



Oregon Alcohol and Drug Policy Commission 2023-2025 Substance Use Disorder State Spending Financial Analysis

EXECUTIVE SUMMARY

The Alcohol and Drug Policy Commission (ADPC) is an independent state agency tasked with improving access to evidence-based, evidence-informed and culturally informed substance use prevention, substance use disorder treatment and recovery support services for all Oregonians. In line with the strategies directed by the ADPC 2026-2030 Comprehensive Plan to address substance use disorder, the ADPC conducted this financial analysis of state agency spending on substance use prevention, substance use disorder treatment, prevention, recovery and harm/risk reduction.

Assessing spending across the substance use disorder (SUD) continuum of care can inform spending decisions of state agencies, the Governor and the legislature. The SUD system in Oregon leverages volatile funding sources, often one-time or time-limited, to fund ongoing services. The Findings and Recommendations section provides insights to help agencies and state leadership consider a more strategic approach to funding a more complete, stable substance use disorder system. A more complete system would ensure upstream prevention and early intervention are supported, as well as treatment and recovery services, while also supporting strategies that reduce the risks associated with substance use.

\$1.5 billion in spending across eleven state agencies is analyzed in this report. Oregon continues to heavily leverage Medicaid funding to support the substance use disorder treatment system, with nearly 60% of total state spending allocated to Medicaid. 99.8% of Medicaid spending is for treatment.

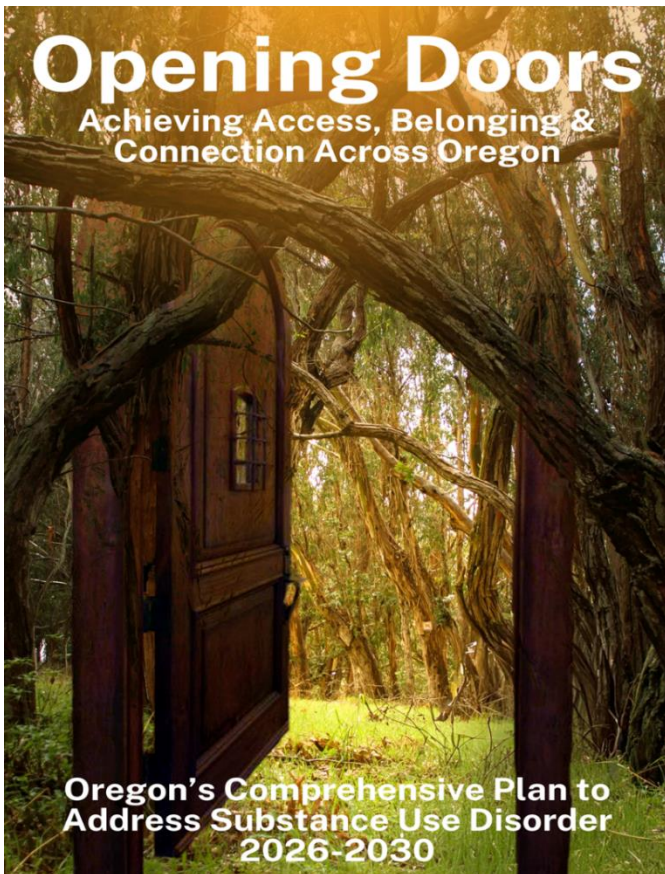
The report summarizes all state agency spending related to substance use disorder by revenue source (i.e., grouped by federal, other, lottery and general fund sources), as well as by area of the substance use disorder care continuum, and by state agency. It also provides a more detailed review of state agency spending.

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INTRODUCTION



An Executive Summary, dashboards for each area of the plan and other information related to community input and the development of the Plan can be found on the [ADPC website](#).

The Alcohol and Drug Policy Commission 2026-2030 Comprehensive Plan includes several strategies related to this financial analysis:

1. Assess state spending across the SUD continuum of care, using the 2021-23 Financial Analysis as a baseline, to inform state budget decisions.
2. Conduct a financial accounting of current primary prevention expenses in this state, including services funded and the funding sources and amounts for those services, as directed by HB 3321 (2025) and make recommendations on the most effective and efficient use of state agency resources.
3. Make recommendation to Governor to prioritize flexible substance-specific funding sources, in particular Cannabis (M110 & Measure 91 allocations to OHA) and Opioid Settlement, for services that are not funded by Medicaid (primary prevention, recovery and harm reduction) to support stable and sustainable funding for an SUD Continuum of Care.

The Alcohol and Drug Policy Commission is tasked with making recommendations regarding budget policy priorities for state agencies and the most effective and efficient use of state agency resources to support substance use disorder programs.

In line with the strategies directed by the 2026-2030 Comprehensive Plan, the ADPC will conduct this financial analysis in 2026 for the 2023-25 biennium, and again in 2028 for the 2025-27 biennium. The 2023-25 analysis examined the [2021-23 Oregon Health Authority Substance Use Disorder Financial Analysis](#), conducted by the Public Consulting Group (2024), and was informed by interviews with Oregon Health Authority and other state agency staff.

The 2023-25 financial analysis differs from the 2021-23 analysis in significant ways and will serve as a new baseline to compare future biennial spending. The 2023-25 analysis is an assessment

of all ADPC-participating state agency spending on substance use prevention, substance use disorder treatment, recovery services and harm/risk reduction associated with substance use.

SPENDING ASSOCIATED WITH A RECOVERY ORIENTED SYSTEM OF CARE

The 2026-2030 ADPC Comprehensive Plan adopts a Recovery Oriented System of Care (ROSC) framework for the state of Oregon. ROSC is a coordinated, person-centered network of community supports spanning prevention, early intervention, treatment, and long-term recovery with health and safety interventions to reduce harms related to SUD incorporated throughout.

Assessing spending across this continuum of care can inform spending decisions of state agencies, the Governor and legislature. The SUD system in Oregon leverages volatile funding sources, often one-time or time-limited, to fund ongoing services. The Findings and Recommendations section provides insights to help agencies and state leadership consider a more strategic approach to funding a more complete, stable substance use disorder system. A more complete system would ensure upstream prevention and early intervention are supported, as well as treatment and recovery services, while also supporting strategies that reduce the risks associated with substance use.

For these reasons, definitions of areas of the continuum of care, with service definitions for where services fall within the continuum of care, were provided to agencies. Every effort was made to define what services or staffing was paid for by the spending identified and to identify the revenue source for the spending. Additional state agencies were included in the analysis, as well as additional spending for some agencies not previously included in the 2021-23 analysis. There are also two notable instances where categories of funding were excluded from this analysis – tobacco funding solely dedicated to tobacco prevention and cessation, and problem gambling spending exclusively related to gambling addiction. Both fall outside of the scope of the work of the ADPC and inflate the overall spending picture related to substance use disorder.

The amount of spending in the 2021-23 analysis may not be compared to the spending in the 2023-25 analysis, but it is hoped that future analyses will be comparable to the current analysis.

METHODOLOGY AND APPROACH FOR ANALYSIS

State agencies were informed throughout the development of the 2026-2030 Comprehensive Plan that the biennial financial analysis would be conducted by the ADPC in 2026. Governor Kotek issued a letter to the participating state agencies on February 9, urging cooperation and collaboration. See Appendix A. The ADPC provided a template, including standardized instructions, definitions, and funding designations, in early March, requesting response by mid-April. See Appendix B. ADPC staff reviewed the agency responses, engaging in dialogue with

the state agencies to work toward accurate, uniform information and interpretation across the state agencies. Agencies reviewed their respective draft agency summaries in June, before inclusion in this final report.

Note about [HB 3321 \(2025\)](#): HB 3321 defined substance use disorder prevention and directed the ADPC to conduct a comprehensive inventory and assessment of existing primary prevention programs in Oregon, including a financial accounting of current primary prevention expenses and services funded in Oregon. That analysis was conducted concurrently to this analysis and informed this final report, with both published in September 2026.

SPENDING SUMMARY

The 2023-25 analysis represents \$1.5 billion in spending across eleven state agencies. The spending summaries below provide an overview of spending by revenue source, how the spending is invested across the continuum of care, and by state agency.

SUD SPENDING BY REVENUE SOURCE

Federal funding is the largest revenue source funding substance use disorder programs and services. 53% of the total funding came from federal funding sources, with the majority of federal funding attributed to Medicaid matching dollars (87%)¹.

Due to the differing methodologies and applicable agencies, the breakdown of revenue sources in this report cannot be directly compared to the 2021-2023 analysis. It is worth noting that federal funding made up a similar percentage of revenue (56%) in 2021-23.

Oregon's General Fund supports 24% of total spending. Other Fund sources support 22.5% of total spending. Lottery Funds represent less than 1%. Where agency funding sources differ between 2021-23 and 2025-27, it will be noted in the agency summary later in the report.

Definitions of revenue sources are included in Appendix B.

TOTAL SPENDING BY REVENUE SOURCE

Table 1: Total Spending by Revenue Source

Funding Category	Sum of Funding Amount	Percent of Total Funding
Federal Funds (FF)	\$790,679,867.53	52.74%
General Fund (GF)	\$358,722,602.00	23.93%
Other Funds (OF)	\$337,503,252.31	22.51%
Lottery Funds Total	\$12,302,856.34	0.82%
TOTAL FUNDING	\$1,499,208,578.18	

¹ For more information about federal Medicaid match rates, please refer to the OHA Medicaid Division section and Appendix G.

Proportion of Funding by Type of Revenue Source (FF/GF/OF/LF)

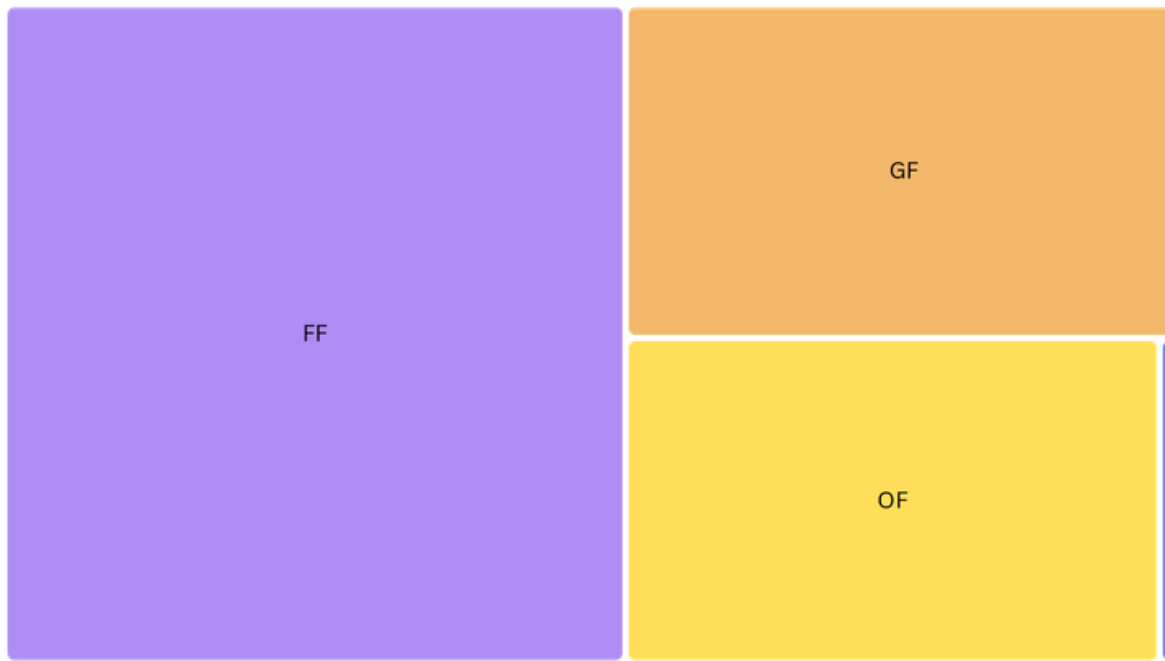


Figure 1: Proportion of Funding by Type of Revenue Source (FF/GF/OF/LF)

Total SUD Spending by Revenue Source

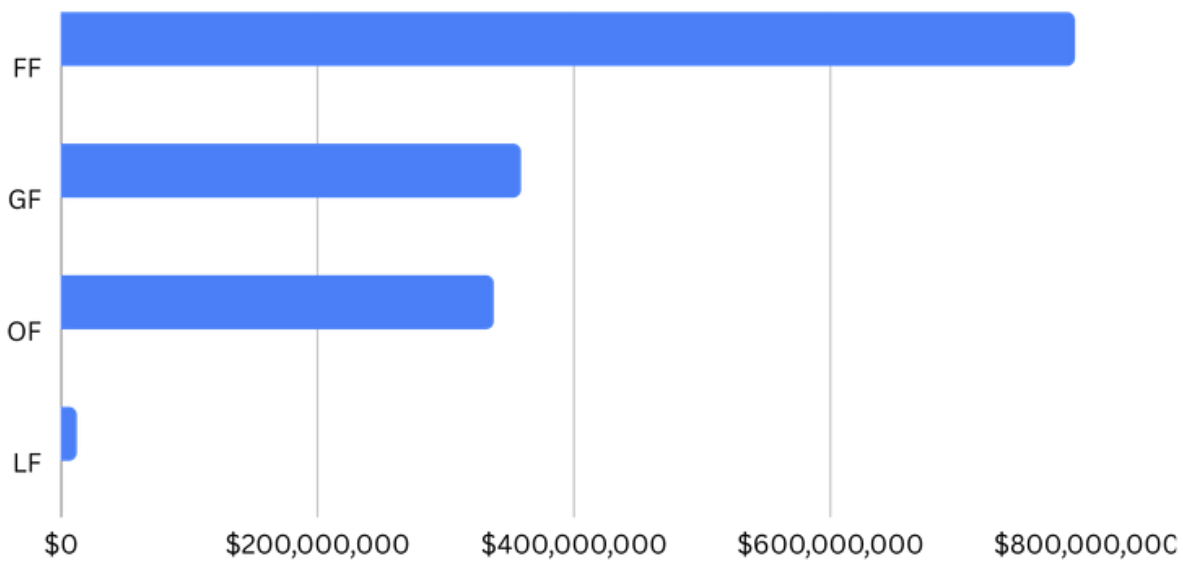


Figure 2: Total Spending by Type of Revenue Source

FF-Medicaid Match

GF

OF-Marijuana DTRSF

FF-SUPTRS

FF-SOR

FF-ARPA

OF-OL

OF-

FF-TitL

LF-L

FF-OD

FF-

FF-

TOTAL FEDERAL FUND BREAKDOWN

FF-Medicaid

FF-Non-Medicaid

10

Table 2: SUD Spending by Federal Revenue Source

Funding Category	Applicable Agencies	Sum of Funding Amount	Percent of Category Funding*	Percent of Total Funding*
Federal Funds Total		\$790,679,867.53		52.74%
FF-Medicaid Match	ADPC, OHA-BHD, OHA-Medicaid, SOCAC	\$686,855,873.40	86.87%	45.81%
FF-SUPTRS (Substance Use Prevention, Treatment and Recovery Services Block Grant)	OHA-BHD, OHA-PHD	\$32,025,086.78	4.05%	2.14%
FF-SOR (State Opioid Response)	OHA-BHD, OHA-PHD	\$30,726,938.32	3.89%	2.05%
FF-ARPA (American Rescue Plan Act)	ODHS, OHA-BHD, OHA-PHD	\$16,115,702.36	2.04%	1.07%
FF-Title IV-B of the Social Security Act	ODHS	\$14,661,046.33	1.85%	0.98%
FF-OD2A (Overdose to Action)	OHA-PHD	\$4,604,250.19	0.58%	0.31%
FF-TANF (Temporary Assistance to Needy Families)	OHA-BHD, ODHS	\$1,928,960.96	0.24%	0.13%
FF-PDMP (Harold Rogers Prescription Drug Monitoring Program)	OHA-PHD	\$1,553,256.16	0.20%	0.10%
FF - Title I - CAPTA (Child Abuse Prevention and Treatment Act)	ODHS	\$1,136,845.34	0.14%	0.08%
FF - SPF-PFS (Strategic Prevention Framework-Partnerships for Success)	OHA-PHD	\$450,399.49	0.06%	0.03%
FF-CDC Alcohol	OHA-PHD	\$255,657.95	0.03%	0.02%
FF-Title XX Social Services Block Grant	YDO	\$130,000.00	0.02%	0.01%
FF-RSAT (Residential Substance Abuse Treatment for State Prisoners)	DOC	\$121,898.00	0.02%	0.01%
FF-BJS Stats (Bureau of Justice Statistics State Justice Statistics Program)	CJC	\$108,958.25	0.01%	0.01%
FF-AOT (Federal Assisted Outpatient Treatment)	OHA-BHD	\$4,939.00	0.00%	0.00%
FF-PATH (Projects for Assistance in Transition from Homelessness)	OHA-BHD	\$55.00	0.00%	0.00%

*Where percentages are less than .001, the percentage is shown as zero.

All Non-Medicaid Federal Funding Sources



Figure 5: Proportion of all Non-Medicaid Federal Funding Sources

Federal Funding Proportions by Agency (Medicaid and Non-Medicaid)

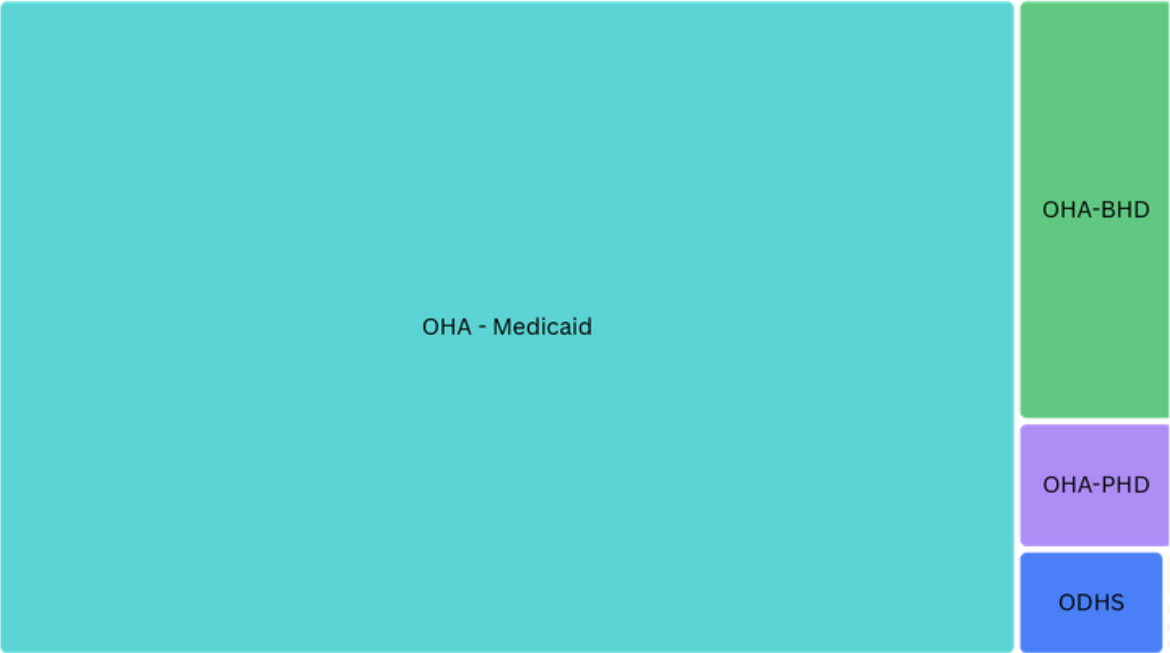


Figure 6: Federal Funding Proportions by Agency for all Federal Funding (Medicaid and Non-Medicaid)

Non-Medicaid Federal Funding by Agency

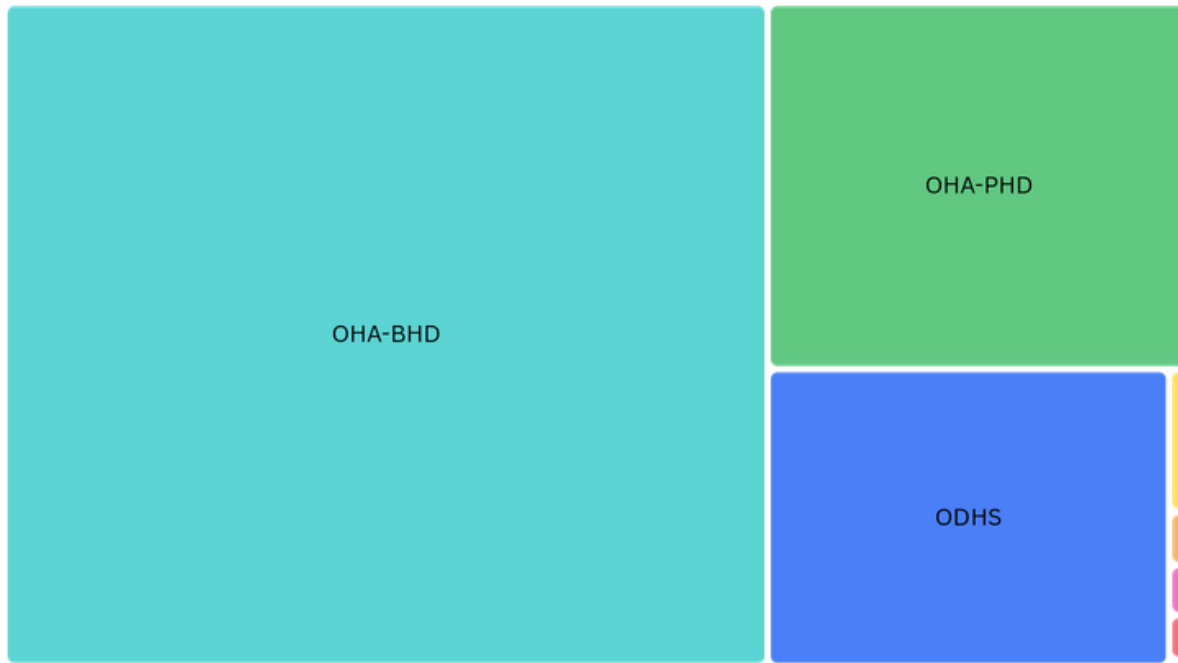


Figure 7: Federal Funding Proportions by Agency for all Non-Medicaid Federal Funding (Note: Federal funding to ADPC, CJC, DOC, SOCAC and YDO equals less than 1%)

TOTAL GENERAL FUND BREAKDOWN

Proportion of General Fund State Medicaid Match vs. Other

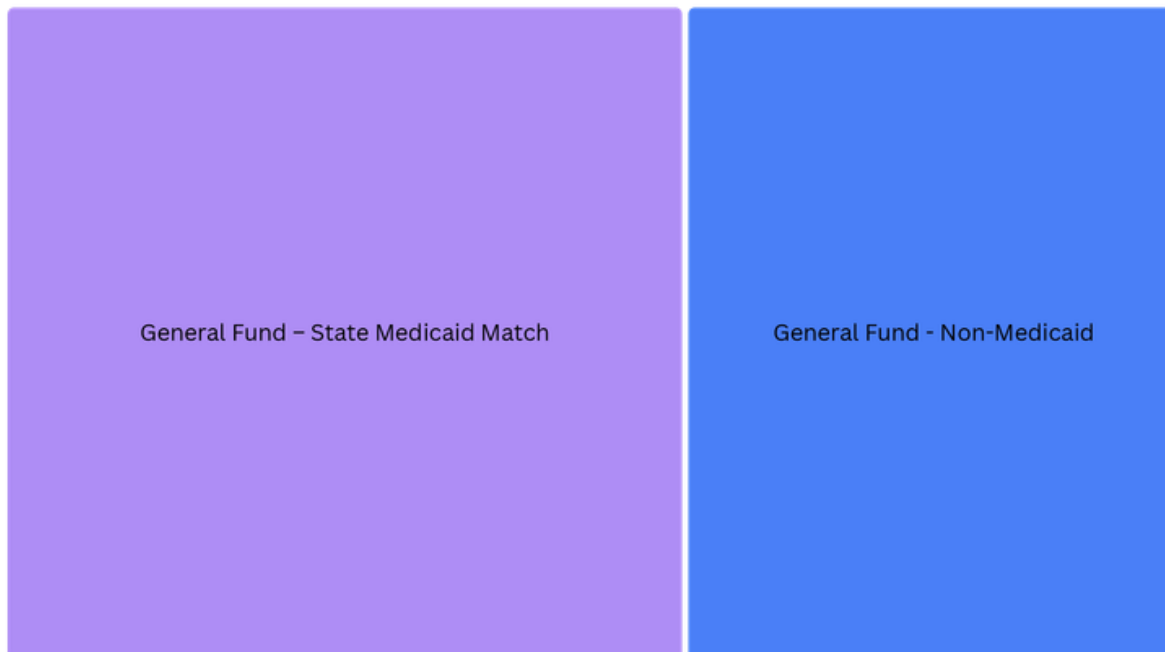


Figure 8: General Fund Proportion State Medicaid Match vs. Non-Medicaid GF

Table 3: SUD General Fund Spending

Funding Category	Applicable Agencies	Sum of Funding Amount	Percent of Category Funding	Percent of Total Funding
GF		\$358,722,602.00		23.93%
General Fund – State Medicaid Match	OHA-Medicaid	\$207,465,420	57.83%	13.84%
General Fund	ADPC, CJC, DOC, ODE, ODHS, OHA-BHD, OHA-PHD	\$151,257,182	42.17%	10.09%

General Fund Proportions by Agency (Including State Medicaid Match)

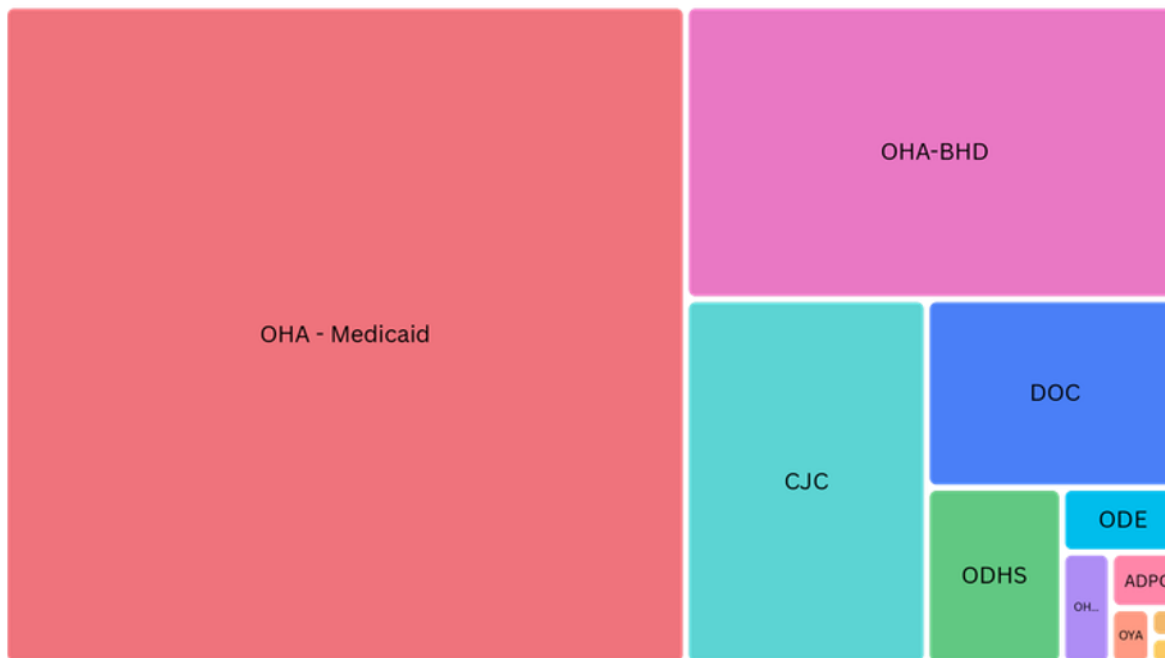


Figure 9: General Fund Proportion by Agency with state Medicaid Match included (Note: ADPC, OYA, SOCAC, YDO and OSP GF spending totals less than 1% of all GF)

Non-Medicaid General Fund Proportions by Agency

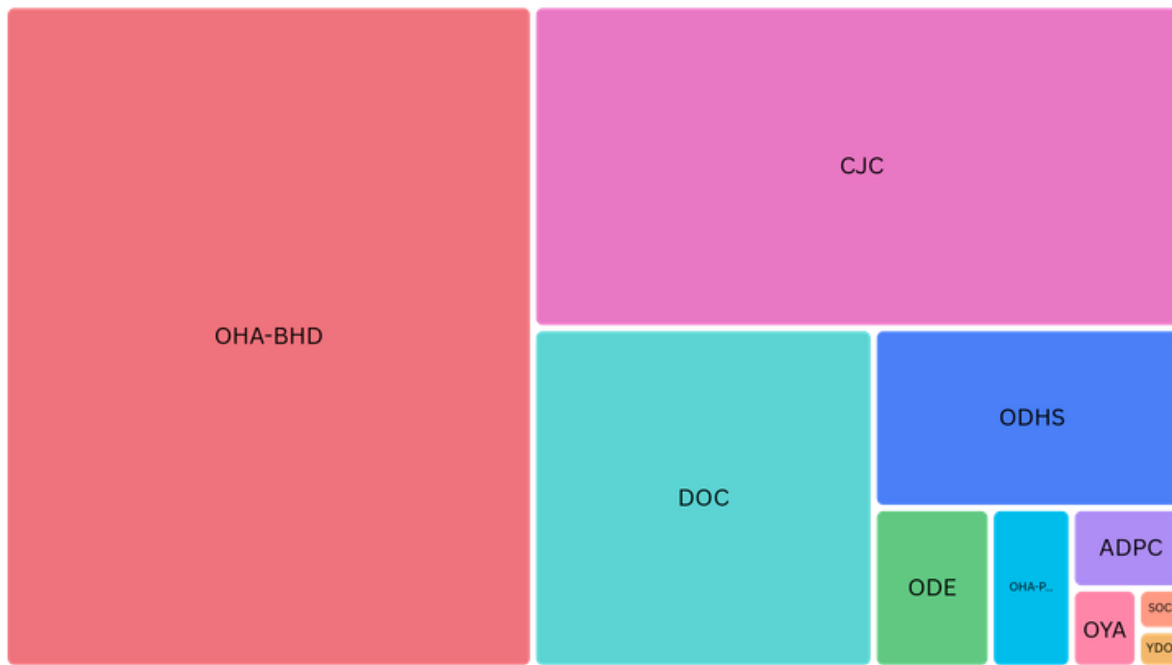


Figure 10: General Fund Proportions by Agency (with GF spent as state Medicaid Match removed)

TOTAL OTHER FUND BREAKDOWN

Proportion of Other Funds by Other Fund Revenue Source

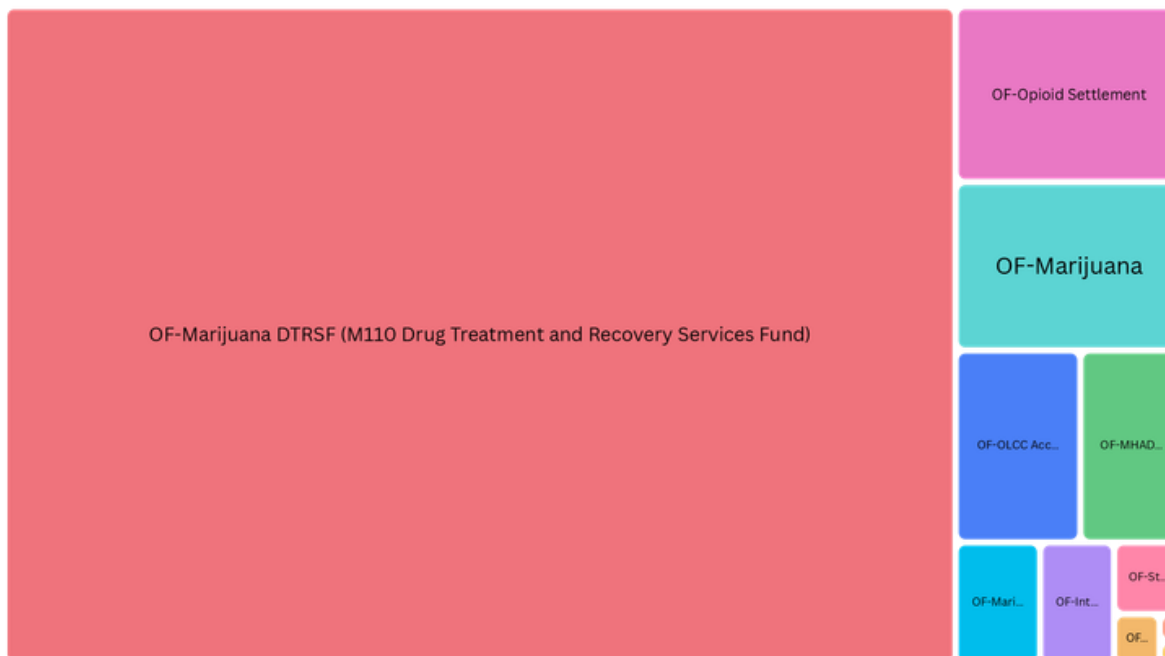


Figure 11: Proportion of Other Funds by Source

Table 4: SUD Other Fund Spending

Funding Category	Applicable Agencies	Sum of Funding Amount	Percent of Category Funding*	Percent of Total Funding*
Other Funds		\$337,503,252.31	100%	22.51%
OF-Marijuana DTRSF (M110 Drug Treatment and Recovery Services Fund)	OHA BHD	\$272,352,949.98	80.70%	18.17%
OF-Opioid Settlement	OHA-BHD, OHA-PHD	\$17,023,151.11	5.04%	1.14%
OF-Marijuana	OHA-BHD, OHAPHD	\$16,594,273.98	4.92%	1.11%
OF-OLCC Account	OLCC	\$10,576,359.71	3.13%	0.71%
OF-MHADSA (Mental Health, Alcoholism and Drug Services Account)	OHA BHD	\$8,374,327.60	2.48%	0.56%
OF-Marijuana Control & Regulation Fund	OLCC	\$4,420,931.00	1.31%	0.29%
OF-Intoxicated Drivers Program Fund	OHA-BHD	\$3,881,212.90	1.15%	0.26%
OF-Statewide Education Initiatives Account	ODE	\$2,049,768.00	0.61%	0.14%
OF-State School Fund	ODE	\$1,100,232.00	0.07%	0.07%
OF-State PDMP (Prescription Drug Monitoring program)	OHA-PHD	\$943,534.17	0.28%	0.06%
OF-Misc.	OHA-BHD	\$184,762.00	0.05%	0.01%
OF- Criminal Fines	OHA-PHD	\$1,749.86	0.00%	0.00%

*Where percentages are less than .001, the percentage is show as zero.

Proportion of Other Fund by Agency



Figure 12: Proportion of all Other Fund Spending by Agency

TOTAL LOTTERY FUND BREAKDOWN

Proportion of Lottery Funds vs. Lottery Bonds



Figure 13: Proportion of Lottery Fund Spending by Fundings vs. Bonds

Table 5: SUD Lottery Funds Spending

Funding Category	Applicable Agencies	Sum of Funding Amount	Percent of Category Funding*	Percent of Total Funding*
Lottery Funds Total		\$12,302,856.34	100%	0.82%
LF-Lottery Bonds	OHA-BHD	\$644,675.34	5.24%	0.04%
LF (Lottery Funds)	ADPC, CJC, OHA-BHD	\$11,658,181.00	94.76%	0.78%

*Where percentages are less than .001, the percentage is show as zero.

Proportion of Lottery Fund Spending by Agency

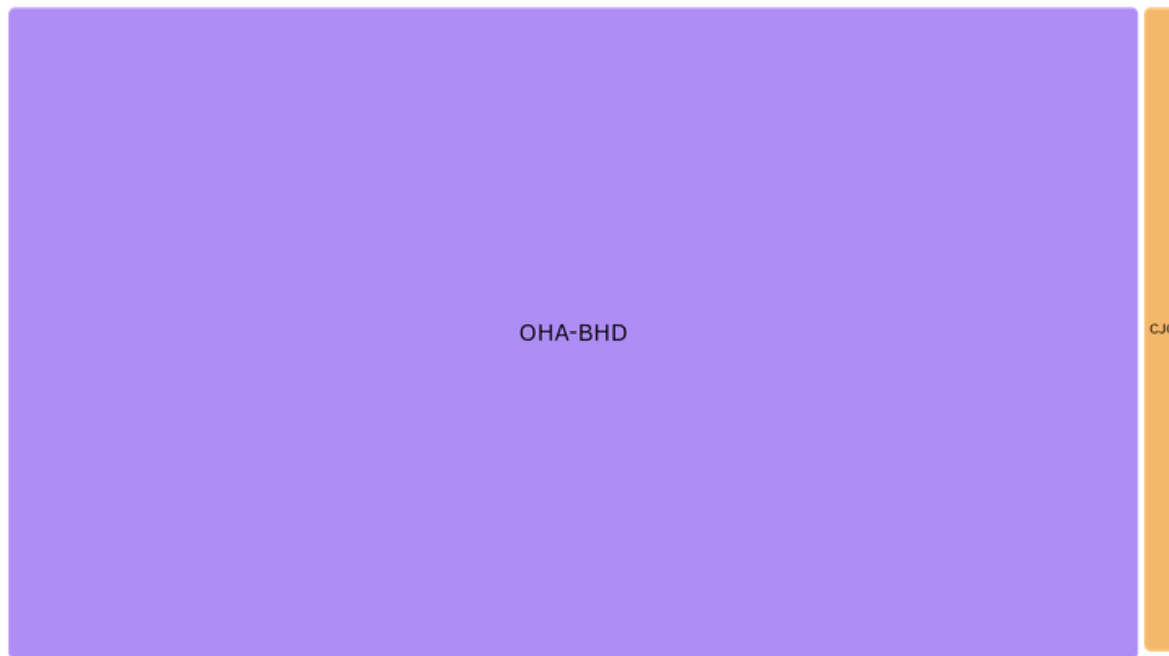


Figure 14: Proportion of All Lottery Fund Spending by Agency (Note that ADPC spending makes up .02% of Total LF spending)

SUD SPENDING BY AREA OF CONTINUUM

The area of continuum designated for spending was determined by the state agencies and reviewed by the ADPC. Instructions to agencies and service descriptions within each area are provided in Appendix C. The continuum of care is based on the Recovery Oriented System of Care (ROSC) framework, a person-centered continuum encompassing primary prevention, early intervention, treatment, recovery and risk reduction throughout the continuum.

In addition to the ROSC-recognized areas, it was necessary to identify additional spending categories for spending that cannot easily be categorized across state agencies or merited a separate category due to the specific nature or setting of the services. This includes Deflection, Treatment Courts, Driving Under the Influence of Intoxicants (DUII), Jail Treatment/MSUD (includes spending on Medications to treat Substance Use Disorder that are delivered in jail settings), Tribal spending, and Drug Screening.

Agencies were asked to categorize spending related to peer delivered services into the appropriate area of the continuum of care. For example, if peer delivered services were delivered in a clinical treatment setting with the purpose of supporting an individual during treatment, the spending would be classified as "Treatment." However, not all spending for peer delivered services could be categorized in this manner based on available information. All efforts were made to identify the services delivered with accuracy and precision to avoid designations such as "other" or "cross continuum."

It must also be noted that a financial analysis related to primary prevention of substance use disorder was prepared concurrent to this ADPC State Agency Financial Analysis, in accordance with HB 3321 (2025). The HB 3321 report was performed by a consultant through contract with the ADPC and has been incorporated into this report. The HB 3321 analysis allowed for a deeper analysis of prevention spending and included local spending. Despite best efforts, a small portion of funding reviewed through the HB 3321 analysis could not be verified as primary prevention funding or any other specific area of the continuum and appears in the below summary as "Other."

The allocation of spending across the continuum of care cannot be compared to 2021-23 for several reasons. First and foremost, the definitions included in Appendix C for this 2023-25 analysis were provided to all state agencies in order to categorize the services funded. The 2023-25 analysis also sought to eliminate all funding categorized as "Other" and to allocate peer delivered services across the continuum of care, whereas the 2021-23 analysis included a separate category for peer delivered services.

Table 6: Spending by Area of SUD Continuum of Care

Area of Continuum	Sum of Funding Amount	Percentage of Total Funding
Treatment	\$1,100,221,958.15	73.39%
Recovery Supports	\$252,231,086.96	16.82%
Harm/Risk Reduction	\$56,770,557.20	3.79%
Primary Prevention	\$39,107,857.36	2.61%
Peer Delivered Services not otherwise categorized	\$11,703,788.11	0.78%
Deflection	\$10,189,595.22	0.68%
Treatment Courts	\$7,436,542.56	0.50%
DUII	\$6,462,785.24	0.43%
Jail Treatment/MSUD	\$6,094,018.67	0.41%
Early Intervention	\$4,832,414.09	0.32%
Tribal	\$2,413,226.24	0.16%
Other	\$1,290,890.78	0.09%
Drug Screening	\$454,037.60	0.03%
Grand Total	\$1,499,208,578.18	100.00%

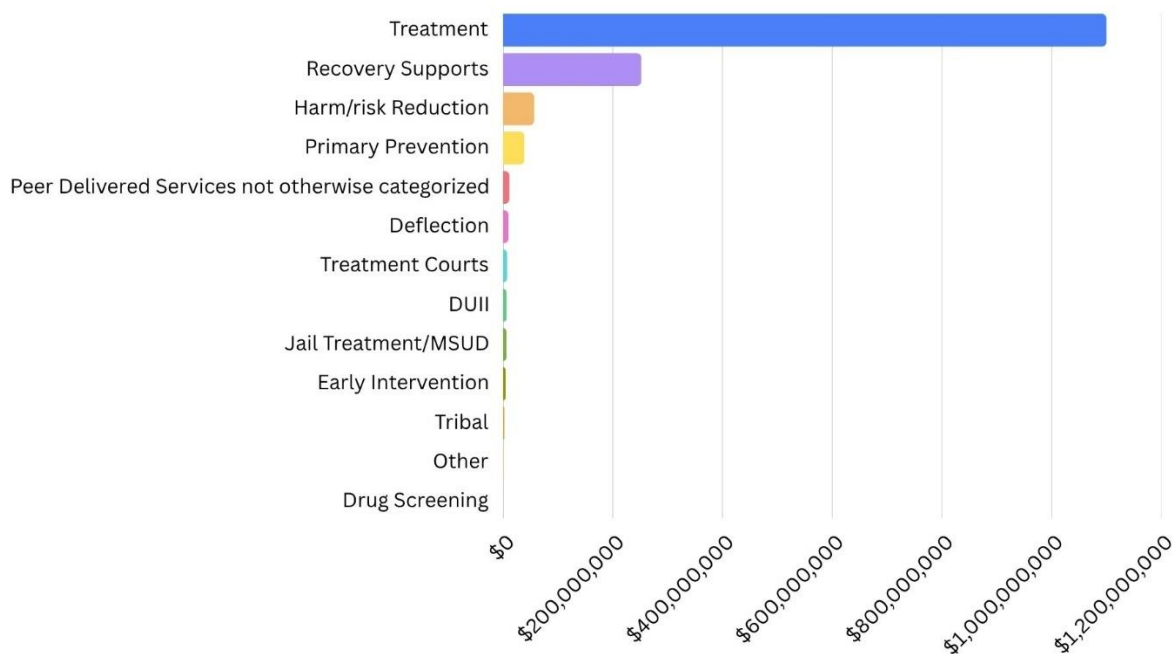


Figure 15: Total Spending by Area of Continuum of Care

Proportion of Spending by Area of Continuum of Care



Figure 16: Proportion of Total Spending by Area of Continuum of Care

TREATMENT SPENDING BY AGENCY

Table 7: Treatment Spending (all revenue sources) by Agency

Agency	Amount of Spending on Treatment	Percent of Total Treatment Funding	Percent of Overall SUD Funding
OHA-Medicaid	\$890,655,686.87	80.95%	59.41%
OHA-BHD	\$175,260,398.77	15.93%	11.69%
DOC	\$22,530,463.47	2.05%	1.50%
CJC	\$7,336,555.90	0.67%	0.49%
ODHS	\$1,379,445.08	0.13%	0.09%
OHA-PHD	\$1,290,223.91	0.12%	0.09%
OYA	\$985,464.00	0.09%	0.07%
ADPC	\$541,966.27	0.05%	0.04%
SOCAC	\$136,703.90	0.01%	0.01%
YDO	\$105,050.00	0.01%	0.01%
Total	\$1,100,221,958.15	100%	73.39%

Proportion of Treatment Spending by Agency

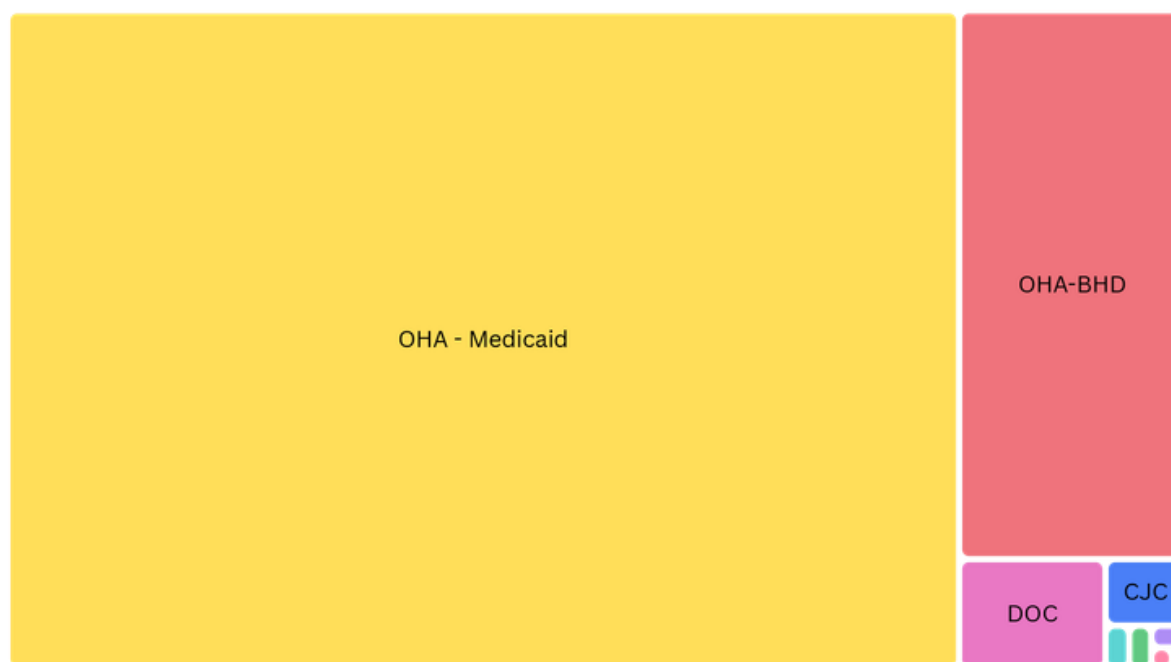


Figure 17: Proportion of Treatment Spending (all revenue sources) by Agency

RECOVERY SPENDING BY AGENCY

Table 8: Total Recovery Spending (all revenue sources) by Agency

Agency	Amount of Spending on Recovery	Percent of Total Recovery Funding	Percent of Overall SUD Funding
OHA-BHD	\$210,860,944.32	83.60%	14.06%
ODHS	\$24,729,922.02	9.80%	1.65%
CJC	\$7,144,965.14	2.83%	0.48%
ODE	\$4,748,073.00	1.88%	0.32%
OHA - Medicaid	\$2,718,640.91	1.08%	0.18%
OHA-PHD	\$1,191,075.41	0.47%	0.08%
ADPC	\$541,966.27	0.21%	0.04%
SOCAC	\$165,499.91	0.07%	0.01%
YDO	\$130,000.00	0.07%	0.01%
Total	\$252,231,086.97	100%	16.82%

Proportion of Recovery Spending by Agency

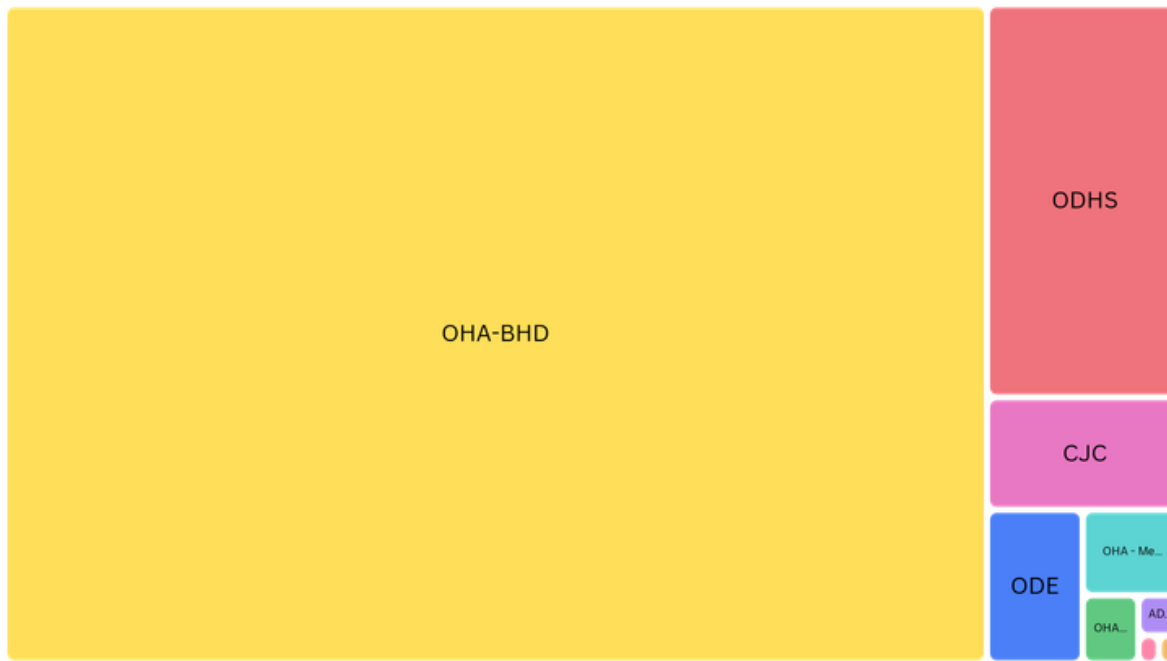


Figure 18: Proportion of Recovery Spending (all revenue sources) by Agency

HARM/RISK REDUCTION SPENDING BY AGENCY

Table 9: Total Harm/risk reduction Spending (all revenue sources) by Agency

Agency	Amount of Spending on Harm/risk reduction	Percent of Total Harm/risk reduction Funding	Percent of Overall SUD Funding*
OHA-BHD	\$48,766,168.16	85.90%	3.25%
OHA-PHD	\$7,047,239.53	12.41%	0.47%
ADPC	\$541,966.27	0.95%	0.04%
CJC	\$155,513.14	0.27%	0.01%
OLCC	\$135,857.21	0.24%	0.01%
ODHS	\$63,197.34	0.11%	0.00%
Oregon State Police	\$39,317.52	0.07%	0.00%
OHA - Medicaid	\$21,298.04	0.04%	0.00%
Total	\$56,770,557.20	100%	3.79%

*Where percentages are less than .001, the percentage is show as zero.

Proportion of Harm/Risk Reduction Spending by Agency

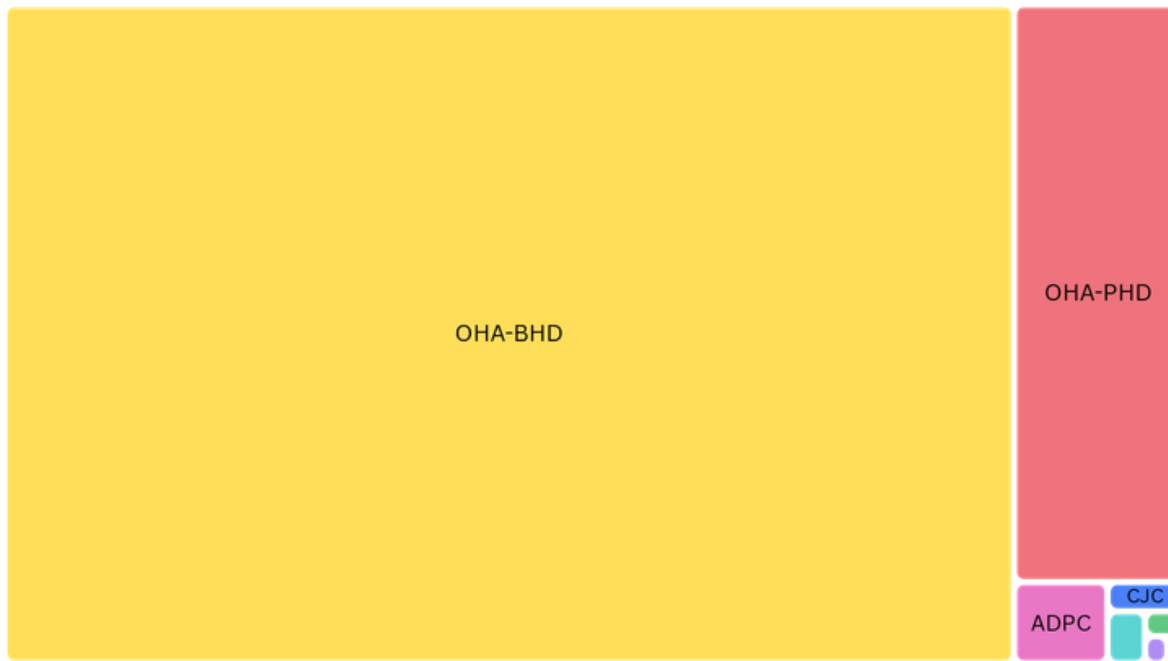


Figure 19: Proportion of Harm/risk reduction Spending (all revenue sources) by Agency

PRIMARY PREVENTION SPENDING BY AGENCY

Table 10: Total Primary Prevention Spending (all revenue sources) by Agency

Agency	Amount of Spending on Primary Prevention	Percent of Total Primary Prevention Funding	Percent of Overall SUD Funding
OHA-PHD	\$19,725,190.87	50.44%	1.32%
OLCC (Regulatory)	\$14,861,433.50	38.00%	0.99%
OHA-BHD	\$1,990,671.74	5.09%	0.13%
ODE	\$1,988,595.00	5.08%	0.13%
ADPC	\$541,966.27	1.39%	0.04%
Total	\$39,107,857.36	100%	2.61%

Proportion of Primary Prevention Spending by Agency

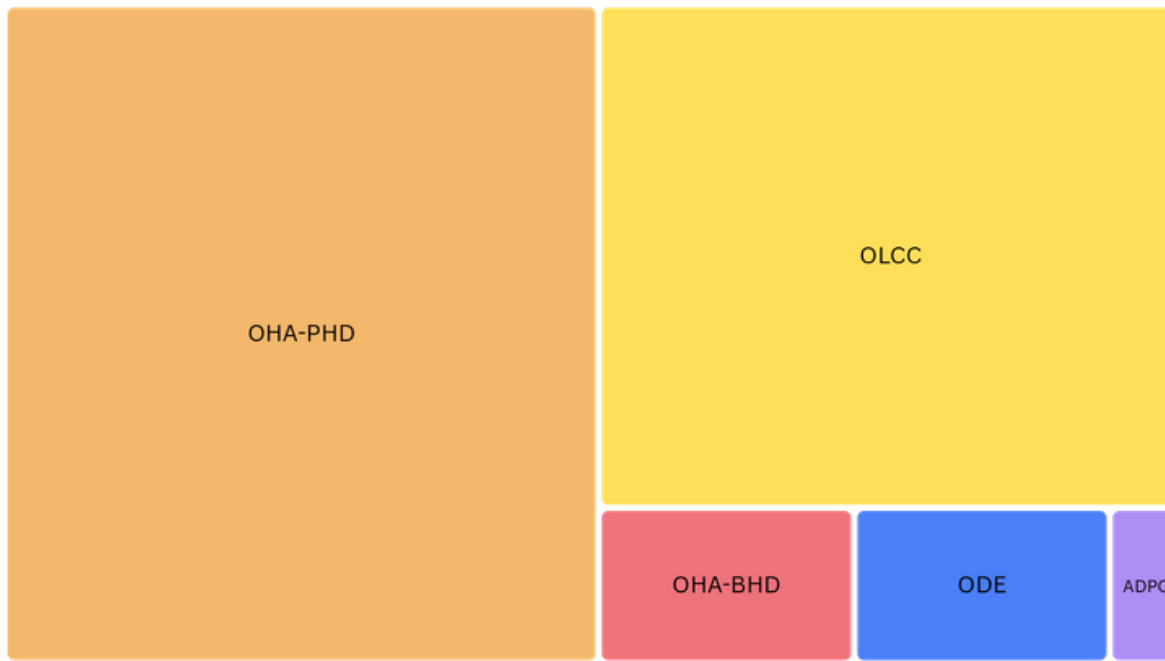


Figure 20: Proportion of Primary Prevention Spending (all revenue sources) by Agency

PEER DELIVERED SERVICES NOT OTHERWISE CATEGORIZED

Table 11: Peer Delivered Services Not Otherwise Categorized (all revenue sources) by Agency

Agency	Amount of Spending on Peer Delivered Services	Percent of Total Peer Delivered Services Funding	Percent of Overall SUD Funding
OHA-BHD	\$10,162,330.63	86.83%	0.68%
CJC	\$1,541,457.49	13.17%	0.10%
Total	\$11,703,788.11	100%	0.78%

Proportion of Peer Delivered Services Spending (Not Otherwise Categorized) by Agency



Figure 21: Proportion of Spending on Peer Delivered Services (not otherwise categorized) by Agency

Note that, when the information was available, peer delivered services were categorized within the area of the continuum of care where the peer supports were deployed. This category should not be categorized as the sum total of spending on peer delivered services.

EARLY INTERVENTION SPENDING BY AGENCY

Table 12: Early Intervention Spending (all revenue sources) by Agency

Agency	Amount of Spending on Early Intervention	Percent of Total Early Intervention Funding	Percent of Overall SUD Funding
OHA-BHD	\$3,796,307.09	78.56%	0.25%
ODHS	\$738,648.00	15.29%	0.05%
YDO	\$190,000.00	3.93%	0.01%
SOCAC	\$107,459.00	2.22%	0.01%
Total	\$4,832,414.09	100%	0.32%

Proportion of Early Intervention Spending by Agency



Figure 22: Proportion of Early Intervention Spending (all revenue sources) by Agency

The remaining areas are wholly or substantially funded through one agency. Altogether, the below spending represents less than 3% of total SUD spending.

Table 13: Agency Spending Breakdown for Other Areas of Continuum (all revenue sources)

Area of Continuum	Sum of Funding Amount	Applicable Agency/ies	Percentage of Total Funding
Deflection	\$10,189,595.22	99% CJC/1% OHA-BHD	0.68%
Treatment Courts	\$7,436,542.56	94% CJC/6% OHA-BHD	0.50%
DUII	\$6,462,785.24	98% OHA-BHD/1.7% CJC/.03% ODHS	0.43%
Jail Treatment/MSUD	\$6,094,018.67	95% CJC/5% OHA-BHD	0.41%
Tribal	\$2,413,226.24	88% CJC/12% OHA-BHD	0.16%
Other	\$1,290,890.78	100% OHA-PHD	0.09%
Drug Screening	\$454,037.60	52% OHA-BHD/42% CJC/6% ODHS	0.03%

SUD SPENDING BY STATE AGENCY

As noted above, amounts below cannot be directly compared to 2021-23 due to differing methodology and a broader Medicaid claims analysis. The agency-by-agency summaries below provide further information about new or additional funding, if applicable.

The spending of several agencies is included for the first time in this analysis – the Oregon Liquor and Cannabis Commission (OLCC), Oregon Department of Education (ODE), ADPC, Youth Development Oregon (YDO), System of Care Advisory Council (SOCAC), and Oregon State Police (OSP). This spending represents a small proportion of overall spending, but includes agencies critical to the implementation of the Comprehensive Plan to address substance use disorder. As part of this analysis, agencies were asked to include spending related to state agency staff.

Table 14: SUD Spending by Agency or OHA Division

Agency	Total Funding	Percentage of Total Funding
Oregon Health Authority - Medicaid	\$894,296,678.82	59.65%
Oregon Health Authority-Behavioral Health Division (BHD)	\$457,725,563.53	30.53%
Criminal Justice Commission	\$41,386,860.49	2.76%
Oregon Health Authority -Public Health Division (PHD)	\$30,544,440.41	2.04%
Oregon Department of Human Services (ODHS)	\$26,963,253.35	1.80%
Department of Corrections (DOC)	\$22,530,463.47	1.50%
Oregon Liquor and Cannabis Commission (OLCC)	\$14,997,290.71	1.00%
Oregon Department of Education (ODE)	\$6,736,668.00	0.45%
Alcohol and Drug Policy Commission (ADPC)	\$2,167,865.08	0.14%
Oregon Youth Authority (OYA)	\$985,464.00	0.07%
Youth Development Oregon (YDO)	\$425,050.00	0.03%
System of Care Advisory Council (SOCAC)	\$409,662.80	0.03%
Oregon State Police (OSP)	\$39,317.52	0.00%
Grand Total	\$1,499,208,578.18	100.00%

*Where percentages are less than .001, the percentage is show as zero.

Total Spending by Agency or OHA Division

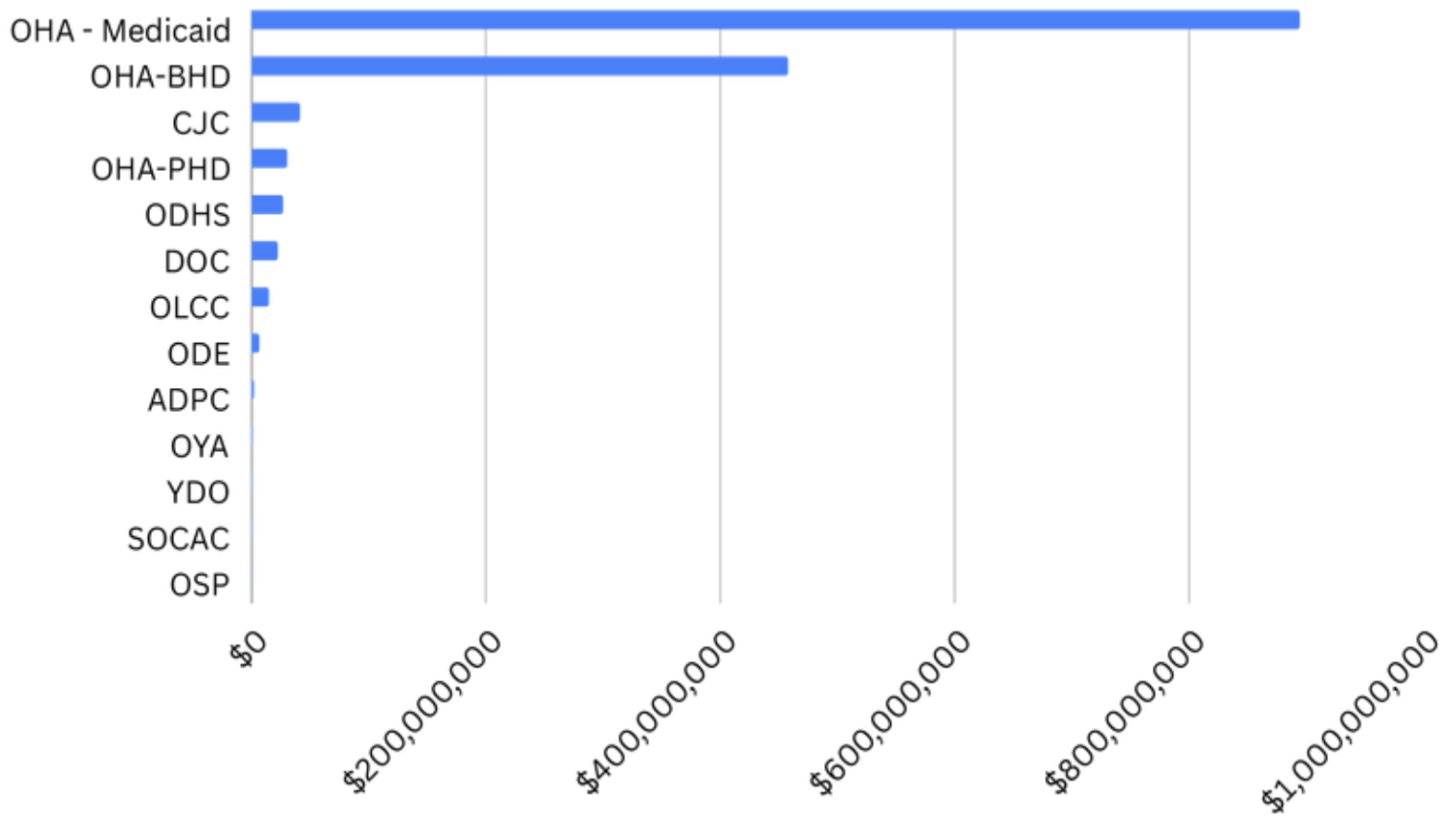


Figure 23: Spending by Agency or OHA Division

Proportion of Spending by Agency or OHA Division

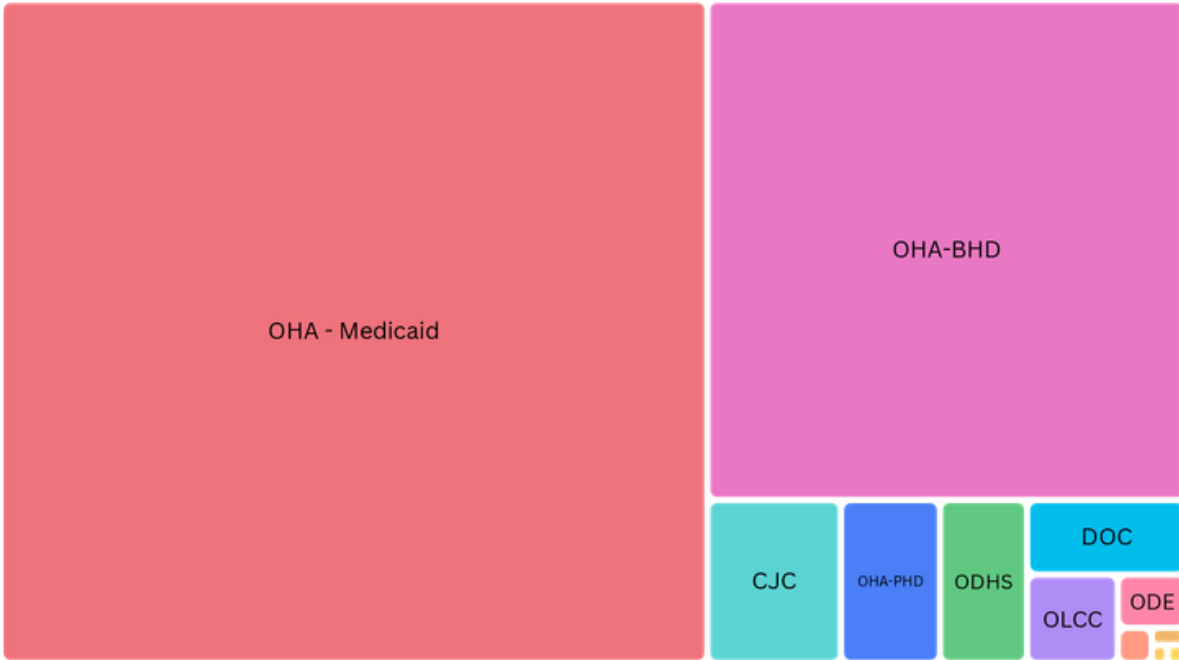


Figure 24: Proportion of Spending by Agency or OHA Division

FINDINGS AND RECOMMENDATIONS

FINDINGS

1. Oregon lacks an overall funding strategy for substance use disorder across state agencies. There is no overall strategy for funding a substance use prevention and substance use disorder treatment and recovery system that meets the needs of people where they are at. There is also no overarching direction to leverage funding strategically.
2. In many cases, agencies blend funding at the agency level to support state staffing, as well as to support grants and contracts to counties, providers, and community-based organizations. This blending can make it impossible to analyze what a particular revenue source is funding. Braiding funding sources, where each fund retains its separate identity, would allow for more precise analysis and prevent entire “pots” of funding from being designated for the most restrictive funding purpose.
3. There is misalignment between need and funding. For example, youth in Oregon Youth Authority facilities have extremely high need, but very little funding is allocated for substance use disorder services at OYA.
4. Oregon’s substance use disorder system largely relies on unpredictable federal funding and volatile, temporary Other Fund sources.
 - a. Total Medicaid spending (Federal Medicaid Match + General Fund State Medicaid Match) is 60% of all spending on substance use disorder. Medicaid spending accounts for 88% of treatment spending. Oregon must carefully consider impacts to SUD treatment spending when implementing policies related to HR1 and Medicaid budget decisions.
 - b. Other Fund sources make up nearly one-quarter of total spending and largely relate to cannabis, beer and wine tax revenue. Substance-specific revenues are generally volatile revenue sources and present counterproductive incentive in the substance use disorder space. Particularly with respect to cannabis revenue allocated to the M110 Drug Treatment and Recovery Services Fund, the nature of the distribution is inherently variable as any change in revenue is absorbed wholly by the fund.
 - c. Other Funds related to opioid settlements will continue to make up a larger portion of spending over the next decade, but these funds are time limited.
 - d. Federal grant funds make up approximately \$104 million or 7% of all spending. These funds have also proven uncertain with shifting federal priorities and requirements.
 - e. General Fund makes up less than one-quarter of all spending.

RECOMMENDATIONS

1. Develop budget and procurement practices to braid funding strategically to maximize revenue sources.
2. Federal Funding
 - a. ADPC will further evaluate federal grant funding allocations for SUD services to ensure allocations avoid duplication, align with overall state strategies to address substance use disorder and have potential to improve the current system.
 - b. ADPC recommends that the 20% set-aside requirement for SUPTRS block grant funding be considered a floor for primary prevention and increase over time. ADPC will develop recommendations for OHA for future grant applications to better leverage block grant funds for primary prevention programs and services, as well as additional recommendations related to the primary prevention set-aside based on the analysis in (a).
3. Cannabis Revenue
 - a. Oregon should proceed with caution when considering cannabis revenue reforms or allocations. Actions at the federal level related to Controlled Substances Act rescheduling and hemp regulation present regulatory uncertainty. In Oregon, the tax exemption on medical marijuana revenue will sunset at the end of 2027, but an extension of the sunset will impact revenue forecasts for the M110 Drug Treatment and Recovery Services Fund.
 - b. ADPC recommends that the Department of Administrative Services Office of Economic Analysis refines its Marijuana Revenue Forecast to consider additional factors.
 - c. ADPC recommends that Behavioral Health Resource Network allocations from the Drug Treatment and Recovery Services Fund be prioritized for services not covered by Medicaid, in particular early intervention and pre-treatment engagement, recovery supports including recovery housing and recovery community centers, and culturally and linguistically specific services across the care continuum.
 - d. ADPC recommends increased transparency on Measure 91 allocations, which includes funding to the state school fund, the Oregon State Police, cities and counties, and two separate pools of revenue to OHA.
4. ADPC will conduct further analysis of 2023-25 funding in the following areas:
 - a. Examine all federal funding sources to develop a risk analysis and strategy to: maximize federal funding to meet the goals of the Comprehensive Plan, avoid duplication, minimize risk, and evaluate current oversight strategies.
 - b. Develop a strategy to track one-time funding allocated through state agencies, including evaluation of impact.
 - c. Conduct further analysis of recovery, peer services and BHRN funding to delineate pre-treatment engagement, housing supports, peer supports in treatment, and peer supports in risk reduction. Examine potential strategies to maximize current funding sources, and develop recovery capital metrics to track outcomes across agencies. Develop recommendations for tracking recovery spending across agencies.

- d. Conduct further analysis of youth-specific funding to develop recommendations for high impact funding strategies to address youth substance use disorder.
- e. Review OHA-BHD transition to new County Financial Assistance Agreements (CFAAs), to compare 2023-25 spending under former contracts and 2025-27 spending under new contracts to understand any impact to SUD services.
- f. Support ongoing tracking of Medicaid spending related to substance use disorder, in collaboration with OHA Medicaid and OHA Health, Policy and Analytics.
- g. Develop individual agency recommendations and goals for funding the continuum of care, with the goal to align funding strategies across agencies to fully address substance use disorder across the continuum.
- h. Collaborate with all advisory entities related to SUD funding, beginning with the Opioid Settlement Prevention, Treatment and Recovery Board, to identify ways to streamline and align efforts.

AGENCY-BY-AGENCY SPENDING SUMMARIES

OREGON HEALTH AUTHORITY (OHA)

OVERALL OHA SPENDING

Table 4: Total OHA Spending

Agency	Total Funding	Percentage of OHA Total Spending	Percentage of Total Funding
OHA - Medicaid	\$894,296,678.82	64.68%	59.65%
OHA-BHD	\$457,725,563.53	33.11%	30.53%
OHA-PHD	\$30,544,620.48	2.21%	2.04%
Total OHA Spending	\$1,382,566,682.76	100%	92.22%

Total OHA SUD Spending

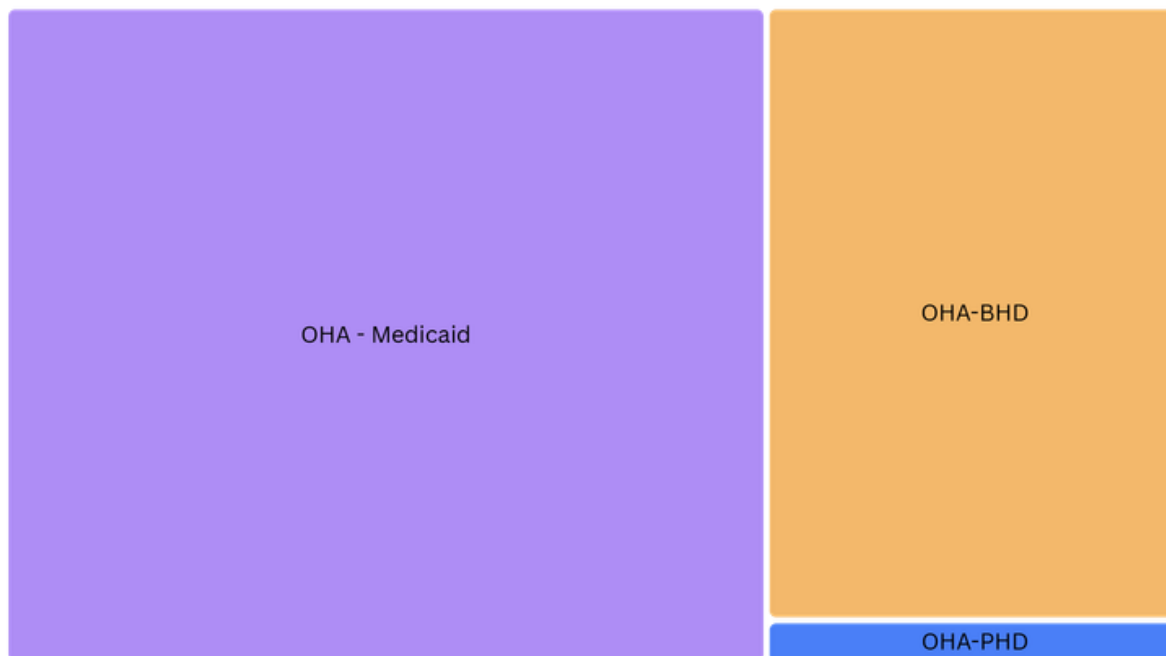


Figure 25: Total OHA Spending by Division (all revenue sources)

MEDICAID

Medicaid substance use disorder spending reported for the 2021-2023 financial analysis totaled \$562 million. The number reported for 2023-25 cannot be compared to the 2021-23 spending as different methodology, developed in collaboration with the ADPC, was utilized. See Appendix C for more detail on the methodology for this analysis.

The following sections present the total Medicaid spending by overall portion of General Fund to Federal Fund Medicaid Match, portion of Medicaid spending through Coordinated Care Organizations and Fee for Service Medicaid, and Medicaid spending across the continuum of care. The information is presented in three different formats through a table and graphs in each section.

Table 16: Total Medicaid Spending by Funding Source

Funding Source	Total Funding by Source	Percentage of Total Medicaid Funding
FF-Medicaid Match	\$685,930,206	76.78%
General Fund – State Medicaid Match	\$207,465,420	23.22%
Total Medicaid Spending	\$893,395,626	100.00%

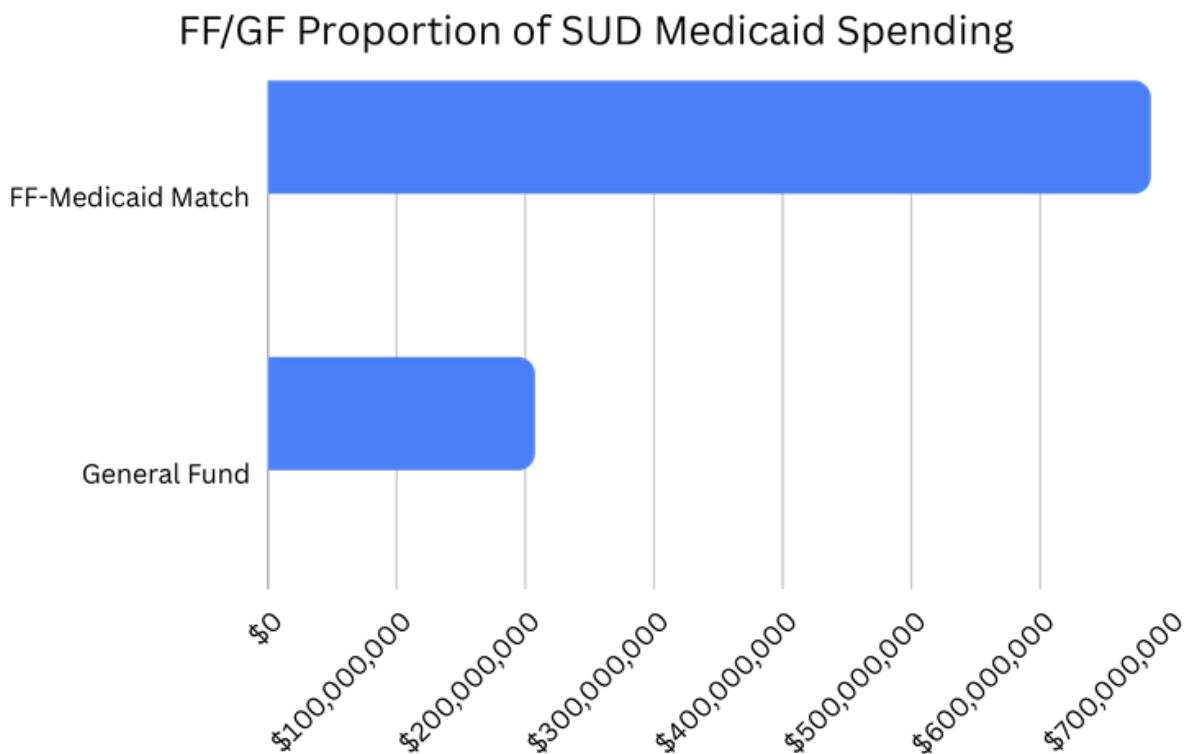


Figure 26: Proportion of Federal and General Fund SUD Medicaid Spending

Proportion of FF/GF Spending SUD Medicaid



Figure 27: Proportion of Federal and General Fund SUD Medicaid Spending

TOTAL MEDICAID SPENDING CCO, FEE-FOR-SERVICE AND ADMINISTRATIVE

OHA used average Medicaid match rates to approximate the General Fund and Federal Fund Medicaid Match. For CCO spending, this was an approximate 24% General Fund to 76% Federal Fund allocation. For Fee-For-Service claims, the allocation used was 16.5% General Fund to 83.5% Federal Fund.

The proportion of CCO to Fee-For-Service spending is virtually unchanged from 2021-23.

Table 17: Total Medicaid Spending by CCO, FFS and Administrative

CCO, FFS or Admin	GF	FF-Medicaid Match	Total Funding	Percent of Total Medicaid Funding
CCO	\$193,796,033.16	\$617,066,030.27	\$810,862,063.43	90.76%
FFS	\$13,592,746.10	\$68,787,533.29	\$82,380,279.39	9.22%
Admin	\$76,642.00	\$76,641.00	\$153,283.00	0.02%
Grand Total	\$207,465,421.26	\$685,930,204.56	\$893,395,625.82	100.00%

CCO, FFS and Administrative Spending as Portion of Total Medicaid Spending

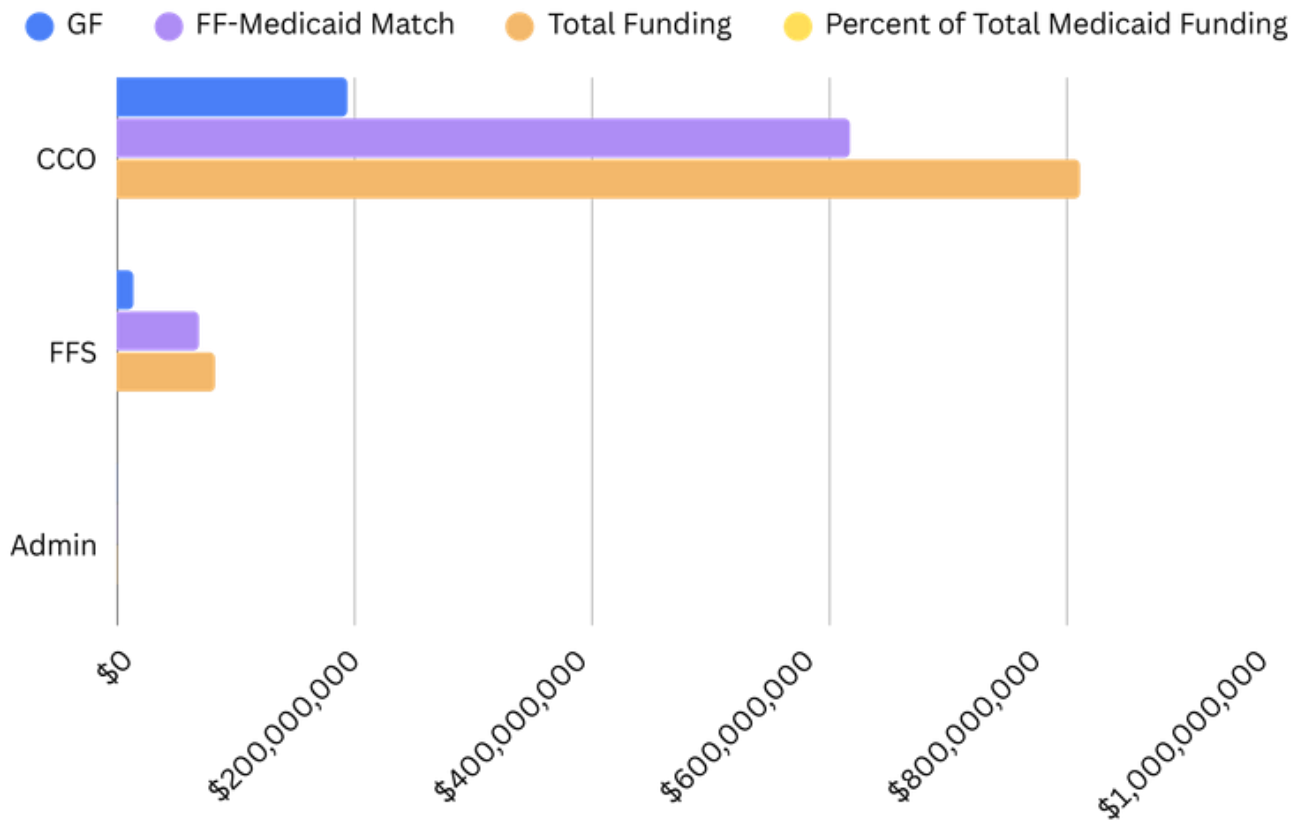


Figure 28: CCO, FFS & Administrative Spending as Portion of Total

Proportion of CCO, FFS and Administrative of Total Medicaid Spending

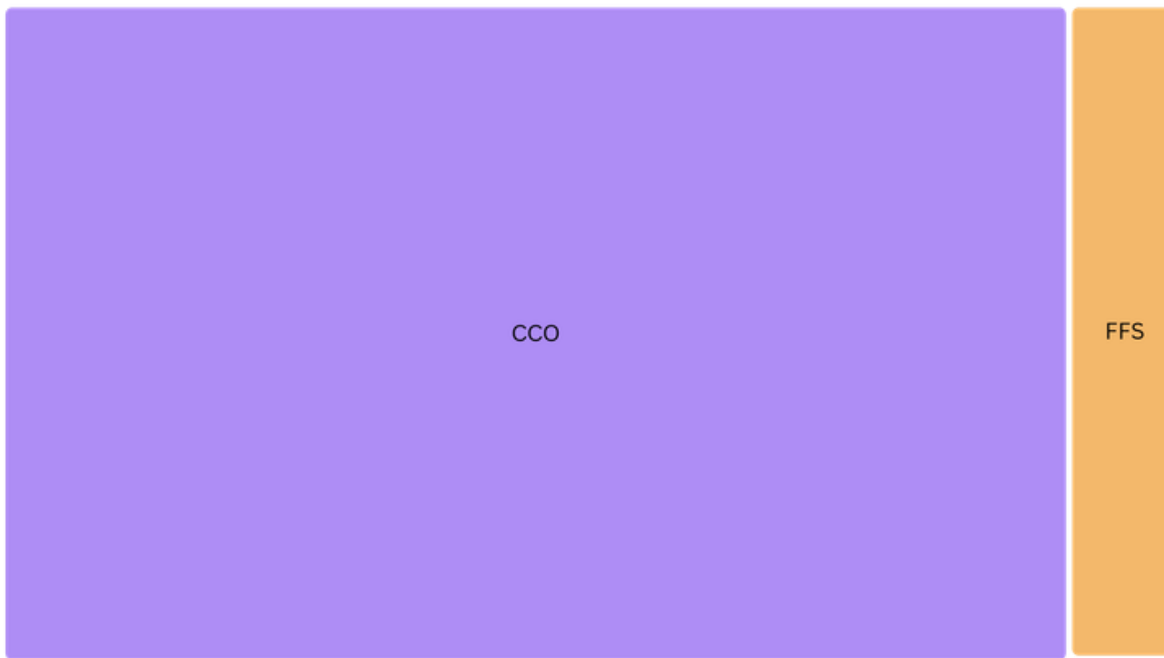


Figure 29: Proportion of CCO, FFS and Administrative Medicaid Spending

TOTAL MEDICAID SPENDING BY AREA OF CONTINUUM

Similar to 2021-23, nearly all of Medicaid spending funds treatment of substance use disorder.

Table 18: Total Medicaid Spending by Area of Continuum

Area of Continuum	Total Funding for Area	Percentage of Total Medicaid Spending*
Treatment	\$890,655,687.00	99.69%
Recovery Supports	\$2,718,641	0.30%
Harm/risk reduction	\$21,298	0.00%
TOTAL	\$893,395,626	100.00%

*Where percentages are less than .001, the percentage is show as zero.

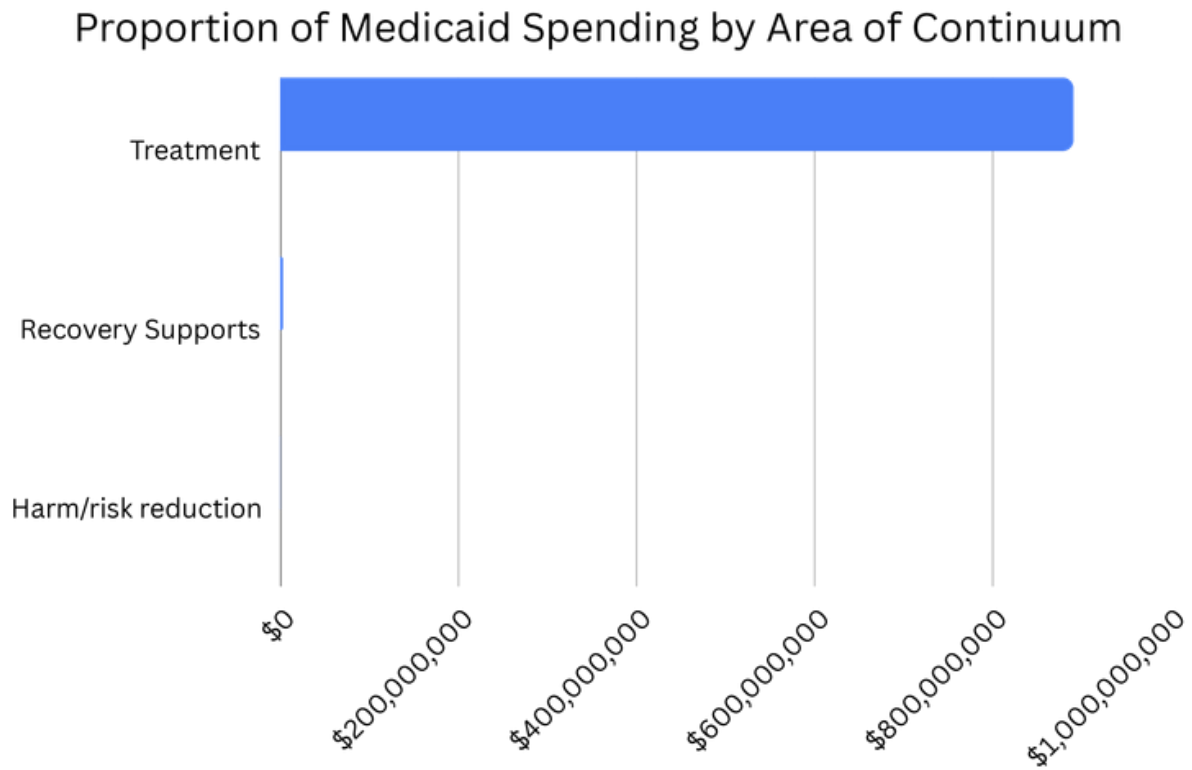


Figure 30: Medicaid Spending by Area of Continuum

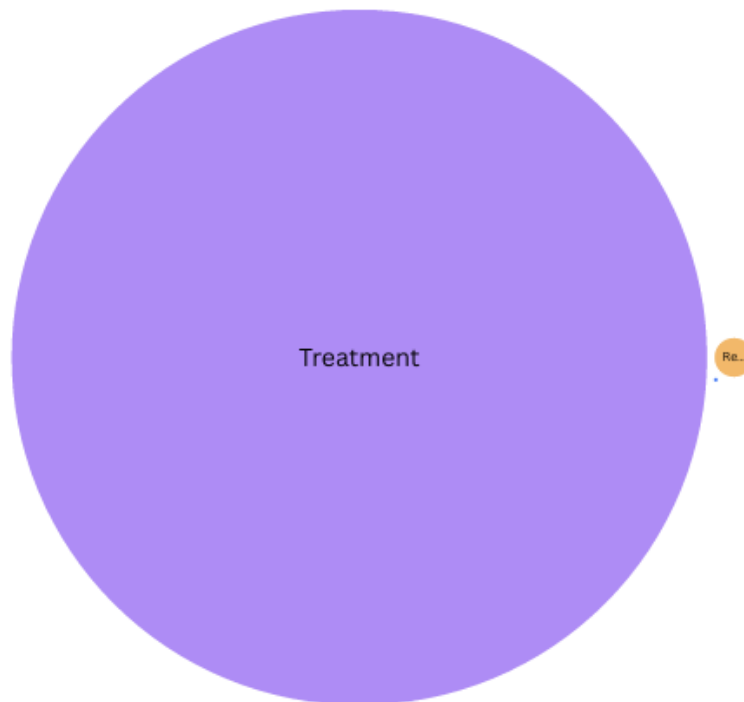


Figure 31: Proportion of Medicaid Spending by Area of Continuum (Treatment, Recovery & Harm Reduction)

BEHAVIORAL HEALTH DIVISION (BHD)

The OHA Behavioral Health Division leads OHA substance use disorder policy and most non-Medicaid substance use disorder recovery, treatment and harm reduction programs. Total spending reported for 2021-2023 was \$335 million, while 2023-25 totaled \$446 million. The higher spending level is related to the full biennium of spending in the Behavioral Health Resource Network program (Measure 110), opioid settlement expenditures, and continued workforce and capital expenditures.

BHD SPENDING BY REVENUE SOURCE

Substance-related revenues remain the largest source of revenue supporting the BHD programs. 63% of the spending was supported by marijuana revenue. General Fund makes up less than 15% of the BHD SUD-related spending.

Table 19: OHA-Behavioral Health Division Spending by Revenue Source

Revenue Source	Total Spending by Source	Percent of Total BHD Spending*
OF-Marijuana DTRSF	\$272,352,950	59.38%
GF	\$67,359,942	14.69%
FF-SOR	\$29,463,191	6.42%
FF-SUPTRS	\$22,961,113	5.01%
OF-Marijuana	\$15,527,586	3.39%
FF-ARPA	\$12,571,415	2.74%
LF-Lottery Bonds	\$11,658,181	2.54%
OF-Opioid Settlement	\$11,567,117	2.52%
OF-MHADSA	\$8,374,328	1.83%
OF-Intoxicated Drivers Program Fund	\$3,881,213	0.85%
FF-TANF	\$1,915,546	0.42%
FF-Medicaid Match	\$569,531	0.12%
LF	\$234,748	0.05%
OF-Misc.	\$184,762	0.04%
FF-AOT	\$4,939	0.00%
FF-PATH	\$55	0.00%
TOTAL	\$458,626,617	100.00%

*All revenue sources that are less than one percent of spending are grouped as Other in the below graphs. Collectively, these sources make up 1.48% of total BHD spending.

OHA-BHD Spending by Funding Source

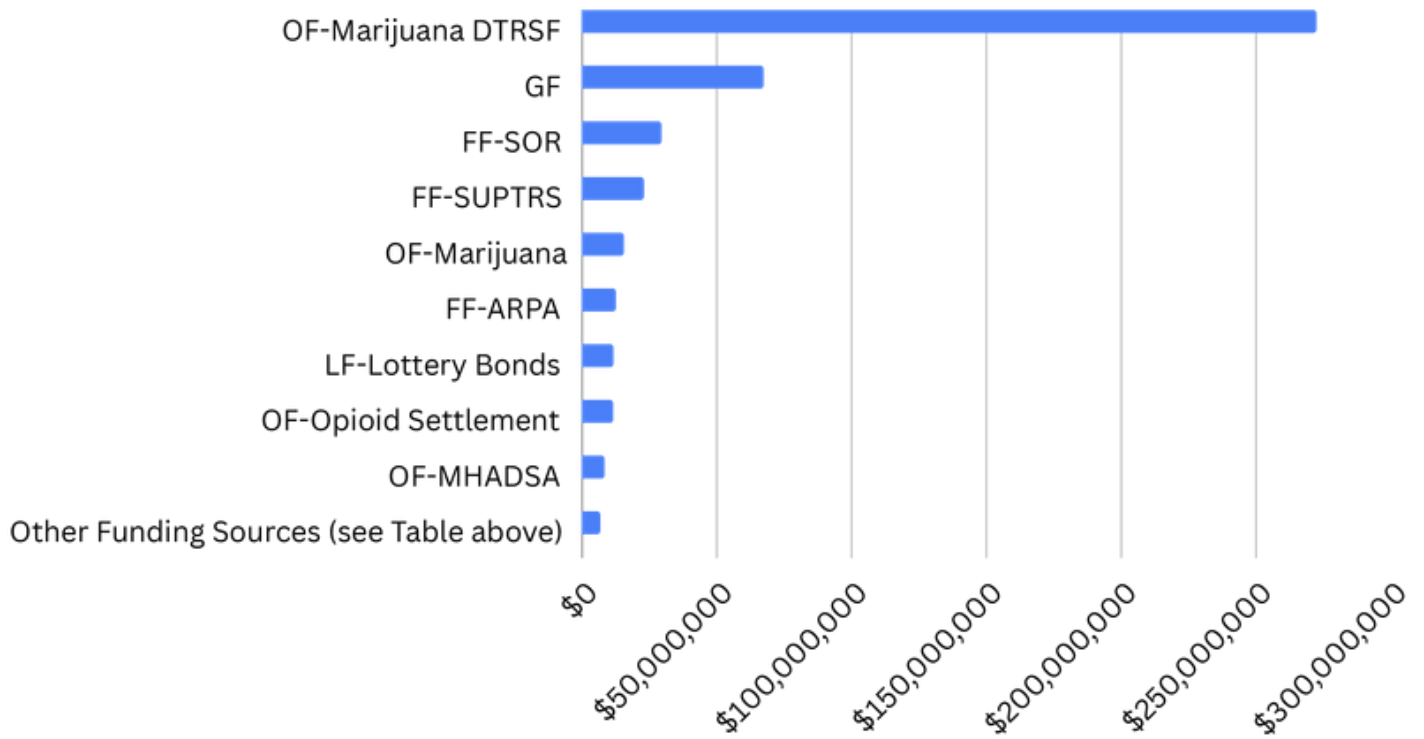


Figure 32: OHA-BHD Spending by Revenue Source

Proportion of BHD Spending by Funding Source

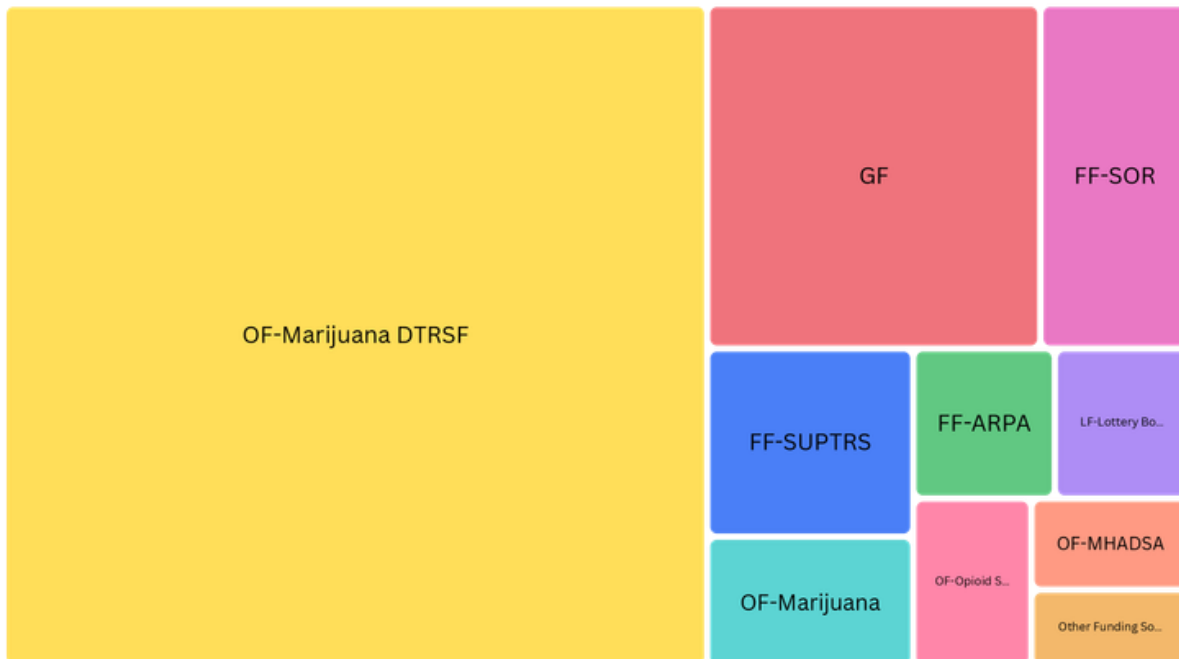


Figure 33: Proportion of BHD Spending by Funding Source

Table 20: OHA-BHD Spending Grouped by All Federal, General, Other and Lottery Funds

Revenue Source	Total Spending by Source	Percent of Total BHD Spending
Other Funds	\$311,887,956	68.00%
General Fund	\$67,359,942	14.69%
Federal Funds	\$67,485,790	14.71%
Lottery Funds	\$11,892,929	2.59%
TOTAL	\$458,626,617	100.00%

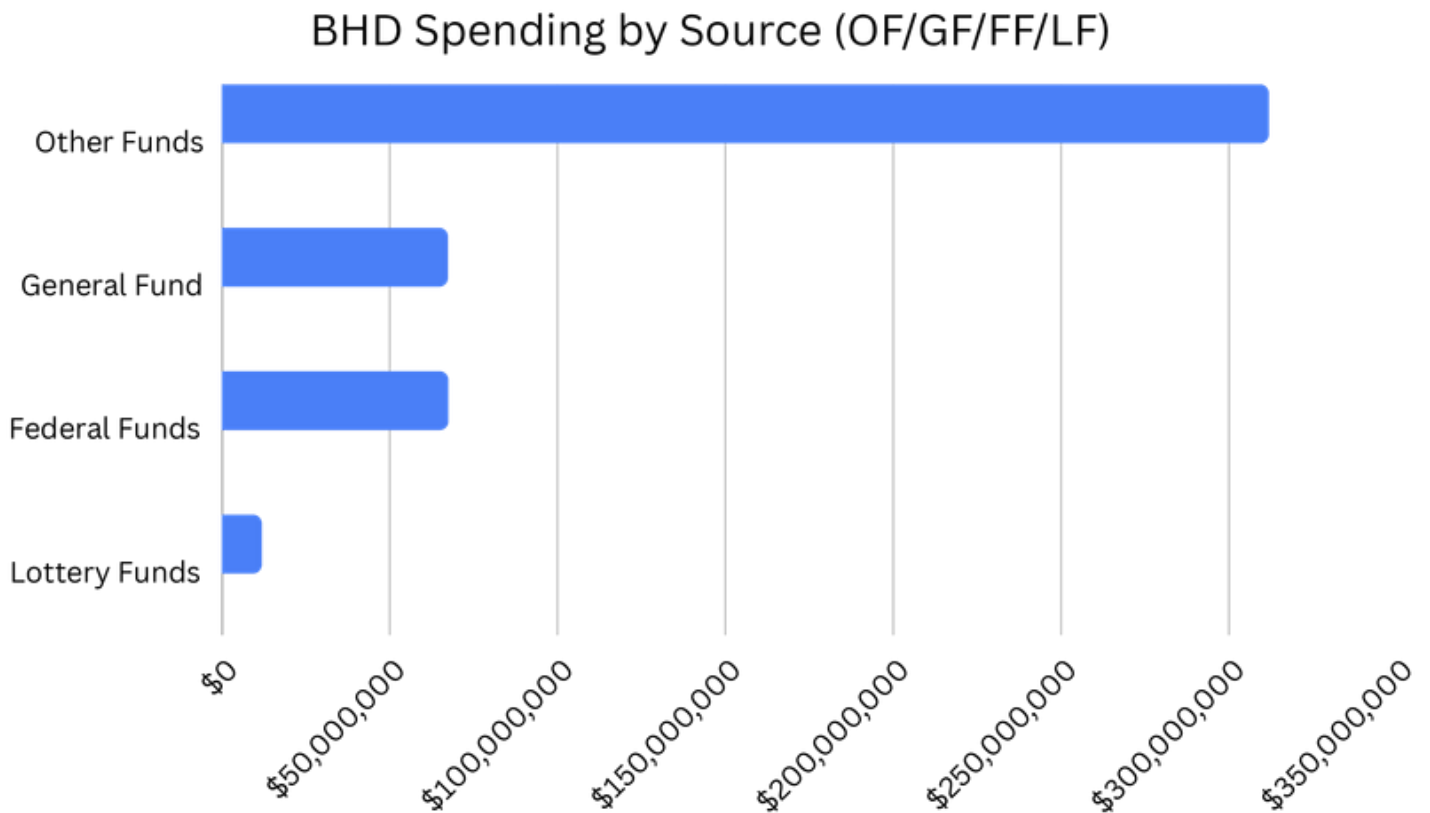


Figure 34: OHA-BHD Spending By Source (OF/GF/FF/LF)

Proportion of BHD Spending by Source (OF/GF/FF/LF)

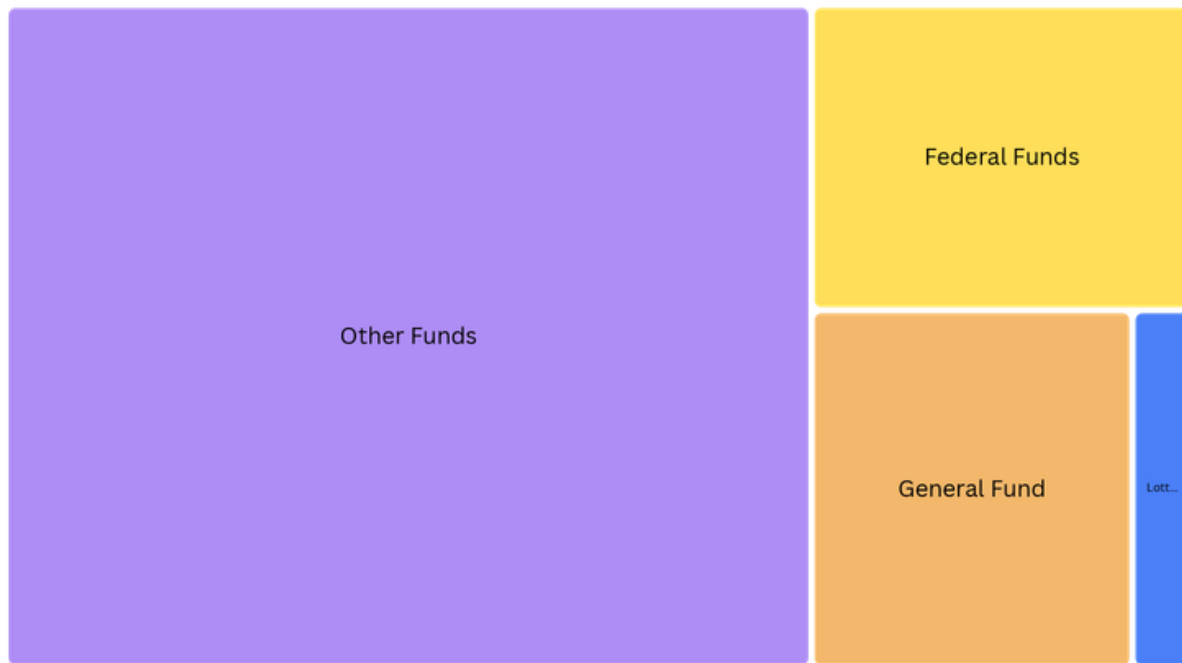


Figure 35: Proportion of OHA-BHD Spending by OF/GF/FF/LF

BHD SPENDING BY AREA OF CONTINUUM

46% of BHD SUD-related spending supports recovery supports. Given that 60% of BHRN spending funds recovery, this is not surprising. Treatment spending makes up 38%, and harm/risk reduction spending accounts for 11% of the total BHD SUD spending.

Table 21: OHA-BHD Spending by Area of SUD Continuum of Care

Area of Continuum	Total Funding for Area	Percentage of Total Medicaid Spending**
Recovery Supports	\$210,860,944.00	45.98%
Treatment	\$175,260,399.00	38.21%
Harm/risk reduction	\$48,766,168	10.63%
Peer Delivered Services not otherwise categorized	\$10,162,331	2.22%
DUII	\$6,331,953	1.38%
Early Intervention	\$3,796,307	0.83%
Primary Prevention	\$1,990,672	0.43%
Treatment Courts	\$457,916	0.10%
Jail Treatment/MSUD*	\$323,506	0.07%
Tribal*	\$294,096	0.06%
Drug Screening*	\$235,277	0.05%
Deflection*	\$147,048	0.03%
Total	\$458,626,617	100.00%

*The amounts reflected for Jail Treatment/MSUD, Tribal, Drug Screening and Deflection are all related to Community Mental Health Program (CMHP) spending related to Service Element 66, flexible funds allocated to CMHPs for substance use disorder services. The drug court spending is supported by SE 66 funds, as well as funding for veterans' peer support allocated to a treatment court. The allocation related to the SE 66 funding is based on estimates from a survey of CMHPs conducted by ADPC in preparation of this report.

**All revenue sources that are less than one percent of spending are grouped as Other in the below graphs. Collectively, these sources make up 1.6% of total BHD spending.

BHD Spending by Area of Continuum

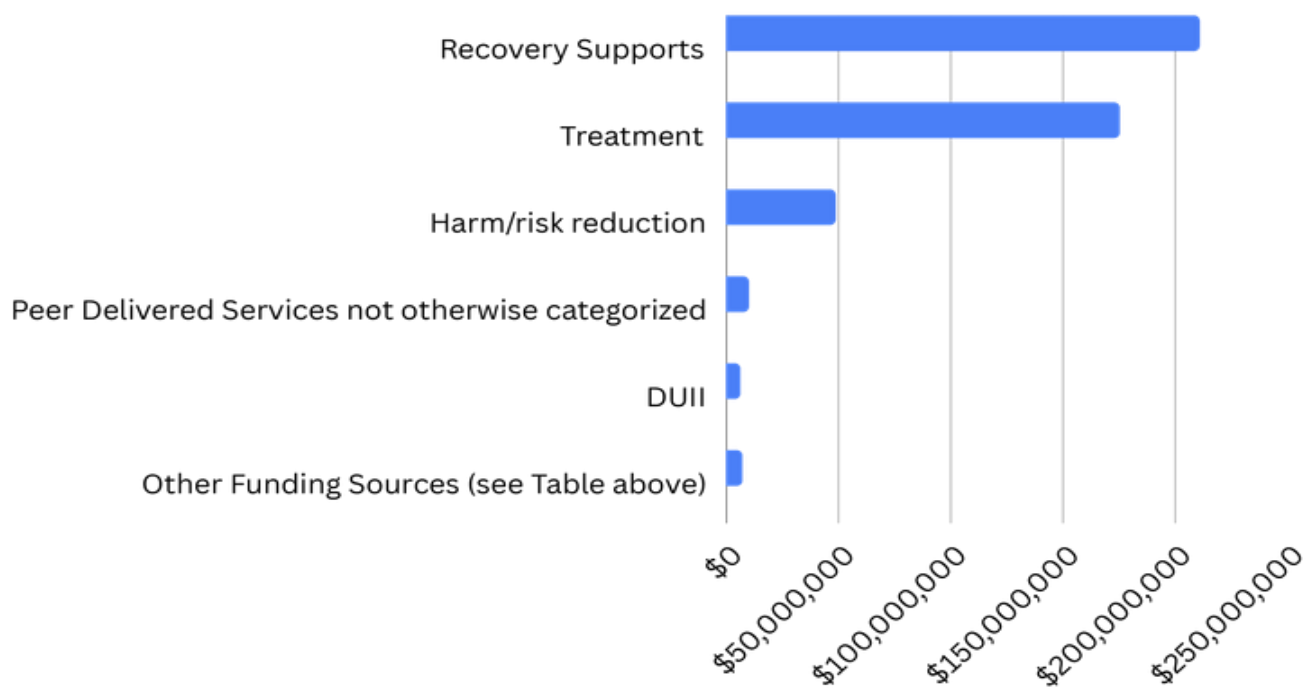


Figure 36: OHA-BHD Spending by Area of SUD Continuum of Care

Proportion of BHD Spending by Area of Continuum

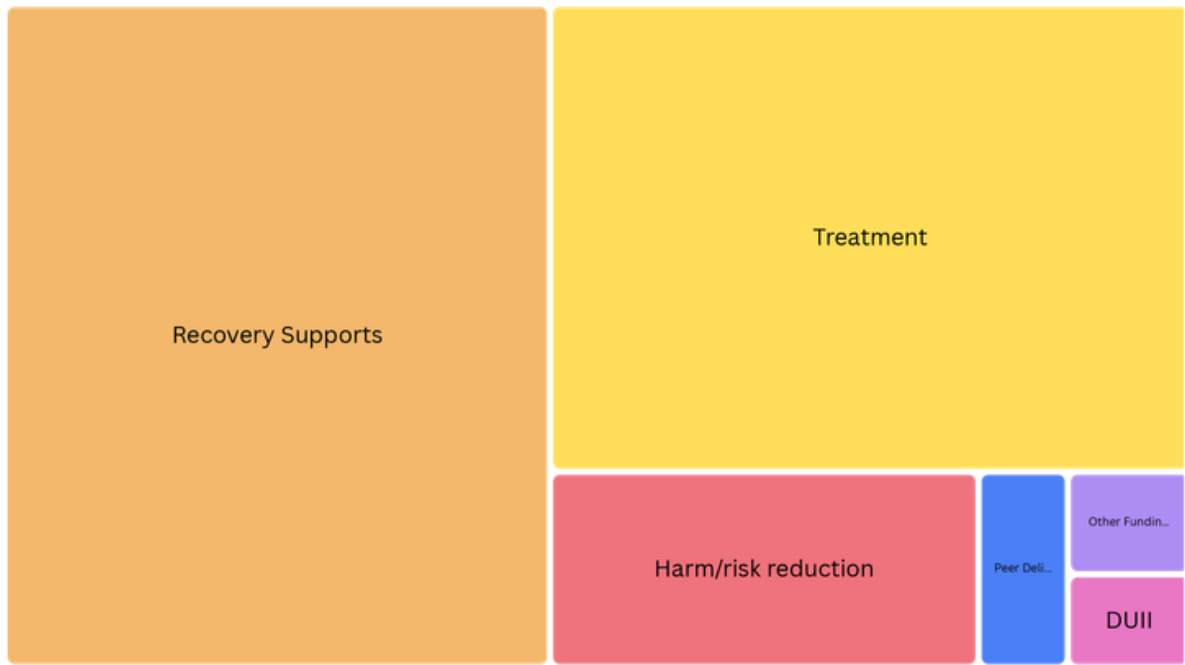


Figure 37: Proportion of OHA-BHD Spending by Area of SUD Continuum of Care

PUBLIC HEALTH DIVISION

The OHA Public Health Division (PHD) has three Centers: Center for Health Protection, which includes the Oregon Medical Marijuana Program and Oregon Psilocybin Services; the Center for Public Health Practice, which includes the Center for Health Statistics; and the Center for Prevention and Health Promotion, which includes Health Promotion and Chronic Disease Prevention, as well as Injury and Violence Prevention, among other programs. Most of the funding for this analysis falls within the Center for Prevention and Health Promotion.

PHD spending for 2021-23 totaled \$60 million. Approximately \$45 million of the 2021-23 total related to tobacco spending, which has been excluded from this analysis as tobacco is not considered to be a substance within the Alcohol and Drug Policy Commission scope. The total 2023-25 amount cannot be compared because of the exclusion of tobacco funding, as well as an increase in SUD spending through opioid settlement funds. There was also increased spending of federal CDC Overdose Data to Action (OD2A) funds, Prescription Drug Monitoring program federal and state funding, federal Substance Use Prevention, Treatment and Recovery Services (SUPTRS) block grant funding, and General Fund dollars.

- Oregon's OD2A funding slightly increased between 2019-2023 and 2023-2028 CDC grant cycles.
- The Prescription Drug Monitoring Program received a one-time GF payment to support the IT system while additional funding could be secured to support the program long term.
- Oregon received supplemental SUPTRS block grant prevention funding with one-time COVID and ARPA funds in 2022 (funding descriptions provided above). The additional federal SUPTRS COVID and ARPA spending occurred between 2022 – 2025.

OHA PUBLIC HEALTH DIVISION SPENDING BY REVENUE SOURCE

Most of the Public Health Division SUD-related spending for 2023-25 (67%) is attributable to federal funding sources. 27% of spending was supported by Other Funds (68% of which came from opioid settlement board funding), and 6.6% came from the General Fund. A description of each revenue source is included in Appendix H.

Table 22: OHA-PHD Spending by Revenue Source

Revenue Source	Total Spending by Source	Percent of Total PHD Spending*
FF-SUPTRS	\$9,063,974	29.67%
OF-Opioid Settlement	\$5,456,034	17.86%
FF-OD2A	\$4,604,430	15.07%
FF-ARPA	\$3,404,287	11.15%
GF	\$2,480,863	8.12%
FF-PDMP	\$1,553,256	5.09%
FF-SOR	\$1,263,747	4.14%
OF-Marijuana	\$1,066,688	3.49%
OF-State PDMP	\$943,534	3.09%
FF-SPF-PFS	\$450,399	1.47%
FF-CDC Alcohol	\$255,658	0.84%
OF-Criminal Fines	\$1,750	0.01%
TOTAL	\$30,544,620	100.00%

* All revenue sources that are less than one percent of spending are grouped as Other in the below graphs. Collectively, these sources make up less than 1% of total PHD spending.

OHA-PHD Spending by Funding Source

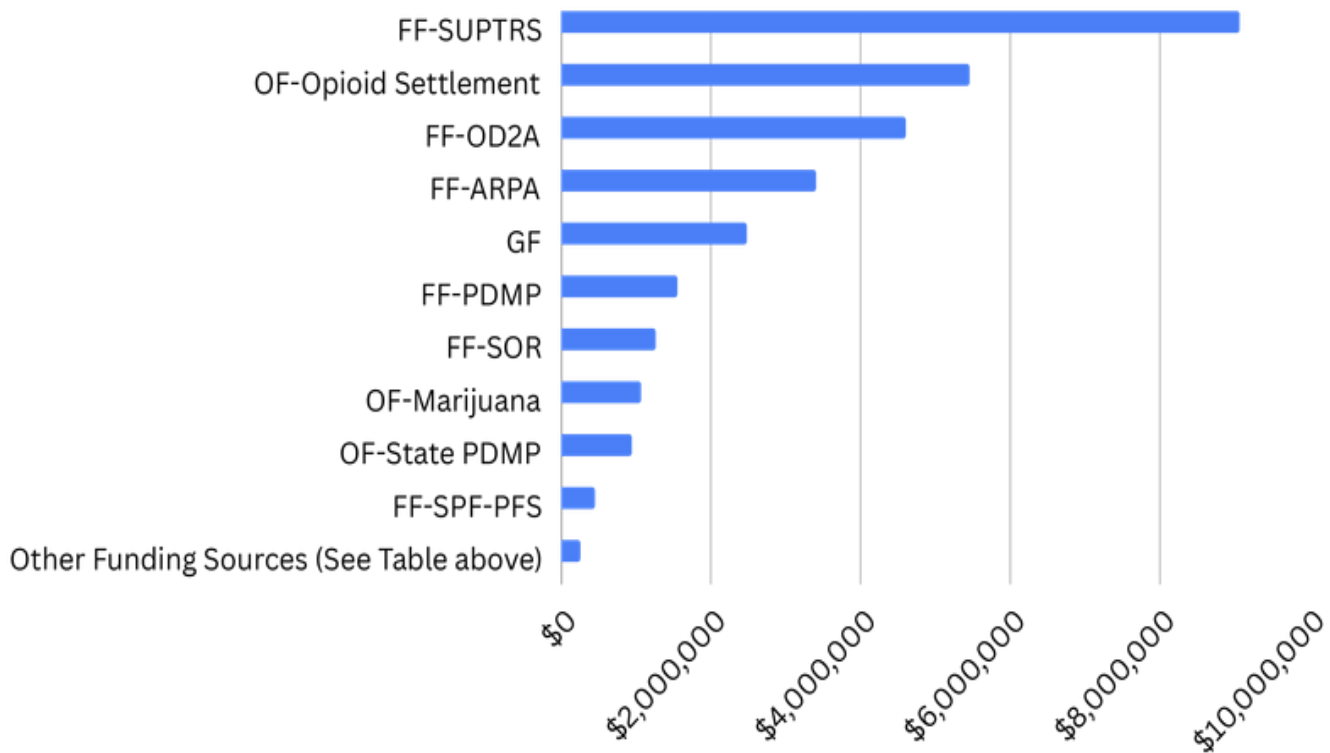


Figure 38: OHA-PHD Spending by Revenue Source

Proportion of PHD Spending by Funding Source



Figure 39: Proportion of PHD Spending by Funding Source

Table 23: OHA-PHD Spending Grouped by all Federal, Other and General Funds

Revenue Source	Total Spending by Source	Percent of Total PHD Spending
Federal Funds	\$20,595,571	67.43%
Other Funds	\$7,468,006	24.45%
General Funds	\$2,480,863	8.12%
TOTAL	\$30,544,620	100.00%

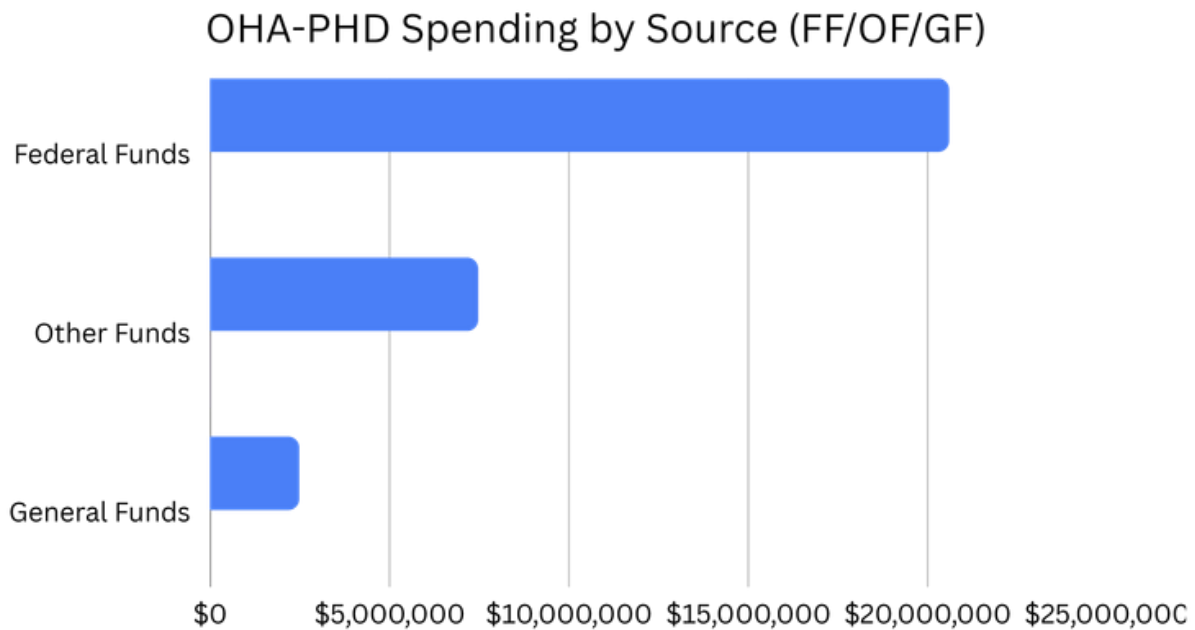


Figure 40: OHA-PHD Spending by Type of Revenue Source (FF/OF/GF)

Proportion of PHD Spending by Source (FF/OF/GF)

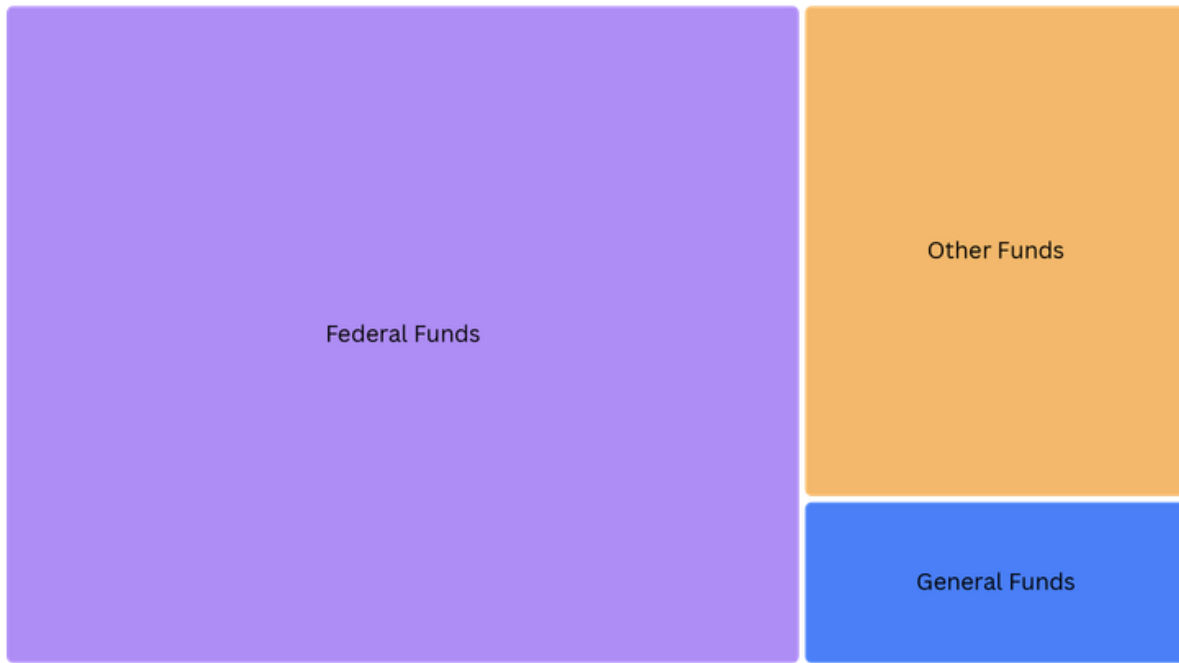


Figure 41: Proportion of OHA-PHD Spending by Category of Revenue Source

OHA-PHD SPENDING BY AREA OF CONTINUUM

The OHA Public Health Division designated the majority of spending as “cross-continuum” substance use disorder spending. All OHA-PHD spending was assessed for the HB 3321 (2025) primary prevention financial assessment. The conclusions made related to the HB 3321 analysis were used to include OHA-PHD spending as primary prevention, or allocated across the continuum based on that analysis. Upon further review by the ADPC, it was concluded that \$1.29 million could not be classified but would be included as “other.”

Table 24: OHA-PHD Spending by Area of SUD Continuum of Care

Area of Continuum	Total Funding for Area	Percentage of Total OHA-PHD Spending
Primary Prevention	\$19,725,190.87	64.58%
Harm/risk Reduction	\$7,047,239.53	23.07%
Other	\$1,290,890.78	4.23%
Treatment	\$1,290,223.91	4.22%
Recovery Supports	\$1,191,075.41	3.90%
Total PHD Spending	\$30,544,620.48	100%

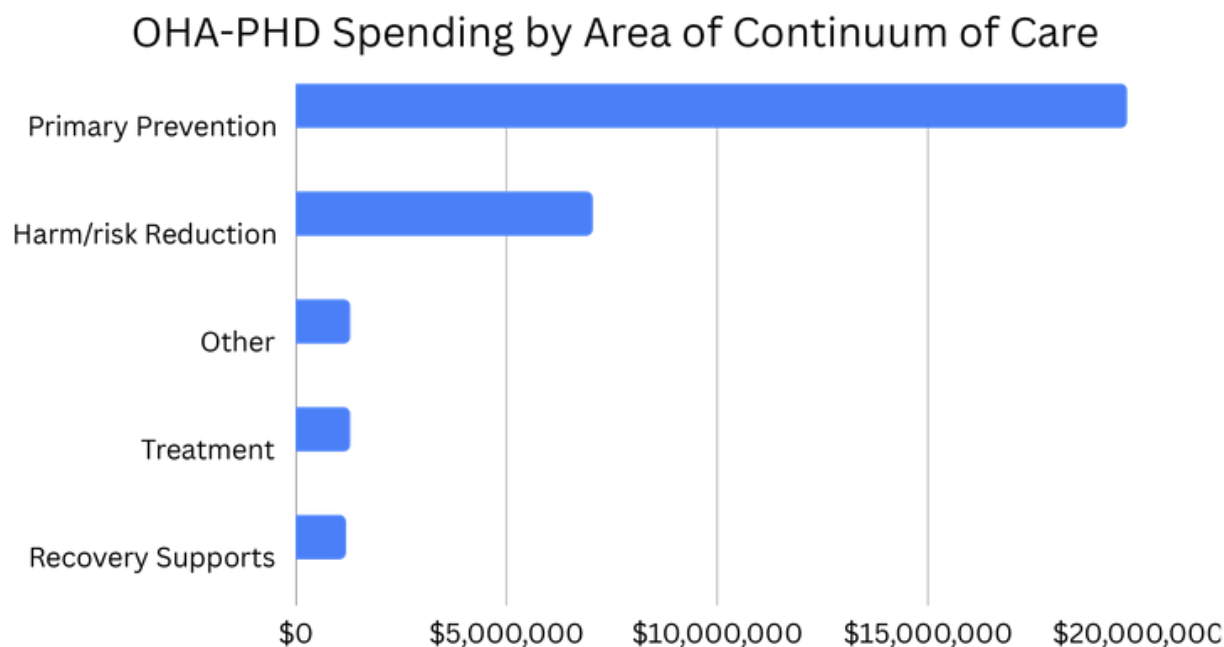


Figure 42: OHA-PHD Spending by Area of SUD Continuum of Care

Proportion of OHA-PHD Spending by Area of Continuum of Care

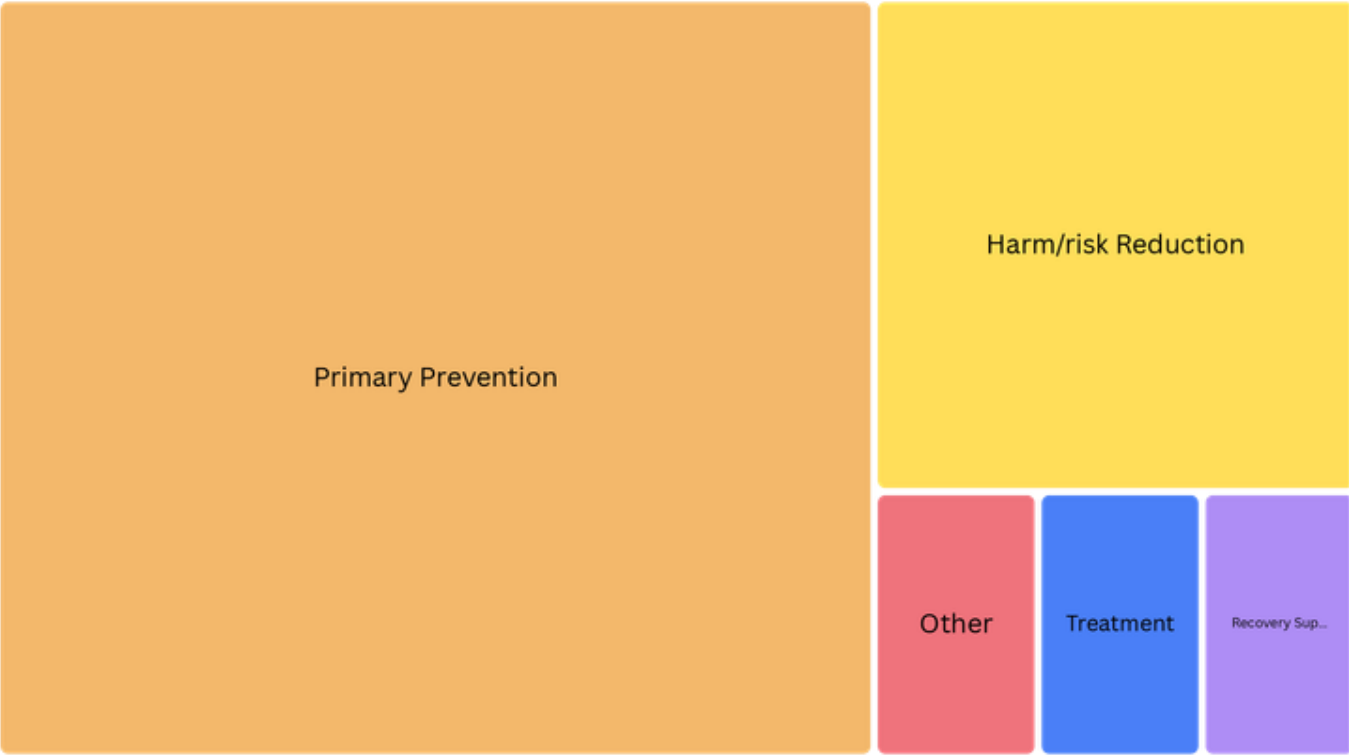


Figure 43: Proportion of OHA-PHD Spending by Area of Continuum of Care

CRIMINAL JUSTICE COMMISSION (CJC)

The Criminal Justice Commission spending was included in the 2021-23 financial analysis with a total of \$20 million in SUD-related spending reported. The 2021-23 analysis included spending related to three main programs: Improving People's Access to Community-Based Treatment, Supports and Services (IMPACTS); Justice Reinvestment Program (JRP); and the Specialty Courts Grant Program (now referred to as the Treatment Courts Grant Program (TCGP). 2023-25 spending grew with the addition of the Behavioral Health Deflection Program (BHD) and the Jail-Based Medications for Opioid Use Disorder Grant Program (JMOUD), as well as increased funding for TCGP and JRP. SUD-related spending now totals \$41.4 million.

98.8% of CJC SUD-related spending for 2023-25 was General Fund-supported. About one percent of the spending came from Lottery Funds, and less than one percent leveraged a US Department of Justice State Justice Statistics Grant.

Table 25: CJC Spending by Revenue Source

Revenue Source	Total Spending by Source	Percent of Total CJC Spending
GF	\$40,870,849	98.75%
LF	\$407,054	0.98%
FF-BJS Stats	\$108,958	0.26%
TOTAL	\$41,386,860	100.00%

CJC Total Spending by Funding Source

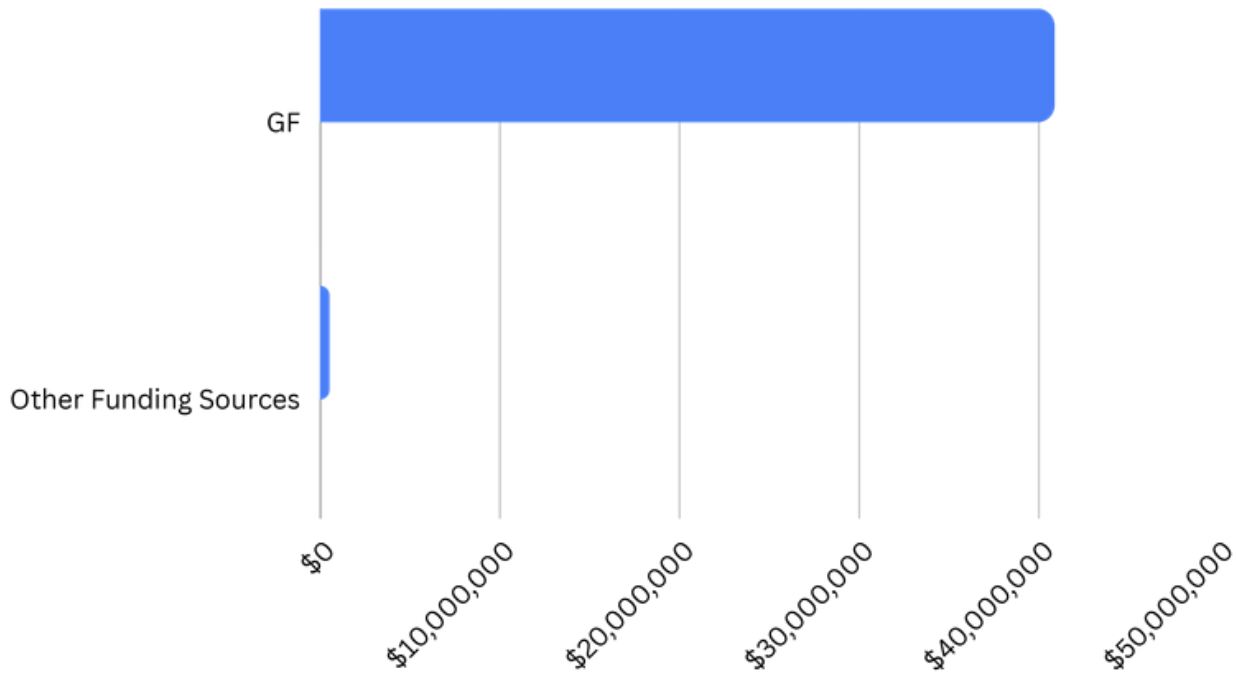


Figure 44: CJC Spending by Revenue Source

Proportion of CJC Spending by Source



Figure 45: Proportion of CJC Spending by Revenue Source

The allocations across the continuum of care were made for purposes of this analysis. Program funding is not allocated in this manner. For instance, the amount categorized for Deflection may not reflect the total of all deflection spending as some deflection spending was more

appropriately allocated to clinical treatment, recovery supports, or another category. While these allocations are subjective, this shows how broadly CJC funding is supporting the substance use disorder system.

Table 26: CJC Spending by Area of SUD Continuum of Care

Area of Continuum	Total Funding for Area	Percentage of Total CJC Spending*
Deflection	\$10,042,547	24.27%
Treatment	\$7,336,556	17.73%
Recovery Supports	\$7,144,965	17.26%
Treatment Courts	\$6,978,627	16.86%
Jail Treatment/MSUD	\$5,770,513	13.94%
Tribal	\$2,119,130	5.12%
Peer Delivered Services not otherwise categorized	\$1,541,457	3.72%
Drug Screening*	\$190,564	0.46%
Harm/risk reduction*	\$155,513	0.38%
DUII*	\$106,988	0.26%
TOTAL	\$41,386,860	100.00%

* All revenue sources that are less than one percent of spending are grouped as Other in the below graphs. Collectively, these sources make up 1.1% of total CJC spending.

CJC Spending by Area of Continuum

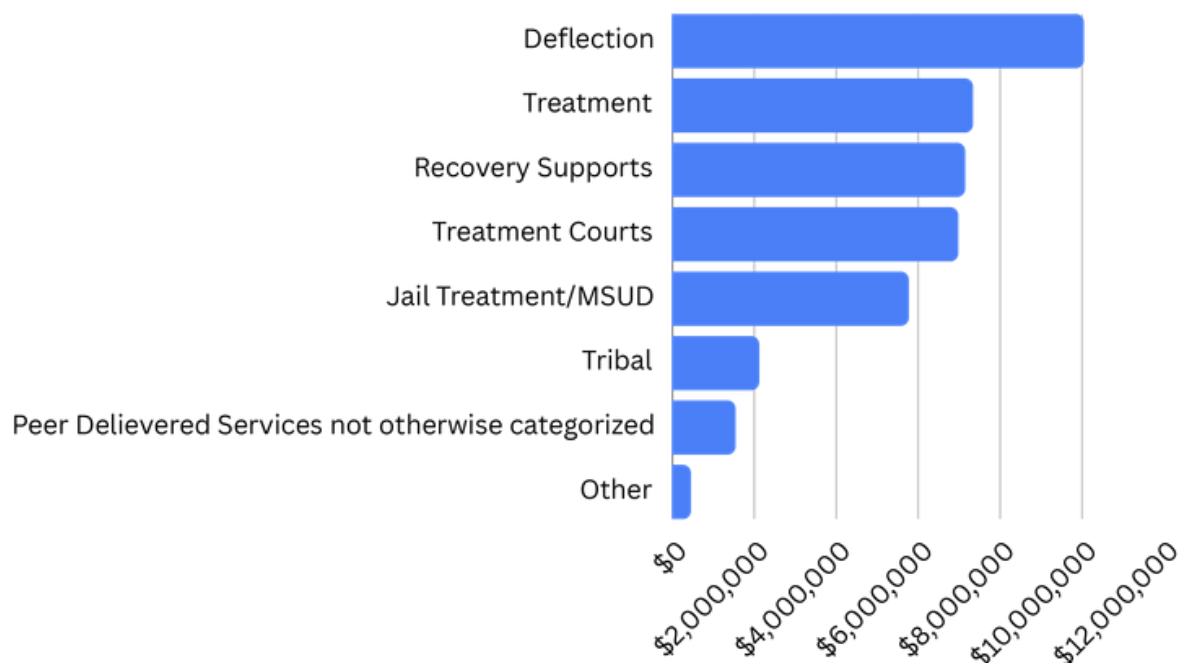


Figure 46: CJC Spending by Area of SUD Continuum

Proportion of CJC Spending by Area of Continuum of Care



Figure 47: Proportion of CJC Spending by Area of SUD Continuum of Care

OREGON DEPARTMENT OF HUMAN SERVICES (ODHS)

OREGON DEPARTMENT OF HUMAN SERVICES SPENDING BY REVENUE SOURCE

The Oregon Department of Human Services (ODHS) reported \$10 million in substance use disorder related spending in 2021-23. The higher amount of spending reflected below for 2023-25 is due to both the additional identification of existing funding related to substance use disorder and additional budget allocation. ODHS identified additional spending for Plans of Care through Child Abuse Prevention and Treatment Act (CAPTA) funding, Child Welfare staffing for Addiction Recovery Teams, Family First/Community Prevention funds, and Treatments Services that were not identified in the 2021-2023 analysis. Additionally, there was an additional budget allocation to expand the Parent Mentor program throughout the state in 2023-2025.

ODHS SUD-related spending occurs within the Child Welfare and the Self-Sufficiency Programs. The majority, 59%, of the total SUD spending is supported by federal funds. Federal Title IV-B funding accounts for 54% of ODHS spending. IV-B funding aims to protect children, prevent neglect, and provide support that allows at-risk youth to remain safely at home. Oregon leverages this funding for its Recovery Support Team, which connects families to appropriate services and supports, and associated recovery supports, including housing, community-based treatment, and recovery services.

40% of the ODHS funding is from the General Fund. General Fund supports housing navigation services for youth, co-occurring intensive treatment for youth in child welfare custody, intensive in-home services for parents, housing, drug screening, and assessment costs that cannot be paid for with other sources.

Federal Title I CAPTA (Child Abuse Prevention and Treatment Act) and CAPTA supplemental funding through ARPA account for only 5% of ODHS funding but serve an important role in funding supports for pregnant and parenting people with substance use disorder. CAPTA funded the implementation of the Comprehensive Addiction Recovery Act (CARA) and Plans of Care, including statewide consistency and compliance with federal requirements related to infants with prenatal exposure to substances and cross-system collaboration to promote family-centered practice, supporting Oregon's broader response to substance use and recovery within child welfare. It also supports Nurture Oregon sites, which support pregnant and parenting participants recovering from substance use disorder, as well as their infants served by these programs.

Federal TANF funds, although the smallest source of funds, are an important source of funding for childcare payments for parents to support participation in SUD services.

Table 27: ODHS Spending by Revenue Source

Revenue Source	Total Spending by Source	Percent of Total ODHS Spending
FF-Title IV-B	\$14,661,046	54.37%
GF	\$11,011,947	40.84%
FF - Title I - CAPTA	\$1,136,845	4.22%
FF-ARPA	\$140,000	0.52%
FF-TANF	\$13,415	0.05%
TOTAL	\$26,963,253	100.00%

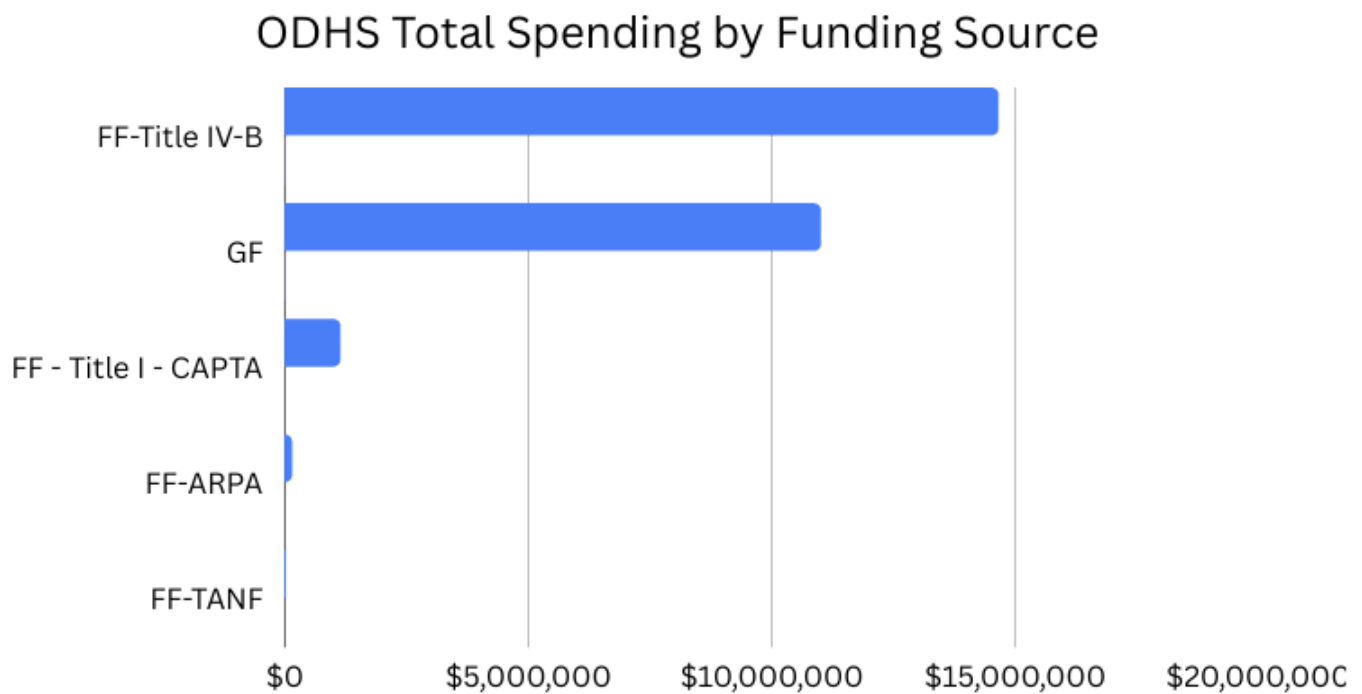


Figure 48: ODHS Spending by Revenue Source

Proportion of ODHS Spending by Source

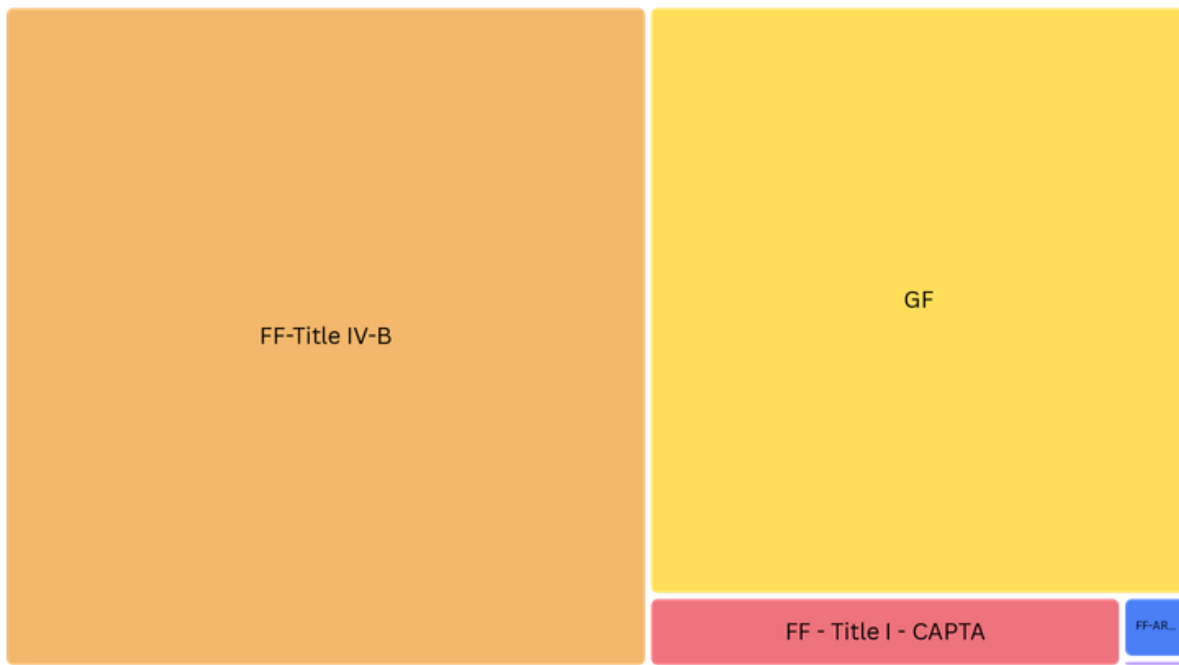


Figure 49: Proportion of ODHS Spending by Revenue Source

Table 28: ODHS Spending by Category of Revenue Source (GF/FF)

Revenue Source	Total Spending by Source	Percent of Total ODHS Spending
Federal Funds	\$15,951,306	59.16%
GF	\$11,011,947	40.84%
TOTAL	\$26,963,253	100.00%

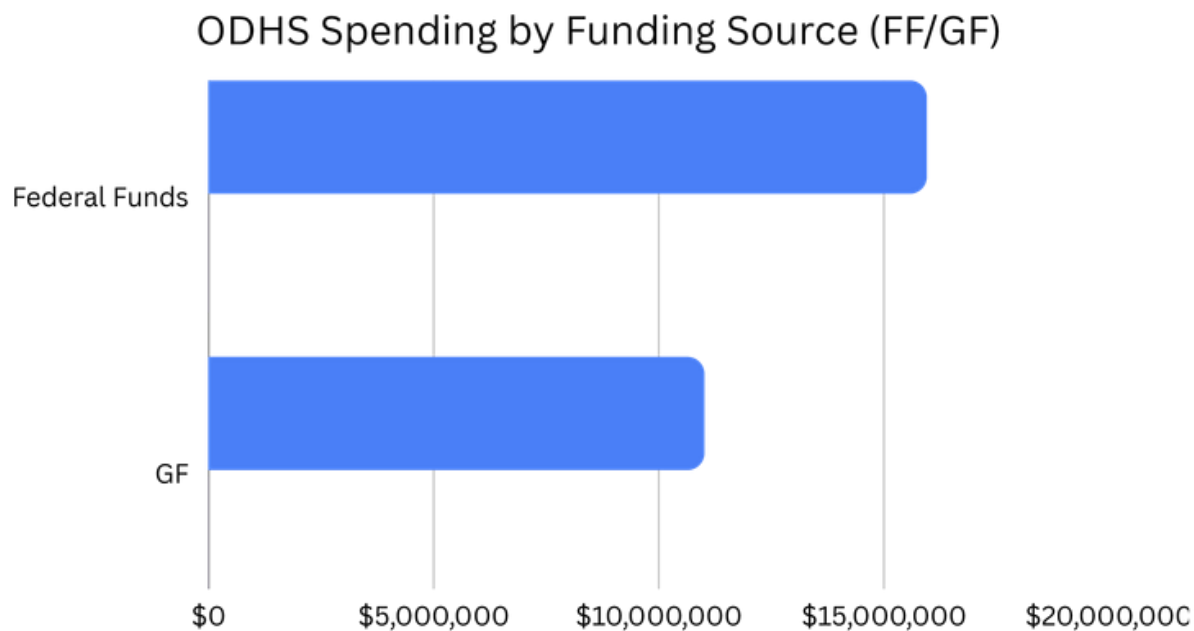


Figure 50: ODHS Spending by Category of Funding Source (FF/GF)

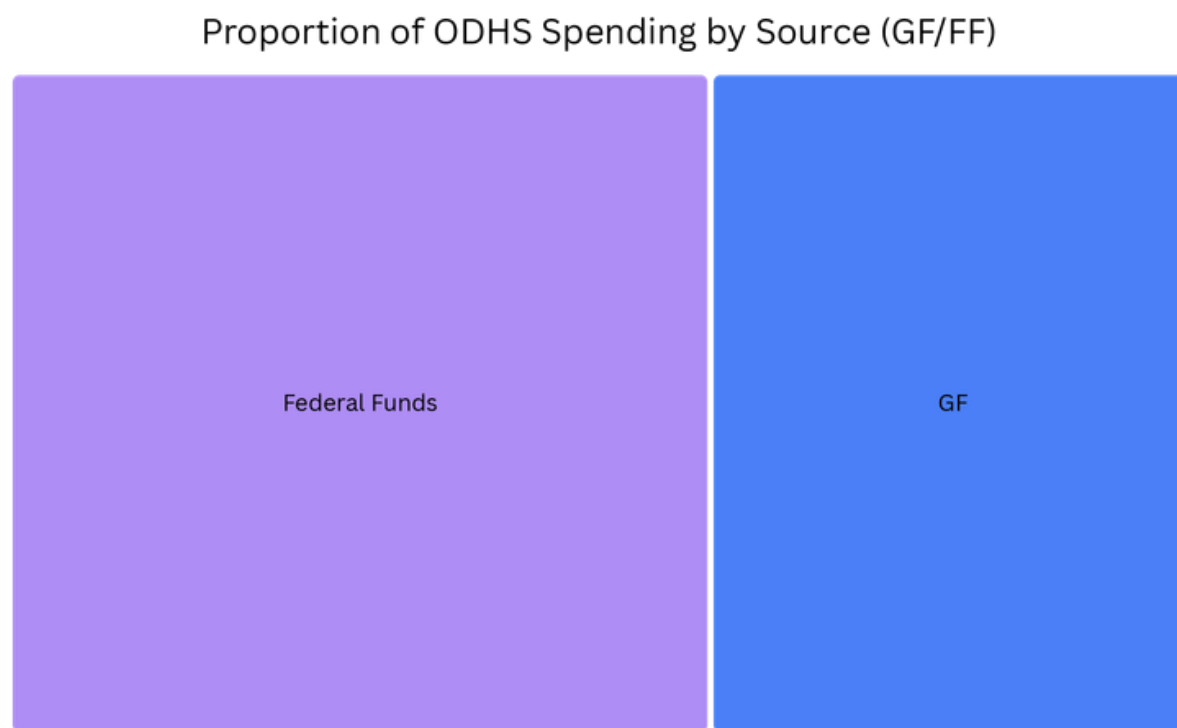


Figure 51: Proportion of Funding by Revenue Source (FF/GF)

ODHS SPENDING BY AREA OF CONTINUUM

For purposes of this analysis, 92% of ODHS spending related to substance use disorder is allocated to recovery services and supports, largely for parents. Only a small portion of funding is allocated to treatment, and only a small sliver supports treatment for child welfare-involved youth with their own substance use disorder.

ADPC, ODHS and OHA are collaborating on access to services and supports for child welfare-involved youth with substance use disorder. Continued focus on prevention, early intervention and effective treatment for youth is an essential strategy to address substance use disorder prevalence in Oregon.

Table 29: ODHS Spending by Area of SUD Continuum of Care

Area of Continuum	Sum of Funding Amount	Percentage of Total ODHS Spending*
Recovery Supports	\$24,729,922	91.72%
Treatment	\$1,379,445	5.12%
Early Intervention	\$738,648	2.74%
Harm/risk Reduction	\$63,197	0.23%
Drug Screening	\$28,196	0.10%
DUII	\$23,845	0.09%
Grand Total	\$26,963,253	100.00%

* All revenue sources that are less than one percent of spending are grouped as Other in the below graphs. Collectively, these sources make up less than 1% of total ODHS spending.

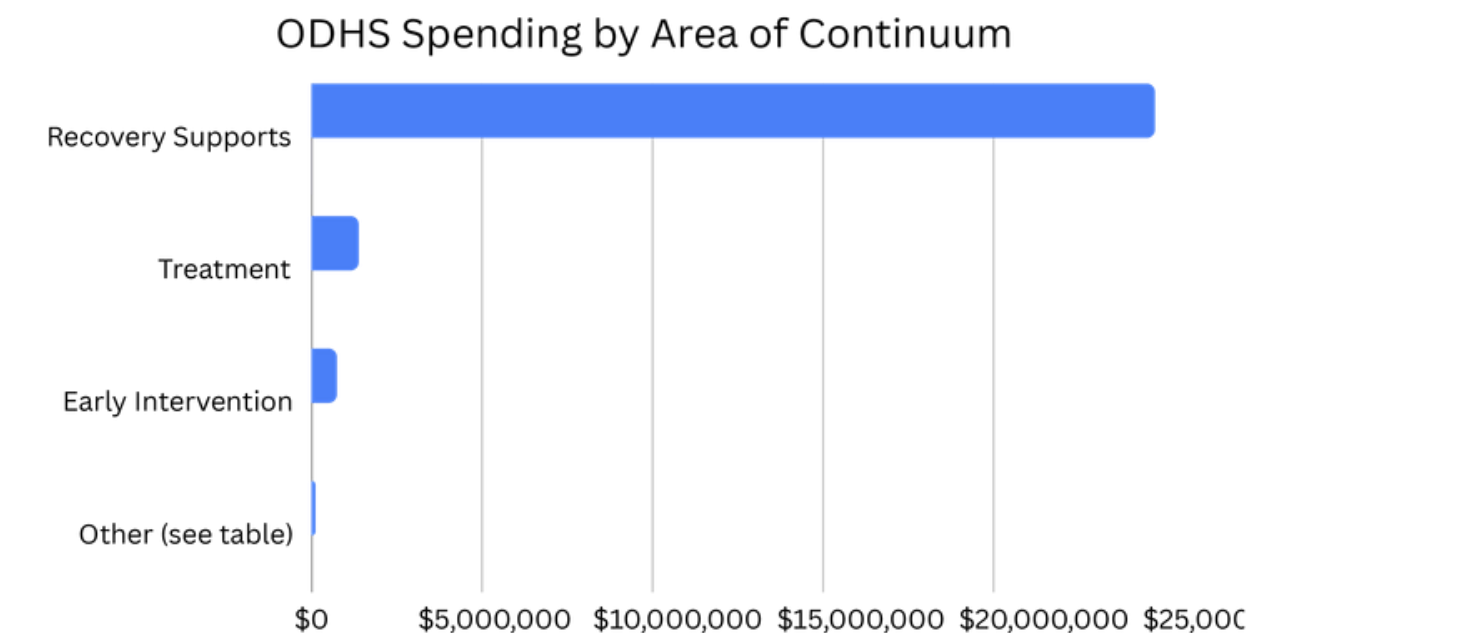


Figure 52: ODHS Spending by Area of SUD Continuum of Care

Proportion of ODHS Spending by Area of Continuum

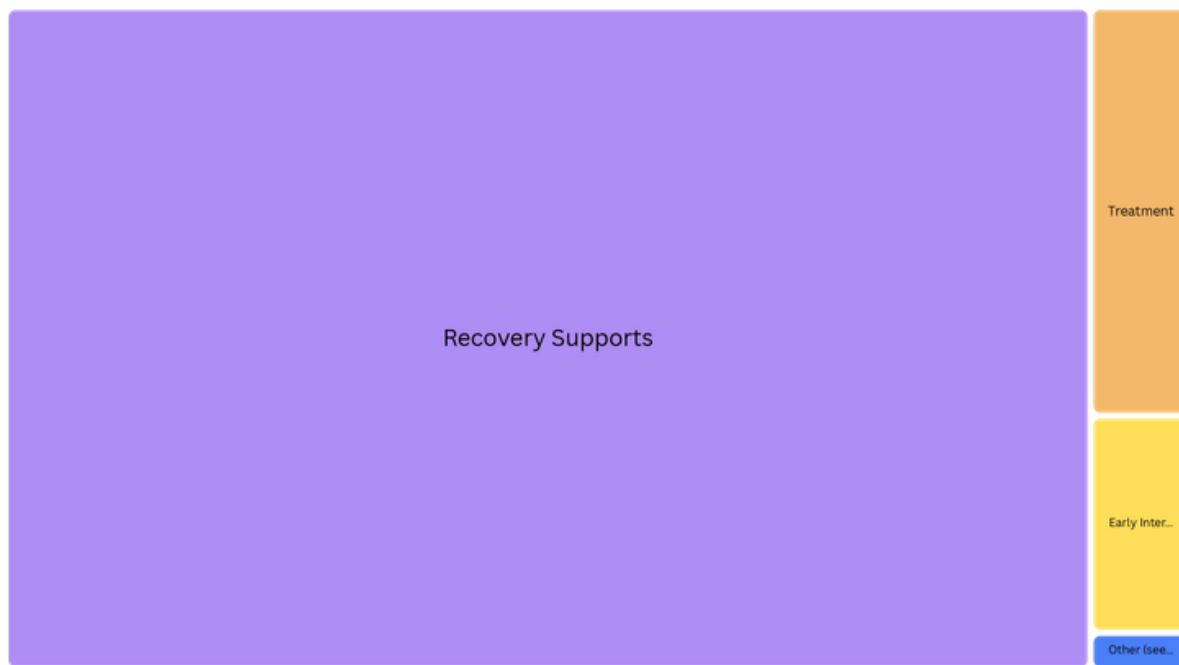


Figure 53: Proportion of ODHS Spending by Area of SUD Continuum

OREGON DEPARTMENT OF CORRECTIONS (DOC)

Department of Corrections (DOC) spending on SUD treatment totaled \$7 million for the 2021-23 biennium. The increased spending for the 2023-25 biennium may be attributed in part to an expansion of treatment funding in the 2023 state budget. However, the higher spending also includes \$9 million in pharmacy spending on MOUD, which was not included in the 2021-23 analysis and cannot be compared.

The majority of funds spent on substance use disorder in DOC were General Fund, with a small amount, less than 1%, from federal Residential Substance Abuse Treatment (RSAT) Program funds.

Table 30: DOC Spending by Revenue Source

Revenue Source	Total Spending by Source	Percentage of Total Funding
GF	\$22,408,565	99.46%
FF-RSAT	\$121,898	0.54%
Grand Total	\$22,530,463	100.00%

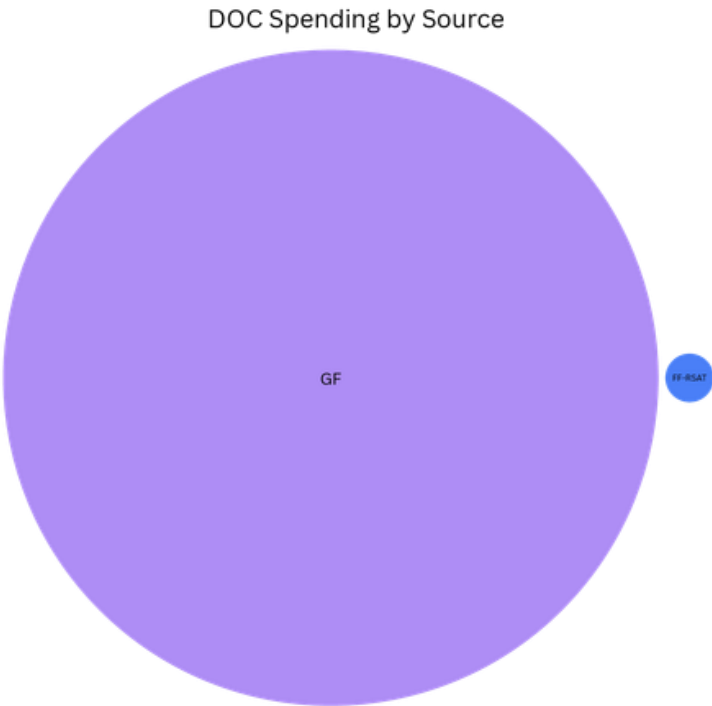


Figure 54: DOC Spending by Revenue Source

DOC SPENDING BY AREA OF CONTINUUM OF CARE

The Department of Corrections provides residential and outpatient substance use disorder treatment at seven facilities. DOC is also seeing growing pharmacy costs for the provision of Medications for the treatment of Opioid Use Disorder (MOUD). All of these costs are considered treatment costs, but for informational purposes, the chart below shows the proportion of spending on Medications vs treatment services. Funding for treatment services includes DOC staffing for direct services, as well as contracted treatment services.

Although the funding amount is not broken out, DOC also purchases and distributes the overdose reversal medication Narcan to those who accept it. Narcan is included as one item in a broader care kit that also includes hygiene products, risk reduction supplies, and information on HIV, HCV, STIs, and more. Following a confirmed diagnosis of a SUD, such as Opioid or Alcohol Use Disorders, practitioners discuss treatment options, including available medications, with adults in custody (AICs).

Naloxone is available in nasal and injectable forms throughout all institutions. It is in emergency response boxes carried by medical staff when responding to an emergency. Security also has access to nasal naloxone.

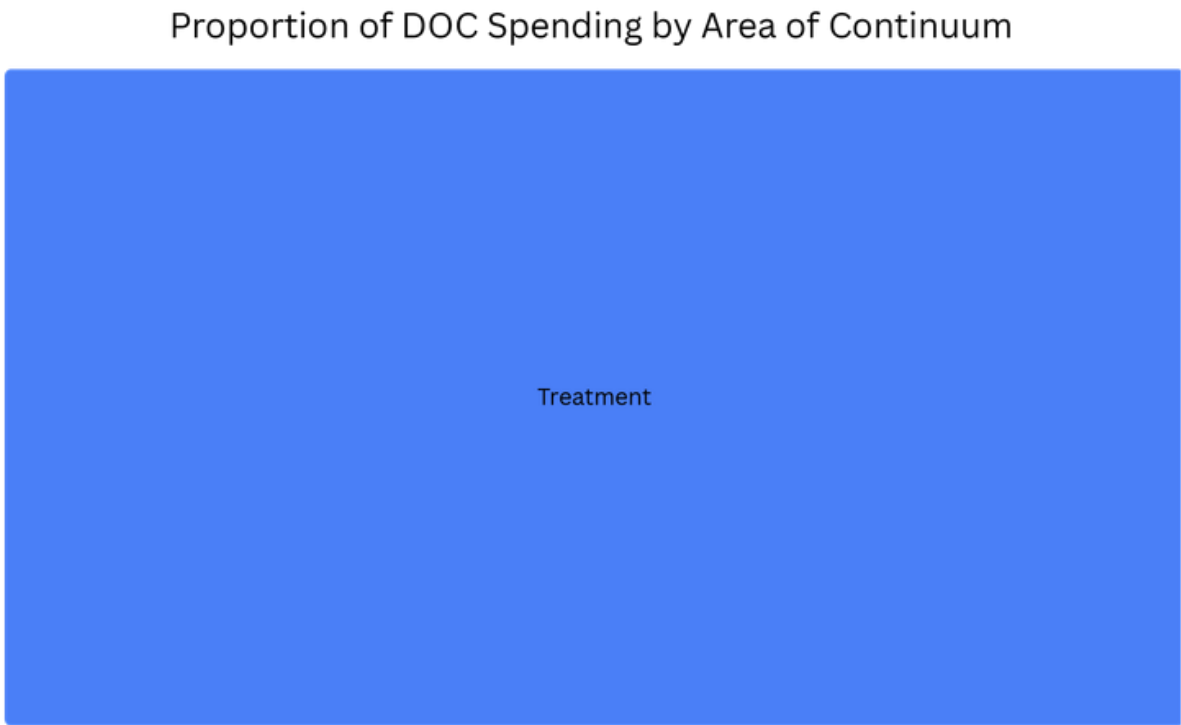


Figure 55: DOC Spending by Area of Continuum (100% Treatment)

OREGON LIQUOR AND CANNABISS COMMISSION (OLCC)

OLCC SPENDING BY REVENUE SOURCE

Oregon Liquor and Cannabis Commission (OLCC) spending was not included in the 2021-23 financial analysis.

As the primary regulatory agency for alcohol and cannabis in Oregon, the OLCC is tasked with ensuring that licensees and permittees comply with all applicable legal requirements. These include, for instance, the prohibition of sales to people under 21 and to visibly intoxicated persons, as well as the mandatory posting of signs to inform consumers about the risks of alcohol and cannabis consumption.

OLCC also:

- Oversees the distribution and sets the statewide price of distilled spirits which are sold via a dedicated network of Liquor Agents, as part of Oregon's controlled model for distilled spirits. OLCC's pricing mechanism for spirits includes a floor price.
- Coordinates educational services to support legal compliance by industry staff (marijuana worker permits, alcohol server permits, training materials for retail clerks).
- Generates revenues for state and local government primarily via the surcharge applied to distilled spirits as well as the collection of taxes: Privilege Taxes for malt beverages, cider, and wine and the tax on agricultural products used by wineries set by ORS 473.045.

All revenues received by the Oregon Liquor & Cannabis Commission (OLCC) are classified as "Other Funds". The OLCC receives revenues from distilled spirits sales; alcohol license fees; administrative fines; server permit fees; taxes on malt beverages, cider, and wines (Privilege Taxes), and on agricultural products used by wineries; marijuana license fees; marijuana tax money; marijuana worker permit fees; and miscellaneous income.

The Oregon Department of Revenue (DOR) administers the State Marijuana Retail Tax. DOR publishes Oregon Marijuana Tax Statistics here:

<https://www.oregon.gov/dor/gov-research/Pages/default.aspx>

OLCC distributes 50% of Privilege Tax collected monthly to the Mental Health Alcoholism and Drug Services Account that is administered by OHA. The total for the 23-25 biennium provided to this account was \$17,635,050.

OLCC estimated staff time for Regulatory Specialists relevant to this analysis. For a full explanation of OLCC estimations for staff positions and programs, see Appendix D.

Table 31: OLCC Spending by Revenue Source

Revenue Source	Sum of Spending Amount	Percentage of Total Funding
OF-OLCC Account	\$10,576,360	70.52%
OF-Marijuana Control & Regulation Fund	\$4,420,931	29.48%
Grand Total	\$14,997,291	100.00%

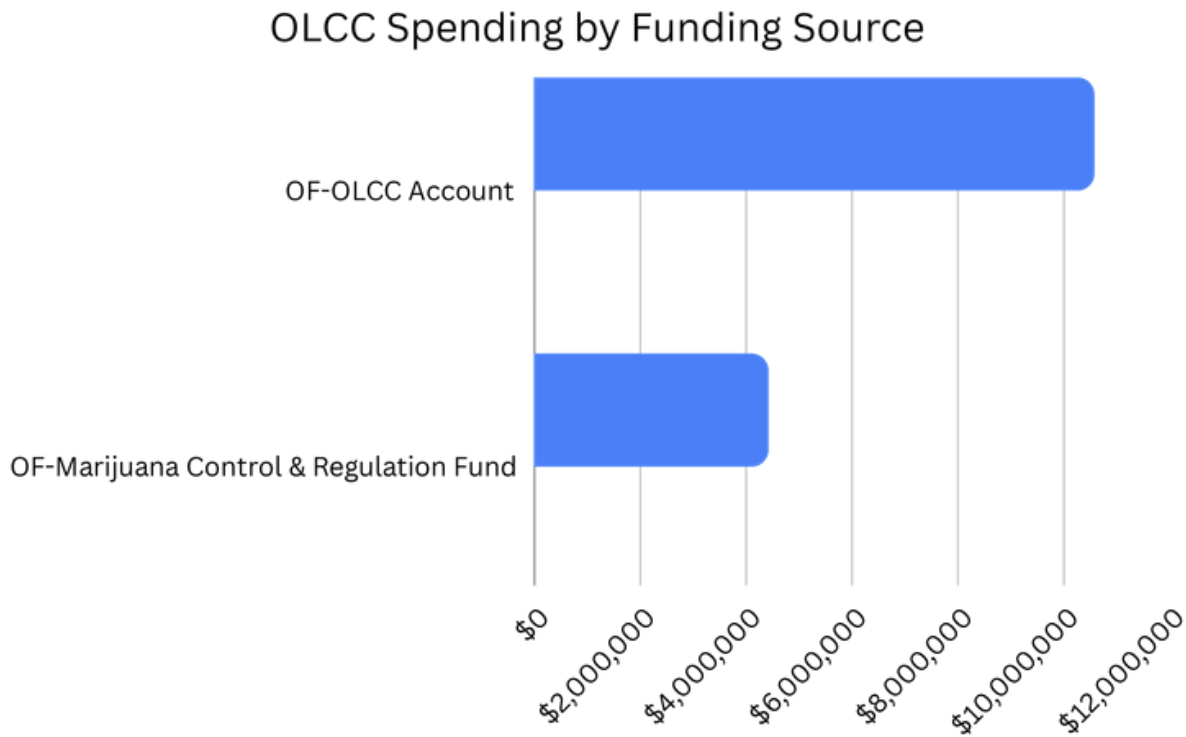


Figure 56: OLCC Spending by Revenue Source

Proportion of OLCC Spending by Funding Source



Figure 57: Proportion of OLCC Spending by Revenue Source

OLCC SPENDING BY AREA OF CONTINUUM OF CARE

OLCC spending is almost entirely reflected in staffing costs for the Minor Decoy Program, ID Checking Classes, the First Call Program, licensee and staff education, and public health policy analysis. These programs are all designed to ensure optimal legal compliance by licensees and permit holders, prevent substance use in youth, and to mitigate risks related to substance use in adults.

The OLCC also spent a small amount of funding on the purchase of opioid overdose reversal medication. OLCC set policy in November 2024 on the deployment of overdose reversal kits, allowing any OLCC staff to request naloxone sprays on a voluntary basis. Naloxone is also stored in First Aid stations and at the reception area of OLCC offices that are open to the public. OLCC also created a specific Workday training module for OLCC staff (“Opioid Overdose Prevention: How to use naloxone nasal sprays”), a course designed in partnership with ADPC & OHA.

Table 32: OLCC Spending by Area of SUD Continuum of Care

Area of Continuum	Total Funding Amount	Percentage of Total Funding
Primary Prevention	\$14,861,434	99.09%
Harm/risk Reduction	\$135,857	0.91%
Grand Total	\$14,997,291	100.00%

OLCC Spending by Area of Continuum of Care

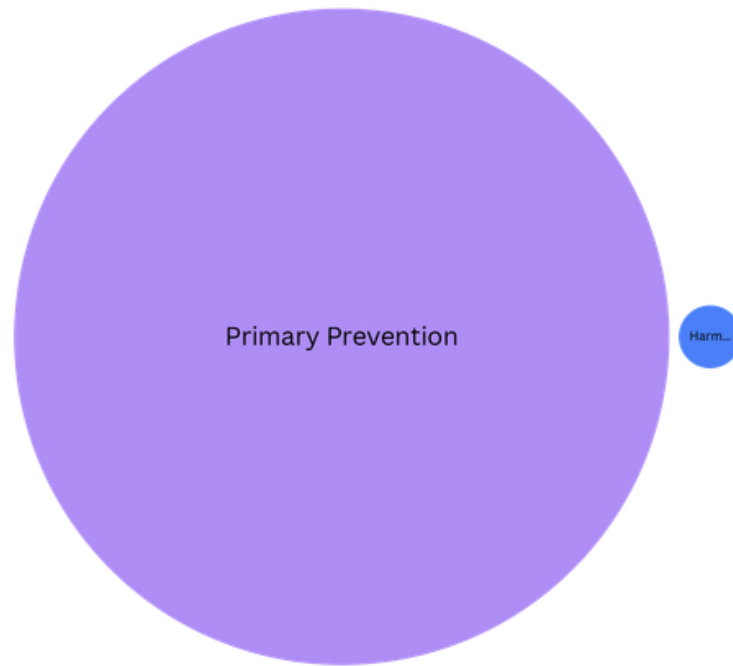


Figure 58: OLCC Spending by Area of SUD Continuum of Care (Primary Prevention and Harm/risk reduction)

OREGON DEPARTMENT OF EDUCATION (ODE)

Recovery Schools: Oregon Department of Education (ODE) spending was not included in the 2021-23 financial analysis. The funding allocated in 2023-25 is largely new funding. ODE first allocated funding in the 2023-25 biennium for the operation of Recovery Schools for young people in recovery from substance use disorder, after the passage of [HB 2767](#) in 2023. As this was a new program, ODE staffing costs as well as school costs increased over the course of the biennium. Three schools were in operation by the end of the biennium.

Prevention: ODE also employs one full-time employee focused on substance use prevention in schools. There was also a one-time allocation for the development of a K-12 social media campaign about opioid use, curriculum supplements for middle and high school grades, and professional learning modules for use in school districts.

ODE SPENDING BY REVENUE SOURCE

Slightly more than one-half, 53%, of ODE spending is General Fund. More than one-half of the General Fund was a one-time allocation for development of a K-12 social media campaign about opioid use, curriculum supplements for middle and high school grades, and professional learning modules for use in school districts. The remaining General Fund supported the ODE staff related to Substance Use Coordination and Recovery School operation (4.42 FTE total), school operations and recovery services, and school coaching and technical assistance.

The remaining 47% of ODE spending is supported through Other Fund sources. This funding, from the Statewide Education Initiatives Account and the State School Fund, supported the Recovery Schools.

Table 33: ODE Spending by Revenue Source

Revenue Source	Sum of Spending Amount	Percentage of Total ODE Spending
GF	\$3,586,668	53.24%
OF-Statewide Education Initiatives Account	\$2,049,768	30.43%
OF-State School Fund	\$1,100,232	16.33%
Grand Total	\$6,736,668	100.00%

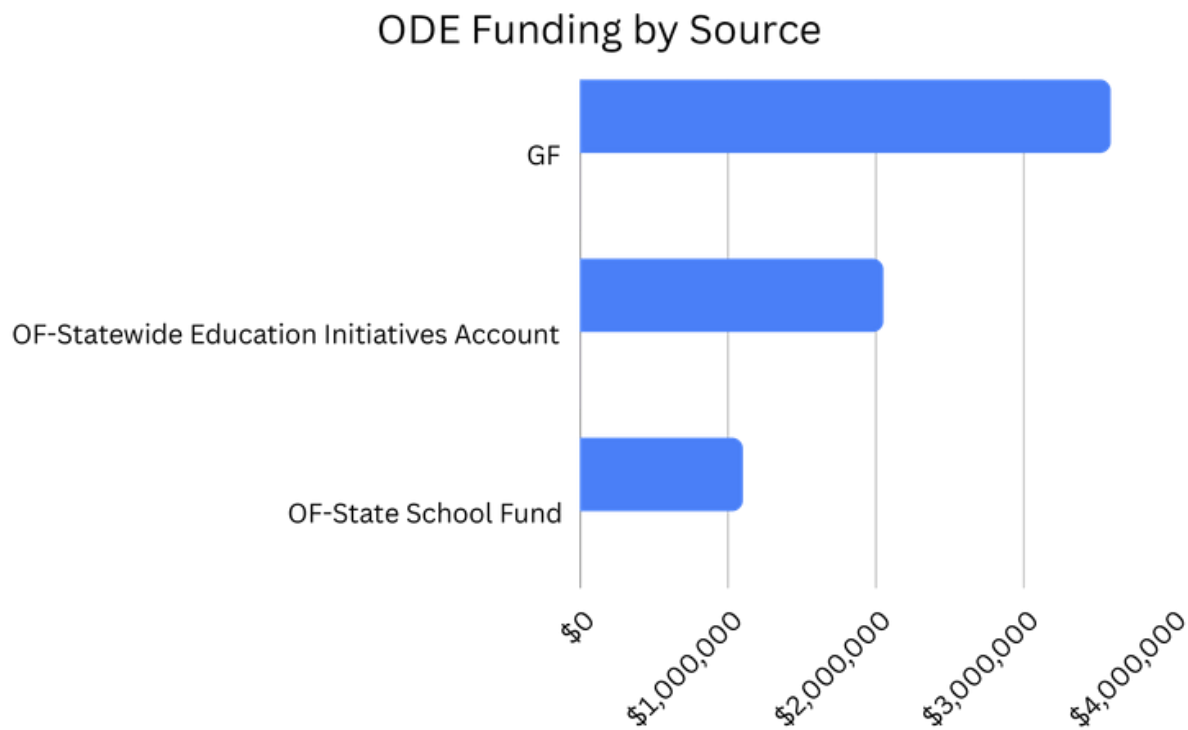


Figure 59: ODE Spending by Revenue Source

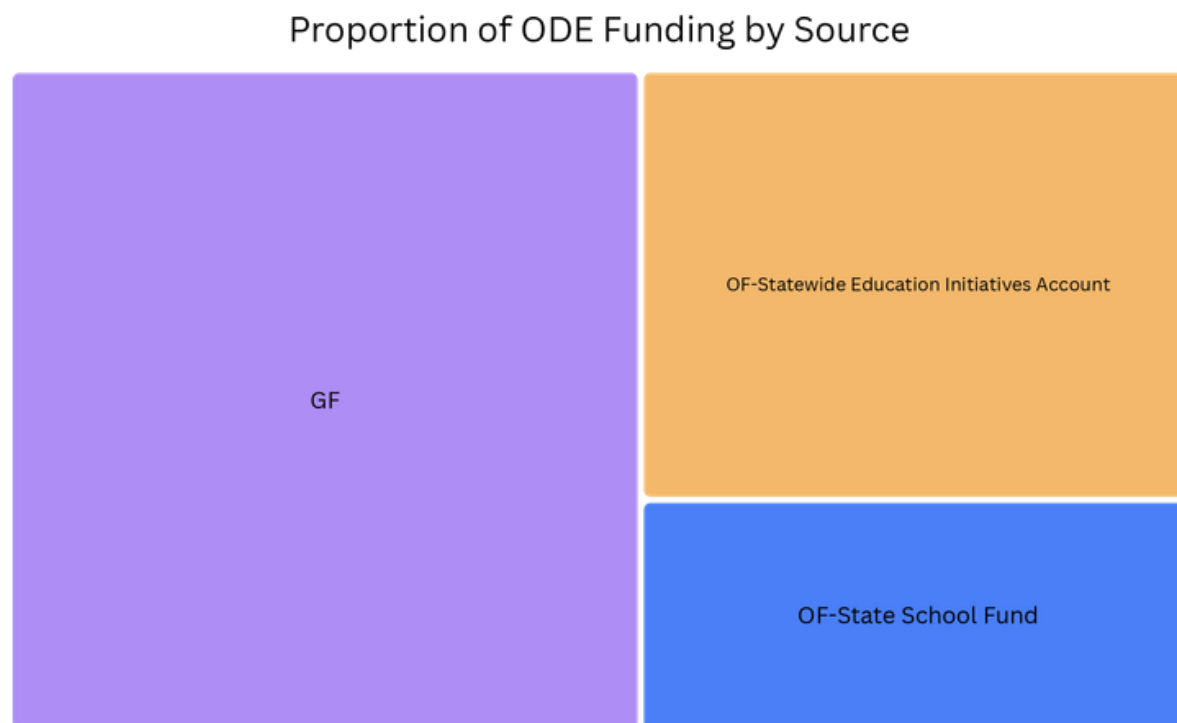


Figure 60: Proportion of ODE Funding by Revenue Source

Grouped by category of funding (i.e., General Fund and Other Fund sources), 53% of ODE funding for substance use disorder is General Fund and 47% supported by Other Funds.

Table 34: ODE Spending by Category of Revenue Source (GF/OF)

Revenue Source	Sum of Spending Amount	Percentage of Total ODE Spending
General Fund	\$3,586,668	53.24%
Other Funds	\$3,150,000	46.76%
Grand Total	\$6,736,668	100.00%

Proportion of ODE Funding Sources (GF/FF)



Figure 61: Proportion of ODE Revenue Sources (GF/OF)

ODE SPENDING BY AREA OF CONTINUUM OF CARE

ODE spent 70% of the SUD-related spending on Recovery Schools, which is all attributed to recovery supports for young people in the SUD continuum of care. The remaining is attributed to Primary Prevention.

Table 35: ODE Spending by Area of SUD Continuum of Care

Area of Continuum	Sum of Funding Amount	Percentage of Total ODE Spending
Recovery Supports	\$4,748,073	70.48%
Primary Prevention	\$1,988,595	29.52%
Grand Total	\$6,736,668	100.00%

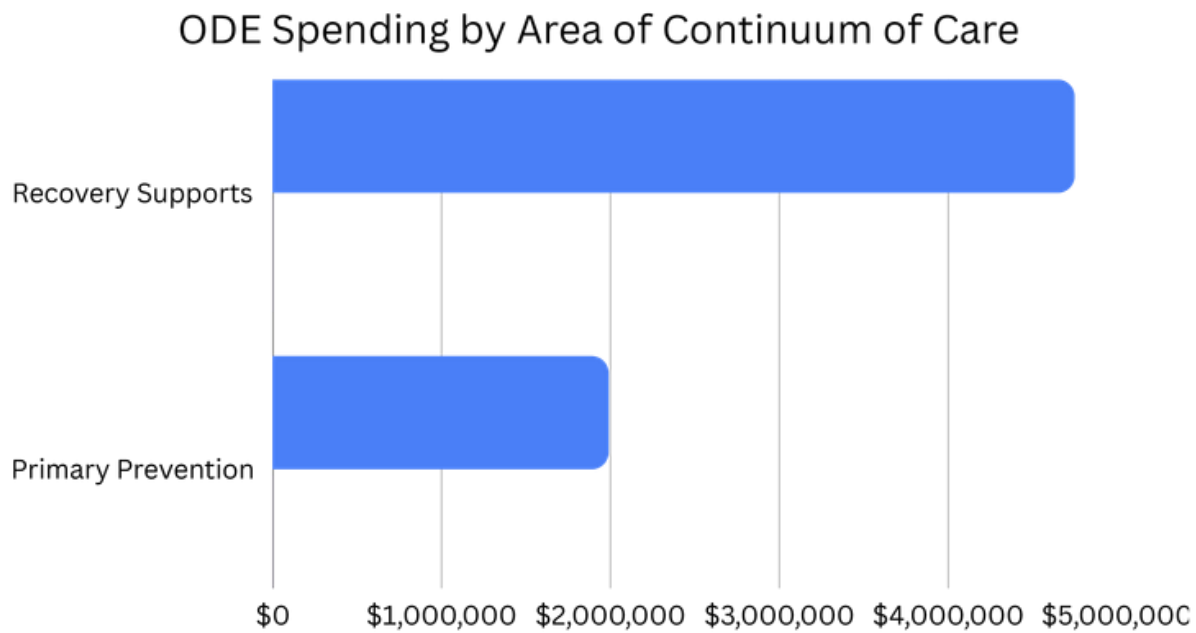


Figure 62: ODE Spending by Area of SUD Continuum of Care

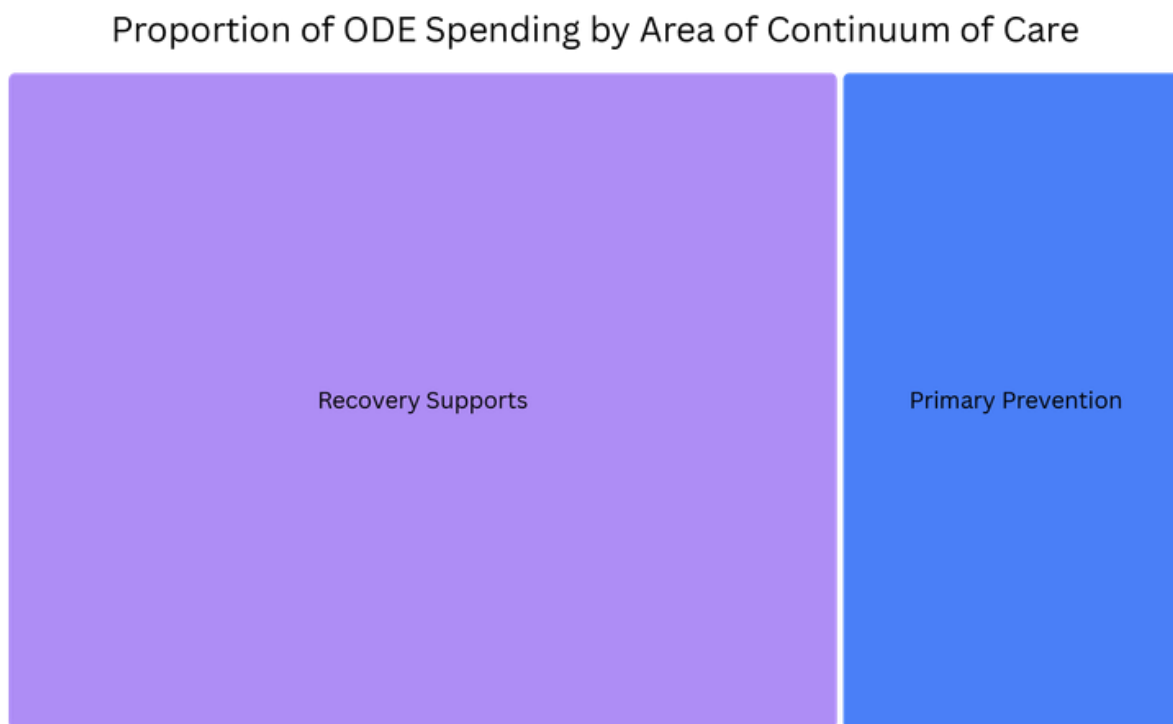


Figure 63: Proportion of ODE Spending by Area of Continuum of Care

ALCOHOL AND DRUG POLICY COMMISSION (ADPC)

The Alcohol and Drug Policy Commission funding does not appear to be included in the 2021-23 financial analysis. The ADPC total budget is included in this report as the Commission is solely dedicated to addressing substance use disorder in Oregon. 78% of the total ADPC budget funds Commission staff. 21% went to grants and contracts for the HB 4002 (2024) study related to barriers to Medications for Opioid Use Disorder and development of the comprehensive plan and associated community engagement. The remaining 1% went to DOJ legal fees, meeting costs, staff trainings, and technology. ADPC costs are distributed evenly across the continuum of care.

Table 36 ADPC Spending by Revenue Source

Revenue Source	Sum of Spending Amount	Percentage of Total ADPC Funding
GF	\$1,816,533	83.79%
FF-Medicaid Match	\$348,458	16.07%
LF	\$2,874	0.13%
Grand Total	\$2,167,865	100.00%

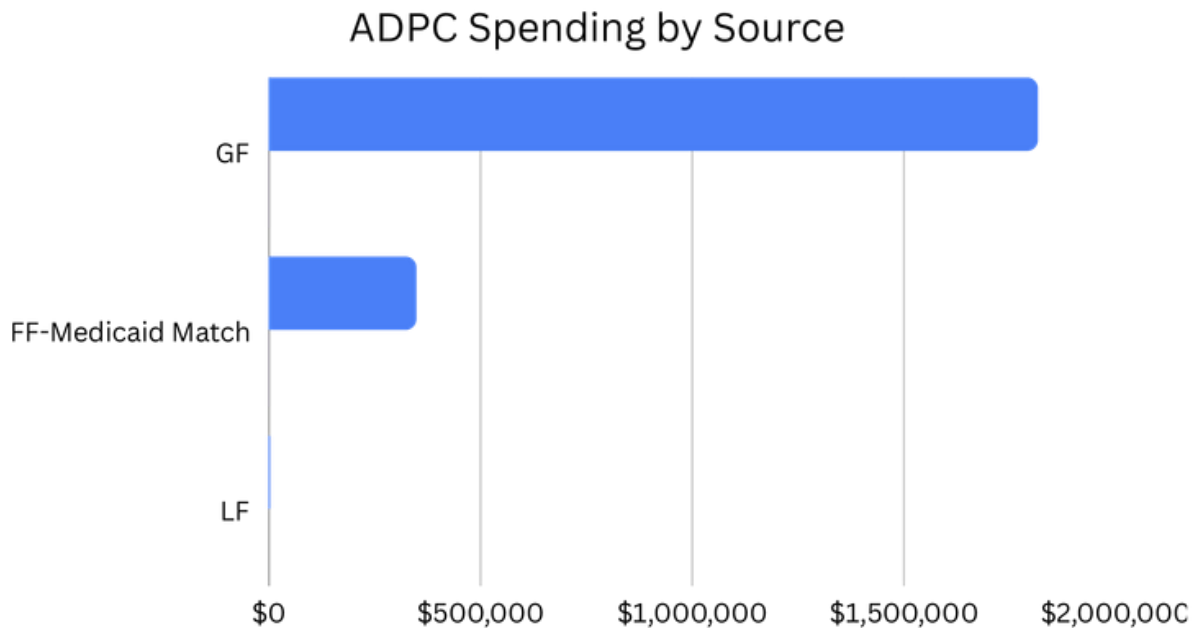


Figure 64: ADPC Spending by Revenue Source

Proportion of ADPC Spending by Funding Source



Figure 65: Proportion of ADPC Spending by Revenue Source (GF/FF/LF)

Proportion of ADPC Funding by Area of Continuum of Care



Figure 66: Proportion of ADPC Spending by Area of SUD Continuum of Care

OREGON YOUTH AUTHORITY (OYA)

Oregon Youth Authority spending on treatment for youth in custody remains virtually unchanged from the 2021-23 financial assessment. 2021-23 spending totaled \$1,040,080, while spending totaled \$985,464 for 2023-25. OYA only receives General Fund to support services to youth with substance use disorder.

Table 37: OYA Spending by Revenue Source

Revenue Source	Total Spending Amount	Percentage of Total OYA Funding
GF	\$985,464	100%
Grand Total	\$985,464	100%

Proportion of OYA Funding by Source



Figure 67: OYA Spending by Revenue Source (100% GF)

OYA provides substance use treatment for youth ages 13-24 at nine youth correctional facilities. 97% of youth newly assessed for substance use between 7/1/23 and 6/30/25 were diagnosed with a substance use disorder. This does not include youth who were within a correctional facility in the agency during that time and assessed with an earlier version of the agency's substance use assessment. Yet, OYA has one of the smallest budgets to address substance use disorder.

Treatment across facilities is best categorized as Outpatient treatment services. This is because despite this being a closed environment, OYA does not have the staffing and structure required

for residential treatment. Several facilities are certified as Outpatient Substance Use Treatment Facilities through OHA. Yet not every facility has capacity to screen and assess for a substance use disorder. Individualized and group counseling treatment can be offered based on client need and staff resources. All of these groups are facilitated by CADC Certified Staff and CADC-Rs, with some Peer Support Specialist participation based on need and availability. All of these staff receive clinical supervision from OYA staff.

Three SUD Treatment Coordinators currently serve the youth through unfunded positions. For a facility-by-facility description of services and additional details about services provided through unfunded positions, see Appendix B.

Proportion of OYA Funding by Area of Continuum of Care

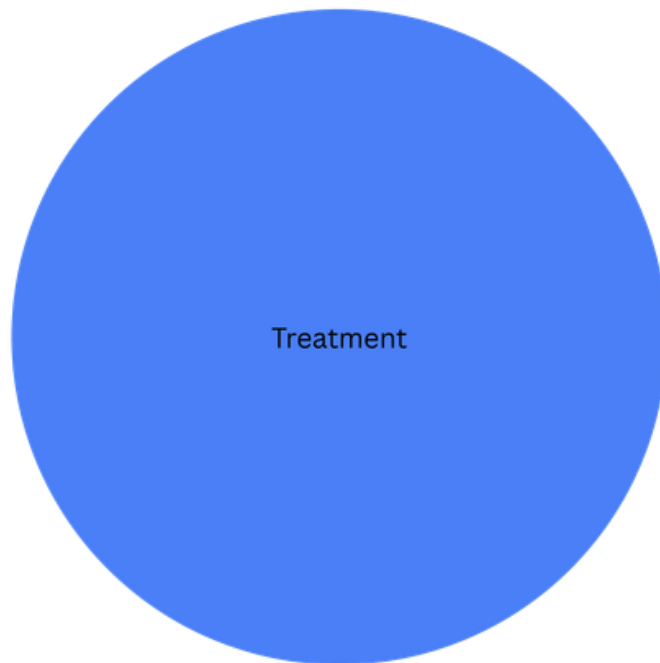


Figure 68: Proportion of OYA Spending by Area of SUD Continuum of Care (100% Treatment)

YOUTH DEVELOPMENT OREGON (YDO)

Youth Development Oregon (YDO) spending was not included in the 2021-23 financial analysis. Much like SOCAC and the ADPC, YDO is established as an independent entity in statute, ORS 417.847, but the budget is within ODE. YDO aligns systems and invests in communities to ensure equitable and effective services for youth ages 6 through 24 to support educational and career success, disrupt youth crime and violence, and affirm youth strengths and safety. This includes coordinating the statewide youth reengagement system in ORS 417.859 and oversight of local high-risk juvenile crime prevention plans under ORS 417.855.

45% of YDO substance use disorder spending came from General Fund-supported Juvenile Crime Prevention funding to support county and tribal high-risk juvenile crime prevention plans, including evaluation to measure changes in juvenile crime and recidivism (ORS 417.850). The remaining spending supported the Youth Solutions (General Fund) and Youth Promise (FF-Title XX (Social Services Block Grant)) initiatives for youth ages 6-24, which address protective factors that prevent school disengagement, unhealthy behaviors, and criminal activity, so that youth may realize their academic goals.

Table 38: YDO Spending by Revenue Source

Revenue Source	Total Spending Amount	Percentage of Total YDO Spending
GF	\$295,050	69.42%
FF-Title XX	\$130,000	30.58%
Grand Total	\$425,050	100.00%

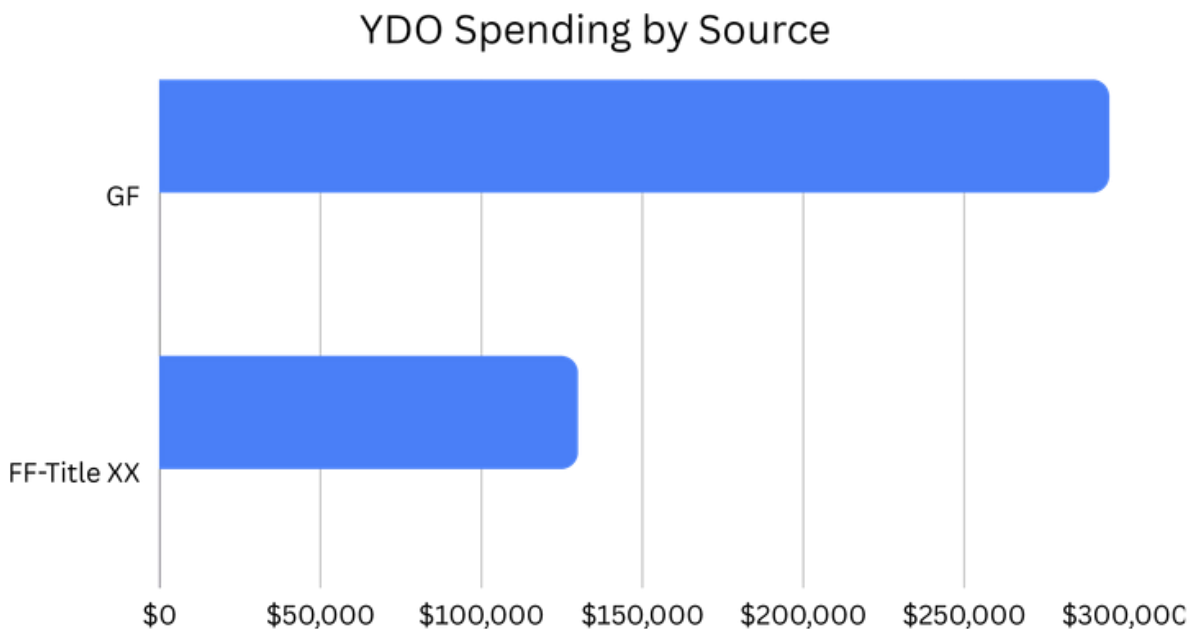


Figure 69: YDO Spending by Revenue Source

Proportion of YDO Spending by Source



Figure 70: Proportion of YDO Spending by Revenue Source

YDO serves an important role in addressing substance use disorder through intervention, increasing strength and protective factors, and promoting positive youth development.

Table 39: YDO Spending by Area of SUD Continuum of Care

Area of Continuum	Sum of Funding Amount	Percentage of Total YDO Spending
Early Intervention	\$190,000	44.70%
Recovery Supports	\$130,000	30.58%
Treatment	\$105,050	24.71%
Grand Total	\$425,050	100.00%

YDO Spending by Area of Continuum of Care

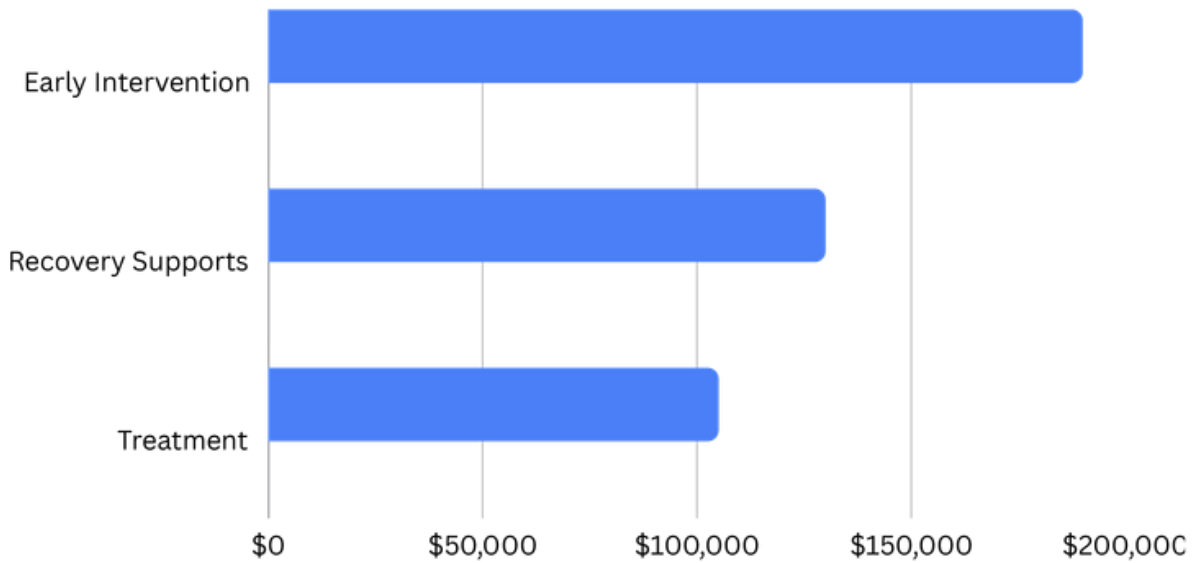


Figure 71: YDO Spending by Area of SUD Continuum of Care

Proportion of YDO Spending by Area of Continuum of Care



Figure 72: Proportion of YDO Spending by Area of SUD Continuum of Care

SYSTEM OF CARE ADVISORY COUNCIL (SOCAC)

No SUD-specific spending for the System of Care Advisory Council was included in the 2021-23 financial analysis. The SOCAC SUD spending is largely supported by General Fund. The 2% attributed to Federal Funds is from a Medicaid match for the portion of staffing costs that supported the SOCAC SUD-related work.

Table 40: SOCAC Spending by Revenue Source

Revenue Source	Sum of Spending Amount	Percentage of Total SOCAC Funding
GF	\$401,984	98.13%
FF-Medicaid Match	\$7,678	1.87%
Grand Total	\$409,663	100.00%

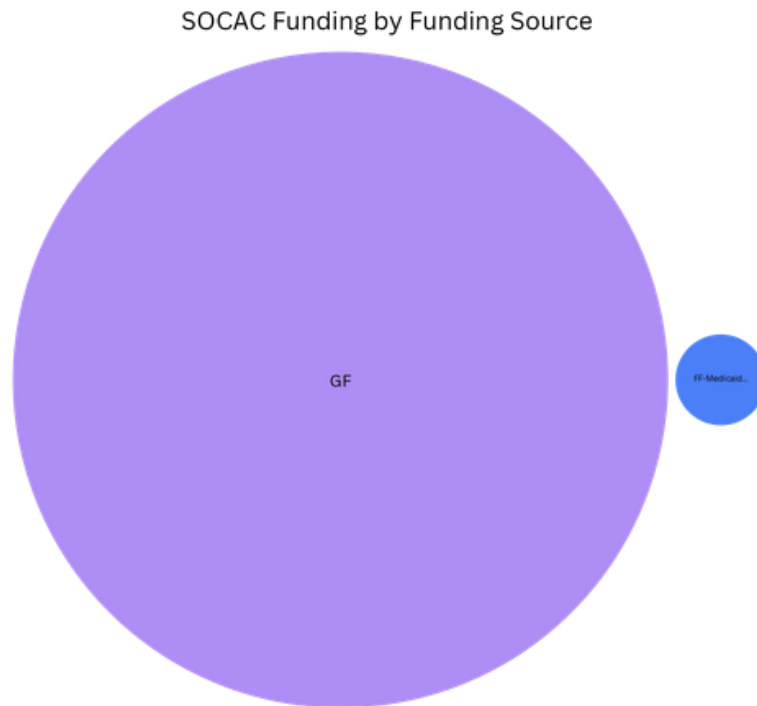


Figure 73: SOCAC Spending by Revenue Source (GF/FF-Medicaid Match)

32% of the Council's 2023-25 SUD spending related to the development of SOCAC Strategic Plan strategies related to youth with substance use disorder. The ADPC and SOCAC collaborated on the establishment and support of the Oregon Youth Addiction Alliance (OYAA), a youth-led entity that developed substance use-specific strategies for both the SOCAC Strategic Plan and the ADPC Comprehensive Plan. The \$131,117 spent in this area funded staff time and OYAA member stipends. The SOCAC work supporting OYAA was allocated between Treatment and Recovery Supports.

The remaining 68% of SOCAC spending related to substance use disorder was allocated through System of Care grants to Local Systems of Care (LSOC) in three counties. LSOC funding

is largely allocated based on local decision-making. The total amount of LSOC funding related to substance use disorder was determined by ADPC staff upon review of grant reports. These funds were spent on Early Intervention, youth recovery supports, and youth treatment.

Table 41: SOCAC Spending by Area of SUD Continuum of Care

Area of Continuum	Sum of Funding Amount	Percentage of Total SOCAC Funding
Recovery Supports	\$165,500	40.40%
Treatment	\$136,704	33.37%
Early Intervention	\$107,459	26.23%
Grand Total	\$409,663	100.00%

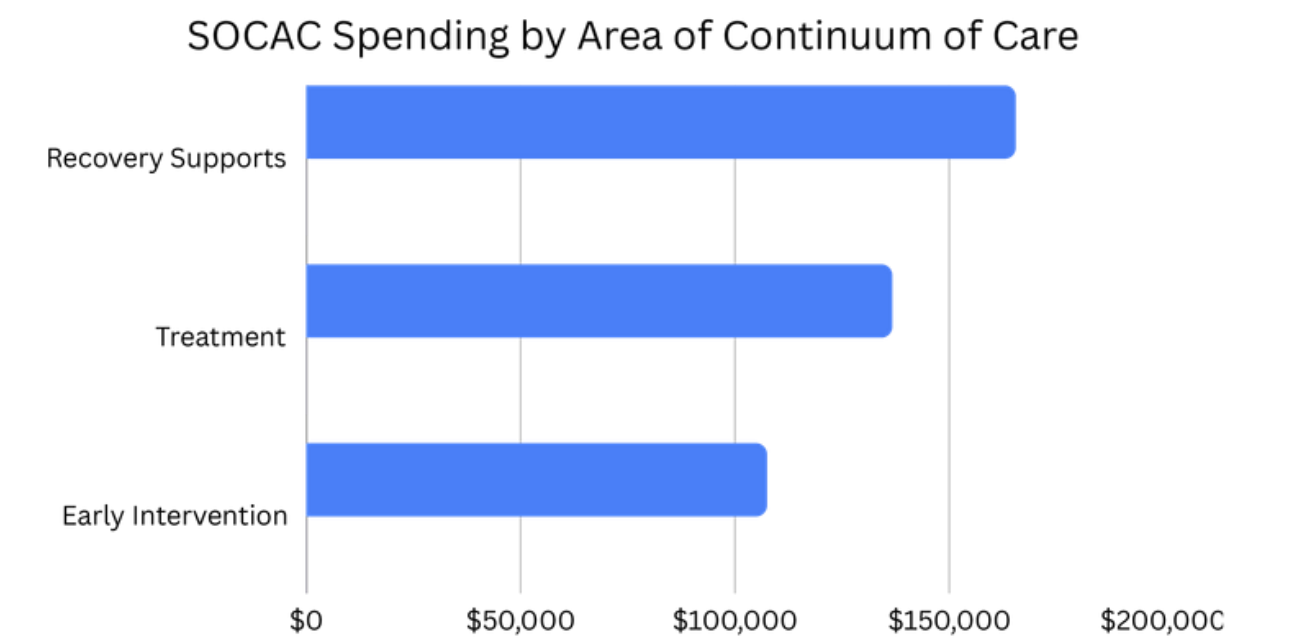


Figure 74: SOCAC Spending by Area of SUD Continuum of Care

Proportion of SOCAC Funding by Area of Continuum of Care

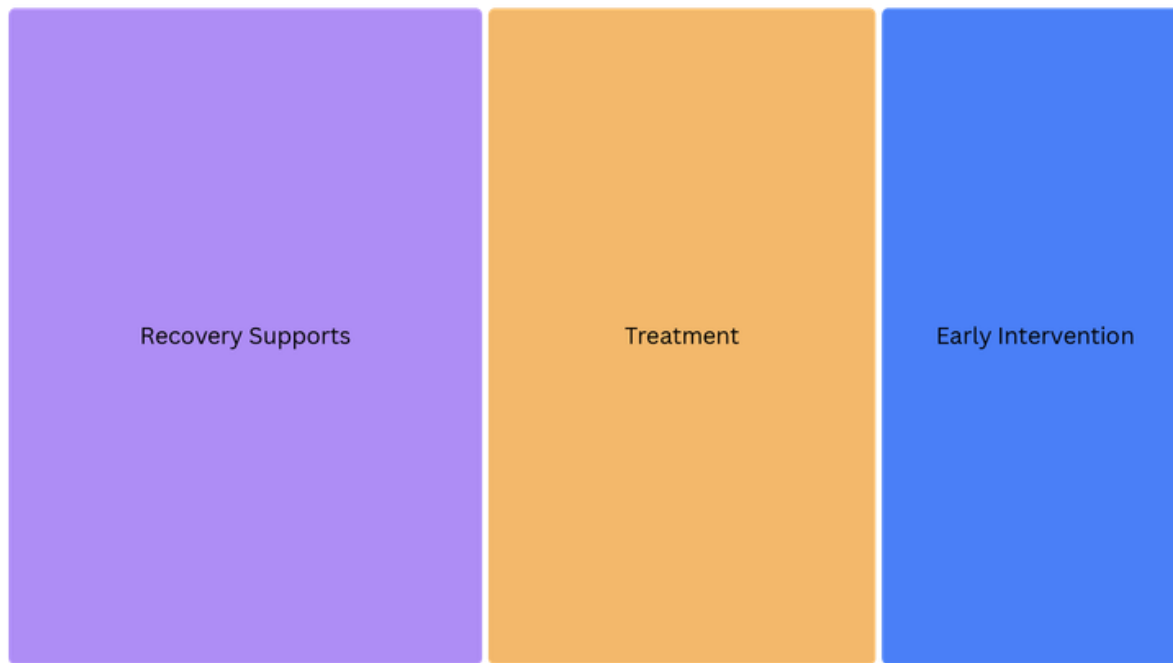


Figure 75: Proportion of SOCAC Spending by Area of SUD Continuum of Care

OREGON STATE POLICE (OSP)

Oregon State Police (OSP) spending was not included in the 2021-23 financial analysis.

Table 42: OSP Spending by Revenue Source

Revenue Source	Total Spending Amount	Percentage of Total OSP Funding
GF	\$39,318	100%
Grand Total	\$39,318	100%

OSP Spending by Source



Figure 76: OSP Spending by Revenue Source (100% GF)

The below OSP SUD-related spending reflects agency purchasing of naloxone. All sworn officers, evidence technicians, and Forensic Services Division or Medical Examiner's Office employees who may encounter narcotic evidence or bodily fluids receive training in the use and administration of intranasal naloxone. All other OSP employees may receive voluntary training based on operational need. The purpose of the OSP Intranasal Naloxone Policy is to treat victims of opioid overdoses and Department employees (including Department K-9's) who are inadvertently exposed to opioids in the course of their employment. Primary locations of intranasal naloxone dosage kits include police vehicles, evidence technician offices, crime labs, and medical examiner offices.

It should be noted that other OSP programs address substance use disorder in Oregon. However, the spending to support these programs cannot be isolated from OSP's law enforcement functions. In particular, ADPC notes:

- OSP labs perform qualitative analysis of physical evidence to determine if and what controlled substance is present. This helps inform our knowledge of the drug supply.
- Toxicology performs qualitative analysis of biological fluids, controlled substances, common pharmaceuticals, and poisons. Quantitative analysis of drugs in blood is performed on postmortem toxicology cases. Volatiles analysis (e.g., blood alcohol determination) is provided for ante-mortem and post-mortem cases. This helps inform our knowledge of the drug supply and substances that cause deaths.
- The OSP Patrol Services Division has a Driving Under the Influence of Intoxicants Program, a Drug Evaluation and Classification Program, and the Ignition Interlock Device (IID) program. These programs deter deaths and injuries related to impaired driving. There is additional information below in the cross-agency spending section related to IID spending in both OSP and OHA.

For purposes of this analysis, the full amount of OSP spending is allocated to risk reduction.

OSP Spending by Area of Continuum of Care

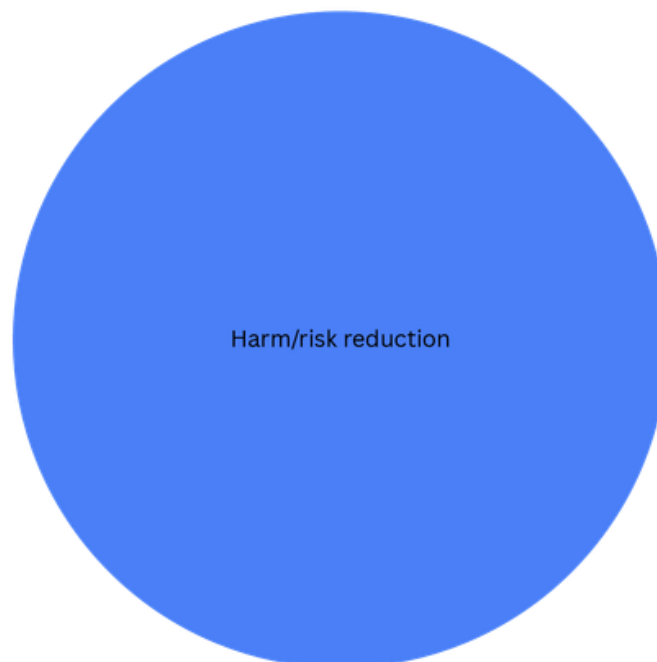


Figure 77: OSP Spending by Area of SUD Continuum of Care (100% Harm/risk reduction)

ADPC PARTICIPATING STATE AGENCIES WITH NO DEDICATED SUD SPENDING

OREGON HOUSING AND COMMUNITY SERVICES (OHCS)

Oregon Housing and Community Services (OHCS) funds the development of Permanent Supportive Housing (PSH), rent assistance and services in PSH, affordable rental housing project development, as well as shelter and transitional housing projects that serve people with behavioral health needs, including people with substance use disorder needs.

By cross-referencing OHCS projects with a substance use disorder provider list, OHCS identified \$138 million in investments. However, ADPC was unable to assess how much of this funding can be accounted for in the continuum of care model used for this analysis. OHCS and ADPC will continue to collaborate to more precisely identify projects developed specifically for individuals with substance use disorder needs. Given that OHA spending also includes capital investments, capital spending may be included separately in future financial analyses.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES (DCBS)

The Department of Consumer and Business Services (DCBS) does not have any direct agency spending that can be attributed to the prevention of substance use disorder or to providing services to individuals experiencing substance use disorder.

The DCBS Division of Financial Regulation (DFR) work related to substance use disorder is centered on regulatory oversight rather than administering programs or funding. DFR is responsible for ensuring that health insurance carriers comply with state and federal requirements related to behavioral health and substance use disorder services, including coverage mandates, network adequacy standards, and parity requirements. The agency has many staff members who devote significant time to reviewing filings, responding to consumer complaints, and enforcing these coverage requirements, but this work is part of the overall regulatory responsibilities of the agency and is not connected to any specific funding that would fit within the assessment categories.

HIGHER EDUCATION COORDINATING COMMISSION (HECC)

The Higher Education Coordinating Commission (HECC) has no 2023-25 spending dedicated to substance use disorder prevention or services.

OREGON DEPARTMENT OF VETERANS' AFFAIRS (ODVA)

The Oregon Department of Veterans' Affairs (ODVA) has no 2023-25 spending dedicated to substance use disorder prevention or services.

CROSS-AGENCY SPENDING

RECOVERY SCHOOLS

As demonstrated in the analysis, the vast majority of Oregon Department of Education's budget for the substance use continuum of care goes to the implementation and operation of recovery schools (\$4.7 million for the 23-25 biennium). [HB 2767](#) (2023) establishes a limited number of approved recovery high schools in Oregon. These schools provide students with a specialized high school education experience tailored to meet the needs of students with substance use and co-occurring behavioral health challenges.

Through ODE, these schools are primarily financed through the State Education Fund and the Student Investment Account, with a small amount of supplemental General Fund from the agency. However, ODE funding streams do not cover all expenses for each program - and local and state agencies cover associated costs.

For example, during the 2024-25 school year (Year 2 of the biennium), one school received \$996,000 from the ODE funding streams but incurred expenses of \$2.4 million. The school made up that \$1.3 million difference with financing from the Oregon Health Authority Behavioral Health Division (via federal funding like State Opioid Response funding and Substance Use Prevention Treatment and Recovery block grant funding, as well as from cannabis revenue via the Behavioral Health Resource Network Program) and funding from Youth Development Oregon.

Oregon's recovery schools offer a variety of strategic educational and recovery-based services, representing a platform for cross-agency partnership and an enterprise-wide strategy to support youth recovery.

NALOXONE/OPIOID OVERDOSE REVERSAL MEDICATION

One strategy included in the ADPC's 2026-2030 Comprehensive Plan is to develop and fund a streamlined statewide naloxone purchasing schema. This financial analysis showed the baseline of agency spending in the state and highlighted a system that is fragmented and siloed, with many gaps and areas to improve. While the majority of agencies did not report naloxone spending, this provides opportunity for agencies to collaborate, increase access to naloxone, reduce stigma, and lead in this space.

Oregon is a member of the Minnesota Multi-State Contracting Alliance for Pharmacy ([MMCAP](#)) which leverages bulk purchasing power to allow agencies to acquire medications and other supplies at discounted prices. The OHA [Save Lives Oregon](#) Clearinghouse, within the Behavioral Health Division, oversees the majority of naloxone spending in the state, which happens through MMCAP. State agencies are eligible to purchase directly through MMCAP and can tailor purchasing to fit the needs and responsibilities of the agency.

According to MMCAP, the total amount spent on naloxone, inclusive of state agencies and local organizations (local law enforcement and first responders, nonprofit organizations, local public health authorities, etc.) who utilize MMCAP in Oregon, was \$11,212,061.91 in the 2023-2025 biennium. State agency partners reported spending \$7,089,520.37. Save Lives Oregon accounted for over 99% of reported state agency spending. Some agencies did not report purchasing naloxone but have a small amount of naloxone spending listed in the MMCAP purchasing data. This could be because the spending was not separated out and rolled into another category, or because of differing policies between facilities (i.e., individual prisons within the DOC system, or specific youth facilities within OYA).

IGNITION INTERLOCK DEVICE/DUII SPENDING

The Oregon State Police is the regulatory authority of ignition interlock devices, interlock service technicians, and interlock service centers throughout Oregon. The Oregon State Police's ignition interlock program, operated out of the Patrol Services Division, consists of law enforcement officers and support staff dedicated to interlock compliance and public safety. The OSP program is solely fee-supported. OSP receives fees from the device makers, service centers, device fees, and IID technician background request fees.

A breath alcohol ignition interlock device (BAIID, also known as an IID) is attached to the vehicle's ignition. It is designed to prevent a motor vehicle from being operated by a person who has consumed an alcoholic beverage. When properly installed and calibrated, the IID will prevent a driver from starting a motor vehicle if the device detects a breath alcohol concentration (BrAC) above the prescribed setpoint.

OSP has identified increasing ignition interlock device compliance as a Key Performance Indicator for the agency. Unfortunately, compliance hovers around 20%. Existing IID violation statutes make enforcement difficult without observing violations first-hand. The Ignition Interlock Program spent the 2023 calendar year enhancing communication and collaboration with courts, prosecutors, Alcohol Drug Screening Specialists (ADSS), and Oregon Driver & Motor Vehicle Services. The program also continues to identify and address issues generated by inconsistent reporting and communication between involved partners.

In accordance with OAR 257-100-0075, there is a fee waiver for individuals required to install an IID who are eligible for and provide documentation of SNAP benefits in Oregon. The fee waiver is provided only through manufacturers under contract with OHA to provide the device service to individuals who meet the indigent standard. OHA leverages funding from the Intoxicated Drivers Program Fund, but that fund does not fully cover the costs associated with installation, monitoring, and removal of IIDs. OHA spent \$941,907.65 on the IID program during the 2023-25 biennium; \$517,071 came from the Intoxicated Driver Program Fund, and \$424,836.65 came from General Fund. The Intoxicated Driver Program Fund also funds treatment services for un- or underinsured individuals who have substance use disorder and are engaged in DUII services.

OHA has identified the General Fund allocation as a budget issue. Without additional funding, OHA is forced to divert General Fund to the program. However, the precise amount needed will depend on how many individuals enroll and the number who qualify for SNAP benefits. At this time, OSP and ODHS do not share data that would allow for the proactive identification of eligible IID participants who qualify as indigent.

APPENDIX A – FEBRUARY 9, 2026

GOVERNOR KOTEK LETTER TO AGENCIES



February 9, 2026

Department of Corrections
Director Mike Reese

Department of Human Services
Director Liesl Wendt

Oregon Health Authority
Director Dr. Sejal Hathi

Oregon Department of Education
Director Dr. Charlene Williams

Oregon Criminal Justice Commission
Interim Director Ryan Keck

Oregon State Police
Superintendent Casey Coddling

Oregon Youth Authority
Director Michael Tessean

Department of Consumer and Business Services
Director Sean O'Day

Housing and Community Services
Director Andrea Bell

Department of Veterans' Affairs
Director Dr. Nakeia Daniels

Higher Education Coordinating Commission
Director Ben Cannon

Oregon Department of Early Learning and Care
Director Alyssa Chatterjee

Oregon Liquor and Cannabis Commission
Director Tara Wasiak

Dear Directors:

As you know, I am focused on building a strong, coordinated behavioral health continuum of care that will help people struggling with mental health and/or substance use disorders wherever they reside in the state.

Aligned with this vision, I have directed the Alcohol and Drug Policy Commission (ADPC) to conduct a financial assessment of state agency spending related to substance use prevention, substance use disorder (SUD) treatment, and recovery support services in order to make recommendations to inform the 2027-2029 Governor's Recommended Budget development. This fiscal analysis is included in the ADPC's 2026-2030 Comprehensive Plan as a strategy to work toward a cohesive plan for funding the SUD continuum of care across relevant state agencies. The ADPC will use the [2021-23 SUD financial analysis](#) as the baseline.

254 STATE CAPITOL, SALEM OR 97301-4047 (503) 378-4582 FAX (503) 378-8970

WWW.GOVERNOR.OREGON.GOV

In addition to the overall analysis of state agency substance use-related funding, the ADPC will seek detailed information for a comprehensive inventory and assessment of existing primary prevention programs in the state, as required by [House Bill 3321 \(2025\)](#) which called for:

1. Financial accounting of current primary prevention expenses in this state, including services funded and the funding sources and amounts for those services; and
2. Inventory of all existing primary prevention programs, including indicated, selective and universal prevention programs.

These analyses will provide a holistic view of funding for the substance use disorder continuum of care supported across your agencies. I understand that some agencies are already beginning to work with staff to achieve these goals through the ADPC work plan process. I appreciate this and ask for your continued collaboration with these efforts to produce a timely result.

Thank you for your assistance with this effort.

Sincerely,

A handwritten signature in black ink, appearing to read "Tina Kotek", written in a cursive style.

Governor Tina Kotek

APPENDIX B – REVENUE SOURCE DEFINITIONS

Abbreviation	Definition
FF-CDC Alcohol	US Centers for Disease Control and Prevention (CDC) funding to twelve states to promote population health through increased capacity in alcohol epidemiology and the prevention of excessive alcohol use and related illness, injury, and death.
FF-SPF	The Strategic Prevention Framework – Partnerships for Success (SPF-PFS) is a Substance Abuse and Mental Health Services Administration (SAMHSA) grant that provides funding to states, communities, and tribes to prevent and reduce substance use, build resilience, and strengthen local prevention provider capacity.
FF - Title I - CAPTA	US Health and Human Services Administration for Children and Families formula grants to states to improve their child protective services (CPS) systems under Title I of the Child Abuse Prevention and Treatment Act (CAPTA).
FF-BJS Stats	The US Department of Justice Bureau of Justice Statistics (BJS) State Justice Statistics Program for Statistical Analysis Centers (SACs) is an annual grant designed to help states collect, analyze, and publish criminal justice data to support strategic planning and national priorities.
FF-ARPA	ARPA funding refers to the \$1.9 trillion American Rescue Plan Act signed into law in 2021 to aid COVID-19 economic recovery. Agencies identified a number of COVID supplements through health and social services grants as revenue sources. All are classified as FF-ARPA for purposes of this report. While funds had to be obligated by late 2024, municipalities and states have until December 31, 2026 to fully expend these allocations.
FF-Medicaid Match	Medicaid is a shared state and federal program. This refers to the federal portion of Oregon's Medicaid spending.
FF-OD2A	US Centers for Disease Control and Prevention (CDC) Overdose Data to Action state grants to monitor fatal and nonfatal overdose data and use that data to implement tailored, evidence-based prevention responses that target populations disproportionately impacted by overdose.

Abbreviation	Definition
FF-PDMP	US Department of Justice Bureau of Justice Assistance (BJA) Harold Rogers Prescription Drug Monitoring Program funding to enhance the capacity of regulatory agencies, law enforcement agencies, and public health agencies to collect and analyze controlled substance prescription data and other scheduled chemical products through a centralized database administered by an authorized agency.
FF-RSAT	US Department of Justice Bureau of Justice Assistance Residential Substance Abuse Treatment for State Prisoners (RSAT) Program formula grant program that enhances the capabilities of state, local, and tribal governments to provide residential substance use disorder (SUD) treatment to adult and juvenile populations during detention or incarceration, initiate or continue evidence-based SUD treatment in jails, prepare individuals for reintegration into the community, and assist them and their communities throughout the reentry process by delivering community-based treatment and other recovery aftercare services.
FF-SUPTRS	The Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant (formerly known as the Substance Abuse Prevention and Treatment (SAPT) Block Grant) is a noncompetitive formula grant to states from SAMHSA to prevent and treat substance use. It mandates that states set aside at least 20% of the funds specifically for primary substance use prevention. All funding designated as SAPT or SUPTRS is designated as FF-SUPTRS for this report. The funding may have been tagged as "SAPT" instead of "SUPTRS" as the spending allocation related to an earlier grant cycle.
FF-SOR	State Opioid Response (SOR) grants through SAMHSA are non-competitive, two- to three-year formula grants to states to combat the opioid and stimulant overdose crisis. This funding provides resources for prevention, harm reduction, treatment—including medications for opioid use disorder (MOUD)—and recovery support services.
FF-TANF	Temporary Assistance for Needy Families (TANF) is a federal block grant awarded to states by the US HHS Administration for Children & Families to help families with children experiencing low-income achieve economic security and stability.

Abbreviation	Definition
FF-Title IV-B	Title IV-B of the Social Security Act is a federal funding stream that provides flexible grants to states and Indian tribes for child welfare services through US HHS Administration for Children & Families. Its primary goal is to keep families safely together, prevent child maltreatment, and support foster care and adoption programs.
FF-Title XX	Title XX refers to the Social Services Block Grant (SSBG) program, which provides federal funds from US HHS Administration for Children & Families to states to support vulnerable populations and promote self-sufficiency.
GF	State revenue allocated by the Oregon state legislature.
LF	State lottery revenue allocated by the legislature to support targeted health initiatives and veterans' services.
LF-Lottery Bonds	Lottery Revenue Bonds to fund capital needs and infrastructure.
OF-Misc	No further information could be gathered on this source of funding.
OF- Criminal Fines	The Oregon Criminal Fine Account (CFA) is a dedicated state fund (established under ORS 137.300) where money collected from court-ordered financial penalties in criminal, traffic, and violation cases is deposited. Allocations are made to OHA from this account for the purpose of grants under ORS 430.345 (Grants for prevention of, intervention in and treatment for substance use disorders) for the establishment, operation, and maintenance of alcohol and drug abuse prevention, early intervention, and treatment services provided through a county.
OF-MHADSA	Revenue from Oregon's Privilege Tax on beer, wine, and cider is distributed to the Oregon Wine Board, to the OHA Mental Health, Alcoholism & Drug Services Account (50% of the amount remaining after the allocation to the wine board), and the remainder to the General Fund, cities and counties. As this is the only allocation of beer and wine revenue to OHA, the funding has been designated as MHADSA.
OF-Intoxicated Driver Program Fund	The Intoxicated Driver Program Fund established by ORS 813.270 is funded by fees to pay for treatment, evaluation, administration, and other services.

Abbreviation	Definition
OF-Marijuana DTRSF	Per M110, all marijuana revenue above statutory allocations from the Oregon Marijuana Account established under ORS 475C.726 is directed to the Drug Treatment and Recovery Services Fund (DTRSF).
OF-Marijuana	Separate from marijuana revenue allocated to the DTRSF, OHA receives two allocations, originally established under Measure 91, from marijuana tax revenues deposited into the Oregon Marijuana Account: 20% to the Mental Health, Alcoholism and Drug Services Account (also funded by beer, wine and cider revenue) and 5% for drug treatment and prevention.
OF-Marijuana Control & Regulation Fund	The Marijuana Control and Regulation Fund established by ORS 475C.297 is funded by licensing fees and a statutory allocation from the Oregon Marijuana Account and appropriated to the OLCC to cover the costs of regulating the cannabis industry, including licensing, compliance checks, and enforcement.
OF-OLCC Account	All revenue received by the Oregon Liquor and Cannabis Commission (OLCC), including alcohol and marijuana licenses, server education fees, and fines, is classified as Other Funds. This Other Funds account directly supports the agency's regulatory functions.
OF-Opioid Settlement	The Opioid Settlement Prevention, Treatment and Recovery Fund was established in 2022 and consists of all opioid-related settlements managed by the State of Oregon.
OF-State PDMP	Each healthcare licensee in Oregon pays \$35 annually to their licensing board to support the operation of the Oregon Prescription Drug Monitoring Program (PDMP). These fees are transferred to OHA from the boards minus a 10% administrative fee.
OF-State School Fund	The Oregon State School Fund (SSF) is the primary source of operational funding for K-12 public schools. It is funded by state revenues and local property taxes.
OF-Statewide Education Initiatives Account	The Statewide Education Initiatives Account is funded by the Student Success Fund to pay for the creation of new programs or the expansion of existing programs at the Oregon Department of Education aimed at improving educational opportunities for Oregon students, especially historically underserved student groups.

APPENDIX C – INSTRUCTIONS TO AGENCIES

Background

The 2023-25 analysis seeks to report state agency spending related to substance use disorder - by funding stream as well as by area of the continuum of care. This spreadsheet is designed to assess all programs in your agency that fund any part of the substance use disorder continuum of care. You have the option of assigning spending to a particular area of the continuum of care, or providing information that will allow us to assign it.

Instructions

1. Agency Substance Use Disorder ("SUD") Programs tab: Please begin by listing all SUD-related programs or funding streams in your agency. This may include a program that only includes state agency staffing and does not fund services in the community. Please include the name of the program, a program description, funding source, the 23-25 budget for the program, and the amount actually allocated through the program in 23-25. If SUD services are only a part of the program listed and you are estimating the amount spent on SUD specifically, please note how you estimated that allocation in the Notes column.

2. Funding Source: We have attempted to be as inclusive as possible but are happy to add additional categories in the dropdown menu. The Agency SUD programs tab allows multiple funding sources to be selected for each program listed. However, the funding detail tab requires one funding source per line.

3. Funding Detail Tab: This tab is where you will break down program spending to provide more information about specific categories and service areas related to the spending. If this is too burdensome and you would prefer to provide us with information in a different format, or provide individual contract or grant information, that works too. You may provide more information using the optional Funding Recipients tab, or contact us to set up a mechanism for sharing. If you choose to categorize the spending, please refer to the Definitions and Service Description tabs to categorize your spending.

The spreadsheet is designed to capture spending by funding source and area of continuum. Therefore, you may only choose one funding source or one continuum area on each line.

Please note whether each line of funding is allocated to agency FTE or through grants, contracts or billed services, broken out on separate lines if possible. For agency FTE, please note type of FTE in the FTE Type column. See the Definitions tab for further explanation of each FTE Type grouping. FTE Type relates only to state agency FTE, not grantee or contractor staff.

Peer Delivered Services: Peer Delivered Services exist across several areas of the continuum. In this tool, we ask that Peer Delivered Services spending be assigned to the relevant Service Categories in which the services take place: Harm/risk Reduction, Treatment (this includes peers in clinical and medical settings), and Recovery spending. In each of these Setting Categories there is a Service Type of 'Peer Delivered Services'. For example, if one were to report on Recovery-related Peer Services spending, they would report in the 'Recovery Service Category' in the 'Peer Delivered Services Service Type'. If it is not possible to differentiate Setting Category as Harm Reduction, Treatment, or Recovery, please use the 'Peer Delivered Services, Other' Setting Category. If possible, please add a note for spending applied to the 'Peer Delivered Services, Other' Service Category.

Primary Prevention spending: Note that ADPC and our contractor, Third Horizon, will be in touch to request additional information related to any primary SUD prevention funding. This is part of the HB 3321 (2025) assessment.

Spending on Naloxone/ Short-acting opioid antagonist: Please note any funds allocated for the purchase of naloxone or other overdose reversal medication. We will be looking at all related spending to assess total state spend and ensure that Oregon is engaging in the most efficient purchasing processes.

Geographic Area served: If funding is allocated by county, feel free to list each county amount separately. You may also list the total amount allocated statewide and signify that each county receives a particular amount.

4. Funding Recipients (Optional) Tab: If you would like to provide information on individual contracts, grants or funding streams and have the ADPC extract the detail, feel free to add information into this tab.

Contact ADPC Director Annaliese Dolph annaliese.dolph@oha.oregon.gov with any questions.

Definitions

Primary Prevention means practices, programs and policies designed to prevent, delay and reduce the incidence and prevalence of youth substance use. Primary prevention services may include information dissemination, positive alternatives to substance use, community-based prevention practices, prevention education, environmental strategies and problem identification, screening, and brief intervention.

Treatment involves medically managed, clinically managed, and evidence-based interventions ranging from outpatient to intensive inpatient. Substance Use Disorder (SUD) treatment services include, but are not limited to, screening; assessment; individual counseling; group counseling; individual family, group or couple counseling; care coordination; medication for use disorders (MOUD, MSUD, MAT); medication management; collection and handling of specimens for substance analysis; interpretation services; withdrawal management for substance use disorders; synthetic opioid treatment; and acupuncture. (OAR 410-172-0670) (153) "Treatment" means the planned, medically necessary, individualized program of medical, psychological, and rehabilitative procedures, experiences and activities designed to remediate symptoms of a DSM-5-TR-TR diagnosis. OAR 309-018-0105

Recovery means a process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential (HB 2513 (2023), SAMHSA, ADPC Recovery Committee). "Recovery" means a process of healing and transformation for an individual to achieve full human potential and personhood in leading a meaningful life as they define it in communities of their choice. OAR 309-018-0105.

Harm Reduction/risk reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use, including but not limited to providing:
(a) Sterile syringes and safe disposal for needles and syringes; (b) Other items that reduce the transmission of infectious disease or prevent injury, infection or overdose (not including naloxone); (c) Wound care supplies; (d) Substance use-related infectious disease screening; (e) Sobering support; (f) Contingency management; (g) Drug checking supplies; (h) Information and education about harm reduction services; and (i) Referral for Hepatitis, HIV, STI, COVID-19, and Tuberculosis (TB) testing, vaccine, or other healthcare services. (Definition based on OAR 944-010-0060 (M110 BHRNs) and ORS 475.757 (SSPs)).

Naloxone/ Short-acting opioid antagonist means any short-acting drug approved by the United States Food and Drug Administration for the complete or partial reversal of an opioid overdose ORS 689.800.

Peer Delivered Services are community-based services and supports provided by peers, peer support specialists, and peer wellness specialists to individuals or family members with similar lived experience. These services are intended to support individuals and families to engage individuals in ongoing treatment and to live successfully in the community. OAR 309-0105.

FTE Type Definitions: *Applies only to state agency staff.* Group 1 - Direct Service: Provision of services, supervision of services, clinical consultation, clinical oversight, licensing, compliance and inspection (e.g. PHN). FTE Type Group 2 - Funder/Partner Resource: grant and program management, program development and administration, community engagement, non-clinical technical assistance and professional development (typically PA, AS, PM, or PEM etc). FTE Type Group 3 - Policy, Research and Evaluation: policy analysis, program evaluation, data collection and analysis (OPA, RA, or PEM).

Treatment Withdrawal Management Definitions: *Withdrawal Management Hospital Medically Monitored* means Withdrawal management (colloquially known as detox) services provided within a hospital setting. *Withdrawal Management; Non-Hospital Medically Monitored* means ASAM Level 3.7-WM Medically Monitored Withdrawal Management (ASAM Level 3.7-WM) means a medical, inpatient setting as described in The ASAM Criteria, Third Edition that provides 24-hour medically monitored intensive inpatient treatment services for patients assessed at ASAM Level 3.7-WM. Patients who meet criteria for admission to this level of care experience severe withdrawal syndrome and need 24-hour nursing care and LMP visits as needed. *Withdrawal Management; Non-Hospital Medically Monitored* means ASAM Level 3.7-WM Medically Monitored Withdrawal Management (ASAM Level 3.7-WM)” means a medical, inpatient setting as described in The ASAM Criteria, Third Edition that provides 24-hour medically monitored intensive inpatient treatment services for patients assessed at ASAM Level 3.7-WM. *Withdrawal Management; Non-Hospital Clinically Monitored* (3.2-WM) ASAM Level 3.2-WM Clinically Managed Residential Withdrawal Management (ASAM Level 3.2-WM) means a setting as described in The ASAM Criteria, Third Edition in which patients experience moderate withdrawal symptoms and need 24-hour support to complete withdrawal management and increase the likelihood of continuing treatment or recovery. Clinically managed services are directed by non-physician addiction specialists rather than medical and nursing personnel. This level emphasizes peer and social support and is for patients whose intoxication is sufficient to warrant 24-hour support or whose withdrawal symptoms are sufficiently severe to require primary medical nursing care services. *Withdrawal Management; Methadone* means Methadone provided outside of an OTP for the purpose of withdrawal management when other methods may result in adverse health consequences.

Medications for Use Disorders (not related to overdose reversal) means Medications used to treat substance use disorders unrelated to overdose reversal medication. Examples include Methadone (daily dosing @ OTP), Buprenorphine (oral, sublingual), Buprenorphine/ Naltrexone (oral, sublingual), Naltrexone (OUD), Naltrexone (AUD), Long Acting Injectable Buprenorphine (1 week), Long Acting Injectable Buprenorphine (1 month), Long Acting Injectable Naltrexone.

Residential treatment means ASAM Level 3.1, 3.3, 3.5, or other non-Withdrawal management programs licensed to provide SUD treatment in a residential setting licensed under ORS 443.415.

Outpatient means Services outlined in 309-19, currently described as ASAM levels 1, 2.1, and 2.5.

Opioid Treatment Programs (OTP) means a program that dispenses and administers opioid agonist medications in conjunction with appropriate counseling, supportive, and medical services.

ASAM Assessment & Diagnosis means Assessments provided using the ASAM criteria for the purpose of needs identification, treatment planning, treatment placement, or other care decisions. Other assessments such as more generalized behavioral health needs assessments do not apply to this category.

Telehealth/ Telemedicine means services provided via telephone or video conferencing to treat SUDs.

Peer Delivered Services in the treatment category include services provided by peers within treatment settings as a part of an ASAM derived SUD treatment plan.

Area of Continuum	Service Type/Description
Primary Prevention	Information Dissemination
Primary Prevention	Positive Alternatives
Primary Prevention	Community-Based Practices
Primary Prevention	Prevention Education

Primary Prevention	Environmental Strategies
Primary Prevention	Problem Identification, Screening & Brief Intervention
Early Intervention	Outreach, screening, community-based intervention and referral
Harm/risk Reduction	Supplies such as safer use supplies, wound care, and other health supplies (not including Naloxone)
Harm/risk Reduction	Staffing
Harm/risk Reduction	Peer Delivered Service
Harm/risk Reduction	Purchase of Naloxone or other overdose reversal medication
Treatment	Withdrawal Management; Hospital Medically Monitored
Treatment	Withdrawal Management; Non-Hospital Medically Monitored
Treatment	Withdrawal Management; Non-Hospital Clinically Monitored
Treatment	Withdrawal Management; Methadone
Treatment	Medications for Use Disorders (not related to overdose reversal)
Treatment	Residential
Treatment	Outpatient
Treatment	Opioid Treatment Programs
Treatment	ASAM Assessment & Diagnosis
Treatment	Telehealth/ Telemedicine
Treatment	Peer Delivered Service
Recovery Supports	Supported Employment
Recovery Supports	Recovery Support Centers
Recovery Supports	Peer Delivered Services
Recovery Supports	Recovery Housing
Peer Delivered Services	Not otherwise categorized within continuum
Drug Courts	Relating to SUD service delivery or coordination
Deflection	
Jail Treatment, Medications for SUD	Medications for Use Disorders (not related to overdose reversal) for non-treatment settings
Tribal	Funding allocated to tribes for SUD continuum
DUII Services	
Drug Screen/Collection	
Other	Please Explain

APPENDIX D – OREGON LIQUOR AND CANNABIS COMMISSION ESTIMATE

Additional information for the 2023 -25 budget:

All revenues received by the Oregon Liquor & Cannabis Commission (OLCC) are classified as “Other Funds.” The OLCC receives revenues from distilled spirits sales, license fees from alcohol, fines, server education fees, taxes on malt beverages and wines (Privilege Tax), marijuana license fees, marijuana tax money, worker permit fees, and miscellaneous income. A full description of the 2023-25 legislatively adopted budget is available [online](#). OLCC Distributes 50% of Privilege Tax collected monthly to OHA for the Mental Health and Drug Services Account– the total for the 23-25 biennium provided to OHA was \$17,635,050.

Clarifications regarding Information Provided for the 23-25 Fiscal Analysis

OLCC has estimated the time spent on each program area for all Regulatory Specialists because the programs listed on the spreadsheet are only a part of their job duties, and funding received is for the entire position with each position having varied steps within it. OLCC used the total FTE hiring authority for the 23-25 budget as the FTE on the spreadsheet and actual money spent on the dollar amounts.

The hours worked by the minor decoys also varies. OLCC had the authority to hire 30 minor decoys at .50 FTE, but actual hours worked will vary based on the minor decoy and staff’s availability to complete the decoy operations. For this estimate, OLCC used the full staffing authority and the total spent.

The following are OLCC’s estimations for staff positions and programs related to OLCC’s spending on substance use disorder related programs that are reflected in the spreadsheet:

- Liquor regulatory specialists FTE: 64 total
 - Actual: \$18,388,070 (personal services & services and supplies)
 - Liquor minor decoys: 20% = \$3,677,614
 - Liquor first calls: 20% = \$3,677,614
 - ID checking classes:15% = \$2,758,210
- Marijuana regulatory specialists FTE: 43 total
 - Actual: \$12,807,695 (personal services, services and supplies & capital outlay)
 - Marijuana minor decoys 18% = \$2,305,385
 - ID checking classes:15% = \$1,921,154
- Naloxone: Spent \$3184.71 on Naloxone in 2024 when the policy went into effect.
- OPA 3: Public Health & Consumer Protection Policy Analyst: 1 FTE: \$322,599 (personal services & services and supplies)
- AS 2: Alcohol Education Program Administrative Assistant: 1 FTE: \$265,345 (personal services & services and supplies)
- FTE and budget for actual decoys: 15 (30 @ .50 FTE) \$66,185

APPENDIX E – ODOC SUD RESOURCES BY FACILITY

A map of all Oregon Department of Corrections (ODOC) facilities can be found at the ODOC website (<https://www.oregon.gov/doc/pages/default.aspx>). All facilities serve male and female adults (18+ years old). Services include residential/intensive outpatient and outpatient treatment services. These services include group and individual counseling at levels based on individually assessed risk and need. All treatment program services are provided by Certified Alcohol & Drug Counselors (CADC) and CADC-Registrant (CADC-R) staff, with some programs also utilizing the roles of adult-in-custody Certified Recovery Mentors (CRM) in the delivery of all services.

Name of Program	Program Description	23-25 Budget
New Directions Northwest (NDN) Powder River Correctional Facility Baker City, OR	• 128 bed unit within a closed custody facility for male adults in custody (AIC). • Certified as an Outpatient Substance Use program through the Health Systems Division of the Oregon Health Authority (OHA), providing treatment in a residential milieu setting. • Clients are referred by the Treatment Assignment Screening Committee (TASC) of ODOC. • Clients must be minimum custody to participate. • Clients consist of those engaged in the Alternative Incarceration Program (AIP) and those assigned Alcohol & Drug (A&D) as part of their Oregon Corrections Plan (OCP). OCPs indicate areas of identified risk/need for intervention and programming while in custody. • All clients are assessed for substance use disorder to include DSM-5tr diagnosis and ASAM Level of Care. • Program is 6-8 months in duration targeting those preparing to release from custody. • When fully staffed, the program consists of 17 counselors, 2 program supervisors, 2 office specialists, and one program manager. • Program challenges include: Difficulty maintaining full staffing due to the rural	General Fund– Contracted Program

	setting; also limited space in the facility for staff and groups. • Staff consists of fully credentialed CADCs and CADC-Rs. The program frequently hires and trains up their own CADC-Rs into CADC-Is.	
Turning Point (Cascadia Behavioral Health) Columbia River Correctional Institution Portland, OR	• 61 bed unit within a closed custody facility for male AICs. • Certified as an Outpatient Substance Use program through the Health Systems Division of OHA, providing treatment in a residential milieu setting. • Clients are referred by the TASC of ODOC. • Clients must be minimum custody to participate. • Clients consist of those engaged in the AIP and those assigned Alcohol & Drug (A&D) as part of their Oregon Corrections Plan (OCP). OCPs indicate areas of identified risk/need for intervention and programming while in custody. • All clients are assessed for substance use disorder to include DSM-5tr diagnosis and ASAM Level of Care. • Program is 6-8 months in duration targeting those preparing to release from custody. • When fully staffed, the program consists of 8 counseling staff, one supervisor, and one program manager. • Staff consists of fully certified CADCs and also CADC-Rs.	General Fund- Contracted Program
Freedom & Recovery (Multi-Cultural Consultants) Oregon State Correctional Institution Salem, OR	• 30 participants within a closed custody facility for male AICs. • Certified as an Outpatient Substance Use program through the Health Systems Division of OHA. Clients live in general population and come to the program offices for day treatment services. • Clients are referred by the TASC of ODOC. • Clients are minimum and medium custody AICs. • Clients consist of those assigned Alcohol & Drug (A&D) as part of their Oregon Corrections Plan (OCP). OCPs indicate areas of	General Fund- Contracted Program

	identified risk/need for intervention and programming while in custody. There are limited openings for AIP clients, with case specific needs that necessitate placement at OSCI. • When fully staffed, the program consists of 2 counseling staff and 1 program manager. • Staff consists of fully certified CADCs, CADCRs, and CGACs. • The program utilizes Peer Recovery Mentors trained and credentialed as CRMs with MHACBO as part of the service continuum. • This program is culturally-responsive, offering treatment counseling, mentoring, and groups for Spanish-speaking AICs. • Challenges faced by this program include: environmental limitations – the space is not air conditioned and gets so hot in the summertime that afternoon treatment groups and sessions often have to be canceled; retaining CRMs can be challenging as they are transferred out to another facility once they reach minimum custody status.	
S.M.A.R.T. AIP Program (ODOC) Coffee Creek Correctional Facility Wilsonville, OR	• 50 bed unit within a closed custody facility for female AICs. • Certified as an Outpatient Substance Use program through the Health Systems Division of the Oregon Health Authority (OHA), providing treatment in a residential milieu setting. • Clients are referred by the TASC of ODOC. • Clients must be minimum custody to participate. • Clients consist of those engaged in the AIP. • All clients are assessed for substance use disorder to include a DSM-5tr diagnosis and ASAM Level of Care. • Program is 6-8 months in duration targeting those preparing to release from custody. • Program staff includes 4 counseling staff and one program manager. RSAT grant funds one limited duration QMHA position focused on case management/transitional planning.	General Fund with additional RSAT Grant Funding

	• The staff consists of fully certified CADCs and internally-credentialed QMHAs. • The program utilizes AIC Peer Recovery Mentors as part of the service continuum. These AICs are credentialed with MHACBO as Certified Recovery Mentors (CRM)s. • A significant program barrier is the cost to certify Peer Recovery Mentors as CRMs. Trainings are currently not permanently funded. In order to retain enough employed AIC Peer Recovery Mentors, the program needs to be able to provide a minimum of 1 CRM training a year. • S.M.A.R.T. was named by the first cohort of clients that graduated from the program and is an acronym that stands for "Sobriety, Motivation, Acceptance and Recovery in Treatment."	
LOTUS SUD Program (ODOC) Coffee Creek Correctional Facility Wilsonville, OR	• Approximately 150 treatment slots for female AICs within a closed custody facility in an outpatient setting. • Clients are referred by their institution Correctional Counselor or Qualified Mental Health Professional (QMHP) counselor. • The program serves all custody levels and any sentence length. Clients live in general population or special housing settings. • All clients are assessed for substance use disorder to include a DSM-5tr diagnosis and ASAM Level of Care. • Utilizing the chronic disease approach, program duration and dosage vary based on assessed individual risks and needs. • Fully staffed, the program consists of 6 counseling staff, 1 office specialist, and 1 treatment services manager. • The staff consists of fully certified CADCs and internally-credentialed QMHAs. • The program utilizes AIC Peer Recovery Mentors as part of the service continuum. These AICs are credentialed with MHACBO as Certified Recovery Mentors (CRM)s.	General Fund

	- Challenges facing this program include: limited space in Coffee Creek medium for staff offices and treatment groups; competing with Oregon Corrections Enterprises jobs and other work-based education to have access to clients in medium for treatment sessions and groups. A significant program barrier is the cost to certify Peer Recovery Mentors as CRMs. Trainings are currently not permanently funded. In order to retain enough employed AIC Peer Recovery Mentors, the program needs to be able to provide a minimum of 2 CRM trainings a year. - The LOTUS program was named by the AIC Peer Recovery Mentors hired and certified to work in the program.	
T.R.U.E. SUD Program (ODOC) Oregon State Penitentiary Salem, OR	- Approximately 250 treatment slots for male AICs within a closed custody facility in an outpatient setting. - Clients are able to self-refer and are also referred by their institution Correctional Counselor or Qualified Mental Health Professional (QMHP) counselor. - The program serves all custody levels and any sentence length. Clients live in general population. - All clients are assessed for substance use disorder to include a DSM-5tr diagnosis and ASAM Level of Care. - Utilizing the chronic disease approach, program duration and dosage varies based on individually assessed risks and needs. - Fully staffed, the program consists of 6 counseling staff, 1 office specialist, and 1 treatment services manager. - The staff consists of fully certified CADCs and internally-credentialed QMHAs. - The program utilizes AIC Peer Recovery Mentors as part of the service continuum. These AICs are credentialed with MHACBO as Certified Recovery Mentors (CRM)s. - Challenges facing this program include: limited institutional space to offer groups; and	General Fund

	frequent institution movement which means that programming AICs may sometimes get moved out to other facilities without an active SUD treatment program. • A significant program barrier is the cost to certify Peer Recovery Mentors as CRMs. Trainings are currently not permanently funded. In order to retain enough employed AIC Peer Recovery Mentors, the program needs to be able to provide a minimum of 1 CRM training a year. • The T.R.U.E. program was named by the first round of AIC Peer Recovery Mentors hired and certified to work in the program.	
Keys to Freedom SUD Program (ODOC) Snake River Correctional Institution Ontario, OR	• Approximately 275 treatment slots for male AICs within a closed custody facility in an outpatient setting. • Clients may self-refer and are also referred by their institution Correctional Counselor or Qualified Mental Health Professional (QMHP) counselor. • The program serves all custody levels and any sentence length. Clients live in general population and special housing settings. • All clients are assessed for substance use disorder to include a DSM-5tr diagnosis and ASAM Level of Care. • Utilizing the chronic disease approach, program duration and dosage varies based on individually assessed risks and needs. • Fully staffed, the program consists of 6 counseling staff, 1 office specialist, and 1 treatment services manager. • The staff consists of fully certified CADCs and internally-credentialed QMHAs. • The program utilizes AIC Peer Recovery Mentors as part of the service continuum. These AICs are credentialed with MHACBO as Certified Recovery Mentors (CRM)s. • Challenges facing the program include: limited space for groups; frequent institution movement which means that programming AICs may sometimes get moved out to other	General Fund

	facilities without an active SUD treatment program; initial staffing presented a challenge after program opening due to the rural setting. This led to a slower program launch than other chronic disease SUD treatment locations. • A significant program barrier is the cost to certify Peer Recovery Mentors as CRMs. Trainings are currently not permanently funded. In order to retain enough employed AIC Peer Recovery Mentors, the program needs to be able to provide a minimum of 1 CRM training a year. • The Keys to Freedom program was named by the first round of Peer Recovery Mentors hired and certified by the program.	
New Foundations COD Program (ODOC) Columbia River Correctional Institution Portland, OR	• 50 bed unit within a closed custody facility for male AICs diagnosed with a substance use disorder and co-occurring mental health condition. • Clients are referred to the program by their assigned QMHP. • The program serves minimum custody AICs. Clients live in a residential milieu setting. • The duration of the program is approximately 9 – 12 months prior to release from prison. • All clients are assessed for substance use disorder to include a DSM-5tr diagnosis and ASAM Level of Care. • Fully staffed, the program consists of 3 Qualified Mental Health Associates (QMHA), 2 QMHPs, and 1 treatment services manager. The program receives dedicated support of a half-time mental health prescriber. RSAT grant funds one limited-duration QMHA position focused on case management/transitional planning. • QMHA staff are fully credentialed CADCs. • The program utilizes AIC Peer Recovery Mentors as part of the service continuum. These AICs are credentialed with MHACBO as Certified Recovery Mentors (CRM)s.	General Fund with additional RSAT Grant Funding

	Challenges faced by this program include: Difficulty in recruiting certified Peer Recovery mentors due to it being a releasing facility. (CRCI does not have its own CRM training program, so Peer Recovery mentors must transfer into the facility already certified.) Also, limited transitional housing resource opportunities for clients.	
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APPENDIX F – OYA SUD RESOURCES BY FACILITY

A map of OYA facilities and additional information can be found on their [website](#). All facilities serve youth ages 13-24. Outpatient substance use treatment is offered at all facilities, with individualized and group counseling treatment offered based on client need and staff resources. All groups are facilitated by CADC Certified Staff and CADC-Rs, with some Peer Support Specialist participation based on need and availability, and with clinical supervision from OYA staff.

Name of Program	Program Description	23-25 Budget
MacLaren Youth Correctional Facility	• 187 bed closed-custody facility, located in Woodburn. • Certified as an Outpatient Substance Use Treatment Facility through Health Systems Division at OHA. • All are screened and assessed for a substance use disorder, including both a DSM-5 diagnosis and an ASAM level of care. • Slated to begin offering consistent medications for Opioid Use Disorder in 2026, with the primary medication being sublingual Buprenorphine. • Nasal spray naloxone located on each living unit and throughout the facility. • This facility employs two Substance Use Treatment Coordinator positions, one funded with General Fund and one that is partially funded by OHA reimbursement to OYA of Other Funds (OF) as Program Analyst 2 positions. The agency has requested permanent funding for approximately two-thirds of the second position and has not yet received this approval.	GF for direct service staff Also leverages OHA OF-Beer Wine revenue and OF-Marijuana revenue to support the positions.

Rogue Valley Youth Correctional Facility	• 50 bed closed-custody facility. • Certified as an Outpatient Substance Use Treatment Facility through Health Systems Division at OHA. • This facility typically does not conduct screenings and intake assessments, but it does have the capacity to do so. • Slated to begin offering consistent medications for Opioid Use Disorder in 2026, with the primary medication being sublingual Buprenorphine. • Nasal spray naloxone located on each living unit and throughout the facility. • This facility employs a Substance Use Treatment Coordinator position that is fully funded as Program Analyst 2 position.	GF for direct service staff
Oak Creek Youth Correctional Facility	• 42 bed closed-custody facility. • The only youth correctional facility that provides care for girls and young women. • All are screened and assessed for a substance use disorder, including both a DSM-5 diagnosis and an ASAM level of care. • Slated to begin offering consistent medications for Opioid Use Disorder in 2026, with the primary medication being sublingual Buprenorphine. • Nasal spray naloxone, located on each living unit and throughout the facility. • This facility does not have a funded Substance Use Treatment Coordinator position. Another budgeted resource is pulled to deliver these services to youth (a line staff known as a Group Life Coordinator II) is in the position 40 hours every week to maintain services. The agency has requested permanent funding and has not yet received this approval.	No Funding

Eastern Oregon Youth Correctional Facility	• 36 bed closed-custody facility. • Certified as an Outpatient Substance Use Treatment Facility through Health Systems Division at OHA. • Does not typically conduct screenings and intake assessments, but does have the capacity to do so • Slated to begin offering consistent medications for Opioid Use Disorder in 2026, with the primary medication being sublingual Buprenorphine. • Nasal spray naloxone located on each living unit and throughout the facility. • This facility does not have a funded Substance Use Treatment Coordinator position. Another budgeted resource is pulled to deliver these services to youth (a line staff known as a Group Life Coordinator II) and is in the position 40 hours every week to maintain services. The agency has requested permanent funding and has not yet received this approval.	No Funding
Tillamook Youth Correctional Facility	• 32 bed closed-custody facility. • This facility submitted paperwork in March 2026 to become certified as an Outpatient Substance Use Treatment Facility through Health Systems Division at OHA. • Does not typically conduct screenings and intake assessments, but it does have the capacity to do so. • Slated to begin offering consistent medications for Opioid Use Disorder in 2026, with the primary medication being sublingual Buprenorphine. • Nasal spray naloxone located on each living unit and throughout the facility. • This facility does not have a Substance Use Treatment Coordinator, and receives clinical supervision by the Statewide	Statewide Coordinator (1 FTE) delivers services

	Substance Use Treatment Coordinator.	
Jackie Winters Transition Program	• 12 bed closed-custody facility. • Co-located at the same site as the Oak Creek Youth Correctional Facility location, so resources are shared between the two buildings. • Both individualized and group counseling treatment can be offered based on client need and staff resources. Groups are facilitated by CADC Certified Staff and CADC-Rs, with some Peer Support Specialist participation based on need and availability with clinical supervision from OYA staff. • This facility receives clinical supervision from the unfunded position of the Oak Creek Substance Use Treatment Coordinator.	No Funding
Camp Florence Transition Program	• 16 bed closed-custody facility. • Co-located at Oak Creek Youth Correctional Facility location, so resources are shared between the two buildings. • This facility receives clinical supervision from the unfunded position of the Rogue Valley Substance Use Treatment Coordinator.	No Funding

Camp Riverbend Transition Program	• 16 bed closed custody facility. • This program is located in Florence, with no other facility nearby. • This facility receives clinical supervision from the funded position of the Eastern Oregon Substance Use Treatment Coordinator.	Funding in RYVCF
Camp Tillamook Transition Program	• 16 bed closed-custody facility. • This program is located at the same site as the Tillamook Youth Correctional Facility location, so resources are shared between the two buildings. • This facility receives clinical supervision from the Statewide Substance Use Treatment Coordinator.	Statewide Coordinator (1 FTE) delivers services

APPENDIX G – MEDICAID

HEALTH POLICY AND ANALYTICS (HPA) REPRICING METHODOLOGY AND SUMMARY

April 16, 2026

As part of the capitation rate development process, the Office of Actuarial and Financial Analytics (OAFA) employs various methodologies to "reprice" \$0-paid Community Care Organization (CCO) encounters to generate proxy, would-be paid amounts for services not tied to FFS reimbursement. For this analysis, we leveraged OAFA's repricing at a claim line level to reprice \$0-paid professional claims and \$0-paid pharmacy claims for Medication-Assisted Treatment (MAT). OAFA adheres to the following methodology when repricing professional claims:

Professional services: A fee schedule was created using CCOs' average reimbursement by procedure code for non-\$0-paid claims. Modifiers that affect reimbursement, such as assistant surgeon, were considered in developing the fee schedule, as well as if the provider type is considered to be a primary care doctor. If a CCO had no paid claims for a given procedure code, modifier, primary care combination, then the statewide average reimbursement was used. If a claim still did not match the statewide fee schedule, then a CCO-specific CCR (cost-to-charge ratio; $\text{paid} \div \text{billed amount}$) for professional services was calculated.

We were able to leverage OAFA's \$0-paid claim repricing for 6.8% of the total professional claims in our data. For the remaining \$0-paid professional claims that did not appear in OAFA's data, we leveraged both paid and OAFA-repriced claims to create a statewide (all CCOs) fee schedule, by procedure code, to generate proxy paid amounts; these claims accounted for 4.9% of the total professional claims in our data. The remaining 88.3% of claims were valued at their original paid amounts.

The total expenditures for CCOs in the 23-25 Behavioral Health (BH) Model – Substance Use Disorder (SUD) report was \$511,680,228. This total was based on CCO caseloads multiplied by the portions of capitation rates that could be readily attributed to Alcohol and Drug Policy Commission (ADPC) services; it reflects OHA spending on capitation rates, and is not a summary of expenditures on claims. For the purposes of HPA's separate analysis, we queried the claims database for claims with services included in the rates. We calculated a total of \$515,294,333 was spent for SUD services using the categories included in the rate components (compared with \$511,680,228 reported in the 23-25 BH Model). While the 23-25 BH Model and HPA totals appear to be very close, the 23-25 BH Model figures include some administrative rate components, suggesting that CCO spending on these services exceeded expectations during the biennium.

HPA also pulled claims data on APDC services that were not captured in the available capitation rate components. An additional \$295,428,844 was attributed to these SUD expenditures for CCOs for this report. These additional services included SUD Emergency Department visits, SUD Outpatient Hospital visits, Inpatient Withdrawal Management, and Medication-Assisted Treatment pharmacy claims.

Of the \$78,844,985 reported as Total Funds for FFS in the 23-25 BH Model – SUD report, HPA independently summarized claims and arrived at a total of \$77,936,642.

CHANGES TO THE MEDICAID CLAIMS ANALYSIS FOR THE 2023-2025 FISCAL ANALYSIS

In April 2026, ADPC staff collaborated with HPA to make modifications to the methodology for analysis of SUD spending. This collaboration was initiated by HPA after identifying there appeared to be missing service codes as well as service code related spending being “blended” across multiple settings. The prior analysis was narrower in its approach due to utilizing methodology for other reporting purposes (for example, Assessment services did not appear to be included in the 2021-2023 analysis). HPA staff identified and made the following changes to the methodology for the analysis of Medicaid spending:

- Addition of Pharmacy Spending
 - Prior analysis did not appear to include spending via pharmacy claims. HPA utilized identified NDC (National Drug Codes) for this analysis as Pharmacy claims do not include diagnostic information (e.g. SUD diagnosis code), which may explain its exclusion due to prior methodology.
- Expansion of spending categories:
 - Risk/ Harm Reduction
 - Take Home Naloxone spending, when a primary SUD diagnosis was added. Prior analysis did not include this code.
 - SUD Hospital Settings
 - Inpatient, Emergency, Outpatient added, compared to hospital spending in the 2021-2023 report, which only included hospital spending if it was related to withdrawal management services (detox), this new methodology reflective of current practice realities, such as MAT provision via outpatient hospital settings.
 - Housing Support Services
 - Prior analysis did not list service codes (Data dictionary included “TBD.”)
 - Other Peer-Delivered services

- Now includes outreach, crisis intervention, skills training, and case management provided by a Peer Professional (described as “providers with a peer specialty in MMIS.”)
- Self-help/ Peer Services Categorization
 - Prior analysis captured this as “other recovery supports”
 - Due to necessity for services to be provided within a treatment setting (requirement for reimbursement), this spending is captured under “treatment” but separate of care settings to provide clarity on peer service spending.

Other Notes

Medications used to treat Substance Use Disorder Pharmacy claims are not included in BH Budget FFS total.

\$162,727.41 in voided SUD claims were identified in the budget analysis. The total amount was removed from claim totals proportional to the spending across the continuum of care.

APPENDIX H – OHA PUBLIC HEALTH DIVISION FUNDING SOURCES

- a. Overdose Data to Action in States (OD2A-S) Grant: OD2A-S is a Centers for Disease Control and Prevention (CDC) cooperative agreement that funds jurisdictions to monitor fatal and nonfatal overdose data and use that data to implement tailored, evidence-based prevention responses that target populations disproportionately impacted by overdose. OD2A-S funds Oregon's overdose surveillance infrastructure, supporting morbidity surveillance, mortality surveillance, and data linkage initiatives. OD2A-S's prevention strategies emphasize harm reduction, linkage to care via navigation programs, public safety partnerships, and outreach by people with lived experience to close gaps in access to care and services.
- b. State Opioid Response (SOR) Grant: The Substance Abuse & Mental Health Services Administration (SAMHSA) SOR program provides resources to states and territories to increase access to medications for the treatment of opioid use disorder (MOUD) and support the continuum of prevention, harm reduction, treatment, and recovery support services for opioid use disorder (OUD) and other concurrent substance use disorders. The OHA Behavioral Health Divisions (OHA-BHD) administers Oregon's SOR grant and provides SOR funding to the OHA Public Health Division (OHA-PHD) to enhance prevention initiatives. This includes both SOR3 and SOR4 investments in AY25 provided to OHA-PHD to support local public health contracts.
- c. Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant: The SAMHSA SUPTRS Block Grant funds jurisdictions to plan, implement, and evaluate activities that prevent and treat substance use. SAMHSA requires that grantees spend at least 20% of their SUPTRS allotment on primary prevention strategies. Since September 2023, OHA has braided OD2A-S and Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) funds to support the Overdose Prevention & Education Program.
- d. Substance Abuse Prevention Treatment Grant (ARPA): Public Law 117-2, the American Rescue Plan Act of 2021 (ARPA), directed the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide additional funds to support states through Block Grants to address the effects of the COVID -19 pandemic for Americans with mental illness and substance use disorders. ARPA allocated funding for Mental Health Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block (SABG) grants to the states. States had until September 30, 2025 to expend these funds.

- e. Substance Abuse Prevention Treatment Grant (COVID-19): The purpose of the program was to provide crisis intervention services, mental and substance use disorder treatment, and other related recovery supports for children and adults impacted by the COVID-19 pandemic. Funding was provided for states, territories, and tribes to develop comprehensive systems to address the needs of individuals with serious mental illness, individuals with substance use disorders, and/or individuals with co-occurring serious mental illness and substance use disorders. Additionally, the program focused on meeting the needs of individuals with mental disorders that are less severe than serious mental illness, including those in the healthcare profession.
- f. Strategic Prevention Framework – Partnerships for Success (SPF-PFS): The purpose of the program is to help reduce the onset and progression of substance misuse and its related problems by supporting the development and delivery of state and community substance misuse prevention and mental health promotion services. The SPF-PFS program is grounded in the Strategic Prevention Framework (SPF), a community engagement model grounded in public health principles, including being data-driven, and focused on providing evidence-based services to high-risk underserved communities. SPF-PFS grant recipients focus on strengthening state and community-level prevention capacity to identify and address local substance use prevention concerns, such as underage drinking, marijuana, tobacco, electronic cigarettes, opioids, and heroin. Using local, state, and national substance use public health data, recipients identify prevention priorities in their communities and develop and implement strategies to prevent the misuse of substances and promote mental health and well-being among youth and adults. Recipients utilize a data-driven approach to identify underserved communities and at-risk sub-populations of focus.
- g. General Prevention Fund: This fund provides resources for state and community efforts to address alcohol, tobacco, and drug prevention, including enforcement of state tobacco retail laws as required as a condition of receiving the Substance Abuse Prevention and Treatment Block Grant.
- h. Criminal Fines: Allocates funds to the Oregon Health Authority for the purpose of grants under ORS 430.345 for the establishment, operation, and maintenance of alcohol and drug abuse prevention, early intervention, and treatment services provided through a county.

- i. Marijuana Tax: Marijuana tax revenue appropriated directly to local counties under ORS 475C.726(3)(c)(B) used to support services partially funded by the CFAA (County Financial Assistance Agreement). The Marijuana Tax Revenue is not tied to a specific plan, the only requirements are that 40% of the funds be solely utilized for mental health treatment or for alcohol and drug abuse prevention, early intervention, and treatment (ORS 475C.726 (D)).
- j. Alcohol Epidemiology Grant: The CDC funds 12 organizations to carry out essential public health activities that reduce the impact of excessive alcohol use on individuals, families, and communities nationwide. The intent of these funds are to build public health capacity and infrastructure in states to track excessive alcohol use and related harms and inform prevention strategies. One way we do this is having designated staff who can make data available to inform prevention strategies. This grant also allows Oregon to provide the tools and information needed to carry out public health activities that can prevent excessive alcohol use, including:
- Publishing data dashboards.
 - Mapping the number and location of places that sell alcohol.
 - Creating and strengthening partnerships throughout the state.
- k. Prescription Drug Monitoring Program (PDMP): The Oregon PDMP is a tool to help healthcare providers and pharmacists provide patients better care by providing a comprehensive record of their controlled substance prescriptions. In addition to improving patient care it reduces prescription diversion and serves as a rich data source for tracking emerging issues. It contains information provided by Oregon-licensed retail pharmacies. The program is funded through three funding sources: Prescriber fees, Medicaid funds, and periodic grants. Each is listed below.
- i. Prescriber Fees: This is the primary funding source for the PDMP. Each healthcare licensee in Oregon pays \$35 annually to support the PDMP. This fee is collected by their licensing board and provided to OHA.
- ii. Medicaid funding: The PDMP receives Medicaid funds to support maintenance and operations of the PDMP. The PDMP has an approved APD and renews annually. The amount received is based on a cost allocation approved by Medicaid and a 75/25 split between Medicaid and OHA.
- iii. Harold Rogers Prescription Drug Monitoring Program Grant: Grant funds may be used to support a variety of PDMP implementation or enhancement

activities that encourage the use of PDMPs to improve clinical decision-making and prevent the abuse and diversion of controlled substances.

- l. Opioid Settlement Administrative Fund: Oregon HB 4098 (2022) mandates that no more than 5% of state settlement monies may be spent on administering the Opioid Settlement Prevention, Treatment & Recovery (OSPTR) Board. The opioid settlement administrative budget provides funding for OHA to administer the OSPTR fund, administer the OSTPR Board, and implement and manage OSPTR Board funding allocations. This primarily supports OHA personal costs to carry out these functions. OHA also uses administrative funds for external contractors to facilitate Board meetings, conduct program monitoring for Board investments, and convene the Local Opioid Settlement Learning Collaborative.

- m. Opioid Settlement Prevention Allocation (2024): In May 2024, the OSPTR Board allocated \$13,706,000 of Oregon's opioid settlement funds towards primary prevention initiatives. The Board approved OHA's implementation plan in September 2024, which included \$9,500,000 to 36 Alcohol & Other Drug Prevention Education Program grantees; \$1,800,000 to 8 Regional Health Equity Coalitions; \$2,380,000 to 13 culturally/linguistically specific community-based organizations; and \$450,000 to the Oregon Council for Behavioral Health for Certified Prevention Specialist training. These investments aim to enhance existing infrastructure for primary prevention workforce development and related programming.

APPENDIX I – OREGON HEALTH AUTHORITY BEHAVIORAL HEALTH DIVISION COVER LETTER

April 17, 2026

To: Annaliese Dolph, Director, ADPC

From: Ebony Clarke, Behavioral Health Division Director

Dear Director Dolph,

Enclosed please find the Behavioral Health Division's (BHD's) SUD Financial Analysis data submission, in satisfaction of ADPC's March 2026 data request to State agencies.

Per previous discussions with ADPC, BHD is submitting all grant and contract data via the template ADPC provided, and all administrative costs are attached separately in a format that is routinely used for administrative cost reporting by the Oregon Health Authority.

At the end of this letter, we have also provided some context on how BHD collected the data, in addition to some considerations as you review the data set.

Please do not hesitate to reach out with any questions.

Sincerely,



Ebony Clarke
Behavioral Health Division Director

Data Collection Methodology

Contract and Grants Data

Contract and grant information was compiled from multiple sources. Statement of Work contracts were sourced from our Smartsheet trackers (Active Request Tracker and Completed Tracker). Service element contract data was obtained through an Rbase pull. Rbase is the system used to enter the service element financial data, which then generates the financial pages included in the contract documents.

In addition, the Office of Financial Services provided a Statewide Financial Management Application (SFMA) query that captured all Substance Use Disorder (SUD) funding to report actual payments made during the requested timeframe for Part C (invoice-based) contracts. We used the SUD funding source in this pull because some Mental Health contracts include SUD funding.

This methodology was used for all data except for: Behavioral Health Investments, Behavioral Health Workforce Incentives, Behavioral Health Resource Networks and Administrative Costs. Methodology for those programs is provided below.

Behavioral Health Investments (BHI) Team Data

The Behavioral Health Investments (BHI) team data is rigorously tracked and monitored through a unit within the BHI team (the BHI Data Management Team). The data is initially obtained through the project specific information included within each Grant Agreement and includes the specific funding appropriation, the Grantee, funding amount, the County where the capital develop project is located, the facility type, increased capacity (bed count), project completion/occupancy date. This information is entered into the BHI Action Plan Tracker and then is updated into the BHI Capacity Report that is shared weekly with OHA Executive Leadership and the Governor's Office. Additionally, BHI's network of Invoice and Quarterly Report Smartsheets are updated monthly and quarterly as Invoices, Advanced Payment Reconciliation and Quarterly Reports are submitted by the Grantees. BHI data is then validated in collaboration with the Health Policy Analytics team every other month and utilized to update/refresh the [*Behavioral Health Housing and Licensed Capacity Investments Dashboard*](#).

Behavioral Health Workforce Incentive Data

Information on Behavioral Health Workforce Incentives (BHWI) is derived from three workforce incentive programs. Data comes from grant recipients who reported that funds were used to support individuals delivering SUD services, or, in loan repayment program, financial award data from credentialed SUD providers who fulfilled their two-year service commitment.

Behavioral Health Resource Networks (BHRN)

BHRN data reflects provider-reported expenditure data (actuals) for the 2023–25 period. Because grant agreements do not include a financial breakdown by service area, expenditures were used to categorize spending across the continuum. Expenditures were grouped into three categories: Treatment (SUD treatment, screening, assessment), Recovery (housing, peer services, supported employment), and Harm Reduction (harm reduction services).

Administrative Costs

The administrative costs for Medicaid, Behavioral Health and Health Policy and Analytics were pulled from the state's accounting and payroll systems to include Staffing Cost, Operations Cost and IT Cost. Contracting that is seen as administrative in nature, was not included, as it was captured in the Contracts and Grants section. The cost focused on staff or a team of staff who were either completely dedicated to working on SUD programs or who were completely dedicated across both CMH and SUD programs. In some areas OHA was able to call out the specific SUD program the administrative costs were in support of. While others were broader and grouped as felt appropriate.

Compilation and Quality Assurance

All grant- and contract-level data was individually submitted by subject matter experts who serve as contract administrators and/or contract leads for their associated grants and contracts. In total, 21 individual submissions were received. Final submissions were compiled into an aggregate report.

BHD took multiple measures to assure quality and data integrity. The lead coordinator for this project hosted 10 technical assistance sessions with staff, in addition to 1:1 support. All staff submissions were checked for completion and accuracy prior to aggregating data into the final spreadsheet. A final check of the aggregated data was completed by three staff members.

Considerations

Contract and Grants Data

A key difference in this year's methodology for pulling grant and contract expenditures is that the data was pulled directly from SFMA, whereas the contractor for the last study, PCG, pulled data from the finalized Budget SUD Spend Plan. SFMA provides paid expenditures claims data whereas Budget Spend Plan provides obligations that includes paid and unpaid obligations during the period reported.

Behavioral Health Investments (BHI) Team Data

The 2024 PCG SUD Financial Analysis did not include BHI data in the aggregate totals, although the report including narrative on BHI funds that touched populations living with SUD. As such, the funding totals this year encompass a broader range of SUD housing and residential investments.

Behavioral Health Workforce Incentive Data

BHWI programs during the 2023-2025 biennium were not specific to SUD providers and were based on directives from HB 2949 (2021) and HB 4071(2022). The data provided is a small part of the overall biennial investments that BHWI managed which also included a large focus on diversifying the workforce. More information and data specific to the programs that were created from HB 2949 and HB 4071, can be located within this [dashboard](#).

Similar to BHI, PCG did not include BHWI investments in the 2024 in the aggregate totals, but some SUD-related grants were noted in the narrative of the report.

Behavioral Health Resource Networks (BHRN)

BHRN funding supports multi-service models, and expenditures are not always cleanly separable across service categories. As such, this categorization reflects a practical grouping approach based on reported service activity, rather than a precise allocation of funding by service type. This approach avoids introducing unsupported assumptions while providing a directional view of how resources support the continuum of care.

Administrative Costs

There is staffing across OHA that are still critical to the success of the SUD programs. However, since they were not dedicated to SUD or SUD and CMH they were not included in this analysis. This includes, but not limited to, financial support, human resources, broader information system cost and Medicaid and HPA operations cost.

Other Considerations

In contrast to the 2024 PCG study, BHD staff members, rather than an outside contractor, coded all grant and contract data. Although PCG was provided all executed grants and contracts to assist with coding, it is possible that there are differences in interpretation on how the funds were used for the same grants and contracts. As such, we recommend using caution when comparing data between the 2021-2023 and 2023-2025 biennia.

As noted in the 2024 PCG report, it is likely that not all expenditures that touch populations living with SUD are captured in this dataset. Grants and contracts are labelled as either “Community Mental Health” or “Substance Use Disorder” when entered into BHD’s financial systems, based on the primary populations the funds target. BHI and BHWI investments, for example, are largely coded as CMH, and we took care to use the methodologies noted above to capture SUD-related expenditures for these programs. It is possible other SUD-related funds are captured elsewhere in CMH financial data, especially given the high incidence of co-occurring SUD among people with mental health diagnoses.

All financial data reflect actual amounts paid by OHA during the 2023-2025 biennium and thus may include grants and contracts spending that crossed over multiple biennia.