shall be construed to require the appropriation of funds not otherwise available, or to create any right or benefit, substantive or procedural, enforceable at law by any party against the State of Oregon, its agencies, officers, or employees.

(c) This Executive Order is effective immediately and remains in effect until amended or rescinded.

Done at Salem, Oregon, this [X] day of [X], 2026.

/s/ [X]

TINA KOTEK

GOVERNOR

ATTEST:

/s/ [X]

SECRETARY OF STATE

Draft Order C — Behavioral Health Housing

OFFICE OF THE GOVERNOR
STATE OF OREGON
EXECUTIVE ORDER NO. 26-[X]
ESTABLISHING STANDARDS AND PATHWAYS FOR BEHAVIORAL HEALTH HOUSING

WHEREAS, high acuity behavioral health conditions are chronic conditions requiring long-term disease management, and stable housing paired with appropriate services is a necessary component of that management;

WHEREAS, Oregon does not consistently or effectively deliver permanent supportive housing to the fidelity of evidence-based models of services, and supportive services are frequently disconnected from housing pathways;

WHEREAS, the transition from psychiatric inpatient care to permanent supportive housing is not consistently prioritized, contributing to placements in shelter, failed housing placements, cycling between settings, and rehospitalization;

WHEREAS, the affordable-housing continuum cannot sustainably absorb unmanaged behavioral health acuity, and pressures on that continuum — including anticipated debate over eviction standards and the divestment of nonprofit affordable-housing portfolios to commercial owners — have direct consequences for acute-care demand;

WHEREAS, the Oregon Adult Mental Health Statewide Reform Strategy (the "Strategy") recommends pairing a capital commitment to permanent-supportive and transitional Behavioral Health Housing, sized from the OHSU system-demand model, with two standards designed to prevent placement failure: a defined post-placement support standard and a single funder-of-record for each housing level; and

WHEREAS, the Strategy recommends holding the scope of Behavioral Health Housing to people with high acuity behavioral health conditions, delivered with fidelity, to prevent scope drift;

NOW, THEREFORE, I, TINA KOTEK, Governor of the State of Oregon, by virtue of the power and authority vested in me by the Constitution and statutes of the State of Oregon, do hereby order and direct as follows:

1. Statewide Value-Stream-Mapping Effort.

(a) OHA and Oregon Housing and Community Services ("OHCS") are directed to launch a statewide value-stream-mapping effort with CCOs, hospital systems, key providers, housing authorities, ODHS, counties, and HUD Continuum of Care bodies.

(b) The effort shall map the idealized state — including what guaranteed placement and long-term housing voucher funding would be required at scale for the population — locate where the system breaks down, and identify which entity has authority to act at each breakdown point.

(c) OHA and OHCS shall deliver the resulting map and findings to the Governor no later than [X].

2. Post-Placement Support Standard and Funder-of-Record.

(a) OHA, in coordination with OHCS, is directed to define a post-placement support standard for Behavioral Health Housing, comprising Assertive Community Treatment or Intensive Case Management plus onsite services, and to define a single funder-of-record for each housing level.

(b) These standards shall be designed to reduce placements in shelter, failed housing placements, cycling between settings, and rehospitalization, and shall be completed no later than [X] so that they can be attached as conditions to the 2027–29 Behavioral Health Housing capital request.

3. Acute-Care-to-Housing Pathway Standards.

OHA, in coordination with OHCS, is directed to set acute-care-to-housing pathway standards that prioritize the transition from psychiatric inpatient care to permanent supportive housing — addressing eligibility, timing, funding responsibility, and referral and information-sharing handoffs — and that remain accountable for scale to population need. The standards shall be delivered to the Governor no later than [X].

4. Service-Engagement Approach.

OHA is directed to design the service-engagement approach for Behavioral Health Housing, including how service engagement is mandated within applicable housing models and the use of contingency management for substance-use-disorder abstinence and for medication adherence. The design shall be delivered to the Governor no later than [X].

5. Flexibility for Transitional Housing and Augmented Permanent Supportive Housing.

(a) OHA and OHCS are directed to create the administrative and programmatic flexibility necessary for the expansion of Transitional Behavioral Health Housing and augmented permanent supportive housing, including support for participant service-engagement requirements that operate unobstructed within transitional housing programs and that may have a duration of up to 24 months.

(b) OHA and OHCS shall report to the Governor no later than [X] on the flexibilities established, and shall identify any element that cannot be accomplished without statutory change, for inclusion in the Governor's 2027 legislative program.

6. Housing-Market Pressures Affecting the Behavioral Health Population.

The Governor's Office, with support from OHCS and OHA, will engage proactively on the anticipated eviction-standard debate and on the divestment of nonprofit affordable-housing portfolios, so that impacts on tenants with high acuity behavioral health conditions — and downstream impacts on the acute-care system — are identified and addressed in state housing policy.

7. General Provisions.

(a) All agencies subject to the authority of the Governor shall cooperate with the implementation of this Executive Order and shall provide such information and assistance as the Governor's Office may request.

(b) Nothing in this Executive Order shall be construed to require the appropriation of funds not otherwise available, or to create any right or benefit, substantive or procedural, enforceable at law by any party against the State of Oregon, its agencies, officers, or employees.

(c) This Executive Order is effective immediately and remains in effect until amended or rescinded.

Done at Salem, Oregon, this [X] day of [X], 2026.

/s/ [X]

TINA KOTEK

GOVERNOR

ATTEST:

/s/ [X]

SECRETARY OF STATE

Draft Order D — Forensic and Legal

OFFICE OF THE GOVERNOR
STATE OF OREGON
EXECUTIVE ORDER NO. 26-[X]
IMPROVING FORENSIC AND CIVIL PATHWAYS TO BEHAVIORAL HEALTH TREATMENT

WHEREAS, the Oregon State Hospital is largely consumed by forensic demand: as of June 15, 2026, 374 of the State Hospital's 704 staffed beds were occupied by individuals undergoing competency restoration and another 280 beds by individuals found guilty except for insanity, while the civil commitment population — which once represented 54 percent of the State Hospital's population — now represents less than 8 percent, and as of 2023 Oregon ranked 45th among states for the percentage of state hospital beds occupied by civil patients;

WHEREAS, judicial orders arising from *Oregon Advocacy Center v. Mink* and subsequent litigation require timely admission of individuals undergoing aid-and-assist evaluation, and wait times have fallen from over 40 days in 2022 to an average of 4.4 days in July 2026, within the court-mandated seven-day standard — progress that has come at the expense of access for the civil commitment population, and that artificially lowers forensic demand which would return without the court orders;

WHEREAS, the competency-restoration process is directed at fitness to stand trial rather than long-term stability, and without treatment aimed at sustained recovery many individuals are returned to jail, tried, sentenced, and eventually released in the same or worse condition, cycling back through crisis, re-arrest, and the aid-and-assist queue;

WHEREAS, individuals may wait months in the jail general population for a competency evaluation — time that falls entirely before the seven-day admission timeline begins — and individuals restored to competency are returned to jail, where treatment often cannot continue and medication regimens frequently change with each change in setting;

WHEREAS, magistrate holds available in ongoing criminal proceedings are used inconsistently across the state, and their effectiveness turns on whether a mental health evaluation is obtained before a hold is issued, whether courts and hospitals coordinate, and whether hospitals and community mental health programs have the resources to care for the individuals diverted;

WHEREAS, the individuals in the forensic system are not a separate population from those the civil system serves: they are, in large part, the same individuals, encountered later and at greater cost, after the civil system failed to reach them;

WHEREAS, the Oregon Adult Mental Health Statewide Reform Strategy (the "Strategy") recommends reducing aid-and-assist inflow into the State Hospital by making treatment-focused care available earlier and closer to home — building community-based alternatives for competency restoration treatment, including appropriate housing — so that individuals receive care at the point of need and State Hospital admission is reserved for those who genuinely require hospital-level restoration, thereby reopening civil access; and

WHEREAS, the court-appointed neutral expert's Eleventh Report contains recommendations that have not yet been fully implemented, including Medicaid presumptive eligibility upon discharge and the tracking of funding sources and outcomes for individuals leaving the State Hospital, jails, prisons, and residential treatment facilities;

WHEREAS, House Bill 2005 (2025) permits courts to consider a prior mental health evaluation, but prior evaluations are rarely considered because they are difficult to locate, and courts making

decisions about an individual's treatment and placement therefore proceed without information the State already holds;
WHEREAS, only the superintendent of the state mental hospital may at present seek an order to involuntarily medicate an individual undergoing competency restoration in that superintendent's custody, so that secure residential treatment facilities cannot fully supplement the State Hospital and, absent indemnity, will not offer that service to the State;
WHEREAS, House Bill 2005 (2025) relocated the commitment criteria and left inconsistent language standing in the hold statutes, and county prosecutors have no dedicated source of advice on how to charge, divert, and resolve cases involving individuals with serious mental illness;
NOW, THEREFORE, I, TINA KOTEK, Governor of the State of Oregon, by virtue of the power and authority vested in me by the Constitution and statutes of the State of Oregon, do hereby order and direct as follows:

1. Improving the Effectiveness of Magistrate Holds for Diversion.

(a) OHA, in coordination with the Governor's Office, is directed to take the steps within executive authority necessary to improve the effectiveness of magistrate holds as a tool for diverting an individual out of the forensic system and into the civil commitment process, including holds initiated during ongoing criminal proceedings. Those steps shall address, at a minimum, increasing the mental health evaluations obtained before a hold is issued and encouraging coordination between courts and hospitals on the placement of individuals held.

(b) OHA shall work with CMHPs, hospitals, and — through appropriate channels — the Oregon Judicial Department ("OJD"), to identify the barriers that make use of these holds inconsistent across the state, and shall report to the Governor no later than [X] on the actions taken and any barriers that require statutory resolution or funding.

(c) OHA and the Governor's Office shall support the development of the new statutory "magistrate's hold" process proposed for the 2027 legislative session, which will clarify the process for removing an individual in acute psychiatric crisis in the criminal justice system from a custodial setting to a hospital and the roles and responsibilities of each entity in any subsequent civil commitment process.

(d) Because the diversion this Section seeks depends on the capacity of hospitals and community mental health programs to receive the individuals held, OHA is directed to identify the funding those entities require to do so, together with the funding required for the pre-hold evaluations described in subsection (a), and the route through which that funding will be provided, for inclusion in 2027–29 budget development.

2. Hospital Evaluation, Observation, and Treatment Capacity.

OHA is directed to investigate the licensing, rate-setting, and directed-payment mechanisms it can leverage to ensure that every hospital in the state has evaluation, observation, and treatment facilities for individuals in acute psychiatric crisis who are involved in the criminal justice system, and to report its findings and recommended actions to the Governor no later than [X].

3. Forensic Patient Care Coordination Function.

(a) OHA is directed to establish a function to act as "air traffic control" for forensic patient care, building on existing efforts to create a centralized forensic evaluation system that would consolidate forensic evaluation services into a single entity to coordinate and perform.

(b) The function shall extend beyond centralized evaluation to include decision-making over placements, coordination of services and treatment in community restoration, and post-

discharge supervision to ensure individuals are receiving the services and housing they need to be successful.

(c) OHA shall deliver an implementation design to the Governor no later than [X], identifying the administrative actions, any legislation, and the appropriation required to stand the function up.

4. Single Formulary Across Treatment Settings.

OHA is directed to develop a single formulary across treatment settings so that medication regimens do not need to change every time an individual's placement does — from behavioral health services received in jail custody, to the State Hospital, to community restoration.

5. Technical Guidance on Assisted Outpatient Treatment.

(a) OHA is directed to work with OJD to develop technical guidance on implementing assisted outpatient treatment ("AOT"), for use by courts, community mental health programs, and providers.

(b) The guidance shall be developed so as to support, and be conformed to, the revision of Oregon's AOT statute (ORS 426.133) proposed for the 2027 legislative session — including court approval of the proposed treatment plan, ongoing reporting to the court on adherence by the individual and the service provider, and a remedy structure for non-adherence — and the proposed outpatient treatment-court pilot with an independent treatment monitor. The guidance shall be completed no later than [X].

6. Pre-Release Behavioral Health Services.

OHA is directed to evaluate how other states that authorize up to 90 days of pre-release behavioral health services for individuals in custody are navigating CMS guidance on designated state health programs, and, where possible, to resume implementation and seek renewal. OHA shall report its evaluation and course of action to the Governor no later than [X].

7. Medicaid Presumptive Eligibility upon Discharge.

(a) OHA is directed to implement Medicaid presumptive eligibility for individuals under aid-and-assist or guilty-except-for-insanity orders immediately upon discharge from jail, prison, the Oregon State Hospital, or a residential treatment facility, and to require discharge protocols that restart enrollment in the individual's prior CCO.

(b) Implementation shall make the fullest possible use of medical frailty and inability-to-work criteria so that the work requirements of H.R. 1 are met as efficiently as possible.

8. Tracking of Funding Sources and Outcomes.

OHA is directed to build a tracking system that identifies current funding sources for individuals under aid-and-assist or guilty-except-for-insanity orders and monitors their outcomes after they leave jail, the Oregon State Hospital, or a residential treatment facility — including Medicaid enrollment status, enrollment lag time, emergency department utilization, and criminal justice reentry. The system design shall be delivered to the Governor no later than [X].

9. Review of the Seven-Day Admission Standard.

The Governor's Office is directed to coordinate with the Department of Justice on a preliminary legal review of whether the *Mink/Bowman* seven-day admission standard could be challenged and aligned to the timelines applied in peer states. The review shall be delivered to the Governor no later than [X].

10. Central Repository of Court-Ordered Mental Health Evaluations.

(a) The Governor's Office, with support from OHA, is directed to work with the Office of the Chief Justice and OJD on the development of a central, searchable repository of court-

ordered mental health evaluations, so that a court considering an individual's treatment and placement needs can locate and consider evaluations previously ordered.

(b) The Governor's Office shall establish with OJD, no later than [X], the route by which courts would be required to submit each court-ordered mental health evaluation to the repository, and shall report to the Governor whether that requirement can be achieved by rule or order of the Judicial Department or requires legislation in the 2027 session.

(c) Nothing in this Section directs the Judicial Department or any court. The repository is to be developed with the judicial branch, and this Section commits only the executive resources and coordination the Governor's Office and OHA can provide.

11. General Provisions.

(a) All agencies subject to the authority of the Governor shall cooperate with the implementation of this Executive Order and shall provide such information and assistance as the Governor's Office may request.

(b) Nothing in this Executive Order shall be construed to direct or limit the exercise of judicial discretion, or to require the appropriation of funds not otherwise available, or to create any right or benefit, substantive or procedural, enforceable at law by any party against the State of Oregon, its agencies, officers, or employees.

(c) This Executive Order is effective immediately and remains in effect until amended or rescinded.

Done at Salem, Oregon, this [X] day of [X], 2026.

/s/ [X]

TINA KOTEK

GOVERNOR

ATTEST:

/s/ [X]

SECRETARY OF STATE

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