Myers & Stauffer

2026

House Bill 2015 (2025) Legislative Study

Analysis, Findings, and Recommendations

Acknowledgments

The Oregon Health Authority contracted Myers & Stauffer LC (Myers and Stauffer) for the preparation of this report. All content reflected expresses the sole work of Myers and Stauffer and does not represent OHA support or opposition for the recommendations made herein.

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Report in Brief

House Bill (HB) 2015 (2025) requires Oregon Health Authority (OHA) to study and develop recommendations specific to administrative and financial barriers experienced by providers of mental health residential services covered by the Oregon Health Plan (OHP).[1] Section 1 of HB 2015 requests that OHA conduct the following:

- "(2)(a) Study the potential allowable alternatives or exceptions to current nurse staffing requirements in secure residential treatment facilities to address workforce challenges while balancing the safety of providers and consumers.
- (2)(b) Assess all methodologies permitted by federal law for reimbursing facilities. The authority [OHA] shall consider alternatives to the current reimbursement rate methodology used by the authority [OHA] and recommend a methodology that considers [staffing, bed hold payments, resident acuity, and facility size].
- (2)(c) Determine whether the authority [OHA] may, under federal law, administer residential behavioral health services to medical assistance recipients through options other than through the state's Home and Community-Based Services [HCBS] waiver, under 42 [United States Code] U.S.C. 1396n(c), or a State Plan Amendment [SPA] under 42 U.S.C. 1396n(i).
- (2)(d) Determine the feasibility of supporting the direct discharge of a resident, when deemed medically necessary and clinically prudent,

[1] Oregon State Legislature. House Bill 2015, As Enrolled. (2025 Session).

from a facility to other types of housing without requiring a third-party referral.

- (2)(e) Evaluate options for providing, and develop recommendations for funding, capacity payments to facilities when a resident is hospitalized or temporarily absent due to a law enforcement encounter.
- (2)(f) Study needed actions and take appropriate actions to fill the capacity of newly licensed facilities."[2]

There are three primary settings that are licensed to provide treatment services to adults who do not require a psychiatric hospital level of care (LOC) but are not yet ready to move independently to a community setting: residential treatment facilities (RTFs), residential treatment homes (RTHs), and secure residential treatment facilities (SRTFs). Though these settings are licensed as "treatment facilities" they are currently allowed to offer both treatment and habilitative services and operate under three distinct Medicaid authorities: 1905(a), 1915(i), and 1915(k). Moreover, OHA has functionally treated RTF, RTH, and SRTF settings as synonymous with the services provisioned within them. All these factors are contributing to the unique challenges experienced by OHA staff, Oregon's provider community, and beneficiaries in need of mental health services and supports.

The system is experiencing additional strain due to ongoing litigation and related court motions concerning admission time frames to the Oregon State Hospital (OSH), compounding long-standing challenges associated with OHA's implementation of residential mental health settings and

[2] Ibid.

services. Though court orders and resultant recommendations by the court monitor focus on OSH practices, there are downstream impacts to equal beneficiary access to needed treatment and the mental health residential system's capacity as beds are prioritized for individuals discharging from OSH. This leaves little room for community or voluntary referrals to mental health residential services to receive support from RTFs, RTHs, and SRTFs.

This report is structured to provide context into federal regulations regarding state Medicaid operationalization of mental health residential settings, an analysis of Oregon's mental health residential landscape, peer state examples, and a review of partner feedback from individuals with lived experience, providers, psychiatric hospital staff, advocates, Community Mental Health Programs (CMHPs), and state staff. Based on a thorough review of this information, the following findings and recommendations are made for consideration by the Oregon Legislative Assembly.

Findings

There are 31 findings related to how Oregon is operationalizing mental health residential services under OHP. Findings are intended to represent the perspectives of providers, advocates, and OHA staff and are highlighted with the intention that they support the recommendations made herein.

These findings are framed within a primary, secondary, and tertiary structure and are made to support recommendations provided herein. This framework is not intended to suggest that primary findings are more important than those under the secondary or tertiary level; rather, the framework is used to demonstrate that many of the areas of study within HB 2015 are connected to two issues related to how OHA has operationalized adult-serving RTFs, RTHs, and SRTFs.

Primary Findings

Lack of Distinction Between RTFs, RTHs, and SRTFs as Settings Rather Than Services

- There is a lack of distinction by OHA between "services" and mental health residential "settings," which creates confusion for beneficiaries and providers.

Confluence Between Oregon Revised Statutes and Oregon Administrative Rules

- Oregon Revised Statutes (ORS) give OHA the statutory authority (ORS 413.042 and ORS 443.465) to further refine RTF, RTH, and SRTF operations within the parameters set in statute through Oregon Administrative Rules (OARs). This simultaneously creates flexibility and rigidness in how OHA can operationalize these facilities.

OHA's Use of Medicaid Authorities

- OHA's use of HCBS Medicaid authorities to provision **treatment** and **habilitative** services within licensed treatment facilities is creating administrative complications and potentially unsafe treatment environments for residents.

Secondary Findings

Alternative Models

- Federal authorities are not prescriptive, and there are no regulations indicating an appropriate authority or model for covering mental health residential services.

- Peer states were found to only cover either **treatment** or **habilitation** in the settings reviewed. No evidence was found to indicate one

specific setting covers distinct and separate services dedicated to either **treatment** or **habilitation.**

- The majority of the peer states reviewed for this study are only covering mental health residential **treatment** in settings prescribed under the 1905(a) authority; only Colorado is using a 1915(c) HCBS waiver to cover **habilitative** services in a long-term home dedicated to the needs of individuals with serious mental illness (SMI). While not all states were included in the study, it is relevant to note that other states covering habilitative services for individuals with SMI use a 1915(i), but generally do not utilize treatment settings as the primary service providers.
- Costs are not authority dependent, but authorities may dictate the use of one reimbursement methodology over another.

Admission Practices

- With a few exceptions, providers are required to prioritize admission to individuals discharging from OSH regardless of the provider's ability to meet their needs and consideration for other individuals already served in the setting. No peer state that was reviewed appears to have a similar mechanism for priority admissions.[3]
- Medical necessity is not consistently determined by the Independent Qualified Agent (IQA) prior to admission to an RTF, RTH, and SRTF; furthermore, Chapter 309, Division 35 admission rules are nonspecific

[3] Peer state review was limited to non-forensic populations' access to mental health residential settings funded through their respective Medicaid programs. This partially limits the comparability of peer states to Oregon, given the complexities surrounding access to mental health residential treatment in Oregon as compared to other states.

as to clinical criteria for admission to an RTF and RTH. This is in clear contrast to the admission criteria found in the seven peer states reviewed.

- SRTF clinical criteria are noted, but are separate from RTF and RTH criteria and are enumerated in OHP's mental health residential prioritization rule.
- Federal Medicaid HCBS regulations require states to ensure a lease, residency agreement, or other form of written agreement is in place for HCBS participants. This document must provide protections that address eviction processes and appeals.
- OARs do not require that a signed lease, residency agreement, or written agreement is in place for individuals who are placed in the setting by a supervisory entity such as the Oregon Psychiatric Security Review Board (PSRB) or a court, even when an individual is residing in an HCBS-funded provider setting.

Discharge Practices

- OHA's use of HCBS authorities requires providers to "evict" RTF and RTH residents as part of an involuntary discharge or transfer to another setting, which contributes to a greater length of time in the setting, potential instability for the resident, and unnecessary administrative barriers.[4]
- Despite efforts to streamline the process, and protect residents' rights, there is a greater administrative burden placed on providers

[4] Eviction processes also do not apply to individuals who are placed in an RTF or RTH by PSRB or court order.

and OHA by requiring Behavioral Health Division (BHD) staff to approve notices of involuntary discharge and transfer.

- The lack of prior planning and standardization relative to discharges from RTFs, RTHs, and SRTFs may be creating inequities and unclear goals for when a resident is ready to move to a different setting.

SRTF Staffing

- OAR 309-033-0725 is not setting specific and does not explicitly indicate that 24/7 nursing is a requirement for SRTF Class 1 facilities, though nursing standards are generally enumerated.[5]
- Nursing requirements in SRTF Class 1 facilities are not inherently different from those in peer states, but peer states are allowing the use of on-call nursing in their residential treatment settings, which is not currently permitted by OHA.
- The clinical appropriateness of requiring registered nurses (RNs) to authorize restraints and seclusions is unclear based on a review of OAR, ORS, and best practice.

Hearing and Appeal Rights

- Anecdotal evidence from some HB 2015 work group partners suggests that the length of time between the initiation of the administrative hearing and a determination is extensive and impacts provider ability to involuntarily discharge or transfer a resident from the setting.[6]

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[5] See the Licensing, Classification, and Staffing Requirements section of this report for more information.

[6] Individuals who are forensically involved or are considered to be "Extremely Dangerous Persons" (EDPs) do not have the choice to appeal their placement as OHA does not hold decision-making authority over them. By law, the PSRB and courts control their placements.

- Overall, the framework for hearing and appeal rights enumerated in OAR provides clearer and more structured appeal rights for providers than for beneficiaries.

Reimbursement

- Reimbursement rates are not tied to a Medicaid authority or limited benefit plan, but reimbursement methodologies may be impacted by the type of Medicaid authority or limited benefit plan used to cover mental health residential services.
- Reimbursement is the same for an RTF and RTH regardless of the facility providing "mental health treatment" or "HCBS Residential Habilitation" services. This renders the complex geographic and acuity and setting tiering limited in terms of benefits to residents, providers, and OHA.
- The current reimbursement rates paid to RTF, RTH, and SRTF may not be appropriate to serving individuals who are forensically involved or civilly committed if those rates were developed for the sole purpose of reimbursing for habilitative services under the 1915(i) waiver.
- There is a built-in incentive for Oregon's mental health residential providers to downsize bed capacity as the payment rates for RTHs are higher than those paid to RTFs and SRTFs, which may impact available mental health residential bed capacity across the state.
- The acuity-based tiering system for mental health residential providers places value on a "sickness model of reimbursement" rather than recognition of the improved health of a resident.

- For an individual primarily served by the Oregon Department of Human Services (ODHS) system but served in an RTF or RTH under the1915(k) State Plan option, BHD is the determining factor for how much the setting is paid.
- Bed hold rates are available under the current rate methodology, but their effectiveness in supporting residents and providers is unclear.
- Reimbursement methodologies and the payments made to residential treatment providers in the peer states varies widely, and there is no clear distinction between authority and reimbursement methodology from the review of the seven states.

Tertiary Findings

OHA System Fragmentation

- OHA's mental health service system is fragmented between multiple local entities, the court system, and third parties contracting with OHA, which contributes to inequities in service access and delivery.

Mental Health Service Array: New Services to Meet More Needs

- There is a need for a broader array of mental health services available to OHP beneficiaries.

Case Management and Person-Centered Planning

- The lack of strong case management and collaboration between all "care coordinating" entities is impacting beneficiary access to mental health residential services.

General OAR Observations

- OAR structure and the amount of redundancies, inconsistencies, and lack of specificity regarding SRTF operations and nursing creates difficulty in clear identification of mental health residential standards.

Recommendations

A total of 34 recommendations are made for the Oregon Legislature's consideration based on a review of Oregon practices, peer state analysis, and feedback from involved partners. Recommendations are structured to be responsive to the primary, secondary, and tertiary findings stated above and are not necessarily endorsed by involved partners. Additionally, implementation impacts are presented for each recommendation to provide an initial framework for OHA and the Oregon Legislature's consideration, though further evaluation of impact should be conducted following any future adoption of recommendations. Note, alternative model recommendations required under HB 2015 are included within the primary recommendations.

Primary Recommendations

- **Recommendation 1:** OHA needs to clearly distinguish settings from services offered through improved language in OAR and guidance and education to providers and residents.
    - **Potential Implementation Impacts:** Regulatory changes and partner engagement and education.
- **Recommendation 2:** Leverage the existing 1905(a) authority to cover **treatment services** within RTFs, RTHs, and SRTFs.

    - **Potential Implementation Impacts:** Regulatory changes and partner engagement and education.

- **Recommendation 3:** Remove RTFs and RTHs from the qualified provider list under the 1915(i) and 1915(k) authorities.
    - **Potential Implementation Impacts:** Change in Centers for Medicare & Medicaid Services (CMS) authorities, regulatory changes, partner engagement and education, electronic system modifications, and additional OHA staffing needs.
- **Recommendation 4:** Add a new licensure type for "licensed Supported Living homes" and name them as the qualified provider for HCBS 1915(i) Residential Habilitation and Psychosocial Rehabilitation.
    - **Potential Implementation Impacts:** Change in CMS authorities, statutory and regulatory changes, licensure requirement change, partner engagement and education, electronic system modifications, changes to contractor processes/systems, additional OHA staffing needs.
- **Recommendation 5:** The Oregon Legislature could work with OHA and interested parties to strengthen the definitions of "**residential care**" and "**treatment**" in ORS to improve clarity and define specific tasks associated with each term.
    - **Potential Implementation Impacts:** Statutory changes and partner engagement and education.

Secondary Recommendations

Admission and Discharge Practices

- **Recommendation 6:** OHA needs to examine the impacts of expiring OAR 309-035-0158 and instead admit individuals to RTFs, RTHs, and SRTFs based on established medical necessity, regardless of their involvement with the forensic system or civil commitment status.
    - **Potential Implementation Impacts:** Regulatory changes, partner engagement and education, and changes to contractor processes/ systems.
- **Recommendation 7:** OHA needs to establish medical necessity criteria for mental health residential treatment facilities, inclusive of an indication of a need for treatment and/or as a result of a public safety concern. Additionally, this recommendation includes the need to reconfigure the admissions process so individuals are not placed in a setting prior to a determination that they meet facility admission criteria.
    - **Potential Implementation Impacts:** Regulatory changes, partner engagement and education, additional OHA staffing needs, and changes to contractor processes/systems.
- **Recommendation 8:** OHA should develop and administer oversight activities to conduct quality monitoring of discharge planning at the time of admission to any of the mental health setting array.
    - **Potential Implementation Impacts:** Resident rights considerations, oversight, and additional OHA staffing needs.

- **Recommendation 9:** Implement a discharge process for RTFs, RTHs, and SRTFs using different "tracks" based on treatment refusal, not meeting medical necessity, and other program-initiated reasons.
    - **Potential Implementation Impacts:** Resident rights considerations, regulatory changes, partner engagement and education, and additional OHA staffing needs.

SRTF Class 1 Nursing Requirements

- **Recommendation 10:** BHD should modify current OARs to clarify the role of 24/7 on-site nursing in SRTF Class 1 facilities. Moreover, OHA should publicly indicate in guidance and OAR updates if SRTF Class 1 facilities are allowed to enter into agreements with local hospitals for nursing support, as is an allowable practice for nonhospital facilities per OAR 309-33-0720.
    - **Potential Implementation Impacts:** Regulatory changes, partner engagement and education, and additional OHA staffing needs.
- **Recommendation 11:** OHA staff need to discuss the appropriateness of SRTF Class 1 nursing staff initiating restraints and seclusion with the Oregon State Board of Nursing.
    - **Potential Implementation Impacts:** Nursing scope of practice considerations, regulatory changes, and partner engagement and education.
- **Recommendation 12:** Medicaid and BHD staff should engage the Oregon State Board of Nursing and OHA staff responsible for Division 33 rules to determine feasibility of amending requirements specific to overnight staffing and on-site availability of RNs.

- **Potential Implementation Impacts:** Nursing scope of practice considerations, regulatory changes, and partner engagement and education.

Hearings and Appeals Processes

- **Recommendation 13:** OHA and its partners need to work with the Oregon Office of Administrative Hearings (OAH) to identify ways to shorten hearing and appeal adjudication timelines.
  - **Potential Implementation Impacts:** Partner engagement and education and additional OHA staffing needs.

Reimbursement

- **Recommendation 14:** Medicaid should develop a new reimbursement methodology for **treatment services** provided by RTFs, RTHs, and SRTFs that uses provider-based costs to develop provider-specific rates paid on a monthly basis.
  - **Potential Implementation Impacts:** Payment structure reform, regulatory changes, partner engagement and education, electronic system modifications, and additional OHA staffing needs.
- **Recommendation 15:** Medicaid, in collaboration with BHD, should develop an add-on rate to incentivize providers to care for individuals with high acuity needs, who present behavioral health challenges, or are otherwise a "high-risk" patient.
  - **Potential Implementation Impacts:** Payment structure reform, regulatory changes, electronic system modifications, partner engagement and education, and additional OHA staffing needs.

- **Recommendation 16: Treatment service** reimbursement methodologies need to allow a bed hold rate, based on the statewide average provider-based costs, during the following circumstances: elopement, hospitalizations, involvement with law enforcement, trial visits to other facilities or settings, and when there is a planned discharge or transfer of a resident.
    - **Potential Implementation Impacts:** Payment structure reform, regulatory changes, electronic system modifications, partner engagement and education, and additional OHA staffing needs.
- **Recommendation 17:** Review the existing payment methodology to determine if the currently established rates are appropriate for payment for **habilitation services** provided by the HCBS authorities.
    - **Potential Implementation Impacts:** Partner engagement and education and additional OHA staffing needs.
- **Recommendation 18: Habilitation service** methodologies need to continue allowing a bed hold rate during the following circumstances: elopement, during a 30-day notice period following elopement, hospitalizations, involvement with law enforcement, trial visits to other facilities or settings, and when there is a planned discharge or transfer of a resident.
    - **Potential Implementation Impacts:** Partner engagement and education.
- **Recommendation 19:** Allow for the bed hold payment for **habilitation services** to equal a resident's current payment tier rather than the Tier 1 rates established in the current OHA fee schedule.

- **Potential Implementation Impacts:** Payment structure reform, regulatory changes, electronic system modifications, additional OHA staff, and partner engagement and education.

- **Recommendation 20:** Medicaid and ODHS need to collaborate to publish publicly available information in posted fee schedules and OAR regarding rates paid to providers for cross-placed individuals receiving treatment care in an RTF or RTH.
  - **Potential Implementation Impacts:** Partner engagement and education and regulatory changes.

Actions to Fill Capacity in Newly Licensed Facilities

- **Recommendation 21:** OHA and providers should continue to collaborate to discuss how best to fill capacity in newly licensed facilities and work together to develop strategies to overcome barriers to filling capacity.
  - **Potential Implementation Impacts:** Partner engagement and education.

Tertiary Recommendations

Mental Health Service System Improvements and Licensure Modernization

- **Recommendation 22:** Develop separate certification standards for RTFs, RTHs, and SRTFs wishing to act as a "purpose-intended" treatment facility.
  - **Potential Implementation Impacts:** Statutory and regulatory changes, licensure requirement change, additional OHA staffing needs, and partner engagement and education.

- **Recommendation 23:** Reframe RTFs, RTHs, and SRTFs to be "short-term," **treatment-focused**, and transitional in nature.
    - **Potential Implementation Impacts:** Statutory and regulatory changes and partner engagement and education.
- **Recommendation 24:** Seek legislative support and funding to broaden the mental health service array by developing more services supporting a range of needs. Create additional layers and levels of care in the service system with specific licensure standards.
    - **Potential Implementation Impacts:** Statutory and regulatory changes, licensure requirement changes, payment structure reform, change in CMS authorities, electronic system modifications, resident right considerations, partner engagement and education, and additional OHA staffing needs.
- **Recommendation 25:** OHA and the Oregon Legislature should partner to develop new statutory definitions of the newly created services discussed as part of Recommendation 24.
    - Potential Implementation Impacts: Statutory changes and partner engagement and education.
- **Recommendation 26:** Medicaid needs to develop SMI targeted case management (TCM) for qualifying OHP members.
    - **Potential Implementation Impacts:** Change in CMS authorities, payment structure reform, regulatory changes, and changes to contractor processes/systems.

- **Recommendation 27:** OHA needs to strengthen contract oversight and monitoring of person-centered planning expectations for the IQA for individuals receiving HCBS 1915(i) State Plan option services.
    - **Potential Implementation Impacts**: Additional OHA staffing needs and oversight.

Regulation Modifications

- **Recommendation 28:** Medicaid should establish and clearly define mental health **treatment services** in Chapter 410 rules.
    - **Potential Implementation Impacts**: Regulatory changes.
- **Recommendation 29:** OHA needs to develop SRTF Class 1 and SRTF Class 2 statutory definitions and regulations to provide clarity on requirements specific to secured settings, including their distinct licensed functions.
    - **Potential Implementation Impacts:** Statutory and regulatory changes and partner engagement and education.
- **Recommendation 30:** BHD needs to examine and potentially remove provider administrative barriers from OAR to positively impact providers' ability to open capacity and provide quality of care to individuals.
    - **Potential Implementation Impacts:** Regulatory changes, partner engagement and education, and resident rights considerations.
- **Recommendation 31:** Streamline OARs implementing federal HCBS requirements across ODHS and OHA.

- **Potential Implementation Impacts:** Regulatory changes and partner engagement and education.

- **Recommendation 32:** Modify OAR 309-035-0175 Rights, Freedoms, and Protections to include a "bill of rights" specific to **treatment services** provided in RTFs, RTHs, and SRTFs to create uniform standards when residing in mental health settings.
  - **Potential Implementation Impacts:** Resident rights considerations, regulatory changes, and partner engagement and education.

- **Recommendation 33:** OHA should conduct an administrative review of, at minimum, all Chapter 309 Division 33 and 35 and Chapter 410 Division 172 and 173 rules to identify redundancies, misnamed Division titles, and consistency errors.
  - **Potential Implementation Impacts:** Regulatory changes, partner engagement and education, and additional OHA staffing needs.

Collaboration with PSRB and Judicial System

- **Recommendation 34:** Collaborate with PSRB and the court system to build capacity and capability, explore different financing options, and further coordinate to reduce barriers to the safest and least restrictive local community placement.
  - **Potential Implementation Impacts:** Partner engagement and education.

Table 1 illustrates the connection between recommendations and potential implementation impacts across settings.

Table 1: Implementation Impact and Recommendation Groups

Potential Implementation Impact	Recommendations
Additional OHA staffing needs	3, 4, 7, 8, 9, 10, 13, 14, 15, 16, 17, 19, 22, 24, 27, 33
Change in CMS authorities	3, 4, 24, 26
Changes to contractor processes/systems	4, 6, 7, 26
Electronic system modifications	3, 4, 14, 15, 16, 19, 24
Licensure requirement change	4, 22, 24
Nursing scope of practice considerations	11, 12
Oversight	8, 27
Partner engagement and education	1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 29, 30, 31, 32, 33, 34
Payment structure reform	14, 15, 16, 19, 24, 26
Regulatory changes	1, 2, 3, 6, 7, 9, 10, 11, 12, 14, 15, 16, 19, 20, 26, 28, 29, 30, 31, 32, 33
Resident rights considerations	8, 9, 24, 30, 32
Statutory changes	4, 5, 22, 23, 24, 25, 29

Introduction

HB 2015 was passed by the Oregon State Legislature on June 23, 2025, and signed by Governor Tina Kotek on July 24, 2025.[7] The bill's preamble recognizes that licensed residential behavioral health programs in Oregon confront substantial barriers to both development and operation, which affect the state's capacity to effectively utilize current and future investments intended to expand bed capacity. The intent of HB 2015 is primarily focused on reviewing mental health residential settings covered by OHP to determine potential efficiencies, gaps, and barriers to operationalizing these settings in Oregon. OHA is tasked with examining solutions — administrative and financial — to eliminate obstacles to the optimal development and operation of residential behavioral health programs statewide.

Myers and Stauffer presents this report in direct response to the request established under HB 2015. The following represents a comprehensive body of work addressing each enumerated requirement of the bill. The insights contained within this report include:

- A review of Medicaid authorities and coverage allowances specifically pertaining to mental health residential settings, including federal and state requirements related to staffing, licensing, and HCBS settings rules, as well as reimbursement methodologies.
- A structured assessment of current adult facility discharge and housing pathways, mapping clinical, administrative, legal, payor, and

[7] Oregon State Legislature. "2025 Regular Session – HB 2015 Enrolled."

housing barriers and quantifying their impact on length of stay across residential and secure residential facilities.

- An in-depth analysis of discharge barriers and housing challenges, incorporating a critical review of existing transition models.
- A summary of best practices from peer states relevant to these regulatory and operational topics.
- An analysis of best practices and peer state solutions, with strategic consideration of how HCBS Medicaid authorities can be leveraged to drive direct transitions and sustain long-term housing stability.
- Actionable recommendations to strengthen and modernize mental health residential treatment practices across Oregon.

For conciseness and ease of review, Appendix I is provided to demonstrate HB 2015 requirement alignment with report content. The report sections noted within Appendix I are hyperlinked and may be used for easier navigation within this report.

Oregon's Organizational Structure

Healthcare in Oregon is administered by two main governmental agencies, OHA and ODHS. Each is important to understand as they administer different parts of the Medicaid program that are used to provide mental health residential services to beneficiaries.

Oregon Health Authority

OHA, created in 2009 through ORS 413.032,[8] is the state agency overseeing OHP (Medicaid), public health programs, and statewide health policy.[9] The mission of the agency ensures all people and communities can achieve optimum physical, mental, and social health through collaboration, prevention efforts, and affordable, quality healthcare access. OHA is organized into eight divisions, including BHD, Medicaid, and OSH.[10]

OHA By the Numbers

As of January 2026, there were over 1.4 million individuals enrolled in OHP. This equates to 34% of all Oregonians and 58% of children between 0 and 17 years of age who receive their health benefits through Medicaid.[+]

+OHA. "The Dashboard." (February 12, 2026). Accessed March 2, 2026.

OHA holds responsibility for overseeing all aspects of the state's Medicaid program but directly administers only certain parts of the program. In addition to all mandatory covered Medicaid services, OHA also administers the HCBS 1915(i) State Plan option for individuals with SMI. 1915(i) is an optional HCBS State Plan benefit available to individuals who meet certain eligibility criteria. Additional details regarding the federal 1915(i) Medicaid authority are detailed in the **Alternative Models: Provisioning Mental Health Residential Services** and **Oregon's Mental Health Residential Facilities: Medicaid Authorities and Services** sections of this report. Furthermore, OHA is responsible for reimbursement and oversight of

[8] Oregon Legislature. ORS 413.032 Establishment of Oregon Health Authority. (2009).
[9] OHA. About OHA.
[10] Per OHA's website, BHD and Medicaid are separate divisions no longer housed under the Health Systems Division as of April 1, 2024. OHA. Health Systems Division Organizational Chart.; OHA. OHA Programs and Divisions.

different types of licensed facilities, including those that are in-scope for HB 2015.

Oregon's Medicaid delivery system is organized through the 16 Coordinated Care Organizations (CCOs) that service areas according to counties, including overlapping coverage in some regions. Further, local behavioral health services are provided through the Oregon's CMHPs, which receive funding via OHA through County Financial Assistance Agreements. OHP services are reimbursed through managed care or through fee-for-service (FFS) open card. There are some services, like adult mental health residential settings and services, that are carved out of CCO contracts and are reimbursed through FFS.

Oregon Department of Human Services

ODHS also is a stand-alone state agency and is Oregon's primary human services agency, providing direct support to more than one million Oregonians each year to promote well-being, independence, and safety. ODHS administers economic assistance, child welfare, aging and disability services, and funds and oversees a range of residential and community-based programs.[11] Though ODHS does not directly license the settings that are named in HB 2015, ODHS does leverage these facilities to serve individuals enrolled in the 1915(k) State Plan option. Unlike the 1915(i) State Plan option that is directly overseen and administered by OHA, ODHS holds responsibility for day-to-day administration of the 1915(k) State Plan option. For more information on the 1915(k) Medicaid authority, see the **Oregon's Mental Health Residential Facilities: Medicaid Authorities and Services** sections of this report.

[11] ODHS. About ODHS.

Terms and Definitions

Landscape reviews of complex settings, funders, and federal Medicaid rules is challenging without first establishing what the review includes. This section of the report is a reference point for readers to gain a comprehensive understanding of parameters and definitions for the terms and concepts frequently used throughout this analysis. Appendix II provides further detail regarding operational terms, including facility types and behavioral health nomenclature that is relevant for this interim report.

In-Scope Settings

HB 2015 specifically names five setting types that should be reviewed as part of the requirements stated in the bill;[12] however, on February 6, 2026, OHA confirmed with Myers and Stauffer that only the settings defined in Table 2 should be included in the final legislative report.[13] Further, throughout this report, the terms "setting" or "facility" rather than "services" or "programs" are used when describing the in-scope residential settings. This is because these facilities may offer different types of services and supports depending on how the service is funded and under what Medicaid authority they are accessed by enrolled OHP beneficiaries. Moreover, only facilities that are licensed to provide mental health services or licensed as both mental health and substance use disorder (SUD) providers are included in this study; those that are SUD-licensed only are outside the scope of HB 2015.

[12] Oregon State Legislature. Enrolled House Bill 2015.
[13] HB 2015 Kick-off Meeting Follow-up. Kristen Donheffner, OHA. Received by Jacquelyn George, Myers and Stauffer. February 6, 2026.

Table 2: In-Scope Residential Settings

Service setting	ORS definition	OAR definition summary
RTF	A facility that provides for six or more individuals with mental, emotional, or behavioral disturbances or alcohol or drug dependence, residential care, and treatment in one or more buildings on contiguous properties.	A program licensed by OHA's BHD to provide 24/7 services and supports. RTFs may serve between six to 16 residents. RTFs do not include facilities as defined in ORS 443.405.[14]
RTH	A facility that provides for five or fewer individuals with mental, emotional, or behavioral disturbances or alcohol or drug dependence, residential care, and treatment in one or more buildings on contiguous properties.	A program licensed by BHD to provide 24/7 services and supports for up to five residents. RTHs exclude facilities as defined in ORS 443.405.[15]
SRTFs	Not defined specifically in ORS 443.400; only references to "RTF" and "RTH" are found in 443.400; however, ORS 443.465 specifies that OHA has the authority to adopt rules applicable to SRTFs and specifies what the rules must cover.	Any RTF, or portion thereof, approved by BHD that restricts egress from the facility using approved locking devices on exit doors, gates, or closures.[16]

[14] Oregon Legislature. Definitions for ORS 443.400 to 443.455. 2025 Edition; Oregon Secretary of State. Definitions for OAR 309-035-0105.
[15] Ibid.
[16] Oregon Legislature. Definitions for ORS 443.400 to 443.455; ORS 443.465 Secure residential treatment homes and facilities. 2025 Edition; Oregon Secretary of State. Definitions for OAR 309-035-0105.

Excluded Settings

The other residential treatment settings named in HB 2015 are secure residential treatment homes (SRTHs) and "Transition aged youth residential treatment homes" (sometimes referred to as Young Adults in Transition [YATs]). OHA made the decision to exclude these two settings namely for the following reasons:

- As of February 2026, OHA did not have any licensed SRTHs enrolled with OHP; therefore, there are no settings of this type to review.[17]
- OHA is primarily organizing and leading the effort to comply with Section 2 of HB 2015 that is specific to YATs. A separate report updating the Legislative Assembly on YAT efforts will be submitted by OHA on or before September 15, 2026.[18]

Also excluded from this report are the OSH operated SRTFs, as they are distinctly different operationally from the in-scope SRTFs for this analysis. Additionally, OHA licenses mental health adult foster homes (AFHs) that provide HCBS to individuals living with an SMI. Individuals who reside in RTFs, RTHs, and SRTFs may access AFH services as their needs or acuity changes. Though AFHs, including those separately licensed by ODHS, may experience some of the same operational challenges as those under review as part of the HB 2015 analysis, Myers and Stauffer does not include AFHs in this report as they are not specifically named or defined in HB 2015.

[17] HB 2015 Kick-off Meeting Follow-up. K. Donheffner. Received by J. George. February 6, 2026.
[18] Ibid.

Habilitation, Rehabilitation, and Treatment Service Categories

Figure 1 introduces the concepts of habilitation, rehabilitation, and treatment service categories. These are relevant to HB 2015 in that services provided in RTFs, RTHs, and SRTFs fall within at least one of these three categories.

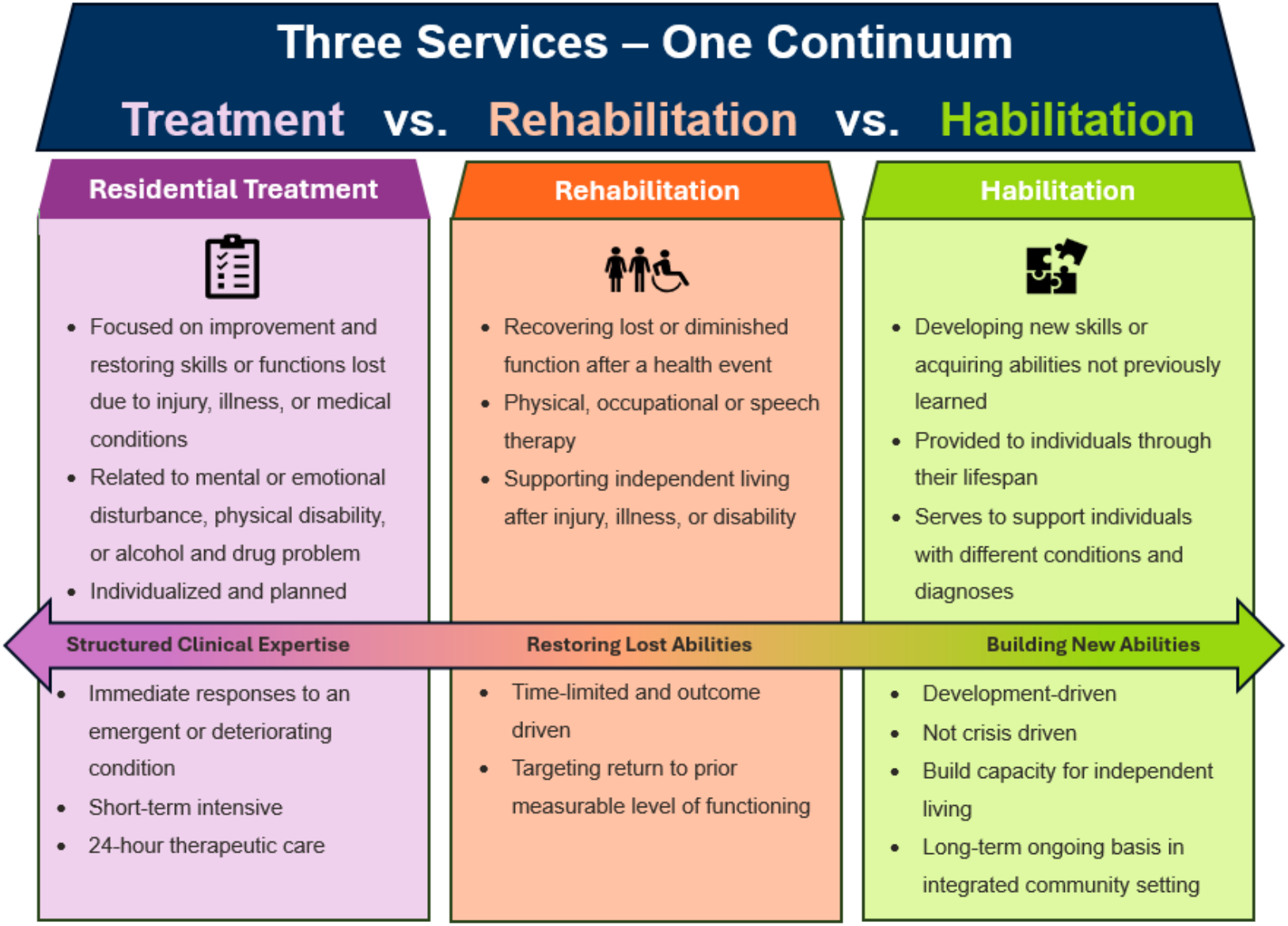
Habilitation services are "designed to assist participants in acquiring, retaining, and improving…self-help, socialization and adaptive skills…"[19] Habilitation is identified as an HCBS under 42 Code of Federal Regulations (CFR) § 440.180.[20] Under HCBS programs, habilitative services can take place in one or more of the following settings and are usually provided by nonclinical, direct care staff:

- Within or outside of a home setting.
- In a provider-owned or controlled home.
- In a nonresidential setting and involving structured, scheduled activities.[21]

Additionally, OAR 410-173-0005 defines habilitation as, "services that support an Individual to develop, maintain, or improve skills and competencies necessary to function as independently as possible to the extent as they would if they did not have a disability or chronic condition."[22]

[19] CMS. Instructions, Technical Guide and Review Criteria, Version 3.7. p. 161. 2024.
[20] National Archives. 42 CFR § 440.180 Home and community-based waiver services. 2006.
[21] CMS. Instructions, Technical Guide and Review Criteria, Version 3.7. pp. 161-163. 2024.
[22] Oregon Secretary of State. OAR 410-173-0005 Definitions.

Figure 1: Treatment to Habilitation - Services for Different Needs



As defined in the Social Security Act (SSA), rehabilitative services are "any medical or remedial services (provided in a facility, home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level."[23] In the case of mental health, rehabilitation services are thought of those that help to enable individuals to "gain the skills and confidence for successful community living."[24] Mental health rehabilitation services usually are provided by a multidisciplinary team of clinical and nonclinical professionals.[25]

By contrast, treatment services are generally understood as the "provision, coordination, or management of health care and related services by one or more health care providers."[26] ORS 443.400 defines treatment as "a planned, individualized program of medical, psychological or rehabilitative procedures, experiences and activities designed to relieve or minimize mental, emotional, physical or other symptoms or social, educational or vocational disabilities resulting from or related to the mental or emotional disturbance, physical disability or alcohol or drug problem."[27] Treatment for mental health needs may take various forms but is intended to assist in managing and/or mitigating the impacts of a mental health diagnosis on an individual's ability to function, and is provided by trained clinical professionals. Mental health treatment may include psychotherapy, medication, case management, support groups, peer support, and

[23] Social Security Administration. SSA, Section 1905(a) [42 U.S.C. 1396d].
[24] Frontiers in Psychiatry. The growing evidence for mental health rehabilitation services and directions for future research. p. 1. Helen Killaspy and Christian Dalton-Locke. November 20, 2023.
[25] Ibid.
[26] University of New Mexico, Health Sciences. Definition of "Treatment".
[27] Oregon Legislature. Definitions for ORS 443.400 to 443.455. 2025 Edition.

hospitalization.[28] Sometimes, these types of treatment may take place in a residential setting as is seen in Oregon with RTFs, RTHs, and SRTFs.

Medicaid Authorities

There are nine Medicaid authorities under which states must comply with federal standards established by CMS (See Appendix IV and **Detailed Review of Medicaid Federal Authorities**); however, states are granted flexibility in how they choose to operate their Medicaid programs and cover services. One of these flexibilities is how states choose to use Medicaid authorities to provide services to Medicaid-eligible individuals. Medicaid authorities are outlined in the SSA and define how services are covered, accessed, and reimbursed within the parameters of the specific authority.

HCBS and Non-HCBS Settings and Services

HCBS services prevent institutional placement by providing Medicaid-funded services and supports in an individual's home or community setting instead of in nursing facilities or other institutions. The Kaiser Family Foundation (KFF) estimates that in 2023, approximately 5.1 million individuals received Medicaid services in their homes, compared to 1.4 million people who received care in an institution.[29] HCBS services can be provided through the Medicaid State Plan or as part of a specialized waiver program. All states offer HCBS through the 1915(c) waivers, Section 1115 Demonstrations, 1915(i) State Plan HCBS, 1915(j), or the Community First Choice (CFC) 1915(k) option.[30]

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[28] Mental Health America. Mental Health Treatments. 2026.
[29] KFF. Medicaid Home Care (HCBS) in 2025. Maiss Mohamed, Alice Burns, Molly O'Malley Watts. January 5, 2026.
[30] KFF. What is Medicaid Home Care (HCBS)? Maiss Mohamed, Alice Burns, Molly O'Malley Watts. February 18, 2025.

Non-HCBS programs are facility-based care settings and are not considered home and community-based. These types of non-HCBS settings include nursing facilities, intermediate care facilities, hospitals, and some psychiatric facilities.

Forensic and Civil Commitments

Individuals who are involved in the forensic system or who are civilly committed to a setting are important to discuss for this report because of how these individuals are prioritized for placement in RTFs, RTHs, and SRTFs.

Forensic Populations: Aid and Assist and Guilty Except for Insanity

Individuals who are forensically involved include those under an aid and assist (A&A) order and those who have been found "guilty except for insanity" (GEI).

A&A provides competency restoration to help restore an individual's ability to take part in their own criminal defense. These services may occur in the community or OSH.[31] A&A is the process that occurs prior to adjudication of an individual's criminal case.

The finding of GEI occurs post-adjudication and is made if a court finds that, at the time of engaging in the criminal conduct, an individual lacks the substantial capacity to either appreciate the criminality of the conduct or to conform their conduct to the requirements of law, and but for a qualifying mental disorder, the individual would have had such substantial capacity.[32] Following a criminal court's GEI ruling for conduct that would constitute a felony, Oregon's PSRB determines the type of care the individual needs,

[31] OHA. Intensive Services: Oversight of Court-Ordered Behavioral Health Treatment.
[32] Oregon Department of Justice. Victim Services: For Cases Before the Psychiatric Security Review Board. p. 1. October 28, 2011.

conditions of their release, and the level of supervision they require. BHD's Intensive Services Unit works with OSH, PSRB, and other partners to find the type of care the Board requires.[33] CMHPs provide oversight to PSRB GEI clients on conditional release and provides status reports to the PSRB.[34]

Civil Commitment

The civil commitment process occurs when a court finds that an individual who has a mental illness, as defined by statute, should be required to receive mental health treatment.[35] Judges determine when an individual needs to be civilly committed and places them under the jurisdiction of OHA.[36, 37] ORS 426.060 allows for OHA to delegate their placement authority placement to CMHPs for civilly committed individuals.[38] Per OAR 309-033-0290 Placement of Persons under Civil Commitment, OHA has delegated the authority to CMHPs, to place the individual in a residential or community setting, such as a RTF, RTH, or SRTF.[39]

According to OHA staff, most individuals who are under a civil commitment are first committed to an acute care setting; however, if the person is deemed to be "extremely dangerous" (referred to as an "EDP") they may be

[33] OHA. Intensive Services: Oversight of Court-Ordered Behavioral Health Treatment.
[34] PSRB. "Conditional Release."; PSRB Conditional Release Consultation Report. (2022).
[35] OHA. Civil Commitment.
[36] OHA. Intensive Services: Oversight of Court-Ordered Behavioral Health Treatment.
[37] Email: Question re: placement options for civil commitment. Michael Johnson. Received by J. George. May 7, 2026.
[38] Oregon Legislature. ORS 426.060 Commitment to Oregon Health Authority; powers of authority; placement; transfer. 2025.
[39] Oregon Secretary of State. OAR 309-033-0290 Placement of Persons under Civil Commitment. Eff. May 28, 2024.

committed to OSH.[40] [41] Individuals may be placed voluntarily in residential placements. Individuals may also be voluntarily committed to OSH, or placed in residential placements with guardian consent, subject to administrative rule and federal court orders.

Mink-Bowman Judicial Rulings

Mink-Bowman refers to consolidated federal court cases in Oregon requiring OSH to admit A&A criminal defendants within seven days of a court order, committing them to the state hospital to reduce the time that they spent spend in jail awaiting mental health services. The ruling also ensures that GEI individuals remain on the same admission list as A&A defendants in the sequence the orders are issued. *Mink-Bowman* concerns two types of criminal defendants: A&A individuals and GEI individuals. *Mink-Bowman* reflects the courts' recognition that jails are not appropriate settings for and do not have the resources to provide mental health treatment, and prolonged detention without hospital care can worsen individuals' conditions. OHA is required to pay a fine for each day an A&A defendant who is ordered to OSH is in jail longer than seven days.

The first case, *OAC v. Mink*, was brought in 2002 by the Oregon Advocacy Center (OAC, now Disability Rights Oregon [DRO]) against OSH and OHA to reduce the time criminal defendants who are unfit to proceed due to mental illness spend in jail pretrial. The court concluded that indefinite custody in jail of such individuals is unjust and lacks any constitutionally sufficient

[40] Email: Question re: placement options for civil commitment. Michael Johnson. Received by J. George. May 7, 2026.
[41] EDPs are placed under the jurisdiction of the PSRB and like felony GEIs, the PSRB determines if they are committed to OSH, conditionally released, or discharged from jurisdiction. These commitments are for two years, unlike a "regular" civil commitment of 180 days.

justification. It held that OSH must admit, within seven days, defendants found unable to stand trial because they cannot "aid and assist" in their own defense.[42]

In the second case, *Bowman v. Matteucci*, plaintiffs Jarod Bowman and Joshawn Douglas-Simpson, two criminal defendants who were adjudicated GEI and ordered to civil commitment in OSH brought an action against OSH and OHA in 2021 for violation of their substantive due process rights. These claims stemmed from prolonged detention in jail after adjudication while awaiting transfer for treatment. The plaintiffs spent over eight and six months, respectively, in custody awaiting admission to OSH. The court held that, consistent with *OAC v. Mink*, OSH must admit GEI individuals within seven days of a court order.[43]

These cases were formally consolidated and are referred to collectively as *Mink-Bowman*.[44] Together, they require OSH to admit both A&A individuals (from *Mink*) and GEI individuals (from *Bowman*) within seven days of a court order for commitment.

In 2022, DRO filed suit against OHA and OSH for failure to comply with *Mink-Bowman*. The court issued an order (the "Mosman Order") reaffirming the seven-day requirement and establishing maximum timelines for admitting A&A and GEI individuals.[45] In 2023, the court issued an amended order (the "Amended Mosman Order") incorporating additional recommendations from a neutral expert and allowing limited flexibility in certain maximum

[42] Oregon Advocacy Center et al. v. Mink et al., Civ. No. 02-339-PA (D. Or. May 15, 2002).
[43] Govinfo.gov. Bowman v. Matteucci, No. 3:21-cv-01637-HZ (D. Or. Nov. 1, 2021).
[44] Document 238-1 Interim Agreement, Case 3:02-cv-00339-MO (Dec. 17, 2021).
[45] Oregon.gov. DRO v. Allen et al., No. 3:02-cv-0039-MO (Sep. 1, 2022).

time frames based on the charges underlying the commitment.[46] After continued noncompliance, DRO filed a motion for contempt in January 2025, which the court granted, reinforcing Oregon's obligation to meet required timelines.[47] The most recent United States District Court Order in June 2026 limits who may be admitted to OSH. Per the order, individuals with a ""non-person Level C felony charge" that have a sentence of 90 days or less, and pretrial detainees being held in jail on a list of charges—which includes aggravated harassment, mail theft and identify theft—cannot be admitted to the [OSH]."[48]

Assessments

There are many different types of assessments used for various purposes through the Medicaid program. Standardized and norm-referenced assessment instruments produce results that are generalizable to a population of individuals who share similar characteristics. Assessments may also be in the form of "state-developed" tools that states develop and customize for specific purposes. These "home grown" tools are not generally standardized and normed, but they are considered to be "uniform," which means they use consistent questions and formatting.

OHA currently uses three assessments: the standardized Level of Care Utilization System (LOCUS) and two state-developed residential setting-specific versions of the Level of Service Inventory (LSI).[49] These assessments are used for determinations regarding 1915(i) level of need (LON), and

[46] Oregon.gov. DRO v. Allen et al., No. 3:21-cv-01637-MO (D. Or. July 3, 2023).
[47] Disability Rights Washington. Trueblood v. Washington, No. C14-1178 MJP (W.D. Wash. July 7, 2023).
[48] Oregon Public Broadcasting. Oregon State Hospital back in compliance following federal judge's order. Conrad Wilson. June 22, 2026.
[49] Oregon Secretary of State. OAR 410-173-0005.

reimbursement levels for mental health residential services,[50] respectively. OHA is moving toward one assessment tool, the interRAI Community Mental Health (CMH) assessment for LON, placement, and acuity-based reimbursement decisions. OHA anticipates beginning to use the tool for LON and reimbursement decisions starting on July 31, 2026.

The Short-Term Assessment of Risk and Treatability (START) is one risk-assessment instrument PSRB may use to determine the risks associated with a mental health diagnosis for individuals in their custody, however PSRB does not assign levels of care based upon a START score. The START assessment relies on professional clinical judgment to evaluate risk domains pertinent to typical psychiatric practice and care. These domains include: risk to others, suicide, self-harm, self-neglect, substance abuse, unauthorized leave, and victimization.[51] PSRB decisions are based upon the evidentiary records in totality.

OHA's use of standardized and normed assessment will be a critical factor to explore relative to how assessment results are used for RTF, RTH, and SRTF admission, discharge, and rate reimbursement.

Reimbursement Models

There is flexibility and variability in the types of reimbursement models available to Medicaid programs when paying for covered services. Oregon's RTFs, RTHs, and SRTFs are reimbursed through an FFS model[52] that operates through direct reimbursement to providers for each service rendered based

[50] OHA. LSI for Residential Treatment User Manual. p. 3.
[51] National Library of Medicine. Short-Term Assessment of Risk and Treatability (START): The case for a new structured professional judgment scheme. Christopher D. Webster, Tonia L. Nicholls, Mary-Lou Martin, Sarah L. Desmarais, and Johann Brink. 2006.
[52] OHA. Behavioral Health Fee Schedule, February 2026. February 1, 2026.

on an established fee schedule.[53] In addition to an FFS model, Medicaid can also be operationalized through managed care programs that use capitation or other models of reimbursement to pay for services.[54] Available reimbursement models are detailed in Appendix III. Of note, although OHA uses an FFS model to pay for RTFs, RTHs, and SRTFs, there is further variability in the current reimbursement methodologies for each of these three services.

Reimbursement Methodologies

Similarly to reimbursement models, there are varying methods for establishing a payment rate for Medicaid covered services. These methods are referred to as "reimbursement methodologies" that are established through a rate setting process. General reimbursement methodology and rate setting guidance is enumerated in 1902(a)(30)(A) of the SSA, which states:

> "…payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that the services under the plan are available to beneficiaries at least to the extent that those services are available to the general population."[55]

Reimbursement methodologies are not a service rate themselves; rather, reimbursement methodologies are how states develop a service rate, considering factors that may be unique to a state or service. Reimbursement methodologies are established in the Medicaid State Plan or in waiver authorities used to cover a specific service. Though there are some federal

[53] KFF. Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts. June 22, 2015.
[54] Ibid.
[55] SSA. Section 1902(a)(30)(A).

requirements regarding reimbursement for certain provider types, such as an institutional provider (e.g., hospital) or federally qualified health centers, these established federal standards do not apply to FFS methodologies.[56]

The reimbursement methodologies most important to highlight for this report are flat, cost-based/provider-based, tiered, and negotiated/ contracted rates and rate adjustors. It is important to note that states have a wide degree of flexibility in the data used to inform payment rates. Moreover, the federal government does not prescribe the kind of rates or reimbursement methodologies states employ to pay providers for delivered services.[57]

Flat Rates

Flat rates are static, predetermined rates, that are published on a fee schedule. These rates are used to reimburse providers for a unit of service (e.g., a set amount of time or a number of items). Flat rates do not vary by providers but do vary by the service themselves.[58] Flat rate methodologies generally incentivize volume over quality in that providers receive the benefit of increased payments the more they bill for a service or services.

Cost-Based/Provider-Based Rates

States may reimburse providers specific rates based on data submitted by providers in cost reports. This reimbursement method known as "cost-based" or "provider-based" reimbursement is used to pay providers specific rates based on costs associated with staff wages and benefits, training and education time, and other related operational factors like vehicle ownership.

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[56] Medicaid and CHIP Payment and Access Commission (MACPAC). Rate Setting for Medicaid Home- and Community-Based Services. p. 2. August 2025.
[57] MACPAC. Rate Setting for Medicaid Home-and Community-Based Services. pp. 3-4. August 2025.
[58] CMS. Rate Methodology in a FFS HCBS Structure. p. 21. February 2016. Ralph F. Lollar.

Some states have moved away from cost-based rates in favor of prospective payments or standard fee schedules.[59] However, cost-based rates are still used by at least 10 states as part of HCBS rate setting[60] and cost-based rates continue to be a major model in reimbursing facilities like hospitals and nursing homes.[61]

Tiering

Tiered rates differ from flat rates in that a tiered rate structure considers a participant's needs to inform a variable rate. When compared to a flat rate, tiered rates are more nuanced in how providers receive payment for serving individuals with varying degrees of ability and capacity. Tiered rate methodologies are typically informed based on an assessment of needs. Following a functional assessment to determine a participant's needs, an individual is assigned to an assessment level that then corresponds to a rate tier. Rate tiers generally group together individuals with similar characteristics so the rate assigned to each group is consistent with the needs or participants and reflects the level of intensity required to serve them.[62]

States have wide flexibility in the design of their rate tiers and can choose to have multiple groups within the tiered rate structure. A three-tiered method that is considered low, medium, and high needs may be preferential to tiered systems with many levels of tiering. Many groups within a tiered reimbursement methodology, while helpful in recognizing minute nuance,

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[59] Myers and Stauffer. The Case for Cost Reports. Part One: Are Medicaid Cost Reports Still Necessary?
[60] MACPAC. Rate Setting for Medicaid Home- and Community-Based Services. p. 5. August 2025.
[61] Myers and Stauffer. The Case for Cost Reports. Part One: Are Medicaid Cost Reports Still Necessary?
[62] CMS. Rate Methodology in a FFS HCBS Structure. Ralph F. Lollar. February 2016.

may pose potential challenges if the groups are not well defined or are overly complex. However, tiered rates do help to mitigate the risk of providers choosing to serve individuals with less intense needs, an issue inherent with a flat rate reimbursement model.

Rate Adjustors

Rate adjustors are used in tandem with reimbursement methodologies to assist in promoting further definition and recognition of factors that impact challenges to serving individuals. Rate adjustors, like geographic factors or bed size, are typical and are used throughout Medicaid programs and different authorities.[63]

OHA currently uses a tiered rate structure to reimburse RTFs, RTHs, and SRTFs. The reimbursement method for these services also considers geographic and capacity rate adjustors. Reimbursement for Oregon's RTFs, RTHs, and SRTFs is further explored in this report.

Condition-Specific Program

Condition-Specific Program and Condition-Specific Facility mean programs or facilities that treat a narrowly defined illness, disorder, or condition, such as behavioral and mental health conditions, SUD or addiction, including but not limited to:

- Alcohol, illicit drugs, and gambling.
- Physical health conditions, including, but not limited to:
    - Cancer.

[63] CMS. Tiered Rates: Trends in Acuity-Based and Geography-Based Rate Variation.

    - Diabetes.
    - Bariatric care.
- Developmental disabilities (DDs).[64]

OHA Activities in Motion

As of June 2026, OHA is implementing numerous policy and operational changes that may impact mental health services through RTFs, RTHs, and SRTFs.

At minimum, these activities include:

- Review and discussion with providers regarding changes to prioritization and waitlist management practices currently prescribed in OAR.
- Collaboration with the Governor's Office on the development of a pilot site for Permanent Supportive Housing (PSH) Tier 3, which is intended to provide additional wraparound intermittent clinical and habilitative supports for individuals who are ready to move from a mental health RTF to a less restrictive setting.
- Assessment practices that dictate enrollment to programs, services, and determine tiered payment rates, inclusive of a new assessment tool (the interRAI CMH) for use in the 1915(i) Medicaid State Plan option.
- Policy and procedural changes to the person-centered service planning process and case management practices.

[64] Oregon Secretary of State. OAR 410-141-3500 Definitions. Eff. January 1, 2026.

- Medical necessity revisions specific to SRTFs.
- Regulation updates that require temporary OARs be in place through at least June 2026.
- Amendment and renewal of the 1915(i) Medicaid State Plan option.
- Updates to system integration and capacity to exchange data directly with providers.

All the abovenamed changes may result in systematic and significant impacts to RTFs, RTHs, and SRTFs facilities. Throughout this report, these changes are noted along with the potential ramifications on the operationalization of the in-scope mental health settings.

Alternative Models: Provisioning Mental Health Residential Services

States design and administer their Medicaid programs within the framework of broad federal requirements. States retain flexibility to determine who is eligible, what services are covered, how those services are delivered, and the methods and rates for paying providers, which are required to be addressed in a State Medicaid Plan. Section 1902 (42 U.S.C. 1396a) provides the requirements of a State Plan for Medical Assistance (or a SPA). A State Plan details how the program is administered, provider participation requirements like credentialing and supervision, eligibility categories, reimbursement, services, oversight, and beneficiary protections.[65]

States operate their Medicaid programs within the parameters set by Medicaid authorities that are named in the SSA. These Medicaid authorities are broadly split into two major categories: those that authorize services under a Medicaid State Plan and those that use waivers to forgo specific Medicaid requirements, such as those related to providing services statewide and how Medicaid eligibility is determined for individuals who need long-term care (LTC). Medicaid and the CHIP Payment and Access Commission (MACPAC) reports that "States can use waivers to offer a specialized benefit package to a subset of Medicaid beneficiaries, to restrict enrollees to a specific network of providers, or to extend coverage to groups beyond those defined in Medicaid law."[66] Table 3 provides a summary of the types of Medicaid authorities by State Plan and waiver distinctions.

[65] Social Security Administration. SSA Section 1902 [42 U.S.C. 1396a].
[66] MACPAC. Waivers.

Table 3: Medicaid Authorities - Medicaid State Plan and Waiver Distinctions

Medicaid State Plan	Waivers
• Section 1905(a) • Section 1932(a) • Section 1915(i) • Section 1915(j) • Section 1915(k)	• Section 1915(a) • Section 1915(b) • Section 1915(c) • Section 1115

Detailed Review of Medicaid Federal Authorities

The following details are provided regarding two of the nine Medicaid authorities, Section 1905(a) and Section 1915(k), listed in Table 3. Further information about five other authorities (Sections 1915(a), 1915(b), 1932(a), 1915(j), and 1115) is found in Appendix IV. Two limited benefit plans are also explored to address potential alternative models for administering residential mental health services to individuals qualifying for OHP. Note that as 1915(i) and 1915(c) authorities are excluded from review per HB 2015 language, details of these authorities are not included herein. However, further information on both authorities may be accessed on the CMS HCBS Authority webpage.[67]

- **Section 1905(a)**: Section 1905(a) defines the scope of all Medicaid State Plan services and eligibility for a state's Medicaid program. The services named in Section 1905(a) are available to anyone enrolled on a State's Medicaid program as long as medical necessity is met. All Medicaid State Plan services covered under the Section 1905(a) authority are approved via a SPA with CMS.[68]

[67] CMS. Home & Community Based Services Authorities.
[68] Social Security Administration. SSA Section 1905(a) [42 U.S.C. 1396d].

Within Section 1905(a), "other diagnostic, screening, preventive, and rehabilitative services" are named. Known as the "rehab option," states can choose to cover optional behavioral health services, like rehabilitative services, therapies, medication management, psychotherapy, etc. through this allowance. Per a MACPAC brief issued in 2021, as of September 2015, approximately 46 states and Washington D.C. covered at least one service under the "rehab option."[69]

1905(a) services may be delivered through an FFS or managed care model.

- **Section 1915(k)**: Also known as the CFC option. 1915(k) allows states to provide home and community-based attendant services and supports to eligible Medicaid enrollees under their State Plan. This State Plan option was established under the Affordable Care Act of 2010. The option provides a 6% increase in federal matching payments to Oregon for service expenditures related to this option.[70]

Appendix V provides a further comparison and summary of the Medicaid authorities previously detailed. There are a few notable differences in how authorities operate, particularly when comparing those that are incorporated as part of a Medicaid State Plan versus a waiver:

- Though the 1915(a) authority is considered a waiver authority because it waives provisions under 1902(a) of the SSA, this authority practically is a contracting mechanism by which states may choose to

[69] MACPAC. Behavioral health services covered under state plan authority. January 11, 2021.
[70] CMS. Community First Choice (CFC) 1915(k).

operationalize managed care.[71] Per CMS data, 13 states and Puerto Rico use this authority to administer voluntary managed care programs.[72]

- Most State Plan authorities are not approved for a time limited period, and do not require a renewal period. The exception to this is the 1915(i) authority that requires a renewal of the option every five years when the enrollment is targeted to those with specific conditions, ages, or Medicaid eligibility groups.
- All HCBS authorities, regardless of whether they operate through a State Plan or waiver, are subject to HCBS requirements, including the HCBS settings rule of 2014 (see page 62 for more information on the settings rule).
- Only two authorities, 1915(c) and 1915(j), allow limitations to the number of individuals who may enroll, thereby creating a waitlist for services under those authorities.

Limited Benefit Plans

These plans are in place to manage a subset of benefits or services for a particular subpopulation and can include Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs).

PIHPs are Medicaid managed care arrangements that primarily provide or coordinate inpatient or institutional services, often related to behavioral health, mental health, or substance use treatment. States use PIHPs to manage specialized, high-cost services separately from broader Medicaid

[71] Social Security Administration. SSA Section 1915(a) [42 U.S.C. 1396n].
[72] CMS. Managed Care Authorities.

managed care programs. PIHPs may also coordinate some related outpatient services, but their defining role is coverage of inpatient or institutional care. Payment is generally made through a prepaid capitated arrangement in which Oregon pays the PIHP a fixed amount per enrollee each month, allowing the plan to assume some financial risk while encouraging cost control and coordinated care.[73, 74]

PAHPs are Medicaid managed care arrangements that cover outpatient or ambulatory services but do not provide inpatient or institutional care. States commonly use PAHPs to administer specialized benefits, such as dental services, nonemergency medical transportation, outpatient behavioral health treatment, or disease management services. Because they only manage outpatient services, PAHPs are generally narrower in scope and lower in cost than PIHPs or comprehensive managed care organizations (MCOs). Payment is usually made through prepaid capitated arrangements or other fixed payment methods that give states more predictable Medicaid spending while encouraging efficient management of outpatient services.[75, 76, 77]

Alternative Models and Reimbursement

Except for the managed care authorities (1915(b), 1932(a), 1115 authorities) that outline capitation payments for managed care, Medicaid authorities do not specify the service delivery model and reimbursement methodology

[73] MACPAC. Types of managed care arrangements. June 4, 2020.
[74] KFF. Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts. June 22, 2015.
[75] MACPAC. Types of managed care arrangements. June 4, 2020.
[76] KFF. Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts. June 22, 2015.
[77] National Archives. 42 CFR § 438.3 SubCh C Standard contract requirements. August 5, 2026.

states are obligated to use when covering mental health residential services. States have options when choosing which model and methodology works best for the services covered under that authority, but these decisions must be approved by CMS through a SPA (in the case of a State Plan authority) or through a waiver. State Plan reimbursement information is in Section 4.19 of the Medicaid State Plan, whereas waivered service methodologies are included directly in the waiver preprint application.

Costs Associated with Alternative Models

Alternative models themselves are not necessarily the primary drivers of costs, meaning that the model chosen does not in and of itself mean that existing costs will move upward or downward. Quantifying costs associated with alternative models is dependent on multiple variables. There is not a standard method for determining the costs of any alternative model without first considering the specific model(s), any necessary rate changes, and the type and amount of supports needed to implement a new model(s).

However, with all alternative models, there are likely to be planning costs related to the development and implementation of the new coverage model. Moreover, costs are associated with different factors that are irrespective of service delivery model chosen. These include:

- Potential reimbursement methodology changes (e.g., moving from a flat fee rate schedule to a tiered or capitated rate model).
- Moving from FFS to managed care models of delivery. Associated costs may be related to procurement of MCOs, information technology (IT) system changes, and administrative staff time.
- Identified needed rate increases for provider services. Rate increases may be necessary to appropriately compensate providers for services

delivered. A rate increase can occur regardless of a coverage model and is not dependent on implementing a new model.

Federal Requirements for Mental Health Residential Settings

Research and review of the SSA, CFRs, and CMS-published policies and guidance indicates there is no federal prohibition against receiving Medicaid-funded services in mental health residential settings, with the noted exceptions of services provided in institutions for mental diseases (IMDs) or if an individual is an inmate of a public institution.[78] Further, according to research published by the Office of the Assistant Secretary for Planning and Evaluation under the federal Department of Health and Human Services, "Residential [mental health] treatment settings are governed almost exclusively by state statutes and regulations, rather than by federal laws."[79] This is consistent with Myers and Stauffer's research indicating that the federal government does not specify mental health residential staffing, licensure, or prescriptive oversight requirements.

Mental Illness and Medicaid

More than one in three adult Medicaid enrollees have a mental illness.

10% of these individuals are diagnosed with an SMI.

+ KFF 5 Key Facts About Medicaid Coverage for Adults with Mental Illness. (February 2025). Accessed March 26, 2026.

[78] National Archives. 42 CFR § 435.1009 SubCh C Institutionalized individuals. July 12, 2006; National Archives. 42 CFR § SubCh C 1010 Definitions relating to institutional status. July 12, 2006.
[79] Office of the Assistance Secretary for Planning and Evaluation. State Residential Treatment for Behavioral Health Conditions: Regulation and Policy. Peggy L. O'Brien, PhD, Maureen T. Stewart, PhD, Mackenzie C. White, BA, Morgan C. Shields, PhD, MSc, MA, and Norah Mulvaney-Day, PhD. April 30, 2021.

Though states have significant latitude in determining how to cover and operate mental health residential settings under their Medicaid program, all HCBS Medicaid authorities require services to be compliant with specific rules governing individual rights to privacy, autonomy, and choice.

Home and Community-Based Settings Requirements

The federal HCBS settings rule (effective March 17, 2014) set standards regarding where Medicaid-funded HCBS may be delivered under authorities, such as 1915(c), 1915(i), and 1915(k).[80] States were required to meet the HCBS settings requirements beginning March 17, 2023, consistent with CMS transition and compliance guidance. The intent of these requirements is to ensure that people who receive Medicaid-funded HCBS can access the benefits of community living and receive services in the most integrated setting appropriate.

For State Plan HCBS under section 1915(i) and 1915(k) authorities, federal regulation requires the delivery of services in settings that are compliant with HCBS settings requirements, including the tenets of community inclusion, autonomy, and individual choice.[81, 82] Federal requirements also require additional protections for individuals who receive services in provider-owned or controlled residential settings.[83] CMS guidance explains that provider-owned or controlled residential settings must include a legally

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[80] National Archives. Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers. Effective March 17, 2014.
[81] National Archives. 42 CFR § 441.710 State Plan Home and Community-Based Services Under Section 1915(i). August 5, 2026.
[82] National Archives. 42 CFR § 441.530 Home and Community-Based Setting. August 5, 2026.
[83] CMS. Provider-Owned or Controlled Settings: Guidance on Residency Agreements and Tenant Protections.

enforceable residency agreement (or comparable agreement) that provides, at minimum, protections comparable to those available under the jurisdiction's landlord-tenant laws, including eviction protections.

CMS further identifies typical residency agreement elements, such as agreement length, payment terms, security deposit use and return, maintenance expectations, notice before entry, and conditions and processes for eviction, termination, and appeals.[84] Federal rules also require that residents in HCBS provider-owned or controlled settings have key rights, such as privacy, lockable doors, and control over schedules and visitors. Any restriction of these rights must be individualized and supported through a person-centered planning process.[85]

[84] Ibid.
[85] National Archives. 42 CFR § 441.710 State Plan Home and Community-Based Services Under Section 1915(i). August 5, 2026.

Oregon's Mental Health Residential Facility Landscape

Operationalization of Oregon's Mental Health Residential Settings

Federal regulations outlined in CFRs and guidance issued by CMS provide states with parameters for how to operate Medicaid programs. However, states have design flexibility in how Medicaid covers services within the parameters set by the federal government. This section outlines how Oregon operates RTFs, RTHs, and SRTFs and provides detail into the Medicaid authorities, reimbursement models, and methodologies used to support these services.

Oregon's Mental Health Residential Settings: State Statutes and Regulations

ORS Chapter 443 - Residential Care; Adult Foster Homes; Hospice is the governing statute that authorizes RTFs, RTHs, and SRTFs. Within ORS Chapter 443, there are sections that detail the following regarding operationalization of these settings:

- Definitions for what qualifies as an RTF, RTH, and SRTF.
- Descriptions of "residential care" and "treatment" that are to be provided in an RTF, RTH, and SRTF.
- "Residential care means services such as supervision; protection; assistance while bathing, dressing, grooming or eating; management of money; transportation; recreation; and the providing of room and board."

- "Treatment means a planned, individualized program of medical, psychological or rehabilitative procedures, experiences and activities designed to relieve or minimize mental, emotional, physical or other symptoms or social, educational or vocational disabilities resulting from or related to the mental or emotional disturbance, physical disability or alcohol or drug problem."
- Licensing requirements, including those that differentiate between settings licensed by OHA and ODHS, qualifications to receive a license, and terms and conditions.[86]

ORS 413.042 and ORS 443.465 give authority to OHA to develop and adopt administrative rules specific to the laws the Authority is charged with administering.[87] OARs, or rules, are used to interpret and expand upon requirements detailed in ORS and CFR. There are two main chapters of rules that are referenced throughout this report, and three primary divisions pertinent to RTFs, RTHs, and SRTFs. These are detailed in Table 4.

Table 4: OAR Chapter and Divisional Descriptions

-	OAR Chapter 309	OAR Chapter 410
Chapter Title	Health Systems Division: Behavioral Health Services	Health Systems Division: Medical Assistance Programs

[86] Oregon Legislature. Definitions for ORS 443.400 to 443.455, 443.405 Exclusions from definition of "residential facility," and Secure residential treatment homes and facilities; rules. 2025 Edition; ORS 443.410 Single license required – 443.422 Siting of licensed residential facilities, and 443.425 License term; contents; renewal; fee – 443.430 Transferability of license; disposition of license fees 2025 Edition.
[87] Oregon Legislature. ORS 413.042 Rules. 2009.; Oregon Legislature. ORS 443.465 Secure residential treatment homes and facilities; rules. 2009.

-	OAR Chapter 309	OAR Chapter 410
RTF/RTH, SRTF Divisions	• Division 33 - Civil Commitment Proceedings • Division 35 - Residential Treatment Facilities and Residential Treatment Homes for Adults with Mental Health Disorders	• Division 172 - Medicaid Payment for Behavioral Health Services • Division 173 – 1915(i) HCBS State Plan Option

Importantly, SRTFs do not have their own stand-alone division or rules specific to their operations. OHA indicated that the intent is to eventually merge applicable rules within Divisions 33 and 35 within Chapter 309 to create a new set of SRTF-specific rules.[88] Additionally, as of the date of this final report, some OAR language is temporary and in effect until November 25, 2026, as indicated on the Secretary of State's website. Appendix VI provides ORS and OAR references and citations that are applicable to RTFs, RTHs, and SRTFs in further detail. Any rules in which temporary language is cited are indicated as such with the [+] symbol. Pertinent ORS and OAR references are included in the following sections detailing admissions, person-centered planning processes, discharge practices, licensing, certification, staff education, reimbursement, and Oregon's implementation of tenancy laws and HCBS settings.

Oregon's Mental Health Continuum of Care

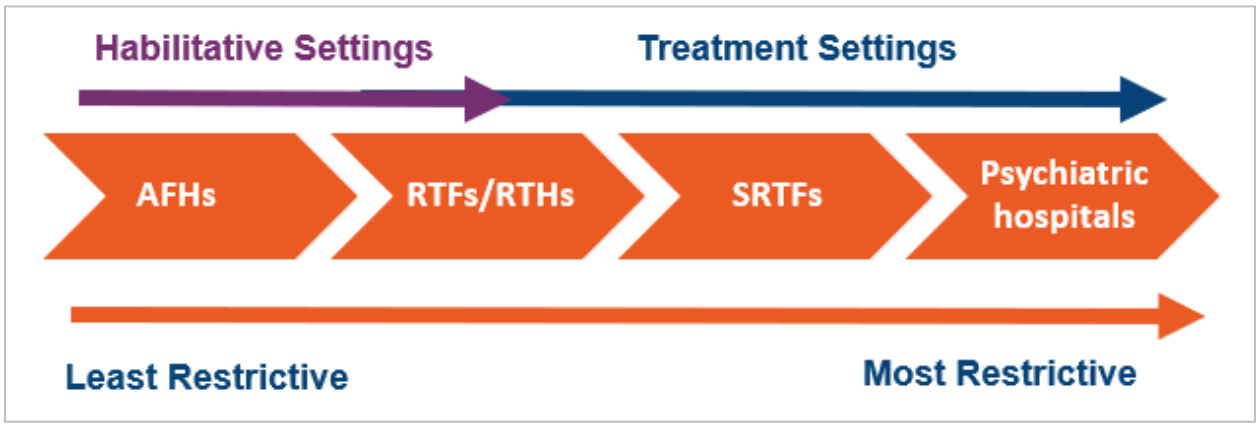
All of the in-scope mental health residential facilities provide services to individuals with mental, emotional, or behavioral health disturbances who require residential care and treatment.[89] RTFs and RTHs may be located in one or multiple buildings that may be on contiguous properties.[90] Per ORS

[88] OHA. HB 2015 - Verification Questions. Sent by J. George.
[89] Oregon Legislature. Definitions for ORS 443.400 to 443.455.
[90] Ibid.

443.465, SRTFs are considered "secure" if egress from the facility is restricted through locking devices on exit doors, gates, or other closures.[91] Some facilities are also licensed to provide services to individuals with a SUD; however, only co-licensed facilities are included in this study.

The mental health residential facilities included herein, as well as the AFHs and OSH, are part of the continuum of care (see Figure 2). The continuum of care is theoretically structured to allow an individual to move between treatment locations, as their needs change. However, as documented throughout this analysis, there are practical barriers, notably in operational processes like admissions and discharges, medical necessity reviews, court-involved processes, and reimbursement procedures that create challenges to an individual's ability to seamlessly transition between mental health residential settings, when needed.

Figure 2: Oregon's Mental Health Residential Continuum of Care



[91] Oregon Legislature. 443.465 Secure residential treatment homes and facilities; rules. 2025 Edition.

Oregon's Mental Health Residential Facilities: Medicaid Authorities and Services

OHA uses three Medicaid authorities, Sections 1905(a), 1915(i), and 1915(k) to cover services within RTFs, RTHs, and SRTFs; however, not all setting types are authorized under these three sections. Table 5 crosswalks the mental health residential settings to the authority in which they operate in Oregon.

Table 5: Oregon Mental Health Residential Settings - Medicaid Authorities

Authority	RTF	RTH	SRTF
1905(a)[92]	Yes	Yes	Yes
1915(i)[93]	Yes	Yes	No
1915(k)[94]	Yes	Yes	No

Feedback provided by OHA staff in February 2026 suggests that the 1915(i) and 1915(k) authorities were originally leveraged to fund RTFs and RTHs for the following reasons:

- Improved rate alignment between these and other community-based settings.
- Enhanced care coordination for individuals residing in these facilities.
- Exploration for future coverage of these settings through the CCO model.[95]

As RTFs and RTHs are allowable settings to receive services under the 1915(i) and 1915(k) authorities, these settings also must comply with federal HCBS

[92] OHA. Oregon State Plan, Attachment 3.1-A 13.d Rehabilitative: Mental Health Services. p. 436. September 19, 2014.
[93] OHA. Oregon State Plan, Attachment 3.1-i 1915(i) State Plan HCBS. pp. 681 and 684. December 23, 2021.
[94] OHA. Oregon State Plan, Attachment 3.1-k 1915(k) Community First Choice State Plan Option. pp. 754 and 765. February 7, 2022.
[95] HB 2015 Monthly Work Group Meeting. February 23, 2026.

settings requirements as discussed in the **HCBS Settings Rule Implementation and Intersection of Oregon Tenancy Laws** section. SRTFs inherently restrict the movement of individuals and must be locked at all times; therefore, SRTFs cannot meet HCBS settings requirements and are excluded from coverage in HCBS Medicaid authorities.

The services available in RTFs and RTHs vary based on the authority used to fund the service. Table 6 provides context into the types of services accessible in these facilities under the 1905(a) and HCBS 1915(i) State Plan option. Importantly, the 1915(k) is not overtly clear in detailing the allowable services as part of this benefit package, which may be received in an RTF and RTH. The 1915(k) only states that:

> "Payment for home-delivered meals, chore services, home-care workers or personal support workers, personal emergency response systems, relief care providers, and environmental accessibility adaptations will not be allowed when they would duplicate other services provided under another benefit or program. Home and community based residential providers [e.g., RTFs and RTHs] must ensure their residents have access to substantially similar services as those living in their own homes."[96]

However, in speaking with a representative of ODHS, it was determined that services provided through the 1915(k) in an RTF or RTH must include those services that are outlined in the RTF and RTH licensure rule, OAR 309-035-0115.[97] Per OAR 309-035-0115, a prospective provider of an RTF or RTH must include information relative to the type and frequency of the clinical services

[96] OHA. Oregon State Plan, Attachment 3.1-k 1915(k) Community First Choice State Plan Option. p. 743.
[97] Key Informant Interview. ODHS. APD Staff. April 15, 2026.

offered to residents in their license application packet. The rule specifically states that offered services include "individual and group counseling, skills training, psychiatric treatment, and the contact information of the LMP [licensed medical practitioner] that provides consultation and oversight of the services offered…"[98] Additionally, the ODHS representative confirmed that 1915(k) services, such as emergency response systems or home modifications are not generally offered to individuals residing in an RTF or RTH who are enrolled on the 1915(k) as it is presumed that those types of services and supports are offered by the facility.[99]

Table 6: Services provided in RTFs and RTHs, by Authority

Authority	Service name	Service description summary	Service category
1905(a)	Mental health services provided to children, adolescents, and adults in residential settings	Specialized form of rehabilitative service dedicated to providing diagnosis, treatment, or care of persons with mental disease who are between the ages of 22 and 64. Therapeutic interventions may be provided in an individual or group setting. Services may also include intake evaluation, assessment, screening, brief intervention treatment, crisis and stabilization services, etc.[100]	Treatment

[98] Oregon Secretary of State. OAR 309-035-0115 Licensing.
[99] Key Informant Interview. ODHS. APD Staff. April 15, 2026.
[100] OHA. Oregon State Plan, Attachment 3.1-A 13.d Rehabilitative: Mental Health Services. p. 436.

Authority	Service name	Service description summary	Service category
1915(i)	HCBS Residential Habilitation	Services to enable an individual to attain or maintain maximum functional level and include supervision, support, and training in the following areas: managing behavioral, financial literacy, social skill development and maintenance, communication, etc. HCBS Residential Habilitation also may include activity therapy through group options provided by a qualified provider in expressive, art, dance, exercise, or play therapies.[101]	Habilitation
1915(i)	Psychosocial Rehabilitation	Includes the following services: • Comprehensive medication services. • Individual, group, and family therapies. • Psychiatric skills training. • Behavioral health counseling. • Psychiatric activity therapy/ community psychiatric supportive treatment. • Assertive Community Treatment (ACT).[102]	Rehabilitation

In addition to the services description summaries provided in Table 6, OHA staff indicated that RTF and RTH services provide "stabilization services" under the 1915(i) and act as crisis respite facilities. OAR 309-035-0217 specifies the requirements of RTFs and RTHs who provide crisis respite

[101] OHA. Oregon State Plan, Attachment 3.1-i 1915(i) State plan HCBS. p. 679.
[102] OHA. Oregon State Plan, Attachment 3.1-i 1915(i) State plan HCBS. p. 683.

services,[103] but OHA does not offer a separate licensure, class, or certification for "crisis respite facilities" based on a review of OAR enacted as of the date of this report.[104]

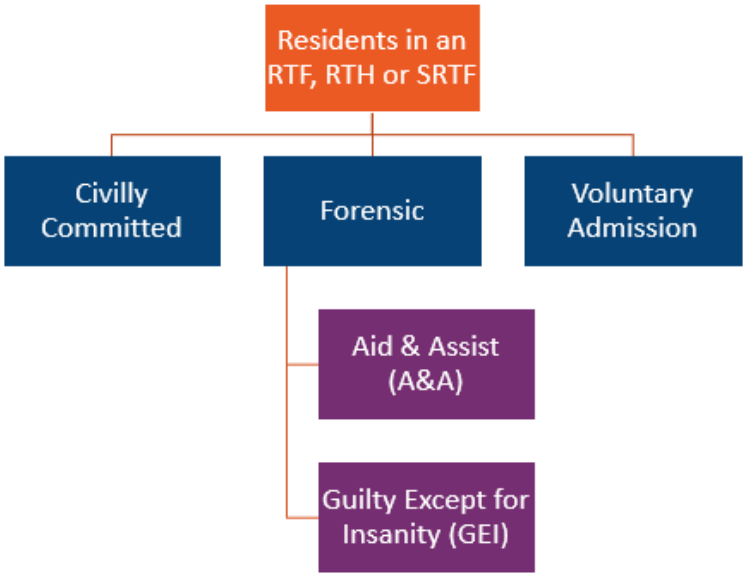
The service description summaries provided in Table 6 indicate a wide variety of activities offered in RTFs and RTHs inclusive of treatment and habilitative services. Without clear understanding of resident needs within these facilities, or how they are allowed to access these services (e.g., a resident's enrollment on an HCBS authority) distinguishing the appropriate type of service may be difficult for providers. For instance, habilitation is appropriate for an individual who is trying to gain a specific skill set and is enrolled on the HCBS 1915(i) State Plan option, whereas treatment is meant to assist in mitigating symptoms related to a diagnosis and is accessible outside of the 1915(i) State Plan option. Though some individuals may require habilitation, rehabilitation, or treatment services simultaneously, individuals in need of only habilitation are likely to have different acuity needs than an individual in need of only treatment or rehabilitation. Understanding which facilities are providing treatment and habilitative services is critically important as this directly impacts an individual's care. Furthermore, it is worth noting that individuals who are involved in the A&A program outside of OSH may not require "behavioral health treatment" but rather need services designed to help the individual participate in their own criminal defense. This type of service is neither specified in ORS nor OAR as a requirement of RTF, RTH, or SRTF providers.

[103] Oregon Secretary of State. OAR 309-035-0217 Crisis Respite Services.
[104] Key Informant Interview, OHA, BHD staff. April 17, 2026.

Admission Practices

Admission to RTFs, RTHs, and SRTFs is driven by a number of factors, including medical necessity, involvement with the justice system, prioritization, and enrollment of a prospective resident in the HCBS 1915(i) or 1915(k) State Plan options.[105] Figure 3 illustrates the populations that may be served by RTFs, RTHs, and SRTFs, though access to these mental health residential settings varies as is evidenced in the following sections.

Figure 3: Populations Admitted to RTFs, RTHs, or SRTFs



RTF, RTH, and SRTF admissions are defined in OAR 309-035-0156 Screening and OAR 309-035-0163 Admission[106]. Within OAR 309-035-0156, the criteria noted in Table 7 are used to determine admission to an RTF, RTH, or SRTF. The rule does not distinguish any differentiating criteria for admissions to an SRTF Class 1 and Class 2 facility.

[105] Admission and placement to a specific setting cannot occur for A&A, GEI, and "Extremely Dangerous Persons" (EDP) populations without a criminal order or PSRB administrative order. CMHPs also have delegated placement authority for civil commitments.
[106] OAR. 309-035-0163 Admission.

Table 7: RTF, RTH, and SRTF Admission Criteria Enumerated in OAR 309-035-0156

RTF/RTH admission criteria	SRTF admission criteria

• "Be assessed to have a mental health disorder or suspected mental health disorder.
• Be at least 18 years of age.
• Not require continuous nursing care unless a reasonable plan to provide care exists, the need for residential treatment supersedes the need for nursing care, and the Division approves the placement.
• Have evacuation capability consistent with the setting's occupancy classification with or without assistance described in OAR 309-035-0145(6)(b).
• Have a verified funding source for the purpose of receiving care and services in a licensed setting including verification of Medicaid eligibility and coverage, as applicable.
• Meet additional criteria required or approved by the Division through contractual
	• "In addition to all RTF/RTH criteria, provider must also evaluate and determine whether a prospective resident is eligible for admission, based on the prospective resident meeting all criteria in OAR 410-172-0720(7)."[108]
	• OAR 410-172-0720(7) criteria:
	• "Prior authorization requests for admission and continued stay for a Secure Residential Treatment Facility (SRTF) shall be reviewed to confirm that the individual meets all the following criteria:
	• The individual does not require 24-hour hospital care and treatment.
	• The individual requires highly structured and secured environmental supports and supervision seven days per week and 24 hours per day to participate successfully in a program of **habilitative** and **rehabilitative** activities.
	• Due to a mental illness and as evidenced by clinically documented[109] instances of behaviors displayed within the last 90 days, the individual presents with one or more of the following:
	  ○ Clear intention or specific acts of bodily harm to others;
	  ○ Ideation and intent of either suicide or of self-harm posing significant risk of serious injury; which if not in a secured

[108] OAR. 309-035-0156 Screening.

[109] The mental illness must be clinically documented by the individual's treating physician, physician's assistant, or advanced practice registered nurse who has been primarily responsible for treating the individual.

RTF/RTH admission criteria	SRTF admission criteria
agreement or condition of licensing."[107]	environment, would allow for opportunity; ○ Inability to care for basic needs that would, if not in a secured environment, result in worsening or development of a significant health condition, ○ The individual's mental health symptoms impact judgment and awareness to the degree that the individual may place themselves at risk of imminent harm; or ○ Significant risk that the individual will not remain in a non-secured place of service to receive the services and supports necessary to stabilize the symptoms of a mental illness that pose a threat to the individual's or others' safety and well-being."[110]

OAR 309-035-0163 Admission does not include the same or differing criteria to those included in Table 7. Rather, this rule describes the requirements providers must establish relative to admission policies and procedures. Additionally, OAR 309-035-0163 requires providers to deliver an orientation to all new residents that includes an explanation and review of the resident's rights, grievance procedures, person-centered planning process, and a discussion of the residency agreement.[111]

In addition to the two rules noted above, a review of other OARs, CMS-approved State Plan language, and partner feedback indicates that access and admission to the mental health residential settings and services is also

[107] Oregon Secretary of State. OAR 309-035-0156 Screening. Eff. June 1, 2026.
[110] Oregon Secretary of State. OAR 410-172-0720 Prior Authorization and Re-Authorization for Residential Treatment. Eff. July 26, 2021.
[111] Oregon Secretary of State. OAR 309-035-0163 Admission. Eff. May 1, 2026.

dependent on a number of factors, including prioritization of forensic and civilly committed persons, medical necessity and prior authorization (PA) approvals, Medicaid authority eligibility, and access to case management.

Prioritization of Forensic and Civilly Committed Populations

An individual's involvement in the forensic system or being under a civil commitment impacts not only their admission to a facility, but also the ability of individuals who are voluntarily seeking admission to an RTF, RTH, or SRTF to be admitted to these settings. Placements in RTFs, RTHs, and SRTFs are determined by different entities, including the CMHPs, hospitals, psychologists or psychiatrists, OHA's IQA, the PSRB, and the courts. However, courts may also mandate that an individual receives services through one of these facility types[112] even if medical necessity is not met. Placements made by the judicial system and PSRB impact at minimum:

- Setting capacity for those individuals who do meet medical necessity criteria.
- The ability of providers to appropriately serve individuals in settings maladapted to meet high needs stemming from their diagnoses.[113]
- BHD general revenue funding solvency as Medicaid funds cannot pay for stays that are not medically necessary.

Moreover, OAR 309-035-0158 Waitlist Management is a temporary administrative rule that has undergone multiple temporary filings dating back to at least December 2025.[114] Previous changes were made to align the

[112] Oregon Legislature. OHA: Secure Residential Treatment Facilities Overview. p. 11. February 4, 2025. Chelsea Holcomb and Samantha Byers, OHA.
[113] OR HB 2015 Partner Work Group. Work Group meeting. March 18, 2025.
[114] Oregon Secretary of State. OAR 309-035-0158, RTFs and RTH for Adults with Mental Health Disorders, Waitlist Management. Eff. July 3, 2026.

OARs with language contained in HB 2015, HB 2024, and SB 739.[115] The most recent set of temporary OAR updates were filed for an effective date of July 3, 2026, and were made to increase prioritization of some A&A defendants who no longer qualified for OSH admission under the June 2026 federal court order, which further restricted OSH admission for A&A defendants who are charged with a list of non-person Class C felonies and the Class A person misdemeanor of resisting arrest.[116] [117]

Impact of Prioritizing Forensic Populations for Admission to Mental Health Residential Settings

"Community residential capacity is at risk of being consumed entirely by Aid and Assist placements if systemic barriers are not addressed quickly."

— HB 2015 Work Group Member

"System is fragmented which makes it difficult to develop programs for high needs individuals. There is a problem of not meeting the care needs for people cycling through the system and coming back through a forensic population."

— HB 2015 Work Group Member

Prioritization for admission to RTFs, RTHs, and SRTFs [118] is based on the priority levels noted in Table 8 as indicated in the most recent temporary rule. Prioritization is based on the earliest date of receipt of a complete referral packet when prospective residents currently share equal priority. The rule also indicates that a mental health residential setting may not consider a prospective resident's county

[115] Oregon Secretary of State. Temporary Administrative Order, BHS 32-2025, Chapter 309, OHA, Health Systems Division, Behavioral Health Services.
[116] Oregon Secretary of State. Temporary Administrative Order, BHS 19-2026. July 2, 2026.
[117] Ibid.
[118] OAR 309-035-0158 does not explicitly indicate if prioritization applies to SRTFs, though it is the understanding of Myers and Stauffer that the rule is interpreted as being applicable to these facilities.

of origin, responsibility, or residency as part of the prioritization process.[119] Not having the ability to consider these factors impacts a provider's Medicaid payment rate (see the **Reimbursement Methods** section for more information), the ability to transition plan meaningfully, and coordination with an individual's identified community.

Table 8: OAR 309-035-0158 Waitlist Management

Priority level	Priority Consideration and Prospective Resident Criteria
First	Prospective residents seeking to transition from the OSH into the community and are: • "A candidate for court-ordered community restoration as an aid and assist defendant pursuant to ORS chapter 161; or • Found guilty except for insanity of a criminal offense and is currently under the jurisdiction of the Psychiatric Security Review Board pursuant to ORS 161.327."
Second	Prospective residents seeking to transition from OSH into the community and are: • "Under a current civil commitment, • Voluntary by guardian, or • Extremely dangerous person commitment pursuant to ORS chapter 426."
Third	Prospective residents seeking admission to programs who are: • "A candidate for court-ordered community restoration as an aid and assist defendant; or • A candidate for court-ordered conditional release who has been found guilty except for insanity of a criminal offense and will be placed under the jurisdiction of the PSRB pursuant to ORS 161.327; or • A candidate for court-ordered commitment to a facility designated by OHA and who is found guilty except for insanity of a criminal offense pursuant to ORS 161.328."

[119] Oregon Secretary of State. OAR 309-035-0158, RTFs and RTH for Adults with Mental Health Disorders, Waitlist Management.

Priority level	Priority Consideration and Prospective Resident Criteria
Fourth	Prospective residents seeking admission to programs: • "As an alternative to or to prevent civil commitment or placement at the Oregon State Hospital; or • For the purpose of transitioning from a program or a secure residential treatment facility; or • For the purpose of transitioning from a community hospital to a community placement;"
Fifth	"The program must give fifth priority consideration to those prospective residents who do not meet the criteria establish [*sic*] in subsection (2)(a),(b),(c), or (d) of this rule."[120]

BHD may grant admission variances to providers who submit a written request clearly outlining the individual for whom the variance is requested. Criteria for variances must meet the requirements specified in the temporary rule filing for OAR 309-035-0115 Licensing.[121]

Per OHA, prioritization rules have historically been a factor in the mental health residential system, and have existed since at least 2018.[122] However, during conversations with Myers and Stauffer, providers and HB 2015 sponsors consistently indicated that the current temporary rules imposed by OHA are creating undue hardship on the ability of providers to safely care for individuals.[123] Further, it is the understanding of Myers and Stauffer that the court monitor did not specifically require OHA to revise OAR 309-035-0158 rule to allow for greater priority for admission to individuals involved forensically or who are civilly committed. Rather, OHA revised the rule to implement recommendations made by the court-appointed monitor to

[120] OAR 309-035-0158, RTFs and RTH for Adults with Mental Health Disorders, Waitlist Management.
[121] OHA. Update on Emergency Rules and Future Rulemaking. pp. 2-3. May 15, 2026.
[122] OHA/MSLC HB 2015 Project Status Check-In (weekly Mar-Sept). April 2, 2026.
[123] OR HB 2015 Partner Work Groups. April 1 and 15, 2026. Work Group meeting.

ensure compliance with *Mink-Bowman*,[124] and address inequities faced by people who are involved in the criminal justice system.

Medical Necessity and Prior Authorization Approval

OAR 410-172-0720 Prior Authorization and Re-Authorization for Residential Treatment outlines the process used by OHA or the IQA to authorize admission and continued stays in RTFs, RTHs, and SRTFs. Of important note, the medical necessity practices between RTFs and RTHs, and SRTFs are distinctly different and separate. Additionally, the process used by the PSRB and courts to place individuals under their jurisdiction is independent from Medicaid requirements to determine medical necessity and appropriateness as set forth in OAR 410-172-0720.

RTFs, RTHs, and SRTFs

According to OAR 410-172-0720, OHA or the IQA is responsible for reviewing PA requests and other documentation to determine the "medical appropriateness" of:

- Recommended length of stay.
- Recommended plans of care.
- The licensed settings.
- Any other [LOC] determination required from OAR 410-172-0600 specifically.[125]

Prior to July 31, 2026, the IQA determined eligibility for the 1915(i) HCBS State plan option at the same time they developed a person-centered

[124] Myers and Stauffer, OHA, Department of Justice: Mink Bowman and HB 2015. April 21, 2026.
[125] Oregon Secretary of State. OAR 410-172-0720 Prior Authorization and Re-Authorization for Residential Treatment. Eff. July 26, 2021.

service plan (PCSP) detailing 1915(i) covered services provided in an RTF or RTH. However, as of the finalization of this report, the IQA does not use a medical necessity form to authorize RTF and RTH stays; rather, the PCSP developed by the IQA acts as the authorization document for services.

OAR 410-172-0720 notes that requests for admission and re-authorization of SRTF services ***shall*** be reviewed for the criteria listed in Table 7, but does not indicate the entity responsible for evaluation.[126] However, the IQA uses form CH-009 for medical necessity determinations for SRTFs. This form suggests different supporting documentation, such as a mental or behavioral health assessment signed by a qualified mental health professional (QMHP), as evidence of a need for medical necessity. Additionally, criteria evaluating if an individual needs a highly structured 24/7 setting, has displayed certain risk behaviors in the last 90 days, or is under an involuntary medication, seclusion or restraint orders are included on CH-009. A review of the form suggests that the provider or another entity apart from the IQA completes the information and sends it to the IQA for a final decision.[127]

PSRB practices

PSRB is reliant on the information generated from the START assessment, along with additional documentation, to determine the risk that an individual poses to themselves or others as part of informed placement decisions. The START assessment does not evaluate the criteria included in OAR 410-172-0720 and does not appear to align with processes used by the IQA for RTF, RTH, and SRTF placements.

[126] OAR 410-172-0720 Prior Authorization and Re-Authorization for Residential Treatment.
[127] Oregon Behavioral Health Support Program. Form CH-009: Secure Residential Treatment Facility (SRTF) Medical Necessity/Medical Appropriateness Review Referral. April 2024.

Authority Eligibility

In addition to base Medicaid eligibility, individuals seeking enrollment on the 1915(i) or 1915(k) are required to meet LON or LOC standards, respectively.[128, 129] If an individual does not meet these criteria, they are unable to access the specific services 1915(i) and 1915(k) covered services provided in an RTF or RTH.

Case Management

An individual's ability to effectively navigate any service system — especially one as complicated as OHA's — is impacted by the availability of case management. Case management is critically important for individuals receiving services so there is a responsible entity helping to coordinate care, make referrals, monitor treatment progress, and determine if and when additional support is necessary to meet the changing needs of an individual.

Case management in Oregon is a web of divergent programs that appear to work in silos. Individuals may receive case management through their CCOs, through enrollment on a 1915(c) waiver, or through a CMHP as part of their eight core service areas delivered under their county financial assistance agreements.[130] Based on a review of OAR and through discussion with partners, it remains unclear the entity responsible for ongoing, continuous case management of individuals with SMI who are residing in an RTF, RTH, or SRTF. Of note, though OHP offers various forms of TCM through the

[128] Oregon State Plan. Attachment 3.1-i 1915(i) State plan HCBS. p. 662.
[129] Oregon State Plan. Attachment 3.1-k 1915(k) Community First Choice State Plan Option. pp. 747-748.
[130] OHA. County Financial Assistance Agreement (CFAA) Update. p. 10. July 7, 2025.

Medicaid State Plan (the 1905(a) authority), TCM specifically for individuals with mental health conditions is not currently an available option.[131]

Person-Centered Plans and Planning

All individuals admitted and residing in an RTF, RTH, or SRTF are required to have a PCSP as part of person-centered planning requirements. OAR 309-035-0190 specifies that plans must be directed by the resident in conjunction with persons identified by the individual, and that providers cannot develop the PCSP.[132] Plans are to identify "services and supports the resident receives and from whom and records the alternative HCBS settings considered by the resident, except as limited by a court, OHA, CMHPs, or PSRB order."[133]

PCSPs and the planning process for the 1915(i) State Plan option are detailed in OAR 410-173-0025. In addition to similar requirements regarding how a plan is developed, who is involved in the process, and the timelines for reviewing the plan (every 90 days or more often), OAR 410-173-0025(3)(a)[134], also requires that the PCSP is reviewed upon an annual assessment of need for the 1915(i) State Plan option.[135] This is a federal requirement as part of the State Plan option that is not necessarily

[131] Oregon Medicaid State Plan, 3.1-A Supplement 1. pp. 450-516.
[132] Person-centered planning is a requirement of an HCBS authority like a 1915(i) or 1915(k) state plan option. Though Myers and Stauffer confirmed that OAR 309-035-0190 is applicable to SRTFs, it is critical to note that SRTFs are not named as qualified providers under the HCBS authorities as they cannot inherently meet HCBS settings compliance.
[133] OAR. 309-035-0190 Person-Centered Service Plan. Eff. January 1, 2026.
[134] Paragraph citation is accurate as of the writing of this report.

[135] OAR. 410-173-0025 Person-Centered Service Planning Process. Eff. February 29, 2024.

applicable to services provided under a 1905(a) authority unless otherwise specified in State Plan language approved by CMS.[136]

PCSPs are also required to document and justify individually based limitations (IBLs). IBLs are used when an HCBS setting's qualities cannot be met due to a threat against the health and safety of the residents, providers, or others. Providers request an IBL by submitting form number CH-003 to OHA's IQA.[137, 138] IBLs are reviewed at least once every 12 months and must document the following criteria:

- Individual's assessed needs that justify use of the IBL.
- Interventions used to mitigate threatening behaviors or risks and the less intrusive methods used to mitigate those risks prior to request of the IBL.
- Clear descriptions of the requested limitation.
- Indications of how data will be regularly collected and reviewed to determine the ongoing effectiveness of the IBL.
- Established time frames to review the IBL to determine if it should expire or if it continues to remain necessary.
- Informed consent of the resident or their legal guardian on the IBL.
- Assurances that the IBL limitations will not cause harm to the resident.[139]

[136] National Archives. 42 CFR §441.725 Person-centered service plan. 2024.
[137] OAR. 410-173-0040 Individually Based Limitations. Eff. February 29, 2024.
[138] Comagine Health. Oregon Behavioral Health Support Program Form CH-003: IBL. June 2020.
[139] OAR. 410-173-0040 Individually Based Limitations.

In conversations and email correspondence with OHA staff and residential providers, both partners confirmed that IBLs are rarely sought due to a perception that residents can, at any time, revoke the IBL. Shared information with Myers and Stauffer suggests that providers are seeking IBLs in instances when a resident has a legal guardian or when the resident is perceived to be "stable enough" to consent to the IBL.

IBLs in Practice

"[IBLs] are not effective in practice…The IBL process relies on the resident giving staff written and ongoing permission to limit their visitors and search their room. Providers choose not to waste limited time and resources on this process."

— Residential provider

Discharge Practices

Discharge practices from mental health treatment settings are key elements in the continuum of care, ensuring individuals transition securely and efficiently to less restrictive settings or community living. In Oregon, involuntary discharges or transfers from RTFs, RTHs, and SRTFs are also referred to as "evictions" because of the confluence of HCBS settings regulations (see the **HCBS Settings Rule Implementation and Intersection of Oregon Tenancy Laws** section for more information).[140] As a note, voluntary discharges or movements by the PSRB or a court are not referred to as an "eviction."

OAR 309-035-0170 Standards for Residency Transfers and Discharges is the primary regulation governing discharge practices for RTFs, RTHs, or SRTFs. The OAR outlines the procedural requirements and guidelines for

[140] SRTF Clarification Meeting. May 5, 2026.

compliance in the transfer and discharge process. Depending on the reason for discharge or transfer, resident and facility responsibilities vary, but generally, 30 days notice is required when an involuntary discharge is taking place.[141] In cases of emergency, an early discharge or transfer may take place with less than 30 days notice, but a resident has the right to at least a 24-hour written notice in advance of the involuntary transfer or discharge.[142] If the PSRB or court orders the movement of an individual, 30 days notice is not required.

In cases of involuntary discharge, residents are afforded administrative hearing rights.[143] Residents may receive assistance in filing an administrative hearing request. The Oregon Residential Facility Ombudsman (RFO) may assist individuals in the filing process.[144] Residents have the right to continue to receive services in the setting during the administrative hearing process and until a decision is rendered.[145] Per rule, BHD-developed involuntary notice forms must be reviewed by BHD and the provider must withdraw the notice if BHD determines that the notice does not meet regulatory criteria.[146]

BHD staff report that this requirement was included in OAR to ensure providers were completing the forms accurately and in their entirety, though providers assert that the added BHD review time is adding to administrative burden and prevents timely discharges and transfers. As a result of collaboration with partners, OHA released a memo on May 15,

[141] This is not applicable if the PSRB or a court moves an individual from the setting.
[142] OAR. 309-035-0170 Standards for Residence Transfers and Discharges. Eff. June 1, 2026.
[143] Ibid.
[144] Connect with Myers and Stauffer. April 23, 2026.
[145] OAR. 309-035-0170 Standards for Residence Transfers and Discharges.
[146] Ibid.

2026, stating that "OHA will pause agency approval of involuntary notices for 6 months; OHA will monitor impacts and consider permanent rulemaking pending outcomes of the pause."[147]

OAR 309-035-0170 outlines 10 scenarios in which a transfer or discharge may occur, though the language in paragraph (6) does not explicitly indicate if these scenarios are specific to voluntary or involuntary transfers. These scenarios are:

- "The resident no longer needs or desires services provided by the program and expresses a desire to move to an alternative setting, unless the resident in placed with the provider by a supervisory entity, or with the consent of the resident's legal representative.
- The resident is assessed by a Licensed Medical Professional or other qualified health professional to require services such as continuous nursing care or extended hospitalization that are not available or cannot be reasonably arranged at the program.
- The resident's behavior is continuously and significantly disruptive or poses a threat to the health or safety of self or others, and these behavioral concerns cannot be adequately addressed with services available at the setting or with services that can be arranged outside of the program setting.
- The resident cannot safely evacuate the setting in accordance with the setting's occupancy classification after efforts described in OAR 309-035-0145(6)(b) have been taken.

[147] OHA. Update on Emergency Rules and Future Rulemaking. p. 3. May 15, 2026.

- Nonpayment of room and board fees in accordance with program's fee policy.
- The resident has moved from the setting or has been absent without notice for more than seven consecutive days and the provider has not been able to confirm the intent to continue or discontinue residency from the resident, the resident's legal representative or the resident's supervisory entity, if applicable. The transfer or discharge process must be voided if the resident returns to the program prior to the final date of residency indicated on the written notice.
- The resident has been incarcerated, and the provider has been notified by the supervisory entity that the resident will remain incarcerated for longer than 30 days. The transfer or discharge process must be voided if the resident returns to the program prior to the final date of residency indicated on the written notice.
- The IQA has determined services and supports from the program are no longer required.
- The resident's revocation has been ordered by the supervisory entity.
- The program has had its license revoked, not renewed, suspended, voluntarily surrendered, or has terminated its Medicaid contract."[148]

As noted in OAR, with the exception of emergency discharges transfers or crisis respite services, a predischarge meeting is required and will include the resident, the resident's legal representative or the supervising entity (if applicable), the CMHPs, and with the resident's permission, other parties

[148] OAR. 309-035-0170 Standards for Residence Transfers and Discharges.

interested in the resident's care. However, OAR does not specify which of any of the above 10 criteria qualifies as an emergency discharge and transfer. This lack of detail may create uncertainty on the part of providers, residents, and others involved in the care and placement of the individual.

Supporting the Direct Discharge of a Resident

RTFs, RTHs, and SRTFs are licensed as treatment facilities providing Medicaid-covered services and supports within the parameters of a facility. Though some residents may consider these settings as their "home," RTFs, RTHs, and SRTFs are not designed to be long-term housing supports for individuals who no longer require treatment services. Supporting this point is OAR 410-172-0720, which specifically states "Residential treatment is not intended to be used as a long-term substitute for lack of available supportive living environments in the community."[149]

The ability of providers to involuntary transfer or discharge an RTF, RTH, or SRTF resident is contingent on providing notices even if the resident is moving to a different facility owned by the same provider. Having another mechanism is necessary to ensure residents have a choice in where they live and to allow providers to discharge individuals who do not meet medical necessity or refuse treatment. Removing HCBS settings requirements from RTF and RTH operations will also remove barriers associated with discharge, which will serve to benefit both individuals and providers.

Once individuals do safely move from an RTF, RTH, and SRTF, it is imperative that supports are available to meet their needs in the community, such as case management, alternative housing arrangements like PSH or supported

[149] OAR. 410-172-0720 Prior Authorization and Re-Authorization for Residential Treatment. Eff. July 26, 2021.

living environments, and habilitative supports accessible in these alternative housing arrangements. Further detail of these areas include the following:

- As already discussed, case management is available in multiple forms throughout Oregon; however, there is no dedicated service (TCM) designed to support the needs of individuals with SMI. Without this service, individuals may have difficulty navigating available housing options outside of an RTF, RTH, or SRTF, and will have a lack of continuity between the treatment facility and their new setting.
- RTFs and RTHs are among a host of setting options available to individuals who may receive habilitative supports through the 1915(i), but there must be housing that can help to support individuals long-term in their communities of choice and in their recovery journeys. PSH and supported living environments are options to provide long-term housing to individuals discharging from a treatment facility, but there must be capacity available to support movement throughout the mental health service array.
- Supports to maintain an individual in a PSH, supported living environment, or another like-facility must be accessible to maintain an individual's independence in the community. Such supports include services like personal care, tenancy supports, and supported employment and education. These services are either funded by OHP today or could be funded by OHP in the future.

Licensing, Classification, and Staffing Requirements

BHD is responsible for licensing RTFs, RTHs, and SRTFs as treatment facilities.[150] To use seclusion or restraints, SRTFs are also required to apply for certification with BHD, per OAR 309-033-720.[151] Licensure standards are the same across all three facilities regardless of whether they provide habilitation, rehabilitation, or treatment services. Licensed capacity in each of the in-scope mental health residential settings is as follows:

- RTFs: 6 -16 residents.
- RTHs: Five or fewer residents.
- SRTF Class 1 and Class 2: 6 -16 residents.[152]

Figure 4 provides a visual representation of the number of mental health residential facilities statewide. Capacity is a reflection of licensed beds, not the number of available beds in each facility. A review of these figures suggests that most licensed residential settings are available along the I-5 corridor, which corresponds approximately to the highest population areas of Oregon.

[150] OAR. 309-035-0115 Licensing.
[151] OAR. 309-033-0720 Application, Training and Minimum Staffing Requirements. Eff. April 7, 2023.
[152] OAR. 309-035-0105 Definitions.

Facilities By the Numbers

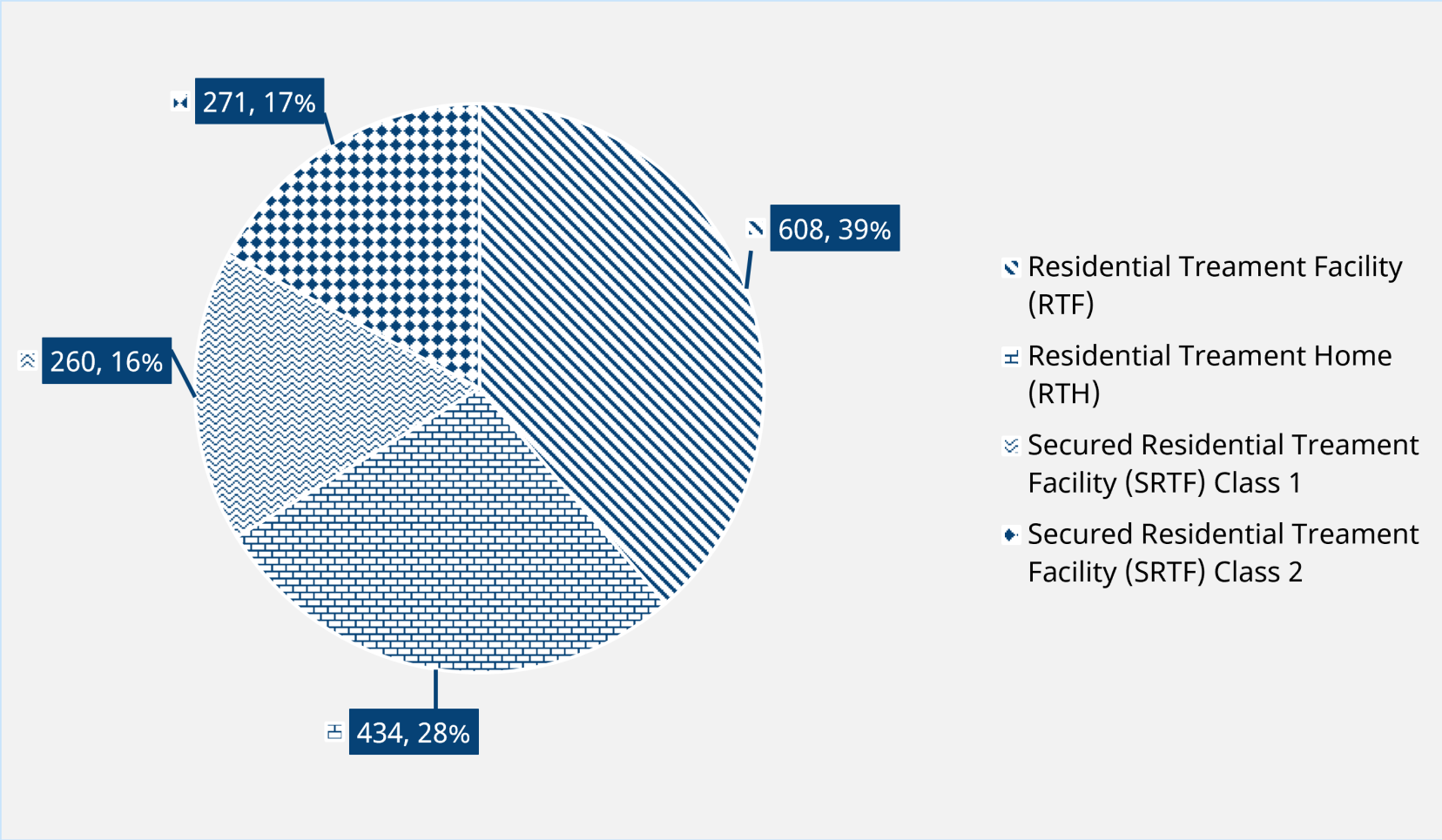
As of February 10, 2026, Multnomah, Lane, and Marion counties had the most mental health residential facility capacity across all licensure types (Multnomah, 462, Lane 205, and Marion 196).[+] According to Oregon Blue Book data accessed on March 2, 2026, the three counties with the highest population in 2024 were Multnomah (800,227), Washington (611,389) and Clackamas (426,567).[++]

Though Lane and Marion counties are not in the top three for population, these counties are either in the tristate area (Marion) or a county seat home to a university (Lane).

+ Q. HB 2015 Partner List. Samantha DuPont. Received by Jacquelyn George, February 24, 2026.

++Oregon Secretary of State. Oregon Blue Book. Accessed March 2, 2026.

Figure 4: Number and Percent of Licensed Capacity, In-Scope Residential Mental Health Facilities[153] [154]



[153] HB 2015 Partner List. Samantha DuPont, OHA. Received by J. George, February 24, 2026.
[154] SRTF Class 1 and 2 counts do not include OSH SRTFs.

BHD also classifies settings into Class 1, 2, or 3 facilities based on facility type and staffing requirements. SRTFs may be licensed as a Class 1 or Class 2 facility. Class distinctions are detailed in OAR 309-033-0520 and are summarized in Table 9.

Table 9: Summary of Oregon's Facility Classification

Class	Summary
Class 1	• Facilities that are approved to be locked to prevent egress from the building, use restraint and seclusion, and involuntarily administer medication. These settings may include a hospital, regional acute psychiatric care facility, or other nonhospital facility approved under OAR 309-033-0530. • State hospital or residential facility operated by a state hospital. • A facility that, in BHD's opinion, restricts an individual's liberty to the same degree as the facilities in this class.[155]
Class 2	• Facilities that are approved to be locked to prevent egress from the building. This includes SRTFs and other facilities that, in BHD's opinion, restrict an individual's liberty to the same degree as the facilities in this class.[156]
Class 3	• An approved residential facility that is not otherwise included in another class of facility. • Class 3 facilities are prohibited from locking doors to prevent egress.[157]

Current OHA Efforts to Fill Capacity of Newly Licensed Facilities

Unofficial 2025 data indicates that BHD received a total of 107 new mental health residential facility licensure applications and approved 42 of them to open (39%). This was a reported 129% increase in the number of approvals from 2024. Data sent by BHD to Myers and Stauffer suggests that there have

[155] OAR. 309-033-0520 Classes of Facility that Provide Care, Custody, or Treatment to Persons Under Civil Commitment or to Persons in Custody or on Diversion.
[156] Ibid.
[157] Ibid.

been a total of 62 licensure applications submitted to the Division, with 6 approvals, 9 denials, and 49 applications under review.[158] Data also suggests that the most common issues related to a mental health facility licensure application includes:

- Incomplete application forms and/or packets.
- Incomplete or nonspecific policies and procedures, including plans of operation.
- Lack of mental health experience.
- The setting does not meet the physical or structural requirements set forth in licensure rules.

Additionally, BHD has worked to streamline the mental health residential application process for prospective providers by:

- Creating an online application process.
- Modifying the application form to clearly identify all required documentation as part of submission.
- Modifying the application checklist form to ensure verification of all required information/documentation is received.
- Collaborating with the Behavioral Health Investments Team early in the grant approval process.
- Re-assigning BHD staff to assist with processing applications.
- Making weekly contact with applicants.

[158] MH LC Residential Applications 052226.xlsx (BHD internal document).

- Developing a procedures guide for prospective applicants on how to submit a mental health residential application.
- Returning incomplete application forms to applicant with a “welcome to reapply with complete form.”
- Requiring applicants to provide all required supporting documentation within 60 days or risk having their application voided.[159]

The Extended Care Management Unit (ECMU) within BHD currently works alongside other agencies to fill capacity of newly licensed facilities, though they are not involved in direct services, referrals to placements, or decisions on placement. For example, the ECMU works with CMHPs in 15 counties to identify placements and remove barriers to placement. CMHPs carry the responsibility of identifying placement providers for A&A, “EDPs,” and civil commitments; whereas OSH and OHA are responsible for identifying placement providers for individuals who are “GEI.”

Additionally, the ECMU coordinates with OSH to assist felony GEI individuals in identifying placements and providing technical assistance and support in confronting barriers to placement. Occasionally, the ECMU may provide consultation or technical assistance to CMHPs and OSH on complex or difficult to place cases in a population not described above. Once a provider receives a referral, they decide about admittance of a potential placement. Individuals who are admitted without an open bed may be placed on a provider’s waitlist. This occurs outside of the waitlist procedures enumerated in OAR 309-035-0158 . ECMU staff meet weekly with the OSH

[159] Ibid.

social work team and the PSRB to discuss topics such as new facilities or open beds in existing facilities to locate a placement for a potential resident. During these meetings, the group may exclude discussion of specific individuals who already have an admission date at a facility. In addition to this process, the ECMU may be consulted by CMHPs or other agencies about particularly challenging cases where an individual is transitioning from an SRTF to a lower level of care.

In addition to these efforts, Medicaid, in partnership with BHD, also hosts monthly office hours for CMHPs and residential providers that act as an open forum for questions regarding licensing and certification. Office hours was developed to proactively troubleshoot provider problems and concerns prior to issues being identified through a formal licensure review by BHD.

Staff Training and Education Requirements

RTF and RTH facility staffing requirements are enumerated in OAR 309-035-0135. Staffing requirements and levels for SRTFs are located throughout OAR Chapter 309, Divisions 32 and 33. Table 10 summarizes these requirements; additional staffing requirements are detailed in Appendix VII.

Table 10: Mental Health Residential Settings: Staffing Requirements

Setting	Facility Staff Training Requirements	Other Staff Requirements
RTF and RTH[160]	• Sixteen hours of preservice training. • Eight hours of annual in-service training. • Cardiopulmonary resuscitation (CPR) certification for direct care staff. • General worker safety training.	• Direct care staff are 18 years or older. • Preliminary background checks, and every three years thereafter. • Other requirements when contractually obligated.
SRTF Classes 1 and 2[161][162]	• Training and demonstrated competency in application of restraints and implementation of seclusion, including identifications of circumstances that may warrant their use. • Identification of medication side effects. • Indicators of medical problems and crisis.	• Adequate number of nurses, direct care staff, licensed independent practitioners (LIP) or physician assistants shall be available to provide emergency medical services, when required.

Nursing Requirements in SRTF Class 1 Settings

A reference in an OHA produced presentation indicates that Class 1 facilities must have an RN on site for medical assessments;[163] however, OAR 309-033-0520 Classes of Facilities that Provide Care, Custody, or Treatment to Persons under Civil Commitment or to Persons in Custody or on Diversion, does not specifically indicate that nursing staff must be on site 24/7 in Class 1 facilities. Two other references to nursing are found in Chapter 309,

[160] OAR. 309-035-0135 Staffing. Eff. June 1, 2026.
[161] OAR. 309-033-0720 Application, Training and Minimum Staffing Requirements.
[162] These SRTF Class 1 and 2 requirements are in addition to the general RTF requirements.
[163] OHA. Secure Residential Treatment Facilities Overview.

Division 33 rules that govern civil commitment proceedings.[164] Table 11 summarizes the nursing provisions required as part of civil commitment proceedings outlined in Division 33 rules. Critically, though these references to nursing are in rule, and BHD confirmed that the Division 33 rules are interpreted to apply to SRTFs, the rules in Division 33 fail to specifically indicate that these nursing requirements are applicable to SRTF Class 1 facilities.

Table 11: Chapter 309, Division 33 Nursing References

OAR 309-33-0720: Application, Training and Minimum Staffing Requirements	OAR 309-33-0725: Medical Services
(3)(a) "An adequate number of nurses….shall be available at the hospital[165] or facility, to provide emergency medical services which may be required."	(2) "At least one registered nurse must be on duty at all times."[166]
(3)(a) "For nonhospital facilities[167]a written agreement with a local hospital, to provide such medical services may fulfill this requirement."[168]	-

[164] OAR. 309-033-0520 Classes of Facilities that Provide Care, Custody, or Treatment to Persons under Civil Commitment or to Persons in Custody or on Diversion. Eff. April 7, 2023.
[165] "Hospital" or "Hospital facility" is defined as "the community hospital, or regional acute care psychiatric facility certified for the use of seclusion or restraints to committed persons and persons in custody or on diversion." OAR. 309-033-0210 Definitions. Eff. January 1, 2026.
[166] OAR. 309-033-0725 Medical Services. Eff. May 28, 2024.
[167] "Non-hospital facility" is defined as "any facility, other than a hospital, that is certified by the Authority to provide adequate security, psychiatric, nursing, and other services to persons under ORS 426.232 or 426.233." OAR. 309-033-0210 Definitions.
[168] OAR. 309-033-0720 Application, Training and Minimum Staffing Requirements.

OAR 309-33-0720: Application, Training and Minimum Staffing Requirements	OAR 309-33-0725: Medical Services
(3)(a) "When such an agreement is not possible, a written agreement with a local physician to provide such medical services may fulfill this requirement."[169]	-

In conversation with OHA, BHD staff confirmed that OAR 309-33-0725 language governs the requirement mandating SRTF Class 1 facilities to have a nurse on site 24/7, and that this requirement is specifically for an RN to authorize the need for restraint or seclusion against a resident.[170] A nurse is defined in OAR 309-033-0210 Definitions as a "registered nurse, or a psychiatric nurse practitioner, licensed by the Oregon State Board of Nursing but does not include a licensed practical nurse or a certified nurse assistant."[171]

A review of ORS Chapter 426 Mental Health and Developmental Disabilities; Substance Use Disorder Treatment found that there is no explicit mention of who may authorize restraints or seclusion for individuals over the age of 21 in statute, which allows for OHA to do so through rulemaking. The only difference between statute and OAR is that ORS 426.072 suggests that the treating licensed independent practitioner (LIP) be immediately notified of any use of restraints or seclusion against the individual.[172] LIPs are defined

[169] Ibid.
[170] OAR 309-033-0730 (Eff. April 7, 2023) Seclusion and restraint procedures allows for licensed independent practitioner and physician assistants, in addition to RNs to initiate restraints and seclusion. Further, the rule specifies that only a LIP, physician assistant or RN shall monitor and supervise each use of seclusion or restraint.
[171] OAR. 309-033-0210 Definitions. Eff. January 1, 2026.
[172] ORS. 426.072 Care while in custody; responsibilities of licensed independent practitioner; rules. 2025 Edition.

in ORS 426.005 as a physician, nurse practitioner that is authorized to write prescriptions, or a naturopathic physician.[173]

BHD staff also suggested that the Division 33 rules have not been implemented to specifically apply to only civil commitment proceedings.[174] This statement is supported by the fact that no rule within Division 33 addresses any of the following topics:

- The facilities for which Chapter 309, Division 33 rules apply.
- That the availability of 24/7 on-site nursing is only required in SRTF Class 1 facilities.
- That the availability of 24/7 on-site nursing is not required in other facilities accepting civil commitment placements.

Furthermore, the language in OAR 309-33-0720 which states "For nonhospital facilities[175]a written agreement with a local hospital, to provide such medical services may fulfill this requirement" suggests that all SRTFs, regardless of classification, may have a written agreement in place rather than requiring a nurse be onsite for a dedicated period of time.

Appeals and Hearing Rights Processes

As enumerated in Subpart E of 42 CFR Part 431, fair hearings are a federal requirement for Medicaid beneficiaries and applicants:

- "At the time that the individual applies for Medicaid;

[173] ORS. 426.005 Definitions for ORS 426.005 to 426.390. 2025 Edition.
[174] OR HB 2015 Partner Work Group meeting. April 29, 2025.
[175] "Non-hospital facility" is defined as "any facility, other than a hospital, that is certified by the Authority to provide adequate security, psychiatric, nursing, and other services to persons under ORS 426.232 or 426.233." OAR. 309-033-0210 Definitions.

- At the time the agency denies an individual's claim for eligibility, benefits or services; or denies a request for exemption from mandatory enrollment in an Alternative Benefit Plan; or takes other action, as defined at § 431.201; or whenever a hearing is otherwise required in accordance with § 431.220(a);
- At the time a skilled nursing facility or a nursing facility notifies a resident in accordance with § 483.15 of this chapter that he or she is to be transferred or discharged; and
- At the time an individual receives an adverse determination by Oregon with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act."[176]

Additionally, 42 CFR § 431.220 outlines when an individual is required to be granted a hearing. One of the reasons why the Medicaid agency must issue hearing rights is when the individual believes an error was made by the Medicaid agency or an entity working on their behalf (like a CCO) in determining eligibility for covered benefits and services, or when there is a change in the amount or type of benefits or services an individual is offered.[177]

Oregon's hearing and appeals framework is primarily governed by ORS Chapter 183 that establishes due process requirements for administrative actions, including contested case hearings, notice requirements, and judicial review.[178] Additional protections, procedures, and limitations are outlined OARs, primarily found in Chapter 410, that govern civil commitment,

[176] 42 CFR § 431.206 Informing applicants and beneficiaries. November 30, 2016.
[177] 42 CFR § 431.220 When a hearing is required. April 8, 2024.
[178] ORS. Chapter 183 - Administrative Procedures Act; Review of Rules; Civil Penalties.

provider licensing, discharge and transfer processes, grievances, and enforcement actions within behavioral health settings.

All Medicaid administrative hearings are the responsibility of the OAH, in accordance with statutory mandates for each agency. ORS 183.635 Agencies required to use administrative law judges from Office of Administrative Hearings; exceptions, requires state agencies to "conduct contested case hearings, without regard to whether those hearings are subject to the procedural requirement for contested case hearings." OHA is exempted from using an administrative law judge from OAH when the contested case hearing involves informed consent at OSH.[179] Some HB 2015 workgroup members suggested that administrative hearing timeframes are delaying involuntary discharges, and that these issues are compounding challenges related to the prioritization rule and waitlist management. These factors contribute to a provider's inability to care for individuals who need placement in a RTF, RTH, or SRTF.[180]

Reimbursement Methods

As of the date of this report, Medicaid reimbursement for RTFs, RTHs, and SRTFs is a combination of fixed fee rates that use tier and geographic adjustors to modify payments to facilities to account for acuity and differences in Oregon's demographic and population centers. Fee schedules are detailed in Appendix VIII. Importantly, the publicly available fee schedules indicate that, with the exception of the Psychosocial Rehabilitation

[179] ORS 183.635 Agencies required to use administrative law judges from Office of Administrative Hearings; exceptions. (2025). Accessed 2 September, 2026.
[180] HB 2015 Work Group Meeting. April 27, 2026.; OCBH. "HB 2015-line item HCBS review: Recommendation for Policy and Regulatory Revisions regarding HCBS in Provider-Owned or Controlled Residential Settings." August 28, 2025. Sent to J. George.

rates included in Appendix VIII, payment is for RTFs, RTHs, and SRTF Class 1 and 2 facilities. BHD further clarified that these RTF and RTH rates are paid to providers regardless of the Medicaid authority in which a recipient receives OHP benefits.[181] As RTFs, RTHs, and SRTFs are themselves not services, it remains unclear what service (again except for Psychosocial Rehabilitation) must be delivered to receive the rates noted in Appendix VIII.

Acuity tiers are currently[182] based on scores from the LSI assessment,[183] which is also used to determine mental health facility decisions. OAR 410-172-0705 Residential Rate Standardization describes the acuity tiers used for the reimbursement level a facility receives based on an individual's LSI score. In the instance of "cross-placement" where an individual who qualifies for services through ODHS is placed in a RTF or RTH, ODHS and BHD would discuss to determine the appropriate rate tier for the individual.[184] Acuity and tier definitions are summarized in Table 12.

In addition to acuity and geographic factors, mental health residential facility reimbursement is also based on licensed facility capacity; smaller facilities (RTHs) are paid more per day than RTFs and SRTFs.[185] When reimbursed by Medicaid, the mental health residential facilities are reimbursed only on an FFS basis, and not through Oregon's CCOs.[186] Appendix IX highlights the tiers within the reimbursement methodologies

[181] OHA. HB 2015 - Verification Questions. Sent by J. George.
[182] As of March 14, 2026.
[183] Per the OHA LSI User Manual, the purpose of the LSI is "to assess the type and level of Medicaid funded services an individual needs in order to reside in the community-based setting most appropriate to their level of recovery." OHA LSI for Residential Treatment User Manual. p. 3.
[184] Key Informant Interview. ODHS. APD Staff.
[185] OHA. Behavioral Health Fee Schedule February 2026. February 2026. Adult MH Res Standardized Rate tab.
[186] OHA. Behavioral Health Fee Schedule February 2026.

for RTFs, RTHs, and SRTFs. Tier one in each of the fee schedules represents a bed hold day rather than a specific LSI-informed acuity. Tiers 2-5 of the RTF and RTH fee schedules align with the "residential form composite score" that is generated from the LSI assessment.[187]

Of important note, Medicaid is only a funding source for SRTFs when an individual residing in the facility is enrolled on OHP and meets medical necessity as documented on the IQA CH 006 Form.[188, 189] General revenue is used to reimburse SRTFs for the care of residents who do not meet medical necessity and/or are not enrolled on OHP.[190] However, when available, other funding sources such as Medicare, third party insurance, personal resources, or other programs, must be used first prior to Medicaid or general revenue funds to cover mental health residential facilities stays.

Table 12: Mental Health Acuity Residential Tiers, Definitions, and LSI Scores

Acuity Tier	Acuity Tier Definition	RTF/RTH	SRTF
-	-	LSI score range	LSI score range
Tier One	Either an empty bed or an individual whose acuity assessment significantly improves to no longer require the level of support provided in a residential setting, but the individual has chosen to remain in the residential setting.	N/A	N/A
Tier Two	Average of three or more hours of daily active engagement.	0-40	0-40

[187] OAR. 410-172-0705. Residential Rate Standardization.
[188] OHA. Reviews for Medical Necessity and Medical Appropriateness of Secure Residential Treatment Facility (SRTF) Placements. p. 2. March 1, 2024.
[189] Comagine Health. CH-006: PA-BH-Res-PCS. August 2020.
[190] OHA. Reviews for Medical Necessity and Medical Appropriateness of Secure Residential Treatment Facility (SRTF) Placements.

Acuity Tier	Acuity Tier Definition	RTF/RTH	SRTF
-	-	LSI score range	LSI score range
Tier Three	Average of five or more hours of daily active engagement.	41-60	41-60
Tier Four	Average of six or more hours of daily active engagement.	61-79	61+
Tier Five	Average of seven or more hours of daily active engagement.	80+	N/A[191]

As part of implementing a new LON assessment for 1915(i) determinations, OHA is moving toward different scale ranges and tier thresholds for RTFs and RTHs in addition to the SRTFs. The tiers will align with scales generated from the new assessment, the interRAI CMH, and have been verified by OHA to match those that were generated by the LSI. In addition to new tier thresholds for RTFs, RTHs, and SRTFs, OHA is also moving toward standardization of these thresholds with those for the mental health AFH setting. OHA is undertaking this effort to assist in seamless movement between the higher levels of care provided in RTFs, RTHs, and SRTFs and the lower levels of care provided in mental health AFHs. The new threshold ranges are noted in Appendix IX: interRAI CMH Mental Health Residential Facility Tier Thresholds.

HCBS Settings Rule Implementation and Intersection of Oregon Tenancy Laws

A detailed review of OHA's HCBS settings rules is critical to understanding how mental health residential settings are ensuring compliance with federal regulations, specifically related to resident rights and provider and staff safety. This is especially important given the level of partner feedback received (further explored in the **Partner Engagement** section of this

[191] OAR 410-172-0705 Residential Rate Standardization.

report) regarding the misalignment between the purpose of the mental health residential facilities and HCBS settings rules.

OAR 410-173-0035 and 411-004-0020 outline HCBS settings requirements for 1915(i) and 1915(k) authority services, respectively.[192, 193] OAR 410-173-0035 is an OHA administrative rule whereas 411-004-0020 is an administrative rule under an OAR chapter overseen by ODHS, Aging and People with Disabilities (APD) and the Office of Developmental Disability Services. Both sets of rules align with the federal HCBS settings requirements for 1915(i) and 1915(k) State Plan authorities, as outlined in 42 CFR 441.710 and 42 CFR 441.530. The following bullet points summarize the federal requirements in respective CFRs, which are adapted in OAR for the HCBS 1915(i) and 1915(k) State Plan options.

- Setting is integrated in and supports full access to the greater community, including opportunities to seek employment, work in integrated settings, engage in community life, control personal resources, and receive community resources.
- Optimizes but does not regiment individual initiative, autonomy, and independence.
- Ensures an individual's rights of privacy, dignity, and respect and freedom from coercion and restraint.
- Facilitates individual choice regarding services and supports and who provides them.

[192] OAR. 410-173-0035 Home and Community Based Services and Setting Qualities. February 29, 2024.
[193] OAR. 411-004-0020 Home and Community-Based Services and Settings. July 1, 2017.

- In a provider-owned or controlled setting, a unit or dwelling that is owned, rented, or occupied is under a legally enforceable agreement with the individual receiving services.
- For settings in which landlord-tenant laws do not apply, the State must ensure a lease or residency agreement is in place for each individual receiving HCBS. The document must provide protections that address eviction processes and appeals.[194]
- Modifications of additional requirements for provider-owned or controlled settings must be supported by a specific assessed need and justified in the PCSP.[195, 196]

In response to clarification questions posed to OHA by Myers and Stauffer regarding guidance issued to the public and providers on HCBS rules, OHA confirmed that all information available to the public on OHA's expectations for HCBS settings compliance is found on the OHA HCBS dedicated website[197] and in BHD licensing regulations.[198, 199] The provided references do not make overt references to HCBS settings guidance, rather the information contained on each respective website points to ODHS resources, OARs, and guidance specific to reimbursement and billing.

[194] OARs do not require that a signed lease, residency agreement, or written agreement is in place for individuals who are placed in the setting by a supervisory entity.
[195] CMS. 42 CFR § 441.710 — State Plan Home and Community-Based Services Under Section 1915(i)(1) of the Act.
[196] CMS. 42 CFR § 441.530 Home and Community-Based Setting.
[197] OHA. Home and Community-Based Services (HCBS).
[198] Ibid.
[199] OHA. HB 2015 - Verification Questions. Sent by J. George. March 23, 2026.

Myers and Stauffer confirmed that ORS 90.113 excludes RTFs and RTHs from governance under ORS Chapter 90 - Residential Landlord and Tenant by reference.[200]

[200] ORS 90.113 Additional exclusions from application of chapter. 2025 Edition.

Peer State Examples

Seven peer states were reviewed to provide national comparison points for how other states operationalize their mental health residential settings. This section of the report provides a comparative analysis of the peer state findings of residential behavioral health and Medicaid systems but does not constitute a comparison of insanity-acquittee or comparable forensic systems. Details on each peer state are further specified in Appendix XI.

Methodology for Choosing Peer States

Below is a list of factors that were considered when selecting national examples:

- Use of different Medicaid authorities outside of 1905(a), 1915(i), and 1915(k) to provide coverage for mental health RTFs.
- Different approaches to reimbursing mental health residential treatment than the models and methodology used by OHA.
- Availability of alternative models for providing services to individuals under court-ordered treatment.
- Publicly available information on treatment outcomes.
- Population and percentage of population on Medicaid programs.
- Similarities in demographic and geographic traits to Oregon.
- Federally recognized Native American tribes within state boundaries.
- Culturally divergent populations.

Following a review of the above factors, Arizona, Colorado, Massachusetts, Minnesota, New Mexico, Vermont, and Washington were selected as the foundational peer states from which to draw and potentially leverage experience. Table 13 provides a summary view of each selected state's basic demographic profile, inclusive of total population, percent of the population served by their Medicaid programs, the number of federally recognized Native American tribes within state boundaries, and the number of Medicaid authorities used to cover mental health residential services.

Table 13: Peer State Demographic Summary

State	Total State Population	Percent of Population Served by Medicaid	Number of Federally Recognized Native American Tribes	Number of Authorities Used to Cover Mental Health Residential Services
Oregon	4,200,000	34%	9	Three
Arizona	7,582,384	26.6%	22[201]	One
Colorado	5,957,493	19.5%	2[202]	Two
Massachusetts	7,136,171	23.5%	2[202]	One
Minnesota	5,793,151	20.3%	11[203]	One
New Mexico	2,130,256	36.1%	23[204]	One
Vermont	648,493	24.8%	0	Two
Washington	7,958,180[205]	23.2%[206]	28[202]	One

[201] Arizona Department of Education. Office of Indian Education: Tribal Nations.
[202] National Conference of State Legislators. Map Monday: Tribal Presence in the States. Updated November 2023.
[203] Minnesota Secretary of State. Tribal Government .
[204] New Mexico Secretary of State. Native American Election Information Program.
[205] United States Census Bureau. Population Estimates by Age (18+): July 1, 2024.
[206] CMS. Medicaid and CHIP Scorecard 2024.

HB 2015 Study Factors: Review and Comparison of Peer State

Each peer state selected for this study has at least one mental health residential setting that is comparable in some aspect to Oregon's RTFs, RTHs, and SRTFs. The following list provides a short description of each state's mental health residential settings used for this comparative analysis.

- **Arizona:** Behavioral Health Residential Facilities (BHRFs). BHRFs provide 24/7 care, inclusive of SUD treatment, to individuals with a behavioral health condition and meet at least one serious functional impairment.[207]
- **Colorado:** Mental Health Transitional Living (MHTL) Home Level 1 and Level 2. MHTL is defined as "A community-based residential agency providing residential support to individuals who require ongoing support with daily living due to their behavioral health diagnosis but whose needs do not rise to the level of hospitalization."[208]
    - MHTL Level 1: provide clinically ***monitored*** [emphasis added] services…
    - MHTL Level 2: provide clinically ***managed*** [emphasis added] services…[209]
- **Massachusetts:** Adult Community Crisis Stabilization (CCS) services.[210] Adult CCS is defined as "a sub-acute community based mental health service for adults with mental illness, SUD or comorbid mental illness

[207] AHCCCS. AHCCCS Medical Policy Manual, 320-V – Behavioral Health Residential Facilities. p. 3.
[208] 2 CCR 502-1 Behavioral Health. p. 14.
[209] 2 CCR 502-1 Behavioral Health.
[210] CBHCs are covered by MassHealth and certain private insurance plans and are committed to providing treatment to individuals regardless of an individual's health coverage status. Mass.gov. Community Behavioral Health Centers.

and SUDs who are in need of staff-secure, safe, and structured crisis stabilization and treatment services that serves as a medically necessary, less restrictive, and voluntary alternative to inpatient psychiatric hospitalization."[211]

- **Minnesota:** Intensive Residential Treatment Services (IRTS). IRTS are medically monitored, 24-hour staffed, community-based programs for adults with a diagnosed mental illness who experience functional impairment.[212]
- **New Mexico:** Adult accredited residential treatment center (AARTC) for mental health.[213] AARTCs are structured to support residential or inpatient treatment for individuals with SMI based on three tiers structured around the LOCUS.[214]
- **Vermont:** Intensive Residential Recovery (IRR). IRR is designed as a "short-term" 24/7 residence for adults who require more intense services prior to moving to a community placement.[215]
- **Washington:** RTFs and Intensive Behavioral Health Treatment Facilities (IBHTFs).
    - **RTFs:** A facility in which 24-hour on-site care is provided for the evaluation, stabilization, or treatment of residents for substance

[211] 104 CMR 28.00: Licensing and Operational Standards for Community Services. September 20, 2022. p. 2.
[212] Minnesota Statute. 245I.23 Intensive Residential Treatment Services and Residential Crisis Stabilization. 2025.
[213] New Mexico Administrative Code (NMAC). 8.321.2.11 Adult Accredited Residential Treatment Center (AARTC) for Adults with Serious Mental Health Conditions. December 10, 2024.
[214] New Mexico HCA. New Mexico Health Care Authority Medicaid Behavioral Health Policy and Billing Manual. p. 14. April 1, 2025.
[215] Vermont DMH. Intensive Residential Recovery.

use, mental health, co-occurring disorders, or for drug exposed infants.[216]

- **IBHTFs:** A specialized type of RTF designed for individuals who no longer require care in state hospitals but are voluntarily seeking continued treatment and support to aid their reintegration into the community.[217]

Table 14 summarizes HB 2015 study areas and these components across the selected peer states. Subsequent to the table, specific examples from peer states are used to illustrate how OHA may be able to modify practices to ease administrative burden, improve services to individuals with varying acuity levels, and leverage different Medicaid authorities to offer services within and outside of federal HCBS rules.

[216] WAC. WAC 246-337-005(27) Definitions.
[217] Washington HCA. Intensive behavioral health treatment facilities.

Table 14: HB 2015 Study Factors: Peer State Comparisons

State	Medicaid Authority	Admission Practices	Discharge Practices	On-Site Nursing Requirements	Reimbursement Structure
Arizona	• 1115 • 1905(a)	• Treatment plans developed within 48 hours of admission. • Cannot admit an individual to ensure community safety, provide safe housing and shelter, act as a permanent placement, an alternative to detention or incarceration, or to prevent elopement and wandering.	The Arizona Health Care Cost Containment System (AHCCCS) allows BHRFs to develop continued stays and discharge plan policies, but they must adhere to certain criteria established by AHCCCS and be submitted for approval.	RN must be present or on call.	• FFS • Capitation[218]
Colorado	-	-	-	-	-

[218] AHCCCS. AHCCCS Medical Policy Manual, 320-V – Behavioral Health Residential Facilities. p. 5; AHCCCS. AHCCCS Medical Policy Manual, 320-V – Behavioral Health Residential Facilities. pp. 6-7; AAC. R9-10-706 Personnel. (K)(5); AHCCCS. Behavioral Health Outpatient Fee FFS Fee Schedule Effective January 1, 2026; AHCCCS. Behavioral Health FFS Rates and Codes, Behavioral Health Outpatient Fee MCO Fee Schedule Effective January 1, 2026.

State	Medicaid Authority	Admission Practices	Discharge Practices	On-Site Nursing Requirements	Reimbursement Structure
MHTL Level 1	1915(c)	• Provider agency must ensure an individual's needs can be met (directly or through coordination) prior to admission. This must be based on a preadmission assessment. • Admission is not granted to individuals needing 24-hour medical or nursing care or who have acute physical illnesses that are not managed through medication or therapy.	• Prior to discharge because of increased care needs, agency will document how efforts were made to meet an individual's needs through alternative means. • Agencies will coordinate voluntary or involuntary discharge with the individual, all legal representatives, and the medical or behavioral health providers who will be responsible for services per the discharge plan. • Transferring to other healthcare facilities for additional care requires the MHTL provider to	None specifically outlined. Homes must have appropriate staffing levels to meet the individual acuity, needs, and assistance of residents.	FFS[219]

[219] HCPF. Informational Memo Differences between Mental Health Transitional Living Home Level 1 & 2. p. 2; 2 CCR 502-1 Behavioral Health. pp. 123-124; 2 CCR 502-1 Behavioral Health. p. 127; HCPF. Home and Community Based Services: Community Mental Health Supports (CMHS) Waiver. p. 10.

State	Medicaid Authority	Admission Practices	Discharge Practices	On-Site Nursing Requirements	Reimbursement Structure
		• Transfers are arranged if care cannot be provided to individuals needing this LOC or who develop a need for 24- hour medical or nursing care.	evaluate the individual prior to readmission or will discharge accordingly. • When an individual is discharged, it is the MHTL agency's responsibility to develop a discharge plan and coordinate the transition to a different LOC. Care coordination efforts must be documented in the individual's record.		
MHTL Level 2	1915(b)(3) waiver	Same as MHTL Level 1	Same as MHTL Level 1	Providers must ensure availability through telehealth or on-site consultation of an authorized practitioner or nurse 24/7.	Capitation[220]

[220] HCPF. Section 1915(b) Waiver. p. 28. March 4, 2026; 2 CCR 502-1 Behavioral Health. pp. 123-124 and 127; HCPF. State Behavioral Health Services Billing Manual. pp. 62 and 135. January 2026.

State	Medicaid Authority	Admission Practices	Discharge Practices	On-Site Nursing Requirements	Reimbursement Structure
Massachusetts	1905(a)	Within 24 hours of admission, Adult CCS must screen a newly admitted individual for risks associated with suicide and substance use/misuse using a standardized screening tool. Admission procedures also include reviewing the individual's medical and behavioral health history for trauma, physical or sexual abuse, and violence to develop an individualized treatment plan and begin to plan for discharge and aftercare services.	• Prohibited from discharging to a shelter or the street. • Discharge plans must include a summary of the course of treatment, prescribed medications at discharge, and recommended aftercare services.	Each Adult CCS must have at least one RN manager responsible for supervising all nursing staff employed by the Adult CCS. Staffing pattern must include sufficient nursing staff 24/7, including a licensed practical nurse (LPN) available for second and third shifts on weekdays and during all weekend shifts. At least one master's level clinician must	• FFS • Capitation[221]

[221] 104 CMR 28.00: Licensing and Operational Standards for Community Services. p. 23; Commonwealth of Massachusetts MassHealth. Provider Manual Series. Community Behavioral Health Center Manual. p. 21. January 1, 2023; 104 CMR 28.00: Licensing and Operational Standards for Community Services. pp. 23-24.

State	Medicaid Authority	Admission Practices	Discharge Practices	On-Site Nursing Requirements	Reimbursement Structure
				be on site at least one shift per day.	
Minnesota	1905(a)	Individuals must be 18 or older and meet established clinical criteria.	Three types of discharges: success, nonprogram initiated, and program initiated.	Program sites must have an RN on staff who qualifies as a behavioral health practitioner. They must work at the program location at least eight hours per week.	Daily rate per provider[222]
New Mexico	1905(a)	Admitted based on LOCUS criteria for the LOC placement. See Appendix X for more information.	Driven by resolution of the primary mental health concern, as informed by the LOCUS.	RNs or a licensed physician's assistant to administer medication-assisted treatment (MAT) for SUD.	Provider tier-based rates[223]

[222] Minnesota State Plan. Attachment 3.1-A, 13.d. Rehabilitative services. pp. 461-464. Approved September 15, 2022; Minnesota Statute. 245I.23 Intensive Residential Treatment Services and Residential Crisis Stabilization; Minnesota Department of Human Services. Provider Manual: Intensive Residential Treatment Services (IRTS).

[223] New Mexico HCA. New Mexico Health Care Authority Medicaid Behavioral Health Policy and Billing Manual. pp. 13-16 and 17; NMAC. 8.321.2.28. Medication Assisted Treatment (MAT): Buprenorphine Treatment for Opioid Use Disorder. December 10, 2024; New Mexico HCA. New Mexico Health Care Authority Medicaid Behavioral Health Policy and Billing Manual.

State	Medicaid Authority	Admission Practices	Discharge Practices	On-Site Nursing Requirements	Reimbursement Structure
Vermont	Concurrent 1905(a) and 1115 waiver authorities	Admitted if all five admission criteria are met. See Appendix X for more information.	Dependent on whether an individual is discharging from the state or a private IRR.	State run IRR requires nursing staff; no information on on-site requirements was available.	Capitation[224]
Washington	-	-	-	-	-
RTFs	1905(a)	Admission restricted to individuals 18 or older whose primary care need is the treatment of a mental health disorder and meets medical necessity.	Discharge summary must be developed and include a continuing care recommendation and scheduled follow-up appointments.	RN or LPN must be on site during medication administration or during the use of restraints/ seclusion; must otherwise be available by phone 24/7.	• FFS • Capitation[225]
IBHTFs	1905(a)	Limited to individuals 18 or older whose primary care need is	Phased approach, inclusive of MCO collaboration, discharge planning at least	At least one RN on site and awake, 24/7.	• FFS

[224] Vermont Medicaid State Plan. 3.1-A. Page 6e, p. 52. Eff. July 1, 2025; Global Commitment to Health Section 1115 Demonstration. p. 46. Eff. September 24, 2025; Vermont.gov. IRR Treatment Medical Necessity Criteria Initial Prior Authorization Eligibility Criteria. March 2026; Vermont.gov. River Valley Therapeutic Residence Policy and Procedure – Admission, Intake and Discharge. July 2025; Vermont DMH. "River Valley Therapeutic Residence Policy – Nursing." Eff. July 1, 2025; Vermont.gov. Intensive Residential Recovery.
[225] Washington HCA. Washington State Plan Attachment 3.1-B Page 42; Washington Administrative Code (WAC) 246-337-080 Resident Care Services. Eff. January 1, 2019; Washington HCA. Mental Health Services Billing Guide.

State	Medicaid Authority	Admission Practices	Discharge Practices	On-Site Nursing Requirements	Reimbursement Structure
		the treatment of a mental health disorder, meets medical necessity, and who can perform daily living activities independently.	six months prior to an anticipated date of discharge, and reinforcement of acquired competencies.		• Capitation [226]

[226] Washington HCA. Intensive Behavioral Health Treatment Facilities: A toolkit for implementing WAC 246-341-1137. p. 10. January 2025; Washington State Legislature. WAC 246-341-1137 Intensive behavioral health treatment services—Certification standards; Washington HCA. Intensive Behavioral Health Treatment Services A toolkit for implementing WAC 246-341-1137; Medicaid.gov. Washington State Plan Amendment (SPA) 24-0025. (Eff. July 1, 2024).

Key Analysis Points

Myers and Stauffer's review of peer state programs suggests that at least the states analyzed for this study are using a variety of Medicaid authorities and reimbursement methodologies to operationalize their mental health residential settings. Additionally, there are some key takeaways related to discharge practices and application of safety standards for non-HCBS settings. Full peer state findings are integrated throughout the **Findings Analysis** section of this report; however, a few important points related to the HB 2015 study are noted below:

- Peer states are primarily using the 1905(a) authority to cover mental health residential treatment settings, though Arizona, Vermont, and Colorado are using a combination of concurrent 1905(a) and 1115 waiver and 1915(c) authorities, respectively, to cover settings included in this analysis.
- No peer state reviewed appears to have prioritization criteria for admission to a facility.[227]
- Colorado's use of the 1915(c) authority differs from Oregon's use of the HCBS 1915(i) and 1915(k) State Plan options in that MHTL Level 1 homes are specifically not designed as RTHs.

[227] *Trueblood et al. v. Washington State DSHS* was a lawsuit brought in 2014 to compel the state to provide timely competency evaluation and restoration services to class members. Timely competency evaluations and restoration was called into question partially as a result of insufficient funding for beds and personnel. In a filing in 2015, the court entered into a permanent injunction requiring the provision of competency restoration services within seven days (*Trueblood et al. v. Washington State DSHS, pgs. 1-3*). Washington reached a 2018 contempt settlement with the court to provide and expand services to people in the criminal court system and ensure timely evaluations and restoration services for class members.

- Reimbursement methodologies reflect states' use of managed care and are not analogous with the Medicaid authority used to cover mental health residential treatment.
- Minnesota has a three-pronged discharge model in which specific criteria are used to determine when an individual should be discharged from their IRTS settings. This differs from the criteria indicated in OAR in that emergency discharge criteria are not specifically enumerated or differentiated between the non-emergency transfer or discharge criteria that are listed in OAR 309-035-0170(6)(a)-(j).[228]

MHTL Level One Homes: A Habilitative 1915(c) Service

"The purpose of the supportive intervention services [provided in a MHTL Level One home] is to teach [individuals] how to live independently beyond the walls of residential care."+

— Residential provider

+ *HCPF. Home and Community Based Services: Community Mental Health Supports (CMHS) Waiver. Pg. 82.*

- Peer state mental health residential settings ensured resident rights, inclusive of, but not limited to, unlawful discrimination, the right to refuse treatment, association with individuals of the resident's choice, privacy in communications, and visitation rights.[229]
- Vermont's IRR settings disallow a resident to retain personal property if it is deemed dangerous and disruptive to safety and treatment;

[228] OAR 309-035-0170 does indicate processes for when notices of involuntary transfer or discharge can occur, but does not specify criteria to be evaluated to make this determination.
[229] 9 A.A.C. 10. R9-10-311 Patient Rights. p. 74. March 31, 2026; Vermont.gov. RVTR Resident Rights. July 2025; 104 CMR 28.00: Licensing and Operational Standards for Community Services. p. 4.

moreover, the State-operated IRR maintains a “restricted items policy,” that is different than how RTFs, RTHs, and SRTFs[230] operate in Oregon.[231]

[230] ORS 309-035-0115. This does not include SRTFs that operate on the OSH campus, which have restrictions based on variance.
[231] Vermont.gov. RVTR Restricted Items and Search. April 25, 2023.

Partner Engagement

To provide a comprehensive assessment of the mental health residential services offered by OHP, Myers and Stauffer interviewed key state partners. Feedback from these partners was integral to align services with community needs, identify barriers, and develop solutions to address community concerns.

This section is representative of partner perspectives only. The content herein serves to demonstrate the significant complexity and various interpretations of how the mental health residential system is operationalized in Oregon, which in and of itself is representative of the lack of clarity and amount of confusion that exists with mental health residential settings and services funded by OHA.

Methodology for Partner Engagement

Myers and Stauffer used a multipronged strategy for provider engagement inclusive of work groups, key informant interviews, and group conversations with providers and RFO staff. Details concerning the approach are discussed in the following subsections.

HB 2015 Partner Work Groups

The Partner Work Groups were established to support the implementation of the Oregon HB 2015 and assist OHA in evaluating Oregon's adult behavioral health residential system. The work group's primary objective was to identify opportunities to strengthen residential treatment services through review of existing regulatory structures, licensing frameworks, reimbursement approaches, and overall system capacity for both secure and nonsecure residential settings.

The work group focused on identifying opportunities to improve access to residential behavioral health services, improving health outcomes, strengthen recovery-oriented care, and enhancing the long-term sustainability of Oregon's residential treatment system. Key areas of discussion included care coordination and discharge planning, workforce and provider capacity, administrative and licensure requirements, and alignment between residential treatment and community-based supports.

Participants included representatives from state agencies, provider organizations, advocacy groups, and other key behavioral health partners, including:

- OHA.
- National Alliance on Mental Illness Oregon.
- Oregon Council for Behavioral Health (OCBH).
- Association of Oregon Community Mental Health Programs.
- Hospital Association of Oregon.
- Mental Health & Addiction Association of Oregon.
- CMHPs.
- Advocates.
- RFO staff.[232]

[232] Attempts were made to engage the nine federally recognized Native American tribes in Oregon in conversations relative to HB 2015. A conversation was had with OHA's Tribal Liaison on April 2, 2026, regarding how best to seek feedback from tribal partners. No further engagement was had between Myers and Stauffer and the tribal liaisons or any identified member of a Native American tribe.

Individual and Group Key Informant Interviews

Myers and Stauffer collaborated with OHA leadership to identify individual key informants whose professional or lived experience roles offered direct insights into the functioning of Oregon's residential mental health system. Myers and Stauffer confirmed and conducted five individual interviews. An additional five individuals with lived experience (three residing in an RTH and two residing in an SRTF Class 1) were either unable or unwilling to take part in key informant interviews with the Myers and Stauffer team. Participants were selected based on:

- Involvement in residential mental health services.
- Operational oversight responsibilities.
- Lived experience in the residential mental health system, as identified by the RFO.

Recognizing Individuals with Lived Experience

All individuals with lived experience who took part in key informant interviews with Myers and Stauffer were provided a stipend in the form of a gift card in recognition of their time and effort.

In addition to individual key informant interviews, seven groups of key informant interviews were conducted with OHA staff, providers, CCOs, and the Portland Police Department.

Partner Engagement Feedback

The following subsections describe how partner feedback was analyzed and the findings discovered through the analysis.

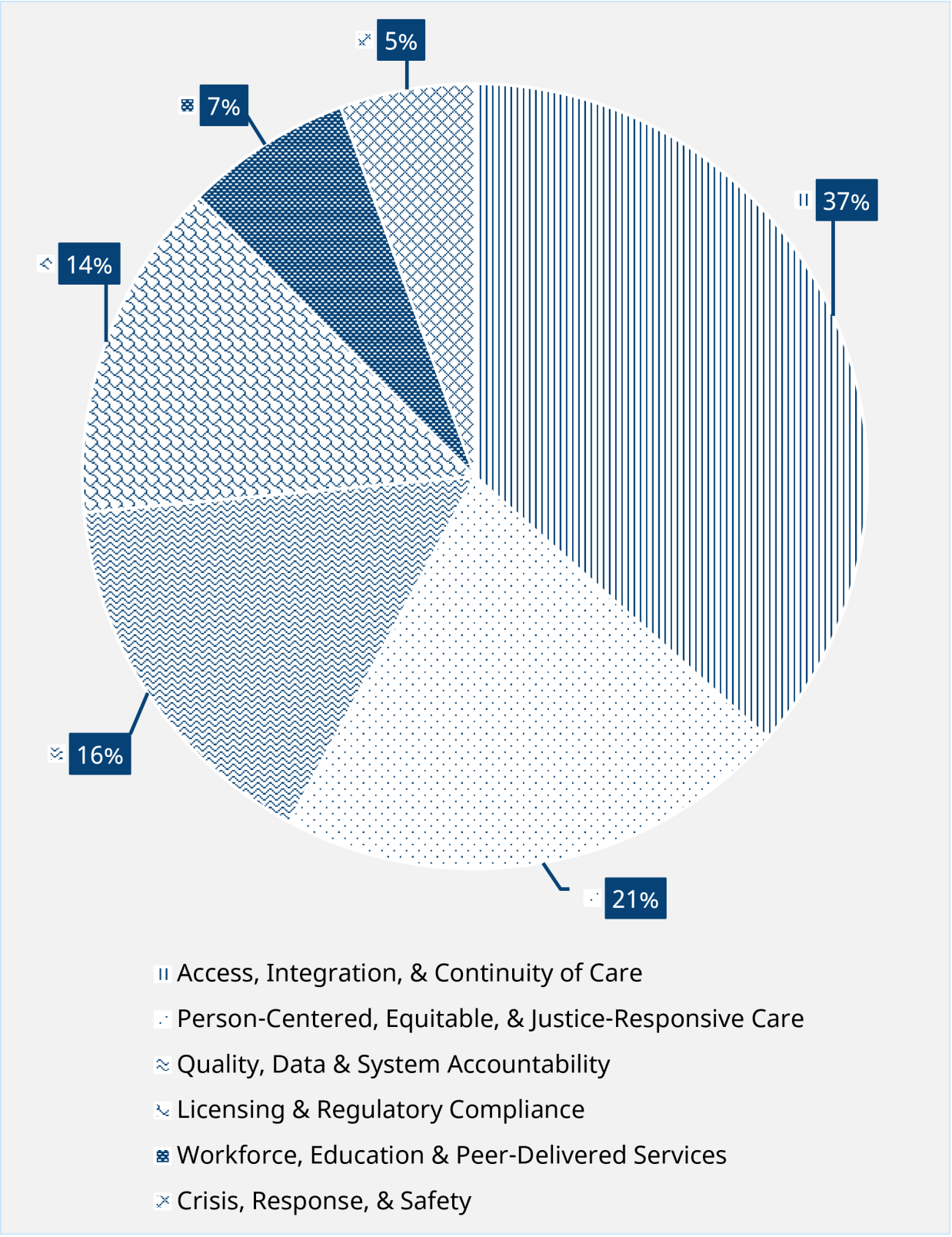
Feedback Analysis Methodology

The feedback analysis methodology was designed to systematically organize, interpret, and align qualitative and quantitative feedback with established strategic priorities and measurable outcomes. Individual feedback was categorized according to a defined set of 19 themes that represented key functions and values of the behavioral health system (e.g., Access, Crisis, Workforce, Quality, Person-Centered Planning, etc.). To reduce overlaps and enhance clarity, related themes were grouped into six broader thematic groupings to better reflect how services are designed, delivered, and governed.

Thematic Analysis

During the partner feedback interviews, a total of 106 partner responses were gathered on a variety of topics that align to the OHA's strategic plan. Figure 5: Partner Feedback Thematic Groups reflects the distribution of partner feedback by thematic grouping as of May 31, 2026.

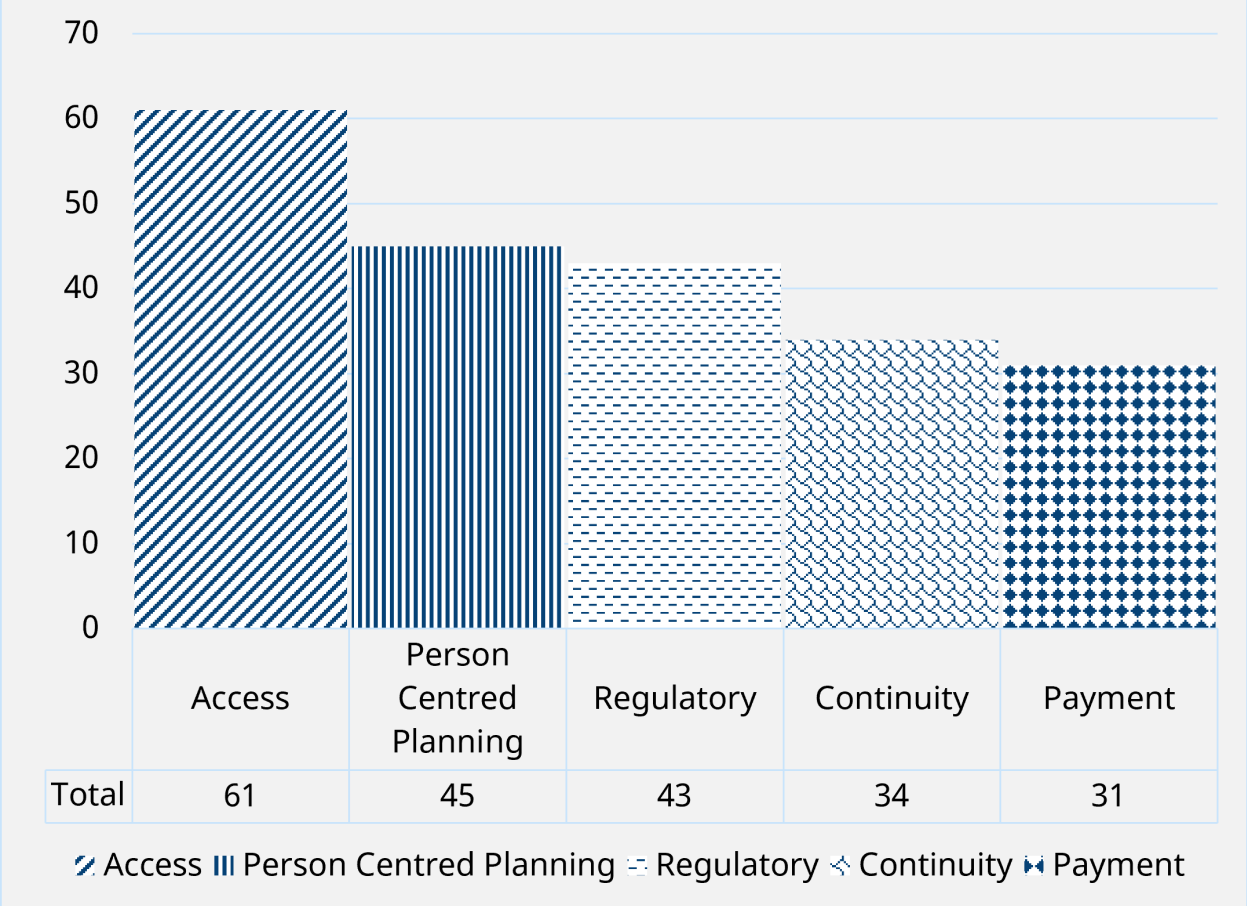
Figure 5: Partner Feedback Thematic Groups



As shown in Figure 6, the following topics were mentioned by partners with the most frequency:

- Access.
- Person-centered planning.
- Regulatory.
- Continuity of care.
- Payment.

Figure 6: Most Frequently Occurring Topics



Partner Feedback Themes

The following section summarizes the topics previously identified through partner and key informant feedback and qualitative analysis conducted through May 31, 2026.

These themes reflect recurring priorities raised across key informant and partner interviews and were organized within broader thematic frameworks to reflect larger system-level concepts and areas of focus.

Information collected during interviews frequently emphasized the importance of person-centered and recovery-oriented care, continuity across transitions and levels of care, timely access to services, sustainable reimbursement strictures, regulatory balance, and stable housing supports. Many insights reflected overlapping system issues and could reasonably fit within multiple thematic areas. However, to support consistency in analysis and reporting, each insight was assigned a single primary thematic code based on the dominant topic reflected in the feedback.

Sub-Theme: Continuity of Care

Continuity of care was a frequent topic during the five key informant interviews and three work group meetings.

The idea of “service coordination” was discussed in the following contexts:

Continuity of Care and Transition Challenges

Partners consistently described continuity of care as one of the most significant challenges within Oregon’s residential behavioral health system. Partners emphasized that transitions between hospitals, residential treatment settings, community-based programs, and permanent housing are often fragmented, resulting in service disruptions, repeated crises, and avoidable readmissions. Several participants noted that individuals

frequently experience a cycle of movement between higher-acuity settings, emergency departments, state hospitals, and homelessness because the system lacks sufficient coordination and community-based supports. Partners also described ongoing challenges related to the availability of RTH and RTF beds, noting that placement options are limited in some regions and that delays in identifying appropriate placements can prolong hospital stays or result in individuals remaining in settings that do not match their current LON.

Community-Based Recovery and Localized Care

Across interviews and work group discussions, partners described a strong desire for a system centered on local, community-based recovery. Partners emphasized that individuals should be able to receive treatment and support within their home communities whenever possible, rather than being displaced to urban or institutional settings far from existing support systems. Partners repeatedly stated that recovery outcomes improve when individuals can maintain connections with family members, trusted providers, peer supports, employment opportunities, and familiar community networks. Partners also noted that limited RTH and RTF availability in rural and remote communities often requires individuals to relocate away from established support systems to access care.

Trauma, Placement Delays, and Capacity Limitations

Several partners also emphasized that transitions themselves can create trauma and instability, though this was not a consistent viewpoint across all partners. Some partners described concerns that individuals often remain in higher levels of care longer than clinically necessary because there are insufficient supportive housing options, limited lower-acuity placements, inconsistent discharge coordination processes, and limited RTH/RTF capacity

across portions of the state. Others noted that movement between programs frequently interrupts treatment relationships and undermines long-term recovery goals. Partners additionally described challenges locating residential settings willing or able to serve individuals with co-occurring conditions, forensic involvement, or higher behavioral support needs, which further contributes to delays in care transitions.

HCBS Requirements and Residential Treatment Operations

Providers and system partners further discussed the tension between residential treatment models and HCBS requirements. Some providers reported operational difficulties related to tenancy protections, bed hold requirements, and discharge limitations that affect their ability to maintain program sustainability and efficiently transition individuals across levels of care. Partners expressed concern that current regulatory structures sometimes treat residential settings primarily as housing models while providers are simultaneously expected to deliver intensive behavioral health treatment and supervision services.

Flexible Pathways and Individualized Supports

Partners also described the need for more flexible and individualized pathways through the system. Rather than a rigid “step-down” structure, partners emphasized that individuals may require different levels of support at different points in recovery and that services should adapt to changing needs over time. Discussions frequently referenced the importance of supportive housing, transitional housing, RTHs, RTFs, and community-based alternatives that can prevent unnecessary institutionalization while still supporting individuals with complex behavioral health, medical, or forensic needs.

Sub-Theme: Person-Centered Planning

Person-centered planning was one of the most frequent topics of feedback during partner discussions.

The idea of "individualized service design" was discussed in the following contexts:

Individualized Recovery Goals and Service Design

Partners consistently emphasized the importance of person-centered planning across Oregon's residential behavioral health system. Across interviews and work groups, partners described the need for systems that focus on the individual's goals, strengths, preferences, and recovery needs. Several partners stated that current systems are often organized around payment structures, legal status, or facility operations instead of individual recovery goals.

Community-Based Care

Partners repeatedly emphasized that individuals experience better outcomes when services are available within their own communities. Partners also stressed the importance of maintaining relationships with providers, peers, family members, and natural supports over time. Many partners described recovery as closely tied to community connection, purpose, and social support. Partners emphasized the need for welcoming and low-barrier systems that allow individuals to receive care locally whenever possible.

Meaningful Engagement and Daily Supports

Work group partners also discussed concerns that some residential settings have become overly institutional in practice. Several partners described settings with limited structured programming, limited rehabilitation

activities, and minimal individualized engagement. Partners stated that person-centered planning should include meaningful daily activities, peer supports, individualized behavioral supports, legal skills training when appropriate, and flexible approaches based on each person's needs.

Flexible Service Delivery Models

Partners also highlighted the need for flexibility in how services are defined and delivered. Partners noted that individuals often need a combination of rehabilitation, habilitation, treatment, peer support, case management, and housing-related supports. Several partners stated that existing regulatory and reimbursement structures do not always align with how services are provided in practice. Partners emphasized that staffing models and program requirements should support individualized care rather than create barriers to service delivery.

Transitions Across Levels of Care

Several partners stressed the importance of helping individuals move between levels of care without causing additional instability. Partners discussed the need for flexible transitions that allow individuals to move into settings that better meet their needs without losing supports or restarting services. Partners emphasized that systems should allow movement across services based on changing needs rather than requiring progression through rigid placement pathways.

Sub-Theme: Provider Reimbursement

Provider reimbursement was a frequent topic of discussion during partner discussions. The idea of "payment" was discussed in the following contexts:

Financial Sustainability and Reimbursement Challenges

Financial sustainability and reimbursement methodology emerged as another dominant theme across partner engagement activities. Providers and partners consistently reported that existing payment structures do not adequately reflect the actual cost of delivering residential behavioral health services, particularly for individuals with complex behavioral health, forensic, or co-occurring needs. Partners described concerns that current rate methodologies rely on outdated assumptions, do not sufficiently account for inflation or workforce costs and often fail to support long-term program sustainability. Providers noted that rate adjustments may take significant time to implement, creating financial instability for programs serving individuals with changing acuity levels. Some partners also reported that selective rate increases across certain tiers create gaps within the broader continuum of care and may unintentionally discourage the development of lower-acuity or transitional programs.

Acuity-Based Payment Models and Operational Stability

Several providers expressed concern that acuity-based payment models can create operational instability. Partners noted that reimbursement tied closely to fluctuating individual acuity scores may produce unpredictable funding changes even when staffing needs remain relatively stable. Partners stated that this creates challenges for workforce retention, program planning, and maintaining therapeutic environments. Smaller programs were described as particularly vulnerable to financial instability under highly variable tiered payment systems. Several discussions also focused on workforce sustainability. Partners noted that reimbursement limitations affect providers' ability to recruit and retain qualified staff, maintain adequate staffing levels, and provide specialized training for individuals

serving forensic, justice-involved, or medically complex populations. Partners emphasized that future payment models should better account for workforce realities, safety considerations, and the intensity of services provided across residential settings.

Fragmented Funding Structures and Medicaid Authorities

System partners also discussed the complexity created by multiple funding streams and Medicaid authorities. Partners referenced the interaction between State Plan authorities, HCBS waivers, county funding, and general revenue funding, noting that fragmented financing structures can complicate placement decisions, reimbursement processes, and service delivery expectations. Partners described challenges associated with aligning Medicaid reimbursement structures with the actual services being delivered in residential settings.

Payment Incentives and System Design

Throughout the engagement process, partners repeatedly emphasized that reimbursement models influence how the residential system develops over time. Some partners stated that current payment approaches may inadvertently incentivize longer residential stays or discourage movement into less restrictive settings. Others described a need for payment structures that better support transitional housing, supportive housing, co-occurring treatment models, and individualized service delivery.

Sub-Theme: Regulatory Measures

Regulatory measures emerged as a theme identified during key informant interviews and work group meetings. Regulatory measures refer to licensing or regulatory concerns or barriers, enforcement actions, impossible or detrimental regulatory compliance, and corrective action plans. These measures establish and enforce minimum standards for providers and

facilities to ensure safety, quality, and accountability. This theme was discussed in the following contexts:

Serving Specialized Populations

Partners suggested residential treatment standards should be tailored to each type of facility to ensure residents get the right LOC for their specific needs. However, partners expressed concern with the system's management of specialized populations, including individuals under A&A orders and individuals with co-occurring disorders. While partners acknowledged the importance of placement for individuals on A&A orders, they expressed concern that residential capacity is at risk of being consumed entirely by the A&A population if systemic barriers are not addressed quickly. One partner reported Oregon's statutes are separated between mental health and SUDs, which creates divided rules and reimbursement models. As a result, consumers often have difficulty meeting treatment goals for mental health when co-occurring treatment is not supported in facilities.

Insufficient Avenues for Providers to Address Concerns

Partners expressed frustration with the feedback process for promoting quality improvement and addressing concerns. For example, providers named concerns with OHA's IQA, with issues ranging from timeliness in communication and review, to lack of communication regarding routine changes, and frequent criteria changes. Providers suggested that they would benefit from a clear, well-documented operational process with regular audits, clear communication channels, and a continuous improvement mindset with a straightforward way to raise any concerns or complaints.

Constraints Limiting the System's Ability to Respond to Immediate Behavioral Health Needs

Partners emphasized the need for immediate solutions to manage forensic, civil commitment, and state hospital capacity issues. It was noted by some HB 2015 work group members that the intent of HB 2015 was to address immediate, concrete barriers preventing Oregon from building, opening, and efficiently operating residential capacity. Concerns were also raised that growing forensic utilization at OSH is limiting access for civil patients. Lack of access to placement prevents individuals from receiving necessary immediate behavioral health support and hinders effective flow through the residential treatment system.

System-Level Barriers Limit Timely Movement Between LOCs

Providers identified referral requirements, waitlist prioritization rules, eviction-related discharge processes, and coordination challenges with third parties as key barriers to transitions across the continuum. These regulatory constraints reduce flexibility in placement decisions.

Sub-Theme: Access

Access to services was one of the main topics of discussion during key informant interviews and participant work groups. The idea of "access" was discussed in the following contexts:

Payment Concerns

Partners reported payment concerns as a contributing factor to lack of access to care. One partner suggested that in some cases, nonpayment of services stands between a hundred thousand(s) to 1.5 million dollars for services rendered. While payment concerns extend across the residential landscape, SRTF funding is an especially pressing matter, as denials of medical necessity threaten the stability of financing SRTF programs.

Policy Changes

Frequent policy changes were cited by partners as a destabilizing factor in the system, leading to limitations in access to services. Partners pointed to unexpected changes from OHA, such as alterations to IMD status or multiple emergency rule filings as causing structural and operational disruptions to programs. Additionally, partners cited timeline policies as a barrier to access, as the time required to acquire, open, and license programs delays acquisition of property.

Assessment Process

The assessment process was noted as burdensome by some partners, which may prevent timely access to care. One provider reported that their program has improved the assessment process by using simplified tools and facility-specific mental health assessment forms.

Population Preferences by Providers

Providers expressed concern that certain patient populations take precedence over others, which limits broader community access to services. Some providers stated individuals under A&A orders may fill slots otherwise taken by other members of the community. Additionally, there is concern that behaviors exhibited by individuals under A&A orders may contribute to other consumers leaving the facilities. Similarly, partners stated prior to the implementation of the prioritization rule, providers were able to exclude high-acuity consumers, which limited access to complex populations. Prioritization of beds and the movement of community members from facilities presents an access challenge for providers working to ensure equity across population groups.

Legal Restrictions

Partners cited the impact of the *Mink-Bowman* lawsuit as hindering access to care. Specifically, partners state the lawsuit has dictated how and when individuals can transition through the system. As a result, individuals may need to interview for multiple settings prior to finding placement.

Limited Residential Capacity

Partners suggested that capacity is a barrier to access, specifically within SRTF settings. Partners noted that staffing and operational barriers have limited development of Class 1 SRTFs, particularly in rural areas. As a result, individuals with higher acuity are often placed in Class 2 settings that may not fully meet their needs. In addition to limited SRTF capacity, partners noted their preference to serve individuals in community-based residential settings rather than the state hospital, but residential capacity across each program is limited.

Sub-Theme: Housing

Housing was mentioned on numerous occasions during partner interviews and work group meetings. The idea of "supportive housing" was discussed in the following contexts:

Supportive Housing Capacity and Access

Housing was discussed throughout nearly every partner engagement activity. Partners consistently identified the lack of supportive housing and community-based placement options as a major challenge within Oregon's behavioral health system. Partners described limited access to transitional housing, PSH, AFHs, and lower-acuity community settings. Partners stated that these shortages contribute to longer stays in hospitals, SRTFs, RTFs, and other restrictive settings.

Continuum of Care and Community Transitions

Partners repeatedly emphasized that residential treatment settings were not intended to function as permanent placements for individuals who could safely live in less restrictive environments with the right supports in place. Partners discussed the need for more housing options across the continuum of care so individuals can transition into community settings while still maintaining access to behavioral health treatment, peer supports, and case management services. Several partners noted that limited housing capacity contributes to repeated cycles of hospitalization, incarceration, homelessness, and residential placement.

Community Connection and Independence

Partners also discussed the importance of helping individuals remain connected to their communities while receiving services. Partners emphasized that individuals should have opportunities to work, build relationships, participate in community activities, and maintain independence whenever possible. Several partners expressed concern that highly restrictive or institutional settings can reduce autonomy, limit choice, and weaken community connection over time.

Population-Specific Housing Needs

Partners further discussed the need for housing models that better reflect differences in clinical, behavioral, medical, and forensic support needs. Several partners described challenges related to serving individuals with very different needs within the same residential setting. Providers noted that some programs were originally designed for specific populations but have gradually shifted to serving broader and more complex groups over time. Partners stated that more specialized housing, purpose-built settings, and treatment environments may improve safety, engagement, and long-

term stability for some individuals when implemented in a manner consistent with HCBS principles.

Housing as a Recovery Support

Throughout discussions, partners consistently described housing as more than a physical place to live. Partners described housing as a key part of recovery and long-term stability. Partners emphasized that stable housing should be connected to treatment, peer support, case management, daily structure, and community integration. Partners also emphasized that future system planning should focus on expanding supportive housing capacity and improving access to flexible community-based housing options.

Findings Analysis

Based on Myers and Stauffer's analysis of federal regulations and guidance, Oregon's operationalization of mental health residential settings, Oregon tenancy laws, peer state settings and services, and partner feedback, the below findings are presented for the Oregon Legislature's review. Findings are structured to highlight primary, secondary, and tertiary observations. This structure is not intended be interpreted as findings by "order of importance" but rather serves as a mechanism to discuss findings in a topical manner. Moreover, this structure demonstrates that the primary findings impact most other areas observed by Myers and Stauffer and that they are the drivers of many of the challenges experienced by OHA's mental health residential service system. Secondary findings are specific to those topics named directly in the HB 2015 legislation and tertiary findings are additional observations made through the course of this study that impact RTFs, RTHs, and SRTFs.

Primary Findings: Services, Settings, Statutes, and OHA's Use of HCBS Authorities

The way in which OHA has operationalized RTFs, RTHs, and SRTFs over many years is compounding the challenges experienced by OHA, providers, and residents. These challenges include those related to licensing and overseeing treatment settings that are largely providing habilitative services, understanding standards to which providers are held, and the experience of individuals receiving services within these settings. Systemic issues that exist in the RTF, RTH, and SRTF service delivery system are not a reflection of any one issue but rather are a symptom of how OHA originally structured the coverage of these settings within OHP.

Lack of Distinction between RTFs, RTHs, and SRTFs as Settings Rather Than Services

Many of the individuals Myers and Stauffer engaged during this study apply the terms RTF, RTH, and SRTF to mean both the **setting** in which services are received, and the **services** themselves that may be rendered to residents. An example of this is when HB 2015 work group members were asked what "services" they provide to individuals with SMI, they indicated "RTF, RTH, or SRTF services." This response indicates at least some lack of knowledge of the reimbursable services that are allowable under OHP. As is demonstrated in Table 6 the Medicaid-covered **services** that RTFs, RTHs, and SRTF **settings**, as qualified providers, may provide are "mental health treatment services," "HCBS Residential Habilitation," and/or "Psychosocial Rehabilitation." The application of RTF, RTH, and SRTF to mean both **service** and **setting** contributes to a significant amount of confusion when attempting to:

- Evaluate if providers are meeting facility licensure standards.
- Determining if rates paid to providers are adequate for services rendered.
- Establishing how or if activities rendered as part of a service description are appropriate for Medicaid payment.

Evidence gathered from the peer state review suggests these states have implemented a distinction between services and settings. For example, Washington's RTFs are the setting in which mental health intervention services may be delivered, according to their approved State Plan.[233]

[233] Washington HCA. Washington State Plan Attachment 3.1-B Page 42.

Another example is Colorado's MHTL - Level One and Two homes; although Colorado does allow providers some flexibility to design programs to meet resident needs, there is a prescribed list of services and activities in Colorado regulations prescribing the minimum service requirements for the settings.[234]

Should OHA work to separate settings from the services provided therein, some of the challenges brought forth in the HB 2015 work groups will be alleviated. Separating settings from services will require a level of effort on the part of OHA to educate staff, providers, and beneficiaries, along with OAR modifications for clarity.

Confluence Between ORS and OARs

ORS 413.042 and ORS 443.465 creates flexibility for OHA to develop regulations that are adaptable and easily amended to reflect changing policy priorities and partner feedback. At the same time, OHA is also bound by any definitions and requirements reflected in statute. An example of this is seen in ORS 443.400, where "residential care" and "treatment" are defined.[235] OAR 309-035-0105 adopts, verbatim, the definition of "treatment" from statute, but does not include any definition for "residential care."[236] The same scenario applies to the definitions of RTF, RTH, and SRTF in that statute defines each of these settings, which are then adopted in OAR.

Given that OHA is statutorily granted the authority to create rules to interpret and expand upon state law, it is well within OHA's right to develop rules specific to policies around operationalization of RTFs, RTHs, and SRTFs.

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[234] Colorado Secretary of State. 2 CCR 502-1 Behavioral Health. p. 117.
[235] ORS 443.400. Definitions for ORS 443.400 to 443.455.
[236] OAR 309-035-0105. Definitions.

However, any divergence between statutes and regulations may create confusion, particularly if statutory definitions are broad and not further refined in OAR.

OHA's Use of Medicaid Authorities

Oregon is using three different authorities to cover treatment and habilitative services provided in RTFs and RTHs[237] without having these authorities act concurrently together (as in the case of Arizona and Colorado). In multiple conversations with OHA and other partners, no definitive answer could be obtained as to why OHA chose to allow RTFs and RTHs as qualified providers under the 1905(a), 1915(i), and 1915(k) authorities. Some partners indicated the "higher FMAP received under an HCBS authority" as a reason why these settings are named as qualified providers under the 1915(i) and 1915(k). However, as previously discussed in the **Detailed Review of Medicaid Federal Authorities** section, only services provided under the 1915(k) authority are eligible for the 6% Federal Medical Assistance Percentage increase.

Furthermore, clear distinctions between licensure related to treatment and habilitative services provided in these settings complicate the coverage landscape. As evidenced by feedback from providers engaged in HB 2015 work groups, they themselves are unclear exactly what services are provided, how they are billing for those services, and the authority in which individuals are enrolled. This confusion is contributing to potential misapplication of HCBS regulations within these settings if providers are

[237] Services in a SRTF are only covered under the 1905(a) authority as these facilities are not home and community-based settings.

provisioning the 1905(a)-covered "mental health services in residential settings" to individuals in their care.

OHA and ODHS permit RTFs and RTHs as qualified providers under the 1915(i) and 1915(k) HCBS authorities that require these settings to adhere to specific federal regulations, namely the HCBS settings regulation. Anecdotal evidence from providers and Medicaid suggests that OHA has interpreted the federal HCBS rules to mean that residents have "any right" available to them, regardless of if that right poses a health and safety issue. However, OHA made modifications to OAR during the writing of this report to require RTF and RTH providers to "have policies and procedures prohibiting weapons… when [the provider] has the right to search a resident's belongings or person under a reasonable cause standard."[238]

Nonetheless, during the writing of this report, providers reported not pursuing IBLs because of the interpretation by OHA that it is a resident's right to revoke an IBL at any time without a person-centered planning meeting. These interpretations by OHA do not appear to align with federal regulation which requires "an established time limit for periodic reviews to determine in the modification is still necessary or can be terminated" but also conflict with OARs that providers maintain safe environments through "safe search[es] for weapons,"[239] and that "Individually based limits [are in place to] limit or restrict HCBS settings to keep the resident and others safe from harm."[240]

[238] OHA. Update on Emergency Rules and Future Rulemaking. p. 2.
[239] OAR. 309-035-0165 Residency Agreement. Eff. May 15, 2026.
[240] OAR. 309-035-0190 Person-Centered Service Plan. Eff. May 1, 2026.

Secondary Findings: HB 2015 Areas of Study

Secondary findings are organized topically, based on HB 2015 areas of study. Secondary findings include those related to alternative coverage models for mental health residential services, admission and discharge practices, SRTF Class 1 staffing, hearing and appeal rights, and reimbursement structures.

Alternative Models

There are four other findings in addition to those mentioned in the **Primary Findings: Services, Settings, Statutes, and OHA's Use of** HCBS Authorities section related to the review of alternative models for covering mental health residential services. These are:

- Federal authorities are not prescriptive, and there are no regulations indicating an appropriate authority or model for covering mental health residential services.
- Peer states were found to only cover either treatment or habilitation in the settings reviewed. No evidence was found to indicate one specific setting covers distinct and separate services dedicated to either treatment or habilitation.
- The majority of the peer states reviewed for this study are only covering mental health residential treatment in settings prescribed under the 1905(a) authority. Only Colorado is using a 1915(c) HCBS waiver to cover habilitative services in a long-term home dedicated to the needs of individuals with SMI. While not all states were included in the study, it is relevant to note that other states covering habilitative services for individuals with SMI use a 1915(i); however, generally do not use treatment settings as the primary service providers.

- Costs are not authority dependent, but authorities may dictate the use of one reimbursement methodology over another.

These four findings are discussed in more detail in the following subsections.

Federal and Peer State Alternative Model Findings

There is no federal regulation prescribing allowable Medicaid authorities for covering mental health residential services. The choice of which authority(ies) is used to cover mental health residential services is at a state's discretion. However, the design of the Medicaid authority (e.g., designed to address administrative practices rather than coverage) or limited benefit plan (e.g., PAHPs) itself may render the choice inappropriate for covering mental health residential services.

As seen by the analysis of the seven peer states reviewed for this report, most states are covering mental health residential treatment services primarily as a 1905(a) service, outside of an HCBS authority. Only Colorado is using a 1915(c) waiver to provide MHTL - Level One services, which the State makes clear is not intended to serve as a residential placement.[241] In fact, Colorado is clearly distinguishing MHTL - Level One and Level Two **settings** by the differences in **services** provided in each MHTL, respectively. As a reminder, the services provided in a MHTL - Level One setting address activities of daily living (ADL) supports, along with skills to support daily living;[242] whereas, services provided in an MHTL - Level Two require at least

[241] Colorado HCPF. Home and Community Based Services: Community Mental Health Supports (CMHS) Waiver. p. 82.
[242] Colorado HCPF. Mental Health Transitional Living Home Level 2 Provider Tool Kit. p. 1.

10 hours of treatment per week, therapeutic services, and interventions.[243] The focus on habilitative services in a MHTL - Level One home makes the use of the 1915(c) waiver, which requires adherence to HCBS regulations, including settings compliance — a better fit than if Colorado was also using the 1915(c) waiver to cover the treatment focused MHTL - Level Two home.

Additionally, no peer state settings reviewed provide dual services that are primarily designed to support treatment or habilitative skills. All settings reviewed, except for the MHTL - Level One homes, were purposely built to provide mental health treatment not habilitative supports to individuals. Habilitation may be an additional component of a settings offering (as is the case in Colorado's MHTL - Level Two that may also provide coordination for daily social and life skills activities/trainings).[244] Rather than the primary focus of services, these supports are offered supplemental to the treatment that is provided in these homes. The review of the other six peer states definitively indicates that treatment is the focus of their residential settings rather than habilitation.

No reviewed state is using a 1915(i) authority or a PAHP to cover residential treatment services, but many states nationwide leverage 1915(i) State Plan options to cover habilitative services for people with mental illness. One of these states is Washington, which was reviewed as part of this study to determine how they are covering residential treatment through their Medicaid program. States using 1915(i) State Plan options are not relying on

[243] Colorado HCPF. Informational Memo Differences between Mental Health Transitional Living Home Level 1 & 2. pp. 3-4.
[244] Colorado HCPF. Informational Memo Differences between Mental Health Transitional Living Home Level 1 & 2. pp. 3-4.

licensed treatment facilities as providers of habilitation. Some examples include but are not limited to those listed in Table 15.

Table 15: Other State Examples of Leveraging 1915(i) State Plan Options for Habilitation

State	1915(i) State Plan Option Habilitation Service(s)	Qualified Provider Types
Kentucky[245]	• In-Home Independent Living Supports. • Tenancy Supports.	• Certified provider agency: For provider agencies offering medication management as part of In-Home Independent Living supports, it must be provided by a pharmacist, doctor, physician's assistant, advanced practice nurse, an RN, or an LPN working under the supervision of an RN.
North Dakota[246]	• Housing Supports.	• North Dakota Medicaid enrolled agency provider of Housing Supports; non-licensed, noncertified.
Washington[247]	• Community Behavioral Health Support Services - Supportive supervision and oversight.	• Adult family home - licensed. • Assisted living facility (ALF) - licensed. • Adult residential care (ARC) facility - licensed as an ALF with a contract to provide ARC services. • Enhanced ARC (EARC) - ALF with a contract to provide EARC services. • Enhanced services facilities - licensed

[245] Kentucky SPA. KY 24-0010 New 1915(i) State Plan Benefit. pp. 27-29, 31-35. Eff. March 27, 2025.
[246] North Dakota SPA. ND 25-0010 1915(i) State Plan Benefit. pp. 118-124. Eff. October 1, 2025.
[247] Washington SPA. WA 24-0001 New 1915(i) State Plan Benefit. pp. 30-31. Eff. July 1, 2024.

Other than Colorado, Arizona and Vermont are the only other states to use a different authority — an 1115 waiver — to cover residential services. However, both states are using the 1115 waiver concurrently with 1905(a) to waive specific requirements of their State Plan and to operationalize services differently than what is normally allowed under section 1902 and 1905(a) of the SSA. Furthermore, none of the nine states in this review are using a PAHP to cover mental health residential services.

Cost Analysis of Alternative Models

Further cost analysis may be necessary following a selection of an alternative model or models for covering mental health residential services. An assumption may be made that any new authority pursued by OHA will require at least some increase in administrative and potentially IT costs due to implementing the new authority. A cost increase resulting from higher reimbursement rates to providers is dependent not on the authority chosen, but on rate rebasing, remodeling, and/or negotiations with a CCO or PAHP, depending on if OHA choses a new alternative model of coverage and any future rate studies undertaken by OHA.

Admission Practices

Admission practices were found to vary widely between Oregon and the nine peers reviewed. In part, Oregon's admission practices are complicated by the *Mink-Bowman* ruling and the prioritization rule implemented by BHD to enforce standards by the court-appointed monitor. Myers and Stauffer presents four primary findings related to admission practices:

- With a few exceptions, providers are required to prioritize admission to individuals discharging from OSH, regardless of the provider's ability to meet their needs and consideration for other individuals

already served in the setting. No peer state reviewed appears to have a similar mechanism for priority admissions.

- Medical necessity is not consistently determined by the IQA prior to admission to an RTF, RTH, and SRTF. Furthermore, the Chapter 309, Division 35 admission rules are not specific to clinical criteria for admission to an RTF and RTH. This is in clear contrast to the admission criteria found in the seven peer states reviewed.
- SRTF clinical criteria are noted but are separate from RTF and RTH criteria and are enumerated in the Medicaid division's mental health residential prioritization rule.
- Federal Medicaid HCBS regulations require states to ensure a lease, residency agreement, or other form of written agreement is in place for HCBS participants. This document must provide protections that address eviction processes and appeals, but OAR does not require these protections for when an individual is placed at a facility by a supervisory entity.

The following subsections offer additional details related to each of the four admission findings.

Impact of Prioritization Rule

OAR 309-35-0158 Waitlist Management is having undeniable impacts on the mental health residential service system in Oregon. Though OHA is working with partners to address challenges resulting from the rule, the rule remains in place as of the date of this report, and individuals discharging from OSH and who are in the forensic and civil commitment populations continue to be prioritized for admission to RTFs, RTHS, and SRTFs above community placements. Based on a review of the *Mink-Bowman* neutral expert's reports,

no evidence was found that a requirement for admission standards to an RTF, RTH, and SRTF have been made to date. Rather, the neutral expert's second report issued on June 5, 2022, discusses an expedited admission and diversion process for OSH but does not specifically name the mental health residential settings as part of this recommendation.[248] The seventh report issue on October 18, 2023, documents OHA's efforts to implement the recommendations agreed to by lawsuit defendants and plaintiffs. Again, no distinguishing recommendation can be identified relative to priority admissions for RTFs, RTHs, and SRTFs.[249] These findings suggest that the implementation of OAR 309-035-0158 is a reflection of OHA's obligation under *Mink-Bowman* to admit OSH within the required timelines, rather than a reflection of the neutral expert's recommendation to prioritize people into mental health residential settings.

All individuals, regardless of how they are referred to treatment services, should be entitled to placement in these settings; however, PSRB is relying on the START assessment, along with other case documentation, to understand an individual's risk rather than an individual's functional capacity. This practice may be leading to an overreliance in SRTF placements for forensically involved individuals because of the perception that SRTFs are "safer" as compared to RTFs and RTHs. Prioritizing individuals for placement in a setting, regardless of the setting's ability to meet the individual's needs is, according to engaged partners, affecting:

[248] Neutral Expert Second Report Regarding the Consolidated Mink and Bowman Cases. p. 24. Debra A. Pinals, M.D. June 5, 2022.
[249] Neutral Expert Seventh Report Regarding the Consolidated Mink and Bowman Cases. pp. 7-26. Debra A. Pinals, M.D. October 18, 2023.

- **Health and safety within the setting.** Providers reported inability to care for individuals who are part of the forensic and civil commitment populations. Additionally, individuals from these populations may have violent criminal offenses that could jeopardize the health and safety of others if proper care and support is unavailable in a setting.
- **Other residents' treatment journey.** Prioritization is mixing the acuity of individuals in a single setting in a manner not previously seen before this iteration of OAR 309-35-0158. A balance needs to be struck between serving individuals with high acuities with individuals with lower acuities, or individuals with highly differentiating diagnoses in the same setting. Mixing of incongruent populations may impact outcomes for residents in a negative way, and without adequate support in place, this could set individuals back in their treatment journeys. The lack of purpose-built housing (further discussed later in this report) that may be used to provide specialized care for specific populations or diagnoses only compounds the issues experienced because of the prioritization rule.

No evidence was found to suggest that peer states have prioritization policies for admission to their residential facilities.

RTF and RTH Admission Criteria

Apart from the procedural criteria listed in OAR 309-035-0156 Screening (see Table 7), there is no publicly available clinical criteria that are used to determine admission to an RTF or RTH. Though the OAR indicates that there may be "additional criteria required or approved by the Division through contractual agreement or condition of licensing," no such criteria was provided for this review; therefore, it is not possible to determine if this criterion is clinical in nature.

The lack of clear clinical admission criteria to RTF and RTH is in contrast with some of the peer states reviewed. For example, Minnesota, New Mexico, Vermont, and Washington all have very specific clinical criteria documented in their regulations and/or policies describing admission to their respective mental health residential treatment settings. New Mexico even relies on standardized mental health assessment (LOCUS) criteria for determining admission into their AARTCs for mental health. Establishing clinical criteria for admission to RTFs and RTHs will support appropriate determinations of need and better distinguish admissions for treatment versus habilitative services within the same setting.

As previously discussed, OHA is in the process of transitioning from the LSI and LOCUS assessments to the interRAI CMH assessment for 1915(i) eligibility and service rate determinations. Though the interRAI is not initially planned to evaluate clinical admission criteria for RTFs and RTHs, OHA could use interRAI data to inform admissions in the future because the assessment evaluates an individual's functional capacity, current limitations, and risks associated with behavioral and physical care needs.

OAR Regulations Governing Admission Criteria for RTFs, RTHs, and SRTFs

The use of multiple rules to discuss admission criteria between RTFs/RTHs, and SRTFs is complicated at best and confusing at worst. From the review of OAR, there does not appear to be a reason why RTF and RTH admission criteria are established in Chapter 309, Division 33 rules (governed by BHD); whereas the SRTF admission criteria are established in a Chapter 410 rule (governed by Medicaid). As RTFs and RTHs are a Medicaid-covered service, it stands to reason that at least medical necessity requirements should fall under the Medicaid Division's rule chapter just like the SRTF criteria rather

than in a BHD rule chapter. Additionally, having multiple rules that include "admission" in their title requires a savvy reader to be familiar with OAR layout and time to navigate complicated regulation language.

Residency Agreements

42 CFR 441.710 and 42 CFR 441.530 are clear that for settings in which landlord-tenant laws do not apply, the State must ensure a lease or residency agreement is in place for everyone receiving HCBS. Such a document is required to list protections addressing eviction processes and appeals. However, OARs do not require that a signed lease, residency agreement, or written agreement is in place for individuals who are placed in the setting by a supervisory entity. This appears to be contrary to federal HCBS settings rules if placed individuals are admitted to an RTF or RTH and receiving 1915(i) and/or 1915(k) services.

Discharge Practices

There are three findings related to discharge practices from RTFs, RTHs, and SRTFs pertinent to HB 2015, inclusive of the following:

- OHA's use of HCBS authorities requires providers to "evict" RTF and RTH residents as part of discharging or transferring them to another setting, which contributes to a greater length of time in the setting, potential instability for the resident, and unnecessary administrative barriers.
- Despite efforts to streamline the process, and protect resident's rights, there is a greater administrative burden placed on providers and OHA by requiring BHD staff to approve notices of involuntary discharge and transfer.

- The lack of prior planning and standardization relative to discharges from RTFs, RTHs, and SRTFs may be creating inequities and unclear goals for when a resident is ready to move to a different setting.

In addition to these three primary findings, the lack of a robust service array for mental health treatment and support services compounds the ability of providers to discharge and transfer residents who no longer require or want treatment services. Mental health service array issues are addressed in the section titled **Mental Health Service Array: New Services to Meet More Needs**.

Application of HCBS Settings Requirements to Treatment Setting Discharges and Transfers

Discharges from RTFs and RTHs are treated as evictions from the setting because of their coverage under the 1915(i) and 1915(k) HCBS authorities. The HCBS settings criterion outlined in 42 CFR 441.710 and CFR 42 CFR 441.530 require that provider-owned and controlled settings "in which landlord tenant laws do not apply…must ensure that a lease, residency, or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law." [250, 251]

The application of HCBS settings requirements, such as eviction standards, to settings that may provide short-term treatment for mental health conditions impacts the ability of providers to effectively discharge

[250] CMS. 42 CFR § 441.710 — State Plan Home and Community-Based Services Under Section 1915(i)(1) of the Act.
[251] CMS. 42 CFR § 441.530 Home and Community-Based Setting.

individuals who are no longer appropriate for, or want, to receive the LOC in an RTF or RTH. As noted in the

Appeals and Hearing Rights Processes section of this report, all Medicaid beneficiaries have the right to a hearing when a benefit or service is reduced. This is unimpacted by a service's coverage under an HCBS authority. However, the eviction process, as required by HCBS standards, further compounds limited bed availability, an increase in provider administrative burden because of the time involved in that process. Furthermore, no peer state reviewed was found to hold providers to "eviction" standards as part of their discharge practices, as the seven peer states do not provide for mental health residential treatment under an HCBS authority.

Involuntary Discharge and Transfer Reviews

Despite BHD's efforts to simplify the involuntary discharge and review process, requiring review by BHD of the notices of involuntary discharge/transfer that are themselves produced by BHD is administratively onerous for providers and removes providers from caring for complex individuals. Furthermore, neither OAR 309-035-0170 nor the forms indicate who at BHD is responsible for reviewing the forms. Some of the reasons for involuntary discharge are related to clinical concerns and if clinicians at BHD are not involved in review, this practice questions a provider's ability to make appropriate clinical decisions related to the care needs of an individual. Providers should not have the ability to discharge a resident simply because of the complex behavioral needs of the individual. However, within the parameters of state law concerning individuals under PSRB or court orders, providers should be afforded the right to ensure that care can be properly provided to all individuals, within the staffing capacity of the

facility, and in consideration of the needs of all residents without overly administrative processes outside of clinical partnership with OHA.

Planning and Standardization of Discharge Practices

There is evidence from three (Arizona, Massachusetts, and Washington) of the seven peer states reviewed that discharge planning is required to occur upon admission to one of their mental health RTFs. Though Minnesota does not specifically specify the timing of discharge planning, the Minnesota Department of Human Services (MDHS) has designated three different types of discharge from an IRTS "Successful," "Non-program initiated," and "Program initiated," complete with their own list of criteria for determining what and how the discharge should occur. This is similar to Oregon outlining the 10 types of discharges in OAR 309-035-0170 Standards for Residency Transfers and Discharges.

Evidence was not found in OAR that discharge planning from Oregon's RTFs, RTHs, and SRTFs must occur upon admission to the setting. Additionally, it is not overly evident as to who must participate in discharge planning in Oregon or in any of the peer states reviewed. This lack of specificity regarding discharge planning and the entities involved in it may be creating distinctions between local collaboration with CMHPs, CCOs, and/or the IQA.

SRTF Staffing

One of the main distinction between SRTF Class 1 and Class 2 facilities is the requirement to have nursing on site 24/7 in a Class 1 facility. The rationale for having nursing on site 24/7 in the Class 1 facilities is to approve restraints and seclusions, when necessary. The following three findings were discovered in relation to this requirement:

- OAR 309-033-0725 does not specifically indicate that 24/7 nursing is a requirement for SRTF Class 1 facilities.
- Nursing requirements in SRTF Class 1 facilities are not inherently different from those in peer states, but peer states are allowing the use of on-call nursing in their residential treatment settings, which is not currently permitted by OHA.
- The appropriateness of allowing RNs to authorize restraints and seclusions is unclear based on a review of OAR, ORS, and best practice.

Application of OAR 309-033-0725

SRTF Class 1 facilities are, according to the interpretation of OAR 309-033-0725 by BHD, required to have a nurse on site 24/7. This rule neither specifies that the nursing requirement applies to the SRTF Class 1 facilities, nor does the rule or any rule in Division 33 define what "on duty" means. As discussed in the section of this report titled **Licensing, classification, and staffing requirements**, OHA has not implemented the Division 33 rules to only apply to civil commitment proceedings, as the name of the Division suggests.

No publicly available information was found indicating how OHA is applying these rules or to which mental health residential settings these rules apply. Additionally, the term "on duty" could be interpreted a number of different ways, including that a nurse is "available" and "reachable" through a phone call, particularly as no definition of the phrase exists. Moreover, as a civil commitment can occur to a number of different facilities, it stands to reason that this Division set of rules should apply to various settings, including RTFs, RTHs, and SRTF Class 2. Yet, no such nursing requirement is in place currently for these settings.

Contradicting the presumed requirement for "on duty" nursing is the allowance in OAR 309-33-0720 Application, Training, and Minimum Staffing Requirements which states "For nonhospital facilities, a written agreement with a local hospital, to provide such medical services may fulfill this requirement [the requirement to have an adequate number of nurses available at the setting]."[252] All in-scope settings qualify as nonhospital per the definitions in OAR 309-033-0120. As such, it appears as if OHA's interpreted requirement for on-site 24/7 nursing in SRTF Class 1 facilities is at odds within their own rules.

On-Call Nursing

On-site 24/7 nursing for each reviewed peer state varied. Requirements for nursing were not immediately clear based on publicly available information for Colorado's MHTL - Level One homes and New Mexico's AARTCs for mental health. Arizona, Colorado's MHTL - Level Two homes, and Minnesota all require nursing to be available but allowed for nurses to be "on-call" or prescribe a minimum number of hours that a nurse is required to be in person at the facility. Massachusetts, Vermont, and Washington are the three peer states that appear to require nursing on site 24/7 without flexibility in hours or on-site requisites.

Based on the peer state research conducted, Oregon's requirement to have a nurse available 24/7 in SRTF Class 1 facilities does not appear to be different than other operationalization of mental health residential services across the nation. As seen in Figure 4, it is also notable that there is only a 1 percentage point difference in the bed capacity between SRTF Class 1 and Class 2 facilities. This finding may suggest that despite differences in

[252] OAR. 309-033-0720 Application, Training and Minimum Staffing Requirements.

requirements, SRTFs seeking Class 1 licensure are not overburdened with the additional criteria surrounding nursing staff in these settings. Conversely, the data may also be suggestive that those facilities applying for Class 2 licensure may be experiencing difficulties with the process.

However, as stated above, it is BHD's interpretation of regulations that may be confounding and complicating the warranted discussion on if nursing requirements are appropriate for certain settings. Separately, the issue of not permitting on-call nursing in SRTF Class 1 facilities may be further exacerbating nursing shortages and the ability of SRTF Class 1 provider availability. Half of the peer states use on-call nurses to assist in tasks; this may be an area for OHA to continue exploring with Oregon State Board of Nursing.

Appropriateness of Having Registered Nurses Authorize Restraints and Seclusion

In a review of ORS the allowance of having RNs authorize restraints or seclusion could not be verified; however, OAR 309-033-0730 Seclusion and Restraint Procedures indicates that "Only a Licensed Independent Practitioner (LIP), physician assistant, or registered nurse[253] may initiate seclusion or restraint procedures."[254] Furthermore, "Each use of seclusion or restraint shall be monitored and supervised by a LIP or [RN]."[255] While OAR 309-033-0730 does not indicate any additional training or educational standards RNs must adhere to prior to authorizing a restraint or seclusion, OAR 309-033-0720 does specify direct care staff training, inclusive of the

[253] OAR. 309-033-0210 Definitions.
[254] OAR. 309-033-0730 Seclusion and Restraint Procedures. Eff. April 7, 2023.
[255] Ibid.

ability to demonstrate competency in the application of restraints and seclusion."[256]

The American Psychiatric Nurses Association (APNA) does support having trained RNs involved in the use of seclusions and restraints. APNA issued a revised standard of practice for seclusions and restraints in February 2022. This standard states that "Any staff providing care to persons at risk for harming themselves or others and who participate in seclusion and restraint shall have received training and demonstrate current competency in all aspects of dealing with behavioral emergencies."[257] Additional information regarding specialized training and educational standards prescribed by APNA are in Appendix X.

The guidance issued by APNA does not state that nurses can "authorize" restraints and seclusion but rather states that nurses who "participate" in seclusion and restraint are required to meet additional training and education standards. Moreover, the guidance also states that "Seclusion or restraint is initiated by qualified staff authorized by the organization to initiate seclusion or restraint in a behavioral emergency and must be followed by an order from a physician or Licensed Practitioner (LP) who is responsible for the care and treatment of the person."[258] This statement this is aligned with OAR 309-033-0730 requirements.

At minimum, the APNA standards suggest that nurses should be supported in their use of restraints or seclusion in a psychiatric setting. BHD should

[256] OAR. 309-033-0720 Application, Training, and Minimum Staffing Requirements. Eff. April 7, 2023.
[257] APNA. Standards of Practice: Seclusion and Restraint. p. 4. Rev. February 2022.
[258] APNA. Standards of Practice: Seclusion and Restraint. p. 8.

confirm that OAR training standards in OAR 309-033-0720 align with the best practices issued by APNA.

Hearing and Appeal Rights

Due process is a federal requirement for beneficiaries who receive an adverse determination relative to eligibility and benefits. Hearing and appeal rights are not specific to HCBS authorities but are the right of any beneficiary enrolled with a state's Medicaid program. A review of Oregon's practices appears to align with federal due process requirements. As such, the following findings are offered:

- Anecdotal evidence from some HB 2015 work group partners suggests that the time between the initiation of the administrative hearing and a determination is lengthy, and delays involuntary discharges for certain residents.
- Overall, the framework for hearing and appeal rights enumerated in OAR provides clearer and more structured appeal rights for providers than for beneficiaries.

Timeliness of Hearing and Appeal Adjudication

Feedback from some HB 2015 work group members suggests that the timelines for hearings and appeals can be extensive. The length of time for a hearing determination, per provider work group member feedback, may impact the ability to involuntary discharge certain residents from the setting. No publicly available evidence was found to support this claim, but it is notable as providers are required to continue provisioning care to

individuals while a hearing and/or appeal is adjudicated per OAR 309-035-0170.[259]

OAR Review of Hearing and Appeals Rights

Myers and Stauffer's review of Oregon's hearing and appeals framework found that individuals involved in civil commitment proceedings are afforded significant due process protections, including access to hearings, legal counsel, and court oversight. Although beneficiaries may receive notice of these actions or have access to internal grievance processes, formal contested case hearing rights are limited, conditional, or not clearly defined.

Provider appeal rights are generally more clearly defined and consistently applied through OARs that govern licensing actions, sanctions, and enforcement decisions that use formal contested case procedures under ORS Chapter 183. By comparison, procedural protections are more limited or less clearly established for beneficiaries related to care transitions, discharge decisions, and placement disputes within the behavioral health system.

Reimbursement

There are eight primary findings related to reimbursement practices reviewed by Myers and Stauffer. These include the following:

- Reimbursement rates are not tied to a Medicaid authority or limited benefit plan, but reimbursement methodologies may be impacted by the type of Medicaid authority or limited benefit plan used to cover mental health residential services.

[259] OAR. 309-035-0170 Standards for Residence Transfers and Discharges. Eff. May 18, 2026.

- Reimbursement is the same for an RTF, RTH, and SRTF regardless of if the facility provides “mental health treatment” or “HCBS Residential Habilitation” services. This limits the complex geographic and acuity and setting tiering in terms of benefits to residents, providers, and OHA.
- The current reimbursement rates paid to RTF, RTH, and SRTF may not be appropriate for serving individuals who are forensically involved or civilly committed if those rates were developed for the sole purpose of reimbursing for habilitative services under 1915(i).
- There is a built-in incentive for Oregon’s mental health residential providers to downsize bed capacity as the payment rates paid to RTHs are higher than those paid to RTFs and SRTFs, which may impact available mental health residential bed capacity across the state. The emphasis should shift away from bed capacity and instead focus on addressing the needs of the residents.
- The acuity-based tiering system for mental health residential providers places value on a “sickness model of reimbursement,” rather than recognition of the improved health of a resident.
- For an individual primarily served by the ODHS system but served in an RTF or RTH under the 1915(k) State Plan option, BHD is the determining factor for how much the setting is paid.
- Bed hold rates are available under the current OHA rate methodology. For reference, no evidence of bed hold rates were found in peer states reviewed for this report.

- Reimbursement methodologies and the payments made to residential treatment providers in the peer states varies widely, and there is no clear distinction between authority and reimbursement methodology from the review of the seven states.

Reimbursement Rates and Medicaid Authorities and Limited Benefit Plans

In the review of alternative models for covering mental health residential services, Myers and Stauffer did not find federal regulations or guidance describing the rates states pay to providers for services rendered. States have the flexibility to design reimbursement methodologies informing provider rates using a variety of methods as seen in the peer state review. Therefore, OHA is not limited by a Medicaid authority or a limited benefit plan when determining if provider rates should be adjusted. Legislative and/or OHA budgets and rate rebasing efforts play a more significant role in determining provider rate decreases or increases than alternative models.

Though there is no federal standard for how states pay providers, some reimbursement methodologies are impacted by the use of certain types of Medicaid authorities or limited benefit plans. For instance, it would not be federally permissible to use an FFS model of reimbursement under a managed care authority like a 1915(b) waiver or 1932(a) State Plan.

RTF, RTH, and SRTF Reimbursement: Same Rates, Different Services

Myers and Stauffer confirmed with OHA staff that the RTF, RTH, and SRTF rates included in Appendix VI are rates paid to providers regardless of the service delivered in the setting. This means that if an RTF provides HCBS Residential Habilitation to a 1915(i) recipient, they receive the same payment as if they were providing mental health services to an individual who is only enrolled on OHP. The complexity of OHA's rates for RTFs, RTHs, and SRTFs

seems to not render a positive return on investment for providers in that the rates do not appear to tie to any specific services or activities provided in the setting. Providers had difficulty describing what exact services were provided by RTFs, RTHs, and SRTFs, which suggests that there is a lack of awareness about what the rates are intending to reimburse.

The analysis conducted by Myers and Stauffer was unable to confirm the appropriateness of the RTF, RTH, and SRTF rates as a review of the rate methodology was not conducted. Despite not having transparency into the rate methodology, OAR 410-172-0705 Residential Rate Standardization indicates that “"Residential Service Costs” means costs associated with the provision of mental health services to individuals in residential treatment programs. Costs include direct and indirect services required to meet an individual’s assessed needs for **personal care and other habilitative services** [emphasis added]. Residential services costs do not include costs related to providing psychosocial rehabilitation services (PSR).”[260] This regulation language suggests that the rates paid to RTFs, RTHs, and SRTFs are not inclusive of the provision of mental health treatment services under the 1905(a) authority.

Furthermore, providers indicated a wide range of activities provided in these settings that suggests the “one-size fits all” rates in Appendix VI may not be appropriate to support treatment services in an RTF, RTH, or SRTF, and that the payment rates are for the facility itself rather than for any service provided. Additionally, no other peer state reviewed was found to use the same settings to deliver multiple services under different authorities;

[260] OAR. 410-172-0705 Residential Rate Standardization.

therefore, peer state methodology examples cannot be leveraged for informing a recommendation to OHA.

Reimbursement Methodology and Consideration of Forensic and Civil Commitment Populations

Again, as Myers and Stauffer was unable to review the methodology used to develop the rates in Appendix VI, the appropriateness of the rate to support the high acuity needs of individuals, particularly those involved in the forensic system or who are civilly committed could not be determined. Despite a nuanced reimbursement structure that considers geography, bed holds, and acuity tiers, the rates paid to RTF, RTH, and SRTF providers do not appear to adequately reimburse providers for caring for patients who they are obligated to prioritize because of OAR 309-035-0158. Based on provider feedback, there may be a need for OHA to re-examine rates paid to RTFs, RTHs, and SRTFs who are serving these populations, but no such rate examination should take place in a silo. Rather, OHA should conduct a rate methodology review in the context of the recommendations posed in this report (see the **Recommendations** section for further details).

Compensation's Impact on Serving Individuals Equally

The RTF, RTH, and SRTF rates listed in Appendix VI show that smaller facilities are paid more than facilities of a larger size. Consider that a Tier 2 payment for RTHs is $420.35 per day

Reimbursement's Impacts on Downsizing

"We made the hard decision to reclassify from an RTF to an RTH because of the higher payment made to RTHs. This was a decision we did not want to make, given our current bed shortage, but we needed to make to continue to operate."

— Residential provider+

+Paraphrased from conversation during a provider-specific HB 2015 work group meeting held on May 4, 2026.

compared to the RTF payment of $310.36 per day. A lower payment rate for larger facilities may be appropriate because the presumption is the provider is serving more people; therefore, making more revenue. However, this assumption may be faulty if the rate itself is not appropriate to reimburse for the services rendered by providers, sufficient to staff and support the needs of residents, and if it has not been recently reviewed. Higher payments to smaller facilities are acting as an incentive for providers to reduce bed capacity, which may be contributing to the limited number of mental health residential treatment beds across the state.

In addition to incentivizing smaller bed sizes, the reimbursement model for RTFs, RTHs, and SRTFs is designed to decrease as a resident stabilizes and their high-acuity needs lessen. Comparing the Tier 2 rate (lowest level of acuity tier) to the Tier 3 (a medium acuity tier) for RTHs, the difference in payment between the two is $103.60. Though acuity tiered payments are beneficial in the sense that they offer providers more financial support for caring for individuals with high needs, the opposite is also true that as an individual's needs diminish, so too does the financial support, despite providers still being held to the same staffing and other licensure standards. One provider engaged in conversations suggested this is a "sickness model of reimbursement," meaning the reimbursement model is incentivizing less stable, less acute patients, likely an unintended

The "Sickness Model of Reimbursement"

"As an individual's acuity goes down, so does our payment. Acuity is going down due to supports provided, but our operating costs remain the same."

— Residential provider+

+Paraphrased from conversation during a provider-specific HB 2015 work group meeting held on May 4, 2026.

consequence. In the case of Oregon, tiered-based acuity payments, coupled with not clearly defining services provided in RTFs, RTHs, and SRTFs, appears to only be compounding financial constraints felt by providers rather than alleviating financial burden.

BHD as the Determiner of Provider Rates

Another factor that contributes to a provider's rate is when an individual who is primarily served by the ODHS system is "cross-placed" into an RTF or RTH and receives services under the 1915(k). In a key informant interview with an ODHS staff member, they confirmed that ODHS and BHD would determine the "tier" of the individual, which is a factor in determining payment. The staff member interviewed suggested that no assessment of the individual would be done to determine the rate tier but rather ODHS and BHD would negotiate the payment rate on a case-by-case basis.

Not having transparency into the rates paid for cross-placed individuals does not allow for providers or the public to have visibility into this process. Furthermore, the negotiated process between BHD and ODHS does not follow OAR 410-172-0705 Residential Rate Standardization that requires a rate tier to be assigned "based upon an independent face-to-face assessment of an individual's need and acuity that is determined in a PCSP."[261]

Reimbursement for Bed-Holds

A bed hold payment is the equivalent of a "retainer payment," which OAR 410-172-0705 Residential Rate Standardization defines as a "payment made for medical, behavioral, or psychiatric related temporary absences of 30 days or less from residential treatment programs for which the Division has

[261] OAR. 410-172-0705. Residential Rate Standardization.

provided prior authorization."[262] The bed hold payments are equal to those listed in Appendix VI under "Tier 1."

No specific evidence of bed hold or retainer payments was found in the peer state review conducted for this report. However, bed hold payments are an important aspect of ensuring provider sustainability and are already factored into OHA and providers' operating budgets.

Peer State Reimbursement Methodologies and Rates

The peer state review indicates states are using a wide range of reimbursement methodologies and paying diverse rates to providers of mental health residential services. Based on the publicly reviewed information analyzed:

- Minnesota and Washington (IBHTs only) use a cost-based provider rate to pay for services.
- New Mexico and Washington (RTFs only) appear to use a negotiated reimbursement rate. These rates were not available publicly.
- All peer states used some form of flat fees, and no states used any type of acuity or geographic tiering or adds in their rate structures.
- Arizona and Washington also appear to use non-Medicaid funds to reimburse for stays that are not medically necessary.

The wide approach to states' reimbursement methods and payment rates suggests that there is federal flexibility in how a state makes payment.

[262] Ibid.

Tertiary Findings: Miscellaneous Observations

In addition to the findings that specifically tie to the HB 2015 legislation, Myers and Stauffer is providing miscellaneous findings that are tangentially related to the tenets of HB 2015 and have an impact on mental health residential services specifically, and on the mental health service system broadly. The areas in which Myers and Stauffer is offering additional findings include:

- Fragmentation of OHA's mental health service system.
- A need for a broad array of mental health services available to OHP beneficiaries.
- The lack of strong case management and collaboration between all "care coordinating" entities.
- OAR structure and the amount of redundancies, inconsistencies, and lack of specificity regarding SRTF operations and nursing.

Details on these miscellaneous findings follow.

OHA System Fragmentation

Based on feedback from OHA, HB 2015 work group members, and a review of publicly available information, the delivery of mental health residential services in Oregon is fragmented and inconsistent based on several factors including:

- How an individual is referred to services.
- If the individual is enrolled on the 1915(i) or 1915(k) plan.
- The level of CCO, CMHP, and the IQA's engagement with residents of a facility and with each other.

This system fragmentation is causing inequities in service access and delivery and is contributing to the challenges of the mental health system in Oregon. Without a cohesive and standardized method for delivering mental health services to vulnerable individuals, the system will continue along a trajectory of inconsistency.

Mental Health Service Array: New Services to Meet More Needs

As shown in Figure 5, there are limited options available to OHP members who no longer need or want treatment services from an RTF, RTH, or SRTF but who may still require some ongoing, habilitative support in a community setting. The RTFs, RTHs, and SRTFs were not initially designed as long-term placement options but were designed as mental health treatment facilities. Acknowledging that some residents may view these settings as their home, the fact remains that these settings are facilities and not adequate substitutes for lifelong home-like environments.

However, there are also very limited options available to individuals in need of acute, crisis stabilization, outside of "stabilization services" that may be provided by some RTFs, RTHs, and SRTFs. The effects of this limited mental health service array are impacting individuals' ability to discharge from settings and are creating a bottleneck in bed availability.

Long-Term Placement in an RTF

"Residential treatment is not intended to be used as a long-term substitute for lack of available supportive living environments in the community. Lack of appropriate and available supportive community living environments shall be addressed and documented in transition management and planning for the recipient."+

+OAR. 410-172-0720 Prior Authorization and Re-Authorization for Residential Treatment.

Case Management and Person-Centered Planning

The role of CCOs, the IQA, and CMHPs was discussed in several HB 2015 work groups, yet it remains unclear who is responsible for providing case management to non-forensically involved beneficiaries who are residents of RTFs, RTHs, and SRTFs. If a beneficiary is a member of a CCO plan, CCOs may provide some LOC coordination, but this activity is not necessarily dedicated to addressing and mitigating challenges related to mental health diagnoses. The IQA serves individuals enrolled in the HCBS 1915(i) State Plan option and is involved in verification of SRTF medical necessity. However, OHA indicated that case management is not included in the IQA's contract.

In the RTF visited by Myers and Stauffer staff, there was clear evidence of a case manager on staff in the facility. This staff member was there to support individuals in their care in the RTF. Additionally, the resident who participated in the key informant interview was able to identify contact information about their IQA assessor and describe the frequency of contact with Myers and Stauffer. While the individual knew who to contact, the case manager at the RTF provided the day-to-day coordination for community activities. This indicated some level of involvement from the IQA and understanding of their role by one individual and RTF, but this was not observed consistently across settings. This, however, is not evidence that the IQA is performing "case management."

Given that potentially multiple entities are providing differing levels of case management within the behavioral health system, without an independent specified entity in charge of case management and person-centered planning for all individuals receiving mental health services, there will continue to be:

- A lack of understanding of services available to meet an individual's needs at a lower LOC.
- Limited, objective support for individuals residing in an RTF, RTH, or SRTF.
- Inconsistent quality standards for case management and person-centered practices across settings.
- Providers filling a needed gap without appropriate reimbursement.

General OAR Observations

There are five specific findings relative to how OHA has structured and implemented OARs for RTFs, RTHs, and SRTFs. Findings include those related to navigating OARs, the lack of rules designed specifically to govern SRTFs, appearance of overly burdensome regulatory requirements for providers, considerations regarding resident civil rights and freedoms, and apparent misalignment between OHA and ODHS rules implementing federal HCBS settings requirements.

Navigating OARs

Navigating OARs is a daunting challenge, even for individuals who are well accustomed to reviewing state administrative regulations. Part of the difficulty in searching OARs is that there are seemingly redundant rules that may exist in multiple Chapters and/or Divisions. Having rules related to behavioral health services and reimbursement separate from the rules governing behavioral health licensure standards makes a concise review of the rules difficult at best.

Moreover, the titles of OAR can be misleading and not specific enough to guide a reader to the correct content. For example, Chapter 309, has a

"Screening" rule and an "Admission" rule within Division 35. OAR 309-035-0163 Admission does not specifically cover admission criteria but rather outlines provider responsibilities related to policies and procedures.[263] There is an opportunity for OHA to combine redundant rules, like those mentioned above, which will allow for improved navigation of the OARs.

Lack of SRTF-Specific Rules

In addition to the lack of clarity in OAR titling and potential redundancies, there is an obvious gap in Chapter 309 regarding a specific SRTF rule set. SRTFs are partially governed by Division 35 rules, though the title of the Division does not name "secure residential treatment facilities" specifically. Without reading each Division 35 rule, it is not overtly clear which rules do and do not apply to the SRTFs. Even when reading through the Division 35 rules, it is not always clear if the rule applies. An example of this is OAR 309-035-0158 Waitlist Management. The rule does not explicitly name any settings in which the waitlist and prioritization requirements apply, and as the title of the Division does not name SRTFs in the title, it remains unclear if the prioritization rule applies to SRTFs.

Per OHA, SRTFs are also governed by Division 33 rules. Like the lack of specificity in the Division 35 title, the Division 33 rules are intended to apply to "Civil Commitment Proceedings" according to the Chapter title posted on the Oregon Secretary of State's website. Nowhere in the Division 33 rules are SRTFs specifically named as a setting in which the rules apply. The lack of clarity in which rules do and do not apply to SRTFs allows varied interpretation of regulations and:

[263] OAR. 309-035-0163 Admission.

- Puts OHA at risk of adverse hearing and appeal findings.
- Presents challenges for providers in understanding the standards to which they are held.
- Is not transparent in a manner that allows full public involvement in taxpayer services.

Overly Onerous Provider Administrative Requirements

Within Division 35 rules, OHA specifies several requirements for provider licensure and operations, including that: all staff are hired prior to the issuance of a license (OAR 309-035-0115) and that OHA must approve notices of involuntary discharge or termination (OAR 309-035-0170), before an individual can be involuntarily discharged or transferred from the facility. Similar requirements were not identified in peer state mental health residential facility licensure standards. Moreover, providers indicated that these requirements put a significant amount of stress on an already fragile residential system and prevent providers from quickly opening more bed capacity and providing quality care to individuals.

Civil Rights and Freedoms

OAR 309-035-0175 Rights, Freedoms, and Protections outlines individual rights for residents of an RTF, RTH, or SRTF. The rights included in this rule include, but are not limited to:

- Having adequate food and shelter.
- Confidential communications in mail, visits, and phone calls.
- Ability to express sexuality in a socially appropriate and consensual manner.

- Have religious freedoms.
- Be free from all forms of discrimination.
- Other HCBS rights when a resident is enrolled in the HCBS 1915(i) State Plan option.[264]

These rights and freedoms are not dissimilar from the peer states reviewed that had publicly available information regarding their "bills of rights" for residents of residential settings. However, this rule only provides limited instances of when a right may be restricted, mostly due to court or PSRB involvement, to ensure the safety of the resident, provider staff, or others in the setting. Some peer states (Massachusetts is an example) provide more extensive language regarding rights restrictions, regardless of forensically involved populations.

Apparent Misalignment between Requirements in OHA and ODHS HCBS Settings Rules

Lastly, there appears to be misalignment between OHA and ODHS rules regarding HCBS settings requirements. OAR 410-173-0035 and 411-004-0020 are similar and align to the federal HCBS settings requirements for 1915(i) and 1915(k) State Plan options well; however, there is disagreement between the rule sets in how they handle modifications to a PCSP. Instead of embedding IBLs and their use directly in the HCBS 1915(i) State Plan option rule as ODHS does, OHA structured OAR 410-173-0035 to point to OAR 410-173-0040 for regulations surrounding use of IBLs. Additionally, the ODHS HCBS settings rule (OAR 411-004-0020) discusses PCSP modifications — an important aspect to HCBS programs — directly in their HCBS settings rule.

[264] OAR. 309-035-0175 Rights, Freedoms, and Protections. Eff. May 1, 2026.

Conversely, OHA points to a different OAR that gives the impression that person-centered planning is not a necessary component to HCBS. Given that modifications to PCSPs when restrictions are warranted are a federal requirement, OHA's rules would benefit from modifications to align to those already in place under ODHS OAR chapters.

Recommendations

The following recommendations are presented for the consideration of the Oregon Legislature, OHA, and involved partners as solutions to address the complex problems facing Oregon's mental health residential system. All recommendations are intended to address systemic pressure points impacting access to adult mental health residential services and settings. Implementation of these proposed recommendations are intended to create opportunities for all individuals to have access to adult mental health residential services and settings.

These recommendations are made in consideration of the findings from analysis of federal regulations; Oregon's operationalization of RTFs, RTHs, and SRTFs; feedback from partners; and the seven reviewed peer states. Recommendations are arranged topically based on HB 2015 requested recommendations and include a justification of why the recommendation was made and how the recommendation will address noted challenges.

Recommendations Addressing Primary Findings

- **Recommendation 1:** OHA needs to clearly distinguish settings from services offered through improved language in OAR and guidance and education to providers and residents.
    - **Justification:** Mental health services may be provided within a variety of settings but without clear distinction between settings and services:
        - There is difficulty determining if service providers are adequately adhering to service requirements.

- Reimbursement methodologies may not represent true service provisioning, which may impact provider payments.
- Beneficiaries are left without a full understanding of what they should and can receive within the setting.

At minimum, modifying OAR 309-035-0105 Definitions and OAR 309-035-0200 Individual Services and Activities to clarify the term "mental health treatment services" is needed to begin differentiating between setting and service. Within a newly created definition, the type and scope of activities included in "mental health treatment services" can be outlined based on the already approved service within the Medicaid State Plan. Additional guidance outlining OAR changes should be developed to assist providers, residents, and other involved parties (e.g., CMHPs, the IQA, PSRB) in understanding these nuanced differences and how these differences impact their respective areas of involvement in the mental health system.

- **Recommendation 2:** Leverage the existing 1905(a) authority to cover **treatment services** within RTFs, RTHs, and SRTFs.
  - **Justification:** Oregon already allows RTFs, RTHs, and SRTFs to provide "mental health services" to adults in these settings, under the 1905(a) authority. The 1905(a) authority is not subject to HCBS settings requirements and would alleviate provider concerns regarding discharge (eviction) standards and would further permit providers to institute a list of prohibited items from the facility, thereby helping to ensure health and safety of the individual, provider staff, and other residents.

- **Recommendation 3:** Remove RTFs and RTHs from the qualified provider list under the 1915(i) and 1915(k) authorities.
    - **Justification:** Including RTFs and RTHs within the qualified 1915(i) and 1915(k) provider lists subjects these facilities to all federal and state HCBS requirements. These types of facilities are not typically seen within HCBS Medicaid authorities, as evidenced by the peer state review conducted for this report. Removing these settings will discontinue the HCBS standards that these settings are currently held to, which will alleviate some provider concerns related to the ability to restrict resident rights for the purposes of safety without requiring an IBL.

      Additionally, removal of RTFs and RTHs from the HCBS authorities will present an opportunity for OHA to provide clarity on the **mental health treatment services** provided in these settings. This will help providers disassociate **habilitative services** provided under the HCBS authorities from the **treatment services** that should be the primary focus of these facilities.
- **Recommendation 4:** Add a new licensure type for "licensed Supported Living homes" and name them as the qualified provider for HCBS 1915(i) Residential Habilitation and Psychosocial Rehabilitation.
    - **Justification:** As a substitute for naming RTFs and RTHs as qualified providers under the 1915(i) authority, the Oregon Legislature can pass clarifying language to direct OHA to create a new licensure type for the provision of mental health habilitation services, like HCBS Residential Habilitation and Psychosocial Rehabilitation. Creating a new licensure type will allow OHA to develop specific

standards for HCBS services and provides clear expectations for providers who want to newly provide or continue providing 1915(i) services. Only those settings that can pass HCBS settings compliance should be permitted to apply for the new license type, and OHA should consider limiting providers to only render HCBS services if they hold this licensure type.

- **Recommendation 5:** The Oregon Legislature could work with OHA and interested parties to strengthen the definitions of "residential care" and "treatment" in ORS to improve clarity and define specific tasks associated with each term.
    - **Justification:** OHA can further define terms like "residential care" and "treatment" so long as the regulatory definitions are not inconsistent with statute. By working together, the Oregon Legislature, with OHA information and guidance, can further refine what is meant by "residential care" and "treatment" to provide specificity and clarification about the required activities that should be made available in RTFs, RTHs, and SRTFs.

Recommendations Addressing Secondary Findings

Admission and Discharge Practices

- **Recommendation 6:** OHA needs to examine the impacts of expiring OAR 309-035-0158 and instead admit individuals to RTFs, RTHs, and SRTFs based on established medical necessity, regardless of their involvement with the forensic system or civil commitment status.
    - **Justification:** As stated previously, OHA is currently working with partners to modify language in OAR 309-035-0158 Waitlist Management in an effort to respond to some of the most pressing

challenges raised by the provider community. However, modifications themselves may not be sufficient if providers remain unable to staff appropriately to meet individuals' needs. Furthermore, consideration must be given to care provided to individuals in their local communities rather than forcing individuals to move across the state simply because of a requirement in an administrative rule. If there is capacity to serve an individual locally, then a local admission should be prioritized.

This recommendation proposes that OHA examine the impacts of expiring OAR 309-035-0158, and instead, admit prospective residents to RTFs, RTHs, and SRTFs based on established medical need rather than on a priority system. Studying removal of the rule prior to full expiration will allow OHA to determine how removal of the rule will effect the State's compliance with *Mink Bowman.* OHA should vet this proposed recommendation with the court monitor to ensure alignment with all recommendations relative to *Mink-Bowman*. Additionally, this new admissions rule should be replicated and included in BHD's new Division specific to SRTF operations (see **Recommendation 29**).

This recommendation works in tandem with **Recommendation 7** regarding the establishment of stronger medical necessity criteria.

- **Recommendation 7:** OHA needs to establish medical necessity criteria for mental health residential treatment facilities, inclusive of an indication of a need for treatment and/or as a result of a public safety concern. Additionally, this recommendation includes the need to reconfigure the admissions process so individuals are not placed in a

setting prior to a determination that they meet facility admission criteria.

Justification: States are permitted to establish medical necessity criteria for services offered under the Medicaid program. Though OAR 309-035-0156 Screening establishes some processes related to admission to a facility, the criteria contained therein are general and are not of a clinical nature. To ensure individuals receive treatment in a facility that best meets their needs, OHA needs to provide detailed medical necessity evaluation criteria within OAR for RTFs, RTHs, and SRTFs. This criteria can be crafted in such a way as to include public safety considerations as part of medical necessity for the mental health residential treatment facilities. This will allow OHA to leverage as many federal dollars as possible to cover these stays for qualifying individuals enrolled in OHP, while curbing the use of limited BHD general revenue funds.

Furthermore, medical necessity and admission criteria should not be determined by the IQA following placement of an individual in a mental health residential setting. The need for **treatment services** in an RTF, RTH, or SRTF should be established well before an individual becomes a resident of such a facility. OHA will need to engage with the PSRB, CMHPs, the IQA, and providers to develop a sound strategy for assessing an individual for medical necessity and admission to an RTF, RTH, or SRTF. Doing so will not only comport with OAR 410-172-0650 Prior Authorization[265] but will also ease issues relative to timely payments to providers if individuals

[265] OAR. OAR 410-172-0650 Prior Authorization. Eff. June 21, 2022.

are assessed to acuity tiers prior to placement in a facility (for more information regarding recommendations on reimbursement, see page 194).

- **Recommendation 8:** OHA should develop and administer oversight activities to conduct quality monitoring of discharge planning at the time of admission to any of the mental health setting array.
    - **Justification:** As the responsible entity for conducting quality improvement and program integrity activities, OHA should develop and conduct oversight of discharging planning efforts across all mental health treatment and habilitative service settings. Discharge planning should be occurring upon admission to a facility or setting, but evidence gathered for this report suggests that discharges are happening in an unstandardized fashion across the state. OHA needs to ensure discharges happen consistently and uniformly and that a specific partner is named as the one required to develop a discharge plan. This may be the provider themselves, the IQA, or the CMHPs. Periodically, OHA should conduct oversight activities to monitor discharge efforts for timeliness of a developed discharge plan; that the plan sets goals, timelines, and names a tentative location for a resident to be discharged to; evaluation milestones to determine when an individual is ready for discharge; and the overall quality of the plan. Having OHA oversee and monitor discharges will provide additional assurance that plans are developed appropriately and in accordance with OHA's own regulations.

- **Recommendation 9:** Implement a discharge process for RTFs, RTHs, and SRTFs using different "tracks" based on treatment refusal, not meeting medical necessity, and other program-initiated reasons.
    - **Justification:** Myers and Stauffer recommends that OHA implement a new discharge process for RTFs, RTHs, and SRTFs modeled after Minnesota's discharge matrix noted in Table 22. Establishing very clear discharge criteria for when treatment is refused, when a resident no longer meets medical necessity, when an individual voluntarily initiates discharge, or when a program initiates a discharge because of issues like elopement, or requiring a higher LOC will set clear expectations for when and why a discharge is occurring. This new process should be included in a modified version of OAR 309-035-0170 Standards for Residency Transfers and Discharges. Exceptions to discharge when an individual does not meet medical necessity but is under a court or PSRB ordered placement should remain.

SRTF Class 1 Nursing Requirements

- **Recommendation 10:** BHD should modify current OARs to clarify the role of 24/7 on-site nursing in SRTF Class 1 facilities. Moreover, OHA should publicly indicate in guidance and OAR updates if SRTF Class 1 facilities are allowed to enter into agreements with local hospitals for nursing support as is an allowable practice for nonhospital facilities per OAR 309-33-0720.
    - **Justification:** As detailed in the **SRTF Staffing** findings section of this report, OAR 309-033-0725 Medical Services neither specifically states that nursing requirements are specific to SRTF Class 1

facilities, nor does the rule define what "on duty" means in the context of 24/7 nursing requirements. Additionally, OAR 309-33-0720 Application, Training, and Minimum Staffing Requirements appears to allow for nonhospital facilities (like a SRTF Class 1) to have a written agreement with a hospital for medical services. Correcting the obvious conflicts within the Division 33 rule set, and establishing nursing requirements for SRTF Class 1 facilities into rule rather than through interpretation, will accomplish the following:

  - Set a regulatory standard that is publicly available and not subject to OHA staff interpretation.
  - Resolve differing requirements within the same Division set of rules.
  - Clarify the settings in which nursing requirements are applicable.

- **Recommendation 11:** OHA staff need to discuss the appropriateness of SRTF Class 1 nursing staff initiating restraints and seclusion with the Oregon State Board of Nursing.
  - **Justification:** Findings suggest that ORS is silent to the use of RNs for authorizing restraints and seclusion. Peer states' use of nurses in facilities that require nursing staff on site or on call also did not render information relative to if nursing staff are used to authorize restraints or seclusion in the seven states reviewed. The APNA guidance also suggests that nurses should not be the party responsible for ordering or authorizing restraints and seclusion. OHA needs to clarify with the Oregon State Board of Nursing the

appropriate use of RNs in the practice of restraints and seclusion and should collaborate to review if available training and educational material meets APNA standards.

- **Recommendation 12:** Medicaid and BHD staff should engage the Oregon State Board of Nursing and OHA staff responsible for Division 33 rules to determine feasibility of amending requirements specific to overnight staffing and on-site availability of RNs.
    - **Justification:** OHA staff feedback indicates that the Oregon State Board of Nursing previously would not permit OHA from considering use of on-call staff in SRTF Class 1 facilities to approve restraints, seclusion, or use of compelled medication. Also, BHD staff who oversee Division 33 rules previously indicated that there was not a willingness to withdraw the requirement for SRTF Class 1 facilities to have nurses overnight, in addition to during "normal" wake hours. Should OHA determine that nurses are required in SRTF Class 1 facilities, the ability of providers to have nurses on call instead of in person and limit the hours in which in-person staffing is required may help mitigate nursing shortages experienced in these facilities.

      There is also established precedent by the peer states reviewed for this report that at least some (Arizona, Colorado, Minnesota, and Washington) permit a modified, on-site schedule (at least eight hours per week) or allow the use of telehealth/on-call nursing in their residential settings. This suggests that modifications to staffing patterns can still help to support individual needs without being overly burdensome to providers.

Hearings and Appeals Processes

- **Recommendation 13:** OHA and its partners need to work with OAH to identify ways to shorten hearing and appeal adjudication timelines.

  Justification: Anecdotal evidence gathered as part of partner engagement suggests that timelines for hearings and appeals can be lengthy, and inhibit providers' ability to proceed with involuntary discharges or transfers. To help ease some provider concerns, OHA, the Department of Administrative Services, and other interested partners should collaborate with OAH to develop a process for improving hearing and appeal adjudication timelines. This process may include:

  - An initial study to quantify the length of time for adjudication under OAH as compared to OHA to make the case for needed change. Study results could be used to make the case for additional funding for OAH staff positions.
  - Developing procedures for OAH to follow in "high priority" cases related to residents who are not under court order and who no longer meet medical necessity criteria or for individuals who pose a danger to staff or other residents.

  This recommendation is not made to, in any way, remove resident protections or be interpreted as removing provider responsibility for continuing to cover care for a resident of an RTF, RTH, or SRTF while the hearing and appeal process is underway and until a determination is made by OAH.

Reimbursement

- **Recommendation 14:** Medicaid should develop a new reimbursement methodology for **treatment services** provided by RTFs, RTHs, and SRTFs that use provider-based costs to develop provider-specific rates paid on a per member, per month (PMPM) basis. New rates should be based on newly defined **mental health treatment service** definitions (see **Recommendation 24** for further information on service definitions).
    - **Justification:** Myers and Stauffer confirmed that the rates posted in the current Behavioral Health fee schedule for RTFs, RTHs, and SRTFs apply regardless of Medicaid authority if an individual is enrolled or the services provided to the individual. This "one size fit all" rate structure is not sufficient for the provisioning of **treatment services** by these residential providers. Having a provider-based rate will improve alignment between the unique and tailored service activities provided by RTFs, RTHs, and SRTFs who render **treatment services**. Furthermore, a provider-based rate will ease complications stemming from the length of time between the IQA's assessment of an individual's acuity tier and providers receiving payment for services rendered.

      Should this recommendation be retained and a new **treatment services** methodology be adopted, Legislative action may be required to fund any increase in rates as a result of the change.
- **Recommendation 15:** Medicaid, in collaboration with BHD, should develop an add-on rate to incentivize providers to care for individuals with high acuity needs, who present behavioral health challenges, or

are otherwise a “high-risk” patient. Add-on rates would be specific to building staff capacity or modifying a physical environment to appropriately care for and provide **treatment services** to these individuals.

  - **Justification:** An add-on rate in addition to a provider’s cost-based rate will help to support and incentivize providers to care for individuals with high acuity needs or who are deemed “high risk” because of demonstrated behaviors. Myers and Stauffer suggest that if an add-on rate is explored, that a process for providers to submit plans for how the add-on rate will be used and retrospective oversight by OHA be a required part of the process. These rates would be negotiated rather than cost-based and could be based on the special needs contracting reimbursement rates established between ODHS and providers to care for individuals with specific medical or behavioral health needs.

    This recommendation aligns with **Recommendation 6** and should not be considered unless **Recommendation 6** is implemented. Additionally, should this recommendation be retained and a new add-on rate be adopted, legislative action may be required to fund any increase in rates as a result of the change.

- **Recommendation 16: Treatment service** reimbursement methodologies need to allow a bed hold rate based on the statewide average provider-based costs during the following circumstances: elopement, hospitalizations, involvement with law enforcement, trial visits to other facilities or settings, and when there is a planned discharge or transfer of a resident.

- **Justification:** Bed hold days are an important aspect to ensuring provider solvency during a resident's period of absence from the setting. Bed hold days are and should continue to be used for hospitalizations, involvement with law enforcement, elopement, or during trial visits to other facilities or settings and if there is a planned discharge or transfer of a resident.

- **Recommendation 17:** Review the existing payment methodology to determine if the currently established rates are appropriate for payment for **habilitation services** provided by the HCBS authorities.
  - **Justification:** If OHA removes RTFs and RTHs from under the HCBS authorities, a full rate methodology review is required to determine if current payment rates are adequate and/or appropriate to the qualified provider types rendering HCBS 1915(i) Residential Habilitation and Psychosocial Rehabilitation. The rate structure itself could be maintained, though OHA will use the interRAI CMH assessment instead of the LSI to inform an individual's tier. Despite acuity-based tiering being a noted challenge for providers financially, modifying the qualified provider type to focus on the provision of lifetime supports rather than on stabilization and treatment may help to steady the population served in these settings. A more homogenous population served in these settings is likely to have less movement between acuity tiers and will offer a more stable financial picture for providers. For this recommendation to have full effect, it needs to be implemented in tandem with **Recommendation 7**.

- **Recommendation 18: Habilitation service** methodologies need to continue allowing a bed hold rate during the following circumstances:

elopement, during a 30-day notice period following elopement, hospitalizations, involvement with law enforcement, trial visits to other facilities or settings, and when there is a planned discharge or transfer of a resident.

  - **Justification**: See justification for **Recommendation 16**.

- **Recommendation 19:** Allow for the bed hold payment for **habilitation services** to equal a resident's current payment tier rather than the Tier 1 rates established in the current OHA fee schedule.

  - **Justification:** Tier 1 rates are between $168.14 and $731.98, less than the acuity-based tiers for RTFs/RTHs (standard rates). This is a significant difference in daily payment for providers, which is impacting financial sustainability.

- **Recommendation 20:** Medicaid and ODHS need to collaborate to publish publicly available information in posted fee schedules and OAR regarding rates paid to providers for cross-placed individuals receiving treatment care in an RTF or RTH.

  - **Justification:** As noted in the **Findings Analysis** section of this report, OHA and ODHS are currently negotiating a payment rate for providers serving "cross-placed" individuals without having these individuals assessed using the LSI. This practice occurs outside of regulation and public view, which may lead to a lack of transparency with partners and reliance on a few staff determining significant amounts of reimbursement in a silo. OHA and ODHS need to collaborate and publish publicly available information regarding the rates paid to providers serving cross-placed individuals. The best method for providing information publicly is

through modification of the fee schedule and OAR 410-172-0705 Residential Rate Standardization. Given that the recommendation is presented herein regarding moving to a cost-based rate for **treatment services** provided in an RTF or RTH, OHA and ODHS would no longer need to determine a tiered rate of payment for these individuals, which will assist in compliance with OAR 410-172-0705.

Actions to Fill Capacity in Newly Licensed Facilities

- **Recommendation 21:** OHA and providers should continue to collaborate to discuss how best to fill capacity in newly licensed facilities and work together to develop strategies to overcome barriers to filling capacity.
    - **Justification:** OHA is already working with providers to determine the best methods for filling capacity in newly licensed RTFs, RTHs, and SRTFs. This effort should continue and be inclusive of discussions regarding mitigating barriers to prospective providers attempting to gain licensure with OHA. Having an inclusive process will help to ensure sustained growth in licensed facilities, thereby alleviating some of the capacity concerns in the mental health residential system.

Recommendations Addressing Tertiary Findings

Additional recommendations are provided for the Oregon Legislature and OHA's consideration. These recommendations are not specifically named in HB 2015 but were identified as appropriate to help mitigate some of the concerns relayed by partners during HB 2015 work group sessions and the tertiary findings discussed in the previous section of this report.

Mental Health Service System Improvements and Licensure Modernization

- **Recommendation 22:** Develop separate certification standards for RTFs, RTHs, and SRTFs wishing to act as a "purpose-intended" treatment facility.
    - **Justification:** RTFs, RTHs, and SRTFs are likely to continue serving individuals with various acuity and treatment needs, even if OHA moves forward with some of the recommendations put forth herein. However, to better treat and serve residents with unique concerns specific to their forensic involvement, civil commitment status, and/or serious co-occurring medical conditions, OHA could collaborate with the provider community to develop separate certification standards for RTFs, RTHs, and SRTFs wishing to provider more tailored supports to specific populations. This recommendation will offer the following benefits to OHA, providers, and residents of these facilities.
        - The creation of a specific certification standard will allow OHA to develop standards for these providers to adhere to and enforce the facilities to treat any individual for which the provider is certified to support.
        - Providers will have the ability to offer improved service offerings to individuals who may need competency restoration services or highly specific medical care to treat their conditions.
        - Lastly, but most importantly, residents will reside with individuals who resemble themselves in terms of their treatment journey. This recommendation is anticipated to

positively impact outcomes for residents who require a less "mixed-acuity facility" to work toward their treatment goals.

- **Recommendation 23:** Reframe RTFs, RTHs, and SRTFs to be "short-term," treatment-focused, and transitional in nature.
    - **Justification:** Limiting RTFs, RTHs, and SRTFs to only providing **treatment services** as discussed **Recommendation 2** and **Recommendation 3**, is a needed first step to align facility licensure standards with the services provided within these settings. However, OHA and providers will need to work together to also reframe the culture surrounding RTFs, RTHs, and SRTFs as lifelong homes for some residents, and instead move toward an understanding that **treatment** is intended to be "short-term," **treatment-focused**, and transitional in nature. As residents improve in their conditions, they should have the opportunity to receive **habilitation** support without requiring the receipt of **treatment services**. **Habilitative** support can be provided in a newly established "licensed Supported Living home" as discussed in **Recommendation 4**, a mental health AFH, or PSH. Moving residents to lower levels of care will help to free needed bed capacity in these treatment facilities that will, in turn, help support quick and appropriate discharges from OSH.
- **Recommendation 24:** Seek legislative support and funding to broaden the mental health service array by developing more services supporting a range of needs. Create additional layers and levels of care in the service system with specific licensure standards.

- **Justification:** The current mental health service array offered by OHA is limited and does not fully address the full spectrum of mental health needs expressed by Oregonians. OHA needs legislative support to build a Medicaid-funded mental health system that will help solve current challenges related to immediate crisis situations, respite, and the need for long-term supportive housing. Table 16 outlines the types of needed services, settings, and potential Medicaid authorities and licensure types are either extant or need to be developed to expand the service array.

Table 16: Considerations for Future OHA Mental Health Service Array

Acuity	Service	Service Description	Licensure Type	Medicaid Authority
High – Treatment (1)	**Inpatient psychiatric hospital**	Psychiatric hospital services that are intended for treatment and to ameliorate the symptoms of behavioral health condition(s).	Inpatient psychiatric hospital	1905(a)
High – Treatment (2)	**Acute crisis centers**	Acute crisis services in settings that can either prevent or allow egress that act as an alternative to inpatient psychiatric hospitals.	RTFs, RTHs, SRTFs, "acute care crisis licensed facilities"	1905(a)
High – Treatment (3)	**Crisis respite**	Services to treat patients experiencing crisis who currently reside in other settings. Intended to be less than 30 days.	RTFs, RTHs, SRTFs, "acute care crisis licensed facilities"	1905(a)
High – Treatment (4)	**Mental health treatment**	See definition in Table 6, intended to be "short-term."	RTFs, RTHs, SRTFs	1905(a)
Medium - Rehabilitation	**Crisis stabilization centers**	Diagnosis, stabilization, observation, and follow-up referral services provided to individuals in a community-based, developmentally appropriate home-like environment to the extent practicable.	Crisis stabilization centers	1905(a)

Acuity	Service	Service Description	Licensure Type	Medicaid Authority
Lower – Habilitation (1)	**Psychosocial Rehabilitation**	See definition in Table 6.	Mental health AFH, "licensed Supported Living home"	1915(i), 1915(k)
Lower – Habilitation (2)	**HCBS Residential Habilitation**	See definition in Table 6.	Mental health AFH, "licensed Supported Living home"	1915(i), 1915(k)
Lower – Habilitation (3)	**In-Home Mental Health Skills Training**	See definition for residential habilitation in Table 6; intermittent support.	No licensure required - services take place in a family home, consumer owned/leased home.	1915(i), 1915(k)
Lower – Habilitation (4)	**PSH, Tier 3**	Community-based, permanent housing with 24/7 supports, Medicaid-reimbursable services integrated within the housing model. Services may include peer supports, medication assistance, group or individual therapy, and tenancy support. Target populations are those with SMI, who are unhoused or have a risk of being unhoused, who need the availability of 24/7 supports but at a lower level than at a treatment facility or hospital.	PSH Tier 3 Units (static or scattered sites); services rendered by qualified practitioners as established in OAR and the Medicaid State Plan.	1905(a), 1915(i), or 1915(k). Multiple authorities should only be leveraged for the purposes of braiding Medicaid funding.

- **Recommendation 25:** OHA and the Oregon Legislature should partner to develop new statutory definitions of the newly created services discussed as part of **Recommendation 24**.
    - **Justification:** ORS will need to be updated to reflect newly created services and settings as proposed in **Recommendation 24**. This will require a detailed review of all current ORS definitions and can be completed with input gathered from the HB 2015 work group sessions.
- **Recommendation 26:** Medicaid needs to develop SMI TCM for qualifying OHP members.
    - **Justification:** TCM is an available Medicaid State Plan service open to all OHP beneficiaries who meet "target group" criteria as specified by OHA. Per the CMS-published State Medicaid Manual, TCM can be provided to target groups based on "age, type of degree of disability, illness or condition…or any other identifiable characteristic or combination thereof."[266] OHA currently provides TCM to 10 target groups but does not have a target group specific to individuals with SMI.[267] By developing an SMI target group, individuals will have objective, dedicated assistance in navigating available services and choices. TCM case managers can also perform other duties, such as program assessments, community referrals, and development of PCSPs. Additionally, OHA can leverage a TCM solution to provide funding support for community organizations providing nontherapeutic services.

[266] CMS. The State Medicaid Manual Chapter 4 – Services, Section 4302.2.
[267] Oregon State Plan. 3.1-A Supplement 1, Targeted Case Management. pp. 482-564.

- **Recommendation 27:** OHA needs to strengthen contract oversight and monitoring of person-centered planning expectations for the IQA for individuals receiving HCBS 1915(i) State Plan option services.
    - **Justification:** Person-centered planning is the core of delivering individual-based care for individuals in HCBS programs. Without a conflict-free standardized foundation in person-centered planning, services will not be individualistic, compliance with federal HCBS standards may be jeopardized, and providers will not have a clear, comprehensive view of an individual's preferences and goals. PCSPs are best developed by an independent agency rather than a service provider where conflicts of interest can occur.

      OHA should enforce a standardized person-centered planning process and template for use by the IQA and conduct monitoring activities to ensure PCSPs are developed after a full assessment of needs for the HCBS State Plan option is conducted. PCSPs should be driven by the individual receiving services and informed by partners engaged in an individual's welfare and by the interRAI CMH assessment. Strengthening practices will assist in ensuring quality services are delivered to individuals in the HCBS delivery system.

Regulation Modifications

- **Recommendation 28:** Medicaid should establish and clearly define **mental health treatment services** in Chapter 410 rules.
    - **Justification:** As the authority for all behavioral health services reimbursed by the federal government (Medicaid), OHA has an obligation to clearly define services that are reimbursable under

OHP. In the review of OAR conducted by Myers and Stauffer, no OAR was clearly identifiable as defining or outlining the scope of "Mental Health Services provided to children, adolescents and adults in Residential settings" as outlined in Section 13.d of the Oregon State Plan. As further evidence that this service is not being fully operationalized in OHP, providers were not able to explicitly identify if they were providing "Mental Health Services" or the HCBS 1915(i) State Plan option services in their settings.

This **treatment service** is already approved by CMS and should be provided to qualifying individuals. Separating settings from services, removing RTFs and RTHs from the HCBS 1915(i) State Plan option, and further defining a new qualified provider option for **habilitation** services will help distinguish the complexities of having licensed treatment providers rendering an unclear set of activities. However, it is necessary for Medicaid to define what "**mental health treatment**" as approved under the 1905(a) authority is and the activities allowed within service delivery.

- **Recommendation 29:** OHA needs to develop SRTF Class 1 and SRTF Class 2 statutory definitions and regulations to provide clarity on requirements specific to secured settings, including their distinct licensed functions.
    - **Justification:** Chapter 309, Division 33 and 35 rules are specific to civil commitment processes and RTFs and RTHs, respectively. BHD staff indicated that "most" of the Division 35 rules and "some" the Division 33 rules apply to SRTFs. Even if a reader conducts a thorough review and analysis of the rules within these Divisions, explicit, clear understanding of the standards that SRTFs are held is

difficult, if not impossible to decipher. More problematic is OHA's practice of "interpreting" specific language in OAR to apply to SRTFs, when the rules themselves do not indicate applicability to the facilities. This is most specifically observed with the 24/7 on-site nursing requirements discussed as part of **Recommendation 10**.

Clearly outlining all services, licensure standards, and other requirements specific to SRTF operations within statute and in a separate Division of OAR will provide transparency to residents and providers and hold OHA to regulatory language rather than interpretation.

- **Recommendation 30:** BHD needs to examine and potentially remove provider administrative barriers from OAR to positively impact providers' ability to open capacity and provide quality of care to individuals.
    - **Justification:** Oversight of providers is an important aspect to ensuring standards are maintained and that quality services are provided; however, overly burdensome regulatory requirements are not necessarily the most effective way for OHA to oversee mental health residential providers. Requiring all staff to be hired prior to the issuance of a license (OAR 309-035-0115) lengthens the process to bring new providers into the service system and contributes to the lack of adequate treatment beds in the system. Moreover, needing OHA to sign off on involuntary discharge or transfer notices significantly impairs providers' ability to care for and serve individuals timely and locally. Reducing regulatory imbalances while strengthening internal monitoring and oversight

practices will help improve timely access to care and minimize overall provider and OHA administrative burdens.

- **Recommendation 31:** Streamline OARs implementing federal HCBS requirements across ODHS and OHA.
    - **Justification:** ODHS and OHA are largely aligned with the federal HCBS settings requirements as enumerated in 42 CFR 441.710 (1915(i)) and CFR 42 CFR 441.530 (1915(k)); however, there are slight differences in language between OAR 410-173-0035 (1915(i)) and 411-004-0020 (1915(k)) that may impact the manner that both departments oversee and determine compliance. The most significant misalignment is seen in the OAR language that outlines requirements for "modifications of additional requirements for provider-owned or controlled settings must be supported by a specific assessed need and justified in the person-centered plan."[268, 269] OHA's Chapter 410 rule is silent to modification allowances. Instead, OHA documents modifications in OAR 410-173-0040 Individually Based Limitations.[270] Conversely, ODHS' Chapter 411 rule specifically states that "(4) When conditions under sections (1)(d) and (2)(d) to (2)(j) of this rule may not be met due to **threats to the health and safety of the individual or others**, the person-centered service plan may apply an individually-based limitation with the consent of the individual or, as applicable, the legal representative of the individual, as described in OAR 411-004-

[268] CMS. 42 CFR § 441.710 — State Plan Home and Community-Based Services Under Section 1915(i).
[269] CMS. 42 CFR § 441.530 Home and Community-Based Setting.
[270] OAR 410-137-0040 Individually Based Limitations. February 29, 2024.

0040."[271] Naming modifications relative to health and safety directly in the 1915(k) settings rule reinforces the right of providers to restrict an individual's rights through a meaningful, person-centered planning conversation that results in an IBL.

There is no reason why IBL allowances should or must be pulled out and separated into multiple OAR Chapter 410 rules. Having separate language in state regulations that are intended to mirror federal compliance for HCBS programs, regardless of authority, suggests different process and oversight practices between OHA and ODHS. Streamlining language between the two rule sets will provide needed clarification on expectations and align HCBS operations between two state agencies operating two programs.

- **Recommendation 32:** Modify OAR 309-035-0175 Rights, Freedoms, and Protections to include a "bill of rights" specific to **treatment services** provided in RTFs, RTHs, and SRTFs to create standard expectations when residing in mental health settings.
    - **Justification:** Myers and Stauffer recommends that certain protections and resident rights be developed and included in a "Treatment Setting Bill of Rights" within OAR 309-035-0175. Specific peer state examples can be leveraged to develop a strong foundation in protecting residents while being less restrictive than what is required under an HCBS model of service provision. For example, OHA should consider adding protections and rights to the

[271] OAR. 411-004-0020 Home and Community-Based Services and Settings.

"Treatment Setting Bill of Rights" to include, at a minimum, the following:

- Residents are treated with dignity, respect, and consideration. (Arizona BHRF)
- Residents are not subject to abuse, neglect, exploitation, coercion, manipulation, etc. (Arizona BHRF)
- Right to refuse drugs, testing, procedures, services, or treatment. (Colorado - MHTL Homes)
- Receive care according to an individual's needs. (Colorado - MHTL Homes)
- Residents have a right to acquire, retain, and dispose of personal property unless certain criteria, such as a court order or if the personal property poses an imminent risk of physical harm to the individual or others. (Massachusetts Adult CCS)
- Residents will be afforded secure storage of items that are removed from the direct possession of an individual while receiving treatment in the setting and will receive a receipt indicating the items removed from the individual's possession. (Massachusetts Adult CCS)
- Residents must be treated kindly and have the right to be safe in their environment. (Minnesota, IRTF)
- Residents retain privacy rights, but those rights may be limited by safety monitoring requirements, room inspections, or searches authorized under policy. (Vermont IRR)

- **Recommendation 33:** OHA should conduct an administrative review of, at minimum, all Chapter 309 Division 33, 35, and Chapter 410 Division 172 and 173 rules to identify redundancies, misnamed Division titles, and consistency errors.
    - **Justification:** As detailed in the **Tertiary Findings: Miscellaneous Observations** section of this report, the current structure of Chapter 309 Division 33, 35, and Chapter 410 Division 172 and 173 is difficult to navigate with redundant rules and mistitling, which presents challenges when attempting to understand provider standards, service definitions, and reimbursement structures. Modifying and merging rules will reduce the number of rules in existence and allow for an improved approach to documenting regulatory requirements, service practices, and provider expectations.

Collaboration with PSRB and Judicial System

- **Recommendation 34:** Collaborate with Oregon's Psychiatric Security Review Board (PSRB) and the court system to build capacity and capability, explore different financing options, and further coordinate to reduce barriers to the safest and least restrictive local community placement.
    - **Justification:** The PSRB and Oregon's court system are working collaboratively with OHA, providers, CMHPs, and other partners to make the best, quickest decisions regarding placement and treatment for the individuals they work with. Medicaid as a system is a highly complicated structure of federal and state rules, laws, funding mechanisms, and localized operations that can often be

misunderstood or misapplied when working with individuals who may be criminally involved with complex behavioral health needs. For this reason, continuing to build a strong partnership with PSRB and the court system to further their understanding of the importance of prioritizing local community options prior to placement will only serve to benefit the individuals who need this type of care the most.

Implementation Considerations

All recommendations presented herein are provided for consideration by the Oregon Legislature and OHA as a direct response to the noted challenges by providers and the HB 2015 bill sponsors. Proper prioritization, planning, and sequencing the implementation of these recommendations in a strategic manner will protect against any unintended consequences resulting from the introduction of too many of these recommendations simultaneously. At minimum, the following operational considerations should be discussed and explored between OHA, providers, and other partners. These considerations include:

- **Consideration 1:** Pave the way toward success and not lose momentum. OHA should identify an internal and external champion for these recommended initiatives.
- **Consideration 2:** Conduct an assessment to include beneficiaries to determine the benefit plan coverage for individuals currently residing in RTFs and RTHs. The goal of the assessment is to understand how many individuals are enrolled in the HCBS 1915(i) State Plan option, the 1915(k) State Plan option, or have “basic” OHP benefits to analyze

if the services provided to the individuals are appropriate to the benefit that the individual is enrolled in.

If the assessment provides evidence that the majority of individuals are receiving mental health treatment services and not HCBS Residential or Psychosocial Rehabilitation services, OHA should pursue an HCBS 1915(i) State Plan option amendment with CMS to remove RTFs and RTHs from the qualified providers named in the 1915(i). There are two associated considerations that require OHA leadership review and discussion:

  - OHA will need to confirm that sufficient alternative options exist to allow individuals to continue receiving 1915(i) covered HCBS services in alternative settings.
  - OHA needs to engage with APD to determine a process for removing RTFs and RTHs from the 1915(k), including alternative options for individuals to receive 1915(k) services in other setting types.

- **Consideration 3:** OHA will need to work with the Oregon Legislature and involved partners to determine appropriate timing to submit a Medicaid SPA to adjust the 1915(i) and 1915(k) State Plan options.
- **Consideration 4:** OHA will require the budget to finance any provider rate increases that are supported by the new methodologies outlined in the **Recommendations** section of the report.
- **Consideration 5:** The rate methodologies recommended herein cannot happen in a silo. OHA will first need to explicitly state the expected services provided in each residential setting, as well as the

staffing requirements of each setting to begin with a rate methodology review that will inform future rate setting.

- **Consideration 6:** Even if OHA and partners work quickly to design and develop new mental health services, these services will be subject to CMS' review and approval timeline. There is little OHA can do to impact CMS timelines, but open communication with CMS, acceptance of technical assistance, and collaborative efforts with partners will help to potentially alleviate documentation issues quicker with CMS as they review required federal material.

Conclusion

Oregon's HB 2015 was created to identify and explore options to address systemic barriers to effective mental health residential implementation, operations, and capacity building. The findings and recommendations presented in this report represent an extensive analysis of current regulations, rules, policies, and procedures, as well as partner voices from advocacy groups, current residential setting providers, cross-system partners, and Oregonians with lived experience. Peer state examples were used to examine similarities and differences to how Oregon has implemented their behavioral health residential settings, licensure, rules, and regulations. This study could not have been completed without the passionate community partners across the state who took the time to provide valuable feedback necessary to inform these findings and recommendations.

There is no single "quick fix" to the current barriers identified within this study. As rules and regulations change over time, sometimes there are unintended consequences of implementation strategies or rule interpretations across agencies and departments. The recommendations in this report are thoughtfully crafted and interconnected, with many relying on the successful implementation of others to achieve their full impact. Together, they represent a meaningful step forward for Oregonians by addressing the challenges faced by individuals within the mental health residential system and enhancing access to behavioral health services and support. However, their long-term success will depend on a strategic and deliberate approach to implementation, the establishment of sustainable funding mechanisms, and the strengthening of workforce capacity statewide. Additionally, OHA will need to work closely with ODHS and other

cross-system partners to effectively implement some of the recommendations.

Appendix I: HB 2015 Requirements: Alignment with Report Sections

HB 2015 Paragraph	HB 2015 Requirement	Report Section
(2)(a)	Study potential allowable alternatives to exceptions to current nurse staffing requirements in SRTFs to address workforce challenges while balancing the safety of providers and consumers.	• **Alternative Models: Provisioning Mental Health Residential Services**, page 55 • **Findings Analysis**, page 144 • **Recommendations**, page 183
(2)(b)(A)-(E)	(2)(b) Assess all methodologies permitted by federal law for reimbursing facilities. The authority shall consider alternatives to the current reimbursement rate methodology used by the authority and recommend a methodology that considers: (A) Staffing costs for a facility. (B) The need to incentivize a facility to hold open a resident's room when a resident is removed from the facility for a brief period of time. (C) The need to pay facility staff a professional wage. (D) The need to incentivize a facility to operate, develop, and staff as large of a program as is possible and safe. (E) The need to encourage facilities to serve residents with similar levels of care needs.	• **Reimbursement Methodologies**, page 49 • **Partner Engagement Feedback**, page 127 • **Reimbursement Models**, page 48 • **Findings Analysis**, page 144 • **Recommendations**, page 183

HB 2015 Paragraph	HB 2015 Requirement	Report Section
(2)(c)(A)-(B)	(c) Determine whether the authority may, under federal law, administer residential behavioral health services to medical assistance recipients through options other than through the state's HCBS waiver, under 42 U.S.C. 1396n(c), or a SPA under 42 U.S.C. 1396n(i). To the extent that alternative models of administering residential behavioral health services to medical assistance recipients are permissible under federal law, the authority shall: (A) Analyze alternative models that have been approved by CMS for use in other states. (B) Evaluate the cost of any alternative models.	• **Alternative Models: Provisioning Mental Health Residential Services**, page 55 • **Peer State Examples**, page 110
(2)(c)(C)(i)	(C) Develop recommendations about: (i) Alternative options that would allow the authority to increase reimbursement rates for facilities.	• **Recommendations**, page 183
(2)(c)(C)(ii)	(ii) Alternative options that would not subject facilities to a requirement that facilities provide an eviction process that is as protective as state landlord-tenant law.	• **Recommendations**, page 183
(2)(c)(C)(iii)	(iii) How alternative models may support facilities in serving residents with high acuity behavioral health needs and what protections are available to ensure that residents with high acuity behavioral health needs are not prematurely or inappropriately discharged for problematic behaviors.	• **Recommendations**, page 183

HB 2015 Paragraph	HB 2015 Requirement	Report Section
(2)(c)(C)(iv)	(iv) A discharge process for residents who decline to participate in treatment and are, therefore, not suited for continued services by a facility.	• **Recommendations**, page 183
(2)(c)(C)(v)	(v) An appeal process for both facilities and residents.	• **Recommendations**, page 183
(2)(d)	(d) Determine the feasibility of supporting the direct discharge of a resident, when deemed medically necessary and clinically prudent, from a facility to other types of housing without requiring a third-party referral.	• **Discharge practices**, page 85 • **Peer State Examples**, page 110 • **Findings Analysis**, page 144 • **Recommendations**, page 183
(2)(e)	(e) Evaluate options for providing, and develop recommendations for funding, capacity payments to facilities when a resident is hospitalized or temporarily absent due to a law enforcement encounter.	• **Alternative Models: Provisioning Mental Health Residential Services**, page 55 • **Peer State Examples**, page 110 • **Findings Analysis**, page 144 • **Recommendations**, page 183
(2)(f)	(f) Study needed actions and take appropriate actions to fill the capacity of newly licensed facilities.	• **Licensing, classification, and** • **Requirements,** page 91 • **Findings Analysis**, page 144 • **Recommendations**, page 183

Appendix II: Extended Acronyms, Key Terms and Definitions

Acronym, Key Terms	Definition
Acuity	"Level of residential service and support needs of an individual experiencing functional deficits resulting from the symptoms of a diagnosed mental health condition or complicating medical, behavioral, or cognitive condition."[272]
Behavioral Health Treatment	"Treatment for mental health, SUDs, and problem gambling."[273]
Capitated Services	"Covered services that a managed care entity (MCE) agrees to provide for a capitation payment under contract with the Authority."[274]
Capitation Payment	"The monthly prepayment to an MCE for capitated services to MCE members."[275]
Care Coordination	"The act and responsibility of CCOs to deliberately organize a member's overall benefits, services, care activities (e.g., assessments, case management, care planning) and information sharing among a member's care team, according to the physical, developmental, behavioral, oral and social needs (including health-related social needs and social determinants of health and equity) of the member."[276]

[272] OAR. 410-172-0705 Residential Rate Standardization.
[273] OAR. 309-019-0100 Purpose and Scope. Eff. June 23, 2017.
[274] OAR.410-141-3500 Definitions. Eff. January 1, 2026.
[275] Ibid.
[276] Ibid.

Acronym, Key Terms	Definition
Care Profile	"The electronic health record that a CCO develops and maintains for all members. The Care Profile is the platform that receives feeds from different data sources used to identify, track, and manage a member's needs and risk level to direct the frequency of the CCOs outreach and care coordination activities/opportunities that shall be offered to the member, including, but not limited to, care management and appropriate care plans."[277]
Care Setting Transitions	"Care setting transitions are a transition between different locations, settings, or levels of care."[278]
Case Management	"Case management means the management of services that are provided to assist an individual in accessing medical and behavioral healthcare, social and educational services, public assistance and medical assistance, and other needed community services identified in the individual's patient-centered care plan."[279]
Client	"An individual found eligible to receive OHP health services whether the individual is enrolled as a CCO member or not."[280]
Community Mental Health Program (CMHP)	"The entity responsible for organization of various services for persons with a mental health diagnosis or addictive disorders, operated by, or contractually affiliated with, a local mental health authority and operated in a specific geographic area of the state under an agreement with the Division pursuant to OAR 309-014-0000."[281]

[277] Ibid.
[278] Ibid.
[279] OAR. 836-053-1403 Definitions of Coordinated Care and Case Management for Behavioral Health Care Services. Eff. March 1, 2018.
[280] OAR.410-141-3500 Definitions. Eff. January 1, 2026.
[281] OAR 309-033-0210 Definitions. Eff. January 1, 2026.

Acronym, Key Terms	Definition
Comparability	The provision of similar benefits to individuals enrolled in a Medicaid program. Some Medicaid authorities allow states to waive comparability which allows the provision of different benefits to individuals enrolled in a managed care delivery system.[282]
Coordinated Care Organizations (CCOs)	"CCO means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Authority under ORS 414.572 to be accountable for care management and to provide integrated and coordinated healthcare for each of the organization's members."[283]
Freedom of Choice	The allowance under the Medicaid program to have individuals chose among services and providers. Some Medicaid authorities waive freedom of choice.[284]
Habilitation	"Means services that support an individual with developing, maintaining, or improving skills and competencies necessary to function as independently as possible and to the extent that they would if they did not have a disability or chronic condition."[285]
High-Risk	"An identified concern, that without mitigation, is likely to cause the individual to experience substantial injury or loss within the next 30 days or the individual has experienced substantial harm within the previous 30 days, and the harm will likely recur without mitigation."[286]
Homelessness	Homelessness means the lack of a decent, safe, stable and permanent place to live that is fit for human habitation.[287]

[282] CMS. Managed Care Authorities.
[283] OAR.410-141-3500 Definitions.
[284] CMS. Managed Care Authorities.
[285] OHA 410-173-005. Definitions. Eff. August 20, 2026.
[286] ODHS. Risk Level Definitions and Quick Reference Chart.
[287] ORS. 458.528 Policy on homelessness.

Acronym, Key Terms	Definition
Independent and Qualified Agent (IQA)	"Oregon's contracted vendor to perform functional needs assessments, person-centered service planning service coordination, transition coordination, service authorizations, and utilization review and management for individuals requesting or receiving 1915(i) HCBS, other Medicaid-funded behavioral health services, or state General Fund behavioral health services in an individual's home or a community-based setting."[288]
Landlord's Agent	"A person who has oral or written authority, either express or implied, to act for or on behalf of a landlord."[289]
Permanent Supportive Housing (PSH)	PSH is a combination of housing and services designed for people with SMIs or other disabilities who need support to live stably in their communities. These services can include case management, substance abuse or mental health counseling, advocacy, and assistance in locating and maintaining employment. PSH is a proven solution for people who have experienced chronic homelessness, as well as other people with disabilities, including people leaving institutional and restrictive settings.[290]
Psychiatric Security Review Board (PSRB)	Oversees individuals who have successfully used an insanity defense in their criminal proceedings and are found to not be responsible for their crimes. The PSRB is made up of two panels (adult and juvenile), and each panel is made up of five panels. PSRB works with individuals to identify treatment within the mental health system and is focused on public safety while caring for those in their custody.[291]

[288] OAR. 410-172-0705 Residential Rate Standardization.
[289] ORS. Chapter 90 – Residential Landlord and Tenant. 90.100 Definitions. 2025 Edition.
[290] OAR. 813-138-000 Permanent Supportive Housing (PSH).
[291] PSRB. About the Board.

Acronym, Key Terms	Definition
Psychosocial Rehabilitation Services (PSR)	"Medical or remedial services recommended by a licensed physician or other licensed practitioner to reduce impairment to an individual's functioning associated with the symptoms of a mental disorder or to restore functioning to the highest degree possible."[292]
Residential Treatment Program (OR)	"A RTF, RTH, SRTF…that is licensed to provide mental health services but does not include adult foster homes as defined in 309-040-0305."[293]
Retainer Payment	"Means a payment made for medical, behavioral, or psychiatric related temporary absences of 30 days or less from residential treatment programs for which the Division has provided prior authorization."[294]
Statewideness	Provisions apply to the entire state. Some authorities (like the 1915(b) waiver authority) allow states to waive "statewideness."[295]
Treatment Setting	A site in which an individual can access healthcare services, "based on the type and acuity of a client's symptoms."[296]
Unstably Housed	"Means an individual or family who is rent-burdened, defined as paying more than 30% of their gross income in rent, or is currently paying more than the Fair Market Rent (FMR), defined by HOME FMRs or is at risk of losing their housing and does not otherwise qualify as homeless or imminent risk, has been notified to vacate their current residence or otherwise demonstrates a high risk of losing their current housing and lacks the resources or support networks to obtain other permanent housing."[297]

[292] OAR. 410-172-0705 Residential Rate Standardization.
[293] Ibid.
[294] Ibid.
[295] CMS. Managed Care Authorities.
[296] Psychiatric-Mental Health Nursing. p. 146. Puchkors, R et. al.
[297] OAR. 813-051-0000 Purpose and Objectives. Eff. April 2, 2025.

Acronym, Key Terms	Definition
U.S. Department of Housing and Urban Development (HUD)	HUD administers federal aid to local housing agencies that manage the housing for low-income residents at rents they can afford. HUD furnishes technical and professional assistance in planning, developing, and managing these developments.[298]

[298] U.S. Department of Housing and Urban Development. HUD's Public Housing Program.

Appendix III: Reimbursement Models

Reimbursement Method	Description
Capitation	Paid on a PMPM amount from the Medicaid agency to an MCO. Capitation rates are preset, and the MCO is at financial risk for providing services. Capitation rates may be adjusted for various factors like age, geography, or health status.[299]
Care management fee	This arrangement is used primarily for FFS providers or provider organizations who operate health homes or patient-centered medical homes. Care management fees are supplemental payments made on PMPM basis for care management and may be adjusted to account for factors like demographics, health status, or a provider's accreditation scores.[300]
Delivery system reform incentive payment (DSRIP)	DSRIP are part of 1115 authorities and provide states with funding to support specific types of providers in changing how they provide care to individuals. DSRIPs use cost savings from initiatives undertaken through 1115 waivers to fund investments into delivery system reforms.[301]
Episode of care (EOC) payment	Single, pre-determined, payments for providers to provide a set of services to individual's receiving treatment for a health event. Episodes have a set beginning and end period and typically include the costs for providing multiple services to the individual during the defined episode. EOC payments can be retrospective or prospective in nature.[302]
Fee-for-service (FFS)	Establishes fee levels for covered services, and payment is received directly by providers. There is no risk to providers, and this model generally incentivizes volume over quality.[303]

[299] KFF. Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts.
[300] Ibid.
[301] Ibid.
[302] Ibid.
[303] Ibid.

Reimbursement Method	Description
Global bundling	A single, pre-defined payment is made for a range of services delivered to an individual over an established period of time. Global bundling payments are risk-adjusted based on health factors like age or gender. This model also incorporates outcome or quality measures to reward high-performing providers.[304]
Pay-for-performance	Rewards providers and/or MCOs for achieving specified quality benchmarks. These payments are required to be made based on performance structure, process, or outcomes and are evaluated using the established benchmarks.[305]
Shared risk arrangements (risk-sharing)	Opposite of shared savings arrangements. Entities involved in shared savings arrangements may also be subject to shared risk with payors. If actual costs for a defined patient population exceed the benchmark then the provider or accountable care organizations (ACO) is responsible for excess costs and is required to return funds to the payer.[306]
Shared savings arrangements (gainsharing)	Opposite of shared risk arrangements. Provider organizations or ACOs can share in accrued net savings for a defined set of patients over a specified time period. Actual costs are compared to benchmarks that are established from utilization experience or cost data. For a provider to receive the savings providers and/or ACOs must achieve quality and performance standards while simultaneously reducing costs.[307]

[304] Ibid.
[305] Ibid.
[306] Ibid.
[307] Ibid.

Appendix IV: Other Alternative Medicaid Authority Details

- **[Section 1915(a)]:** This authority is used to create a voluntary managed care program by executing contracts with MCOs. CMS must approve the State to make payments under this authority.[308] Though CMS lists the 1915(a) authority as a "waiver," this section is, in practicality, a contracting allowance permitted by the federal government. Per publicly available information published by CMS, 13 states and Puerto Rico use the 1915(a) authority to administer 24 managed care plans.[309]
- **Section 1915(b):** Section 1915(b) authorities provide for time-limited waivers of statewideness, comparability, and freedom of choice for Medicaid-covered services. This authority can also be used to provide additional services for enrollees who are not covered by the waiver, as well as limit the number of service providers.[310] There are four types of 1915(b) waiver authorities:
    - **1915(b)(1) Freedom of Choice:** Creates mandatory enrollment into managed care and a managed care plan based on State-developed criteria. For example, some states may exclude individuals with DDs from mandatory enrollment into managed care.[311]

[308] CMS. Managed Care Authorities.
[309] Ibid.
[310] MACPAC. Features of federal Medicaid managed care authorities.
[311] CMS. Managed Care Authorities.

- **1915(b)(2) Enrollment Broker:** Uses a "central broker." Central brokers are agents, facilitators, or negotiators who help individuals navigate managed care enrollment and choices among managed care plans from whom they receive services.[312]
- **1915(b)(3) Non-Medicaid Services Waiver:** States use 1915(b)(3) waivers to provide additional services to beneficiaries enrolled in the waiver. Costs for these services are covered by the savings achieved by the 1915(b)(3) waiver. 1915(b)(3) waivers are required to be used in conjunction with 1915(b)(1) or (b)(4) waivers.[313]
- **1915(b)(4) Selective contracting Waiver:** These waivers restrict the provider from whom the beneficiary may obtain services.[314] They are often used to implement limited benefit plans like a PIHP or PAHP, both of which are explored in further detail below.

1915(b) waivers require an extensive amount of administrative support to implement and include numerous requirements for states to adhere to for CMS approval.

- **Section 1915(j):** This Medicaid authority allows individuals to self-direct personal assistance services under the Medicaid State Plan on a voluntary basis. Individuals set their own provider qualifications, train

[312] Substance Abuse and Mental Health Services Administration (SAMHSA). Medicaid Handbook: Interface with Behavioral Health Services. 2013. p. 9-9.
[313] SAMHSA. Medicaid Handbook: Interface with Behavioral Health Services. p. 9-9.
[314] CMS. Managed Care Authorities.

staff, and determine how much they pay for a service or support item.[315]

- **Section 1932(a):** States use the State Plan 1932(a) authority to require beneficiary enrollment into managed care entities like an MCO or a primary care case manager entity. Per the CMS preprint that states use to submit a request for a 1932(a) authority, "Under this authority, a state can amend is Medicaid State Plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the [Social Security] Act on statewideness, (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230)."[316]
- **Section 1115:** In addition to waiving certain federal Medicaid requirements, 1115 waivers may use funds for activities that are not otherwise allowed by federal Medicaid rules.[317] These waivers are known as "demonstration" waivers in that states have the ability under this authority to "demonstrate" a unique way to cover different populations or provide services.

  Some states use 1115 waivers for broad program changes, though some 1115 waivers are designed to only apply to specific populations (e.g., Medicaid work requirements waivers). Additionally, Section 1115 waivers can be used to authorize mandatory enrollment in managed care, similarly to a 1915(b) waiver, but do so to demonstrate "budget neutrality savings." Savings from 1115 waivers may be used to cover

[315] CMS. Self-Directed Personal Assistance Services 1915(j).
[316] CMS. Attachment 3.1-F Condition or Requirement. OMB. No.: 0938-0933.
[317] KFF. Medicaid Section 1115 Waivers: The Basics. Elizabeth Hinton and Diana Amaya. January 24, 2025.

costs associated with other waiver-related costs that are not coverable by Medicaid programs.[318]

1115 waivers are administratively complex and require public notices, submission to and approval by CMS, budget neutrality demonstrations, monitoring and evaluation, and implementation plans. Additionally, 1115 waivers are subject to different Administrations' interpretation and policy guidance, and some have been challenged in court.[319]

[318] Ibid.
[319] Ibid.

Appendix V: Summary of Medicaid Authority Comparisons

Medicaid Authority	Approval Period	Renewal Period	Enrollment	Program Enrollment Waitlist Allowed[320]	Budget Requirements	Subject to HCBS Settings Rules[321]
State Plan	-	-	-	-	-	-
1905(a)	Indefinite	Not applicable	All populations as described in 1905(a)(i)-(xviii) in the SSA[322]	No	Not applicable	No

[320] National Association of State Directors of Developmental Disabilities Services (NASDDDS). Waiting Lists and Medicaid Home and Community-Based Services. p. 1, 4-5. Robin E. Cooper. November 2017

[321] CMS. Questions and Answers – 1915(i) State Plan Home and Community-Based Services, 5 Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and 1915(c) Home and Community-Based Services Waivers – CMS 2249-F and 2296. p. 2.

[322] SSA, Section 1905(a) [42 U.S.C. 1396d].

Medicaid Authority	Approval Period	Renewal Period	Enrollment	Program Enrollment Waitlist Allowed[320]	Budget Requirements	Subject to HCBS Settings Rules[321]
1932(a)	Indefinite[323]	Not applicable[324]	All State Plan populations except children with certain special needs, Medicare beneficiaries, and Native Americans.[325]	Not applicable	Not applicable[326]	No
1915(i)	No time limit except when targeting enrollment; when targeting, approval is for five years.	Every five years	Individuals must meet State-defined LON criteria; LON is less stringent than institutional LOC.	No	• No program budget requirements. • Individual budgets for participant-directed services are permissible.[327]	Yes

[323] MACPAC. Features of federal Medicaid managed care authorities.
[324] Ibid.
[325] Ibid.
[326] Ibid.
[327] CMS. HCBS Technical Assistance, Website, 1915(i) State Plan Home and Community Based Services. 2026.

Medicaid Authority	Approval Period	Renewal Period	Enrollment	Program Enrollment Waitlist Allowed[320]	Budget Requirements	Subject to HCBS Settings Rules[321]
1915(j)	Indefinite	Not applicable[328]	States may target individuals already receiving 1915(c) waiver services and specific geographic areas.[329]	Yes	• No program budget requirements. • Individual budgets for participant-directed services are permissible.[330]	No
1915(k)	Indefinite	Not applicable	Targeting is prohibited, but individuals must meet institutional LOC.	No	• No program budget requirements. • Individual budgets for participant-directed services are permissible.[331]	Yes
Waiver	-	-	-	-	-	-

[328] Ibid.
[329] CMS. Self-Directed Personal Assistance Services 1915(j).
[330] CMS. HCBS Technical Assistance Website, 1915(j) Self-Directed Personal Assistance Services (PAS).
[331] CMS. HCBS Technical Assistance Website, 1915(k) Community First Choice Option. 2026.

Medicaid Authority	Approval Period	Renewal Period	Enrollment	Program Enrollment Waitlist Allowed[320]	Budget Requirements	Subject to HCBS Settings Rules[321]
1915(c)	Initially three or five years	Every five years	Individuals within a target group (e.g., aging, physical disability, DD, mental illness) who meet an institutional LOC, not including IMD LOC.	Yes	Must be cost-neutral when compared to institutional costs, on an average per capital basis [332]	Yes
1915(a)	Not applicable, contracts with managed care entities will vary.	Not applicable, contracts with managed care entities will vary.	Voluntary enrollment	Not applicable	Not applicable, managed care models may vary.[333, 334]	No

[332] CMS. HCBS Technical Assistance Website, 1915(c) Home and Community-Based Services Waiver. 2026.
[333] MACPAC. Features of federal Medicaid managed care authorities.
[334] SSA. Section 1915(a) [42 U.S.C. 1396n].

Medicaid Authority	Approval Period	Renewal Period	Enrollment	Program Enrollment Waitlist Allowed[320]	Budget Requirements	Subject to HCBS Settings Rules[321]
1915(b)	Initially approved for two years	2-5 years, based on if dually eligible individuals are included.	• All State Plan covered populations[335]	Not applicable	Actual expenditures cannot exceed projected expenditures for approval time period.[336]	No
1115	Five years, but may be approved by CMS for longer or shorter periods.	Every five years, though CMS has discretion on a renewal period.	• All State Plan covered populations. • Any individual not otherwise eligible for Medicaid, but federal match for these individuals is not permissible.[337]	If approved special terms and conditions.	Must be budget neutral.[338]	Yes, if covering HCBS settings

[335] MACPAC. Features of federal Medicaid managed care authorities.
[336] Ibid.
[337] MACPAC. Features of federal Medicaid managed care authorities.
[338] CMS. 1115 Research and Demonstration Project Waiver. 2026.

Appendix VI: Mental Health Residential Settings – Applicable Oregon Revised Statutes and Administrative Rules

Statue or Regulation	Applicable Setting	Key Summary
ORS 443.400	RTF and RTH	Sets definitions for ORS 443.400 through 443.455 and defines OHA as the licensing agency.[339]
ORS 443.465	SRTF	Statutory language regarding the regulation of SRTFs.[340]
ORS 443.400-443.455	RTFs, RTHs, SRTFs	Statutory authority for licensing RTFs/homes; defines facility types, licensing requirements, enforcement, and penalties. Forms the legal basis for OAR 309-035.
ORS 413-042	All OHA licensed behavioral health settings.	Grants OHA authority to adopt rules for administering behavioral health programs, including residential treatment.
ORS 443.400-443.455	RTFs, RTHs, SRTFs	Statutory authority for licensing RTFs/RTHs; defines facility types, licensing requirements, enforcement, and penalties. Forms the legal basis for OAR 309-035.
ORS 413.042	All OHA licensed behavioral health settings.	Grants OHA authority to adopt rules necessary for administration of the laws that OHA is charged with administering.
ORS 426	RTFs, RTHs, SRTFs serving civilly committed individuals.	Governs civil commitment, rights, due process, and placement of individuals with mental illness and dangerous persons. Relevant for facilities serving civilly committed residents.

[339] ORS 443.400. Definitions for ORS 443.400 to 443.455. 2025 Edition.
[340] ORS 443.465. Secure residential treatment homes and facilities; rules. 2025 Edition.

Statue or Regulation	Applicable Setting	Key Summary
ORS 161	SRTFs, forensic residential programs.	Governs individuals under the PSRB or forensic commitment, including placement in a state mental hospital or SRTF and conditions of supervision.
OAR 309	All mental health programs, including community-based residential.	Provides the umbrella of rules for mental health services, including definitions, service standards, rights, and program requirements.
OAR 309-035-0100 to 309-035-0225	RTF, RTH, SRTF, crisis respite	Provides the core licensing and operational standards: home-like environment requirements, staffing, safety, sanitation, rights, admission/discharge, person-centered planning, HCBS compliance, seclusion/restraint limits, penalties. Implements CMS HCBS requirements under 1915(i).
OAR 410-173	RTFs, RTHs, SRTFs	Implements federal HCBS settings rule requirements: community integration, autonomy, rights, lease/residency protections, and IBLs. Applies when facilities receive Medicaid HCBS funding.
OAR 309-019	RTFs RTHs, SRTFs that provide treatment services.	Sets the standards for behavioral health treatment services delivered within residential programs: assessment, service planning, documentation, clinical supervision, and quality assurance.

Statue or Regulation	Applicable Setting	Key Summary
309-033-0520	RTF, RTH, SRTF	Applicable to persons under civil commitment or in custody on a civil commitment hold or on diversion from civil commitment. Prescribes the classes that may be assigned to facilities by OHA's BHD. The class taxonomy applies to SRTFs, as well as state hospital or a residential facility operated by a state hospital.[341]
309-035-0105 Definitions[+]	RTF, RTH, SRTF	Provides definitions for key terms, including RTFs, RTHs, and SRTFs within 309, Division 35 rules.[342]
309-035-0115 Licensing[+]	RTF, RTH, SRTF	Establishes licensing standards for RTFs, RTHs, and SRTFs.[343]
309-035-0135 Staffing[+]	RTF, RTH, SRTF	Details staffing requirements for RTFs, RTHs, SRTFs.[344]
309-035-0158 Waitlist management[+]	RTF, RTH, SRTF	Rule prioritizing individuals for admission in RTFs and RTHs.
410-172-0705 Residential Rate Standardization	RTF, RTH, SRTF	Defines terms used throughout this rule. The rule also describes how standard rates are used to provide habilitative and personal care service within residential treatment programs.[345]

[341] OAR. 309-033-0520 Classes of Facility that Provide Care, Custody, or Treatment to Persons Under Civil Commitment or to Persons in Custody or on Diversion.
[342] OAR. 309-035-0105 Definitions.
[343] OAR. 309-035-0115 Licensing.
[344] OAR. 309-035-0135 Staffing.
[345] OAR. 410-172-0705. Residential Rate Standardization.

Appendix VII: Oregon Staffing Requirements

Setting	Summary of Facility Staff Training Requirements
RTF and RTH	• The program administrator must provide or arrange a minimum of 16 hours of preservice orientation for each program staff within 60 days of hire and prior to working alone with residents. Preservice training for direct care staff must include, but is not limited to: ○ A comprehensive tour of the setting. ○ A review of emergency procedures developed in accordance with OAR 309-035-0145. ○ A review of setting policies and procedures. ○ Background on mental, emotional, or behavioral disorders and conditions. ○ Behavior management, including interventions and de-escalation techniques. ○ An overview of resident rights. ○ Medication management procedures. ○ Food service arrangements. ○ Grievances, complaints, and an overview of the Oregon Residential Facilities Ombudsman program. ○ A summary of each resident's assessment and residential service plan. ○ Culturally responsive care. ○ Completion of the approved course *Mandatory Reporting for Individuals Working in CMHPs*. ○ Completion of an approved HCBS training course. ○ Other information relevant to the job description and scheduled shifts. • The program administrator must provide or arrange a minimum of eight hours of annual in-service training for each program staff. Annual in-service training topics for direct care staff must include, but are not limited to: ○ Culturally responsive care. ○ Implementing residential service plans. ○ Behavior management, including interventions and de-escalation techniques. ○ Daily living skills development. ○ Nutrition.

Setting	Summary of Facility Staff Training Requirements
	○ Opioid overdose kits and administration of a Food and Drug Administration (FDA)-approved short-acting, noninjectable, opioid antagonist medication. ○ Understanding mental illness. ○ Sanitary food handling. ○ Resident rights, freedoms, and protections. ○ Identifying healthcare needs. ○ Complaints, grievances, incidents, and abuse reporting. ○ Psychotropic medications. • The licensee must ensure all direct care staff have and maintain current CPR and First Aid certifications from a Division-approved entity within 60 days of hire and prior to working alone with residents: ○ Accepted CPR and First Aid courses must be provided by or meet the standards of the American Heart Association or the American Red Cross. ○ CPR or First Aid courses conducted online are only accepted by the Division when an in-person skills competency check is conducted by a qualified instructor meeting the standards of the American Heart Association or the American Red Cross. • The licensee must ensure all program staff and entities contracting with the program to provide direct care complete a general worker safety training within 90 days of hire and at least two years thereafter. This training must focus on providing program staff and contracted entities with skills and knowledge regarding: ○ The potential risks that program staff may face in the work environment of a particular behavioral health setting, including but not limited to, behavioral health settings involving mobile crisis intervention teams, as defined in ORS 430.626. ○ Protocols for using safety equipment, emergency communication devices, and alert systems in emergency or crisis situations. ○ The available options for reporting alleged workplace safety violations and allegations of discrimination, retaliation or harassment to the Occupational Safety and Health Division of the Department of Consumer and

Setting	Summary of Facility Staff Training Requirements
	Business Services, the Bureau of Labor and Industries, and other relevant state agencies, including the rights and protections afforded to workers who engage in such reporting. • All program staff and entities contracting with the program to provide direct care must complete a Division-approved LGBTQIA2S+ training within 60 days of hire and prior to working alone with residents and every two years thereafter. This training must include the following elements: ○ Caring for LGBTQIA2S+ residents and residents living with human immunodeficiency virus (HIV). ○ Preventing discrimination based on a resident's sexual orientation, gender identity, gender expression, or HIV status. ○ The defined terms commonly associated with LGBTQIA2S+ individuals and HIV status. ○ Best practices for communicating with or about LGBTQIA2S+ residents and residents living with HIV, including the use of an individual's chosen name and pronouns. ○ A description of the health and social challenges historically experienced by LGBTQIA2S+ residents and residents living with HIV, including discrimination when seeking or receiving care and the demonstrated physical and mental health effects within the LGBTQIA2S+ community associated with such discrimination. ○ Strategies to create a safe and affirming environment for LGBTQIA2S+ residents and residents living with HIV, including suggested changes to policies and procedures, forms, signage, communication between residents and their families, activities, in-house services, and staff training. • Proof of all training completion must be documented in the program staff member's individual personnel file as outlined in OAR 309-035-0125. Proof of training completion for entities contracting with the program must be maintained in the program files.[346]

[346] ORS 309-035-0135. Staffing. 2025 Edition.

Setting	Summary of Facility Staff Training Requirements

SRTF Class 1	• Direct Care Staff Training. A staff person must be trained and able to demonstrate competency in the application of restraints and implementation of seclusion during the following intervals:
	  ○ A new staff person must be trained within the six months prior to providing direct patient care or as part of orientation.
	  ○ Subsequently on a periodic basis consistent with the hospital or facility policy.
	  ○ Documentation in the staff personnel records must indicate the training and demonstration of competency were successfully completed.
	• Trainer Qualifications. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address a person's behaviors.
	• Training Curriculum. The training required for direct care staff must include:
	  ○ Standards for the proper use of seclusion and restraints as described in OAR 309-033-0730.
	  ○ Identification of medication side effects.
	  ○ Indicators of medical problems and medical crisis.
	  ○ Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.
	  ○ The use of nonphysical intervention skills.
	  ○ Choosing the least restrictive intervention based on an individualized assessment of the person's medical or behavioral status or condition.
	  ○ The safe application and use of all types of restraint or seclusion used in the hospital or facility, including training in how to recognize and respond to sign of physical or psychological distress.
	  ○ Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
	  ○ Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin

Setting	Summary of Facility Staff Training Requirements
	integrity, vital signs, and any special requirements specified by the hospital or facility policies and procedures. ○ The use of first aid techniques and certification in the use of CPR, including periodic recertification.
SRTF Class 2	• Direct Care Staff Training. A staff person must be trained and able to demonstrate competency in the application of restraints and implementation of seclusion during the following intervals: ○ A new staff person must be trained within the six months prior to providing direct patient care or as part of orientation. ○ Subsequently on a periodic basis consistent with the hospital or facility policy. • Documentation in the staff personnel records must indicate the training and demonstration of competency were successfully completed. • Trainer Qualifications. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address a person's behaviors. • Training Curriculum. The training required for direct care staff must include: ○ Standards for the proper use of seclusion and restraints as described in OAR 309-033-0730. ○ Identification of medication side effects. ○ Indicators of medical problems and medical crisis. ○ Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion. ○ The use of nonphysical intervention skills. ○ Choosing the least restrictive intervention based on an individualized assessment of the person's medical, or behavioral status or condition. ○ The safe application and use of all types of restraint or seclusion used in the hospital or facility, including training in how to recognize and respond to sign of physical or psychological distress.

Setting	Summary of Facility Staff Training Requirements
	○ Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary. ○ Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by the hospital or facility policies and procedures. ○ The use of first aid techniques and certification in the use of CPR, including periodic recertification.

Appendix VIII: Oregon Behavioral Health Fee Schedules

RTFs and RTHs

Standard - Total PMPD

Bed Size	Tier 1[347]	Tier 2	Tier 3	Tier 4	Tier 5
1-5 (RTH)	$252.21	$420.35	$523.95	$709.97	$984.19
6-10 (RTF)	$186.22	$310.36	$413.96	$517.55	$676.64
11-16 (RTF)	$131.20	$218.67	$297.63	$350.61	$510.32

Portland Metro - Total PMPD

Bed Size	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
1-5 (RTH)	$245.18	$408.63	$512.22	$782.98	$1,085.38
6-10 (RTF)	$179.18	$298.64	$402.23	$521.98	$746.20
11-16 (RTF)	$143.70	$239.50	$328.26	$386.66	$562.79

Non-Urban - Total PMPD

Bed Size	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
1-5 (RTH)	$259.67	$432.79	$536.38	$709.97	$984.19
6-10 (RTF)	$193.68	$322.80	$426.40	$529.99	$676.64
11-16 (RTF)	$130.30	$217.16	$297.63	$357.22	$510.32

SRTF Class 1

Standard - Total PMPD

Bed Size	Tier 1	Tier 2	Tier 3	Tier 4
1-5	$540.03	$900.05	$1,020.57	$1,337.27
6-10	$454.27	$757.11	$877.63	$1,002.95
11-16	$309.54	$515.90	$636.43	$871.70

[347] Tier 1 for RTH, RTF, and SRTFs are bed holds and not reflective of acuity-based rates. The Tier 1 rates are highlighted in gray to distinguish them from true acuity-based payments.

Portland Metro - Total PMPD

Bed Size	Tier 1	Tier 2	Tier 3	Tier 4
1-5	$531.84	$886.41	$1,006.93	$1,474.78
6-10	$446.08	$743.47	$863.99	$1,106.07
11-16	$301.36	$502.26	$622.79	$961.33

Non-Urban - Total PMPD

Bed Size	Tier 1	Tier 2	Tier 3	Tier 4
1-5	$561.63	$936.05	$1,061.39	$1,337.27
6-10	$472.44	$787.39	$912.74	$1,038.08
11-16	$321.92	$536.54	$661.88	$871.70

SRTF Class 2

Standard - Total PMPD

Bed Size	Tier 1	Tier 2	Tier 3	Tier 4
1-5	$450.02	$750.04	$850.47	$1,198.93
6-10	$378.55	$630.92	$731.36	$899.25
11-16	$257.95	$429.92	$530.36	$781.53

Portland Metro - Total PMPD

Bed Size	Tier 1	Tier 2	Tier 3	Tier 4
1-5	$443.20	$738.67	$839.11	$1,322.22
6-10	$371.73	$619.56	$719.99	$991.67
11-16	$251.13	$418.55	$518.99	$861.89

Non-Urban - Total PMPD

Bed Size	Tier 1	Tier 2	Tier 3	Tier 4
1-5	$468.02	$780.04	$884.49	$1,198.93
6-10	$393.70	$656.16	$760.61	$899.21
11-16	$268.27	$447.12	$551.57	$781.53

HCBS 1915(i) State Plan Option: Psychosocial Rehabilitation

Rate	Unit
$259.82	Per diem[348]

[348] OHA. Behavioral Health Fee Schedule February 2026. February 2026. Adult MH Res Standardized Rate tab.

Appendix IX: interRAI CMH Mental Health Residential Facility Tier Thresholds

RTF/RTH interRAI Tiers and Score Thresholds

interRAI Scale Name	Scale Range	Tier 2 Score	Tier 3 Score	Tier 4 Score	Tier 5 Score
Aggressive Behavior Scale	0 to 12	0	1 to 2	3 to 4	5 to 12
ADL Hierarchy	0 to 6	0 to 1	2 to 3	4	5 to 6
Cognitive Performance Scale	0 to 6	0 to 1	2 to 3	4 to 5	6
Instrumental Hierarchy	0 to 6	0 to 2	3 to 5	6	-
Risk of Harm to Others	0 to 6	0	1 to 2	3 to 4	5 to 6
Self-Care Index	0 to 6	0 to 2	3 to 5	6	-

SRTF interRAI Tiers and Score Thresholds

interRAI Scale Name	Scale Range	Tier 2 Score	Tier 3 Score	Tier 4 Score
Aggressive Behavior Scale	0 to 12	0	1 to 4	5 to 12
ADL Hierarchy	0 to 6	0 to 1	2 to 3	4 to 6
Cognitive Performance Scale	0 to 6	0 to 1	2 to 4	5 to 6
Instrumental Hierarchy	0 to 6	0 to 2	3 to 5	6
Risk of Harm to Others	0 to 6	0	1 to 3	4 to 6
Self-Care Index	0 to 6	0 to 2	3 to 5	6

AFH interRAI Tiers and Score Thresholds

interRAI Scale Name	Scale Range	Tier 1 Score	Tier 2 Score	Tier 3 Score
Aggressive Behavior Scale	0 to 12	0	1 to 4	5 to 12
ADL Hierarchy	0 to 6	0 to 1	2 to 3	4 to 6
Cognitive Performance Scale	0 to 6	0 to 1	2 to 4	5 to 6
Instrumental Hierarchy	0 to 6	0 to 2	3 to 5	6

interRAI Scale Name	Scale Range	Tier 1 Score	Tier 2 Score	Tier 3 Score
Risk of Harm to Others	0 to 6	0	1 to 3	4 to 6
Self-Care Index	0 to 6	0 to 2	3 to 5	6[349]

[349] Myers and Stauffer. Oregon Behavioral Health Residential Settings interRAI CMH Score Threshold Tier 1Decisions. December 11, 2025.

Appendix X: APNA Training Standards for Restraints and Seclusion

- "Training programs focused on the prevention and use of seclusion and restraint must:
    - Be standardized throughout the institution.
    - Be approved by the organization ensuring that program components include adequate attention to the clinical contributors to behavioral emergencies, the actual management of those emergencies, and the assessments and interventions necessary to maintain physical well-being.
    - Be evaluated at regular intervals to ensure incorporation of evidence based and best practices.
    - Be provided during a staff member's orientation period and at least annually thereafter.
    - Include an opportunity for staff to demonstrate competency in both knowledge and applied skills.
    - Include content related to the risks for positional asphyxia, aspiration, and traumatization.
    - Include content related to the use of a team, i.e., team roles as well as techniques for facilitating team communication and cohesion.
    - Address concepts related to prevention such as treatment processes, transference, countertransference, use of de-escalation techniques, mediation, providing a least restrictive

environment, problem solving and other nonphysical interventions including pharmacological and nonpharmacological interventions.

- Increase staff self-awareness of how their own culture, biases, values, and perceptions influence their response to a behavioral emergency and how their behavior may escalate a potentially volatile situation.
- Include information on organization-approved policies including physical holds, application and removal of mechanical restraints, principles of monitoring the person in seclusion or restraint and behavioral criteria for release.
- Promote understanding and recognition of the underlying physical and emotional conditions, medications, and their potential effects as well as how age, developmental level, cultural background, history of physical or sexual abuse, and prior experience with seclusion or restraint may influence behavioral emergencies and affect the response to seclusion or restraint.
- Differentiate chemical restraint from medication that may support and assist the person to successfully manage circumstances that could give rise to a behavioral emergency."[350]

[350] APNA. Standards of Practice: Seclusion and Restraint. pp. 4-5.

Appendix XI: Peer State Details

Arizona

Arizona serves less individuals on their Medicaid program, run by AHCCCS, as a percent of their total population than Oregon, but Arizona also has a population of approximately 3.3 million more people than Oregon. In the selected list of peer states, Arizona ranks third in terms of the number of federally recognized Native American tribes within state boundaries. AHCCCS was formed in 1982 and oversees the state's Medicaid program that is fully operationalized under an 1115 waiver.[351] This means that Arizona does not offer other types of authorities for any type of service coverage outside of the 1905(a) and 1115 authorities. AHCCCS operates both an FFS and managed care system with tribal citizens receiving services through the FFS system and most other populations receiving services through managed care.[352] AHCCCS also has regional behavioral health agreements that cover all healthcare needs for individuals with SMI who are not enrolled with the Arizona Department of Economic Security,[353] the separate state Department that operates DD, aging, and other family social services.[354]

Mental Health Residential Services in Arizona: Service Descriptions and Licensure

Specific services provided by BHRFs include:

- Group and individual behavioral health counseling and therapy.

[351] AHCCCS. About the Arizona Health Care Cost Containment System (AHCCCs).
[352] AHCCCS. Delivery System Chart. October 2024.
[353] Ibid.
[354] Arizona Department of Economic Security. Overview of DES Services.

- Behavioral health prevention and promotion, education, and medication training, including but not limited to:
    - Symptom management.
    - Health and wellness education.
    - Medication education and self-administration skills.
    - Relapse prevention.
    - Psychoeducation services and ongoing support to maintain employment work, vocational skills, and educational skill building.
    - SUD treatment.
    - Personal care services when appropriate personal care licensure standards are met.[355]

Arizona statute indicates that there are secured BHRFs to support individuals who are "chronically resistant to treatment for a mental disorder and who are placed in the facility pursuant to a court order…or who have been committed pursuant to a court order…"[356] Further, the Bureau of Residential Facilities Licensing under the Arizona Department of Health Services licenses both BHRFs and secure BHRFs following standards included in Arizona Administrative Code (A.A.C.) R9-10-7.[357] However, a review of AHCCCS Medical Policy Manual,[358] the AHCCCS Covered Behavioral

[355] AHCCCS. AHCCCS Medical Policy Manual, 320-V – Behavioral Health Residential Facilities. p. 3.
[356] Arizona Revised Statute 36-425.06 Secure behavioral health residential facilities; license; annual report; definition.
[357] Arizona Department of Health Services. Residential Health Care Institution License Process—The Basics. (March 25, 2022). p. 5.
[358] AHCCCS. AHCCCS Medical Policy Manual, 320-V – Behavioral Health Residential Facilities. p 2.

Health Services Guide,[359] and fee schedules[360] suggests that AHCCCS is not covering secure BHRF-provided services. This may reflect Secured BHRFs being exempted from "prior and continued authorization…as placement of a member into a Secured BHRF is accomplished pursuant to a court order as specified in ARS 36-550-.09."[361]

BHRF Admission and Discharge

Admission criteria applies regardless of if the member receives the service through FFS or through a managed care model. Further, BHRFs may also provide specialized treatment to meet the needs of specific populations served (e.g., individuals with cognitive or intellectual disabilities, comorbid physical conditions, or individuals who are aging) but must adhere to best practices. All residents of a BHRF are required to have a BHRF-specific treatment plan that connects to the member's service plan. Treatment plans must be developed within 48 hours of admission and:

- Align with Arizona's policies regarding behavioral health services and systems.
- Are designed to be specific to the member's physical and behavioral health needs and developmentally appropriately.
- Include measurable goals.
- Support the member's ability to reintegrate into the community.[362]

[359] AHCCCS. Covered Behavioral Health Services Guide (CBHSG). October 1, 2025.
[360] AHCCCS. Behavioral Health FFS Rates and Codes, Behavioral Health Outpatient Fee MCO Fee Schedule Effective January 1, 2026 and Behavioral Health Outpatient Fee FFS Fee Schedule Effective January 1, 2026. January 1, 2026.
[361] AHCCCS. AHCCCS Medical Policy Manual, 320-V – Behavioral Health Residential Facilities. p 2.
[362] AHCCCS. AHCCCS Medical Policy Manual, 320-V – Behavioral Health Residential Facilities. pp. 3-4.

The AHCCCS Medical Policy Manual specifically indicates when a BHRF is an inappropriate placement for an individual. This includes when the BHRF is treated as:

- An alternative to detention or incarcerating.
- A means to ensuring community safety or providing safe housing and shelter.
- Permanent placements.
- A behavioral health intervention when less restrictive alternatives are available.
- An intervention to prevent elopement or wandering.[363]

Continued stays and discharge plan policies are required to be developed by BHRF and submitted to AHCCCS for approval. Though the policies are developed by each individual BHRF, AHCCCS prescribes minimal standards that discharge policies must be adhered to.[364]

BHRF Resident Rights

Though BHRFs are authorized under an 1115 waiver authority, HCBS settings rules apply when a member residing in the facility receives services through the Arizona Long Term Care System program. However, as of the date of the Arizona State Transition Plan addendum, AHCCCS was in negotiation with CMS to reclassify acute behavioral health treatment facilities, of which BHRFs are a subset, as "solely acute care behavioral health services."[365] This reclassification would remove BHRFs from being

[363] AHCCCS. AHCCCS Medical Policy Manual, 320-V – Behavioral Health Residential Facilities. p. 5.
[364] AHCCCS. AHCCCS Medical Policy Manual, 320-V – Behavioral Health Residential Facilities. pp. 6-7.
[365] AHCCCS. Federal Home and Community Based Settings Rule: Arizona's State Transition Plan Addendum. pp. 3-4. November 2022.

subject to HCBS settings requirements as the service is "treatment-based and transitional in nature." Other settings that are subject to HCBS settings requirements in Arizona are noted in Table 17.[366]

Table 17: Arizona's HCBS Settings

Residential	Nonresidential
• ALFs. • Group homes. • Adult and child development homes.	• Adult day health programs. • Day treatment and training programs. • Center-based employment programs. • Group-supported employment program.

Given the lack of evidence found in BHRF policy manuals, A.A.C., or other publicly available information regarding BHRF compliance with HCBS settings requirements as compared to information found for the settings listed in

Table 17, it is assumed BHRFs are no longer subject to these requirements. In practical terms, this means that BHRFs are not required to:

- Adhere to state tenant laws.
- Enter into residency agreements with members.
- Follow federal rules regarding provider-owned or controlled settings.

Despite not being subject to HCBS settings requirements, BHRFs are required to adhere to resident rights established in R9-10-711. Some rights, such as those related to opening uncensored mail, refusal of treatment, and

[366] Ibid.

association with individuals of the resident's choice may be impacted by court orders or restricted by a resident's representative.[367]

BHRF Reimbursement

BHRF reimbursement is based on a per diem rate that is "inclusive of all treatment services provided by the BHRF, in accordance with the treatment plan created by the treatment team."[368] However, there are a subset of services that may be medically necessary for an individual but are not provided by BHRF staff, such as specialty counseling or ACT. These services are prior authorized and billed separately.[369]

As noted in Table 18 BHRF, reimbursement may occur through an FFS or MCO model depending on how an individual is enrolled in Arizona's Medicaid program. Tribal citizens receive services, including those provided by BHRFs through FFS, whereas most other Medicaid enrolled populations receive services through AHCCCS Complete Care via an MCO.[370] BHRF reimbursement differs between FFS and MCO payments and by modifier usage. BHRF Medicaid payment rates are summarized in Table 18.

Table 18: Arizona Medicaid BHRF Rates

Modifier	FFS	MCO
No Modifier	$261.67	$218.69
TF – Intermediate LOC[371]	$273.91	$228.93
U9 – ASAM Continuum[372]	$289.97[373]	$246.99[374]

[367] 9 A.A.C. 10. R9-10-311 Patient Rights. p. 74. March 31, 2026.
[368] AHCCCS. AHCCCS Medical Policy Manual, 320-V – Behavioral Health Residential Facilities. p. 1. January 14, 2025.
[369] Ibid.
[370] AHCCCS. Delivery System Chart.
[371] AHCCCS. Modifier List and Descriptions.
[372] Ibid.
[373] AHCCCS. Behavioral Health Outpatient Fee FFS Fee Schedule Effective January 1, 2026.
[374] AHCCCS. Behavioral Health FFS Rates and Codes, Behavioral Health Outpatient Fee MCO Fee Schedule Effective January 1, 2026.

AHCCCS also uses general funds, mental health block grant and substance abuse block grant funding to cover BHRF services with the exception of room and board for individuals who are not covered by the Arizona Medicaid program.[375]

Colorado

The Colorado Department Health Care Policy and Financing (HCPF) is responsible for operating the state's Medicaid program known as Health First Colorado, in addition to the Children's Health Plan Plus and other public health programs.[376] Of the peer states included in this interim report, Colorado has the lowest percentage (19.5%) of the total population (5,957,493) enrolled in the Medicaid program than any other peer state. Within Health First Colorado, HCPF offers nine HCBS 1915(c) waivers, six designed specifically for adults and three for children,[377] along with a newly implemented 1915(k) State Plan option that began serving individuals in July 2025.[378] Health First Colorado leverages Regional Accountable Entities (RAEs) to provide physical and behavioral healthcare to members. Additionally, Health First Colorado contracts with two regional MCOs, one of which, Rocky Mountain Health Plan, is also an RAE. MCO coverage is only available in certain geographic areas of the state and covers 13 of the state's 64 counties.[379]

In addition to HCPF, the Behavioral Health Administration (BHA) is tasked with promoting and leading the State's behavioral health priorities and initiatives while responding to the needs of Colorado's communities. The

[375] AHCCCS. AHCCCS Medical Policy Manual, Exhibit 300-2B – AHCCCS Covered Non-Title XIX XXI Behavioral Health Services. p. 7. August 1, 2024.
[376] Colorado Department of Health Care Policy & Financing. About Us.
[377] HCPF. Home and Community-Based Services Waivers.
[378] HCPF. Community First Choice Option.
[379] Health First Colorado. Member Handbook. p. 8. April 2026.

BHA, in partnership with four behavioral health administrative services organizations (BHASOs), operates Colorado's behavioral health safety net, which historically was marred by inconsistencies and disparities across the State's 26 safety net contracts.[380] The BHASOs and RAEs are aligned geographically and work together to provide Medicaid and BHASO-only funded services. Of the safety net services funded by BHASO, behavioral health residential treatment is the third highest funded out of the 14 safety net services.[381]

Further, BHA works closely with the Colorado Department of Human Services' Office of Civil and Forensic Mental Health (OCFMH), which is responsible for operating two state mental health hospitals. Both BHA and OCFMH work to identify how to improve services for civil and forensic populations and provider accountability.[382]

Though residential treatment is offered through BHA, the Colorado peer state findings will focus on those funded by HCPF for the purposes of aligning comparability with Oregon.

Mental Health Residential Services in Colorado: Service Descriptions and Licensure

There are a number of mental health services available through Health First Colorado, but one mental health residential service titled "Mental Health Transitional Living Homes" (MHTL) provides an example of the use of two Medicaid authorities to provision different levels of the same service with clear differences in intent and population. As defined by 2 Code of Colorado Regulations (CCR) 502-1, MHTL is defined as:

[380] BHA. Expenditures, Outcomes, and Effectives of the Safety Net. p. 4. January 1, 2026.
[381] BHA. Expenditures, Outcomes, and Effectives of the Safety Net. p. 13. January 1, 2026.
[382] BHA. About Behavioral Health Administration.

> "A community-based residential agency providing residential support to individuals who require ongoing support with daily living due to their behavioral health diagnosis but whose needs to not rise to the level of hospitalization. There are two levels of mental health transition [*sic*] living homes:
>
> A. "Level One Mental Health Transitional Living Homes" provide clinically ***monitored*** [emphasis added] services…"
>
> B. "Level Two Mental Health Transitional Living Homes" provide clinically ***managed*** [emphasis added] services…"[383]

The terms "clinically managed" and "clinically monitored" are also defined in 2 CCR 502-1. The distinct difference in terms is that clinically monitored services are accessed in the community and not provided directly on site by a provider agency, whereas clinically managed services are directed by clinical personnel (which may also include medical personnel) and are provided on site to address emotional, behavioral, or cognitive concerns.[384]

Additionally, information documented in an informational memo published by HCPF suggests that the MHTL homes are specifically intended to increase the number of residential behavioral health beds available statewide. Specifically, the new capacity offered through the MHTLs are targeted to Medicaid members who "need transitional living in the community after an acute care episode, such as recent or risk-of hospitalization, incarceration, or loss of housing."[385] During the initial phase of availability, the State was

[383] 2 CCR 502-1 Behavioral Health. p. 14.
[384] 2 CCR 502-1 Behavioral Health. pp. 6-7.
[385] HCPF. Informational Memo Differences between Mental Health Transitional Living Home Level 1 & 2. (HCPF IM 25-007). p. 2. February 14, 2025.

targeting the use of MHTL beds to individuals who exit the state mental health hospitals and experience competency challenges.[386]

There are multiple state agencies involved in MHTL operations:

- **HCPF:** Medicaid-reimbursement for providers of MHTL Level One and Level Two services.[387, 388]
- **BHA:** Licensing entity for MHTL Level Two providers.[389]
- **OCFMH:** Responsible for operating the MHTL homes.[390]
- **Colorado Department of Public Health and Environment (CDPHE):** Licensing entity for MHTL Level One providers.[391]

One of the most significant differences between Colorado and the other selected peer states is that Colorado's MHTL homes are operated using waiver authorities versus State Plan authorities. MHTL Level One homes are authorized under the HCBS Waiver for Community Mental Health Supports (CMHS) that serves individuals 18 or older with a mental illness who require a nursing facility LOC.[392] MHTL Level Two homes are provided as a 1915(b)(3) service authorized under the State's 1915(b) waiver program. Individuals who are enrolled with an RAE and/or an MCO are under the

[386] Ibid.
[387] HCPF. Home and Community Based Services: Community Mental Health Supports (CMHS) Waiver. Rates Effective April 1, 2026-June 30, 2026. p. 10. March 5, 2026.
[388] HCPF. State Behavioral Health Services Billing Manual. pp. 62 and 135. January 2026.
[389] HCPF. Informational Memo Differences between Mental Health Transitional Living Home Level 1 & 2. p. 5.
[390] Colorado Department of Human Services. Mental Health Transitional Living Homes.
[391] HCPF. Informational Memo Differences between Mental Health Transitional Living Home Level 1 & 2. p. 5
[392] HCPF. Home and Community Based Services: Community Mental Health Supports (CMHS) Waiver. pp. 4, 52, and 82.

approved 1915(b) and may access all medically necessary 1915(b)(3) services, including the MHTL Level Two homes.[393]

MHTL Level One and Level Two homes are intentionally designed to provide flexible services to fit the needs of residents; however, homes in either level are focused on skill building for successful transition back to the community.[394] Despite not having specific service requirements that must be provided in each setting, all behavioral health residential agencies, including MHTL Level One and Level Two providers, must offer at least the following services and activities as specified in 2 CCR 502-1:

- Screening and comprehensive assessment.
- Group and individual counseling and family therapy.
- Motivational enhancement.
- Educational groups.
- Occupational and recreational therapy.
- Behavioral and physical health pharmacology.
- Medication management.
- Peer, social, and recovery support.
- Care coordination.
- Support for the development of life skills.[395]

[393] HCPF. Section 1915(b) Waiver. p. 28. March 4, 2026.
[394] HCPF. Informational Memo Differences between Mental Health Transitional Living Home Level 1 & 2. p. 2.
[395] 2 CCR 502-1 Behavioral Health. p. 117.

Though MHTL Level One and Level Two settings must provide the same minimum services and activities, there are some distinctions in service provisioning between the two levels that are where the fundamental differences between the two levels are most evident. Table 19 summarizes these distinctions.

Table 19: MHTL-Level Service Distinctions

MHTL Level One	MHTL Level Two
• Responsible for daily living with regular support. • Focus on medication dispensation, ongoing minimal therapeutic activities, regularly scheduled daily activities. • Emphasis on ADL support.[396]	• Six hundred minutes or 10 hours of planned treatment per individual, per week.[397] • Coordinated whole person care, including daily social and life skills activities/training. • Therapeutic services. • Group activities. • Medication management. • Hands-on care resulting from the continued management of mental illness. • Case management and benefit attainment. • Recreational activities. • Educational and support activities. • Therapeutic interventions.[398]

Of important note, the MHTL Level Two homes are required to provide at least 10 hours of planned treatment weekly to each individual residing in the home. The MHTL Level One settings do not require treatment of any kind but instead focus on habilitative skill building and support for ADLs to live

[396] HCPF. Informational Memo Differences between Mental Health Transitional Living Home Level 1 & 2. p. 2.
[397] HCPF. Mental Health Transitional Living Home Level 2 Provider Tool Kit. p. 1.
[398] HCPF. Informational Memo Differences between Mental Health Transitional Living Home Level 1 & 2. pp. 3-4.

independently in the community. The engagement in treatment in the MHTL Level Two homes aligns with the idea of the services provided in these settings as "clinically managed" rather than "clinically monitored." Moreover, as noted in the 1915(c) service definition for MHTL Level One, "The purpose of the supportive intervention services [provided in a MHTL Level One home] is to teach [individuals] how to live independently beyond the walls of residential care."[399]

MHTL Level One Homes: A Habilitative 1915(c) Service

"The purpose of the supportive intervention services [provided in a MHTL Level One home] is to teach [individuals] how to live independently beyond the walls of residential care."+

— Residential provider

+ HCPF. Home and Community Based Services: Community Mental Health Supports (CMHS) Waiver. p. 82.

Based on this information the MHTL Level One Homes under the 1915(c) CMHS waiver can be categorized as "habilitative" and not "residential" while the MHTL Level Two Homes can be categorized as "treatment" services. In this sense, the use of the 1915(c) authority to provide a "habilitative," nonresidential service rather than the "treatment" residential service allows Colorado to tailor oversight and application of federal rules distinctly between the two.

MHTL Admission and Discharge Practices

Admission and discharge practices are the same for both levels of MHTL. These standards are outlined in 2 CCR 502-1. Admission and discharge practices are summarized in Table 20.

[399] HCPF. Home and Community Based Services: Community Mental Health Supports (CMHS) Waiver. p. 82.

Table 20: MHTL Level 1 and 2 Admission and Discharge Standards

Admission	Discharge
• Provider agency must ensure that an individual's needs can be met (directly or through coordination) prior to admission. This must be based on a preadmission assessment. • Admission is not granted to individuals needing 24-hour medical or nursing care or who have acute physical illnesses that are not managed through medication or therapy. • Transfers are arranged if care cannot be provided to individuals needing this LOC or who develop a need for 24-hour medical or nursing care.[400]	• Prior to discharge because of increased care needs, agency will document how efforts were made to meet an individual's needs through alternative means. • Agencies will coordinate voluntary or involuntary discharge with the individual, all legal representatives, and the medical or behavioral health providers who will be responsible for services per the discharge plan. • Transferring to other healthcare facilities for additional care require the MHTL provider to evaluate the individual prior to readmission or will discharge accordingly. • When an individual is discharged, it is the MHTL agency's responsibility to develop a discharge plan and coordinate the transition to a different LOC. Care coordination efforts must be documented in the individual's record.[401]

Coordination is the key factor in reviewing admission and discharge practices for MHTLs. Not only are the provider agencies responsible for making sure the needs of individuals can be met prior to admission, even if that require coordination efforts with outside parties, but providers are also responsible for ensuring post-discharge services for the individual. These requirements help solidify continuity of safe care for individuals under a

[400] 2 CCR 502-1 Behavioral Health. p. 123.
[401] 2 CCR 502-1 Behavioral Health. p. 124.

provider's purview as do the MHTL resident rights enumerated in Colorado regulations.

MHTL Resident Rights

All services provided under the 1915(c) CMHS waiver are subject to meeting compliance with the HCBS settings rules enumerated in 42 CFR § 441.301. In the case of the MHTL Level One service, individuals must also be afforded the protections required when residing in provider-owned and controlled settings.[402] Both MHTL Level One and Level Two homes are required to develop policies and procedures that address individual rights. Developed policies must include the tenants noted in CCR 502-1, Section 2.7. Individual rights apply to individual's served, and when applicable, a designated representative.[403]

MHTL Reimbursement

Table 21 summarizes the rates, procedure codes, and units used to reimburse for the two MHTL levels.

Table 21: MHTL Reimbursement Summary

-	MHTL Level One	MHTL Level Two
Daily Rate	$403.34	$295.85
Procedure Code and Required Modifier	T2033	H0019 + HB
Unit	Daily[404]	Daily[405]

MHTL reimbursement differs in terms of the reimbursement model and the rates paid. MHTL Level One homes are paid on an FFS basis, following the structure of payments under the 1915(c) CMHS waiver. Though some

[402] 42 CFR § 441.301 Contents of request for a waiver. May 10, 2024.
[403] 2 CCR 502-1 Behavioral Health. p. 36.
[404] HCPF. Home and Community Based Services: Community Mental Health Supports (CMHS) Waiver Rates. p. 10.
[405] HCPF. State Behavioral Health Services Billing Manual. January 2026. pp. 62 and 138.

1915(c) CMHS services are reimbursed differently based on geographic considerations, HCPF reimburses the MHTL Level One homes using one flat rate for the entire state.[406] The MHTL Level Two homes are reimbursed through the authorized 1915(b)(3) waiver using a state directed payment rate.[407, 408]

Massachusetts

The Massachusetts' Medicaid program, known as MassHealth, is a unified system that combines Medicaid and the Children's Health Insurance Program (CHIP) to provide coverage for low- and moderate-income residents.[409] Within this structure, MassHealth serves as the state's Medicaid authority, managing policy, financing, and service delivery under state and federal law. It is administered by the Executive Office of Health and Human Services (EOHHS or Office), which oversees healthcare, behavioral health, and social service programs statewide.[410] The Office is comprised of the MassHealth program and 11 agencies, including the Department of Mental Health (DMH) and the Department of Public Health (DPH). The EOHHS plays a central role in coordinating healthcare and human services, aligning Medicaid with broader public health and social support systems.

The State uses its Medicaid authority to implement a managed care system that includes ACOs, MCOs, and Primary Care Clinician plans.[409] These models support care coordination and cost control while allowing Massachusetts to expand services and eligibility using federal flexibility. EOHHS also contracts

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[406] HCPF. Home and Community Based Services: Community Mental Health Supports (CMHS) Waiver Rates. p. 10. Effective April 1, 2026-June 30, 2026.
[407] HCPF. State Behavioral Health Services Billing Manual. pp. 62. January 2026.
[408] State directed payment requirements are further defined in State Medicaid Director Letter #21-001 issued on January 8, 2021.
[409] Mass.gov. MassHealth.
[410] Mass.gov. Executive Office of Health and Human Services.

with private providers and organizations to deliver services under standardized administrative and billing regulations.[411] MassHealth serves a large share of the population, with EOHHS programs reaching about one in three Massachusetts residents.[410]

Behavioral health services are delivered through a regional, managed structure that integrates mental health and substance use treatment into overall care. Partners, such as the Massachusetts Behavioral Health Partnership, work with provider networks across the state to ensure access to community-based and clinical services.[412]

Mental Health Crisis Services in Massachusetts: Service Descriptions and Licensure

Adult CCS is considered part of Massachusetts' Community Mental Health Services, as standards for community services (Subpart A, 104 CMR 28.00) apply to Adult CCS.[413] In addition to the Adult CCS, evidence was found that suggests DMH provides or contracts for residential service sites defined in 104 Code of Massachusetts Regulation (CMR) 28.01 as "a clinical and recovery-oriented environment supported by staff where one or more persons reside or are provided sleeping accommodations."[414] Of note, the definition of residential service sites in CMR specifically excludes CCS programs. Moreover, the Bureau of Substance Addiction Services under DPH also provides "residential rehabilitation services (RSS)" that are centered on SUD and education treatment. These RSS include different types of organized services that are designed specific to different population

[411] Mass.gov. Overview of the Executive Office of Health and Human Services.
[412] MBHP. Massachusetts Behavioral Health Partnership.
[413] 104 CMR 28.00: Licensing and Operational Standards for Community Services. p 26.
[414] 104 CMR 28.00: Licensing and Operational Standards for Community Services. p 2.

needs, such as adults-only, adults with their families, adolescents, and pregnant and postpartum women.[415]

However, due to a lack of further information regarding operations and reimbursement for residential service sites, and the apparent focus of RSS on SUD treatment only, both settings are excluded from further analysis in this report.

Adult CCS is provided in a 24-hour unlocked community treatment setting and is intended on serving individuals on a voluntary basis. Adult CCS are licensed by DMH according to the general standards outlined in Subparts A, C, and D of 104 CMR 28.00. DMH grants different licensure classes to CCS dependent on the age ranges served by the program. Class I licensure types are granted to CCS services provided to adults ages 18 and older.[416]

Services included in the Adult CCS model include crisis stabilization and treatment, care coordination, induction of FDA-approved medications for opioid use disorder, psychiatric evaluation and medication management, peer support or other recovery-oriented services, daily re-evaluation and reassessment for discharge, and psychoeducation, including information about recovery, wellness, and crisis self-management.[417] The service is primarily meant to act as a diversion and alternative to inpatient setting but may be used as a transitional setting when discharging from an inpatient setting if there is capacity at a location and if admission criteria is met.[418]

[415] Mass.gov. Department of Public Health. Substance Addiction Services Description.
[416] 104 CMR 28.00: Licensing and Operational Standards for Community Services. p. 22.
[417] Commonwealth of Massachusetts MassHealth. Provider Manual Series. Community Behavioral Health Center Manual. p. 15. January 1, 2023.
[418] 104 CMR 28.00: Licensing and Operational Standards for Community Services. p. 22.

Adult CCS Admission and Discharge Practices

For admission to an Adult CCS, an individual must:

- Be at least 18 or older.
- Demonstrate symptoms that are consistent with a current Diagnostic and Statistical Manual of Mental Disorders diagnosis and that are reasonably expected to respond to short-term structured treatment.[419]
- Within 24 hours of admission, Adults CCS must screen a newly admitted individual for risks associated with suicide and substance use/misuse using a standardized screening tool. Admission procedures also include reviewing the individual's medical and behavioral health history for trauma, physical or sexual abuse, and violence to develop an individualized treatment plan and begin to plan for discharge and aftercare services.[420] Per regulation, adult CCS are prohibited from discharging to a shelter or the street. Discharge plan requirements are also enumerated in 104 CMR 28 and include the following provisions:
    - A summary of the course of treatment, including a description of treatment interventions and effective strategies used to stabilize the crisis.
    - Prescribed medications at discharge.
    - Recommended after-care services.[421]

[419] Ibid.
[420] Mass.gov. 104 CMR 28.00: Licensing and Operational Standards for Community Services. p. 23.
[421] Ibid.

Community Mental Health Service Resident Rights

Adults CCS are required to adhere to the legal and human rights enumerated in 104 CMR 28.03(1)(a) through (k). Regulation requires that all services enumerated in 104 CMR 28 follow the rights outlined by the State rather than allowing each service provider to create their own policies around beneficiary rights. However, each of the human rights included in 104 CMR 28.03 must be posted "in appropriate and conspicuous places to which persons and family members have access in each service site, and available to any person upon request."[422] Additionally, the notice is required to be written in plain language and translated to a preferred language "to the extent practicable."[423]

Providers of Adult CCS are also required under 104 CMR 28.08 to establish, maintain, and operate a written policy regarding personal possessions and "searches and seizures at service sites."[424] Individuals and legally authorized representatives must be made aware of the policy prior to enrollment.

Individuals have a right to acquire, retain, and dispose of personal property unless certain criteria, such as a court order or if the personal property poses an imminent risk of physical harm to the individual or others. In the event a provider takes possession of an item for storage while the individual is receiving services in the site, the provider will issue a receipt to the individual.[425] Searches are permitted to avoid "imminent risk of harm" even if the individual is not present for the search; however, the "nature of the emergency and the reason the person is not present should be documented

[422] Mass.gov. 104 CMR 28.00: Licensing and Operational Standards for Community Services. p. 4.
[423] Ibid.
[424] Mass.gov. 104 CMR 28.00: Licensing and Operational Standards for Community Services. p. 13.
[425] Ibid.

in the record."[426] Except in the case of emergency, individuals and their legal representatives must be:

- Informed of a search prior to its occurrence.
- Provided an opportunity to consent to the search.
- Present during the search of property.[427]

Adult CCS Reimbursement

Community behavioral health centers (CBHCs) are paid on a daily encounter bundle rate that includes all "designated services." The daily flat fee for CBHCs serving adults is $233.90 and is paid regardless of the number of services provided to the individual on each day.[428] A definition of designated services is not included in 101 CMR 35; however, regulation does specify that "The MassHealth agency pays for crisis and specialty services separately from the bundled encounter rate. Crisis and specialty services may be billed on the same date of service as the encounter bundle, as clinically appropriate. Crisis intervention follow-up services many not be billed on the same day as the crisis intervention per diem service [including Adult CCS]."[429]

Adult CCS is paid using HCPCS S9485 with modifier ET (emergency services) at $748.37 per day.[430]

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[426] Ibid.
[427] Ibid.
[428] 101 CMR 305: Rates for Behavioral Health Services Provided in Community Behavioral Health Centers. p. 8. August 15, 2025.
[429] 101 CMR 305: Rates for Behavioral Health Services Provided in Community Behavioral Health Centers. p. 12.
[430] 101 CMR 305: Rates for Behavioral Health Services Provided in Community Behavioral Health Centers. pp. 8 and 12.

Minnesota

MDHS administers Minnesota's Medical Assistance (MA) program. Founded in 1966, MA delivers Medicaid services to almost one in four state residents. MA operates both an FFS and managed care system, with 232,000 people enrolled in Minnesota's FFS option and 1.2 million people enrolled in health plans.[431] MA is one of three programs that form Minnesota Health Care Programs (MHCP), which provides healthcare coverage to qualifying Minnesotans. MHCP also includes MinnesotaCare (a state-funded health insurance option) and the Minnesota Family Planning program.[432] MHCP members either receive services through FFS or through an MCO depending on how the individual is enrolled in the program. As of the April 2026 enrollment figures, 960,777 individuals were enrolled on MA and an MCO.[433]

MDHS business areas include four main divisions:

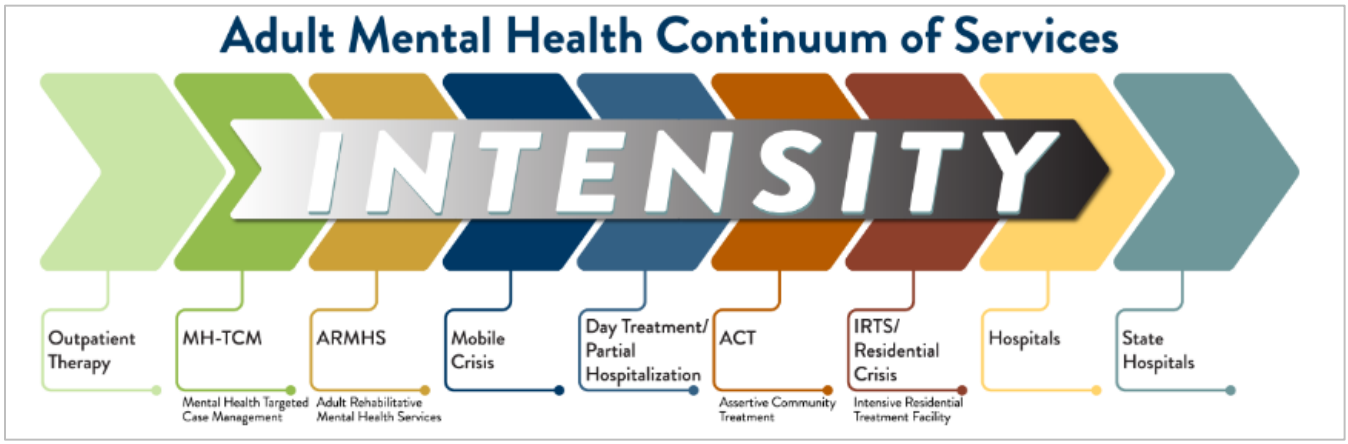
- Aging and Disability Services.
- BHA.
- Homelessness, Housing, and Support Service Administration.
- Health Care Administration.[434]

Mental health services span multiple MDHS divisions and are inclusive of everything from outpatient therapies, traditional healing for Native

[431] Minnesota Department of Human Services. Medicaid Basics.
[432] Minnesota Department of Human Services. Minnesota Health Care Programs.
[433] Minnesota Department of Human Services. Managed care enrollment figures, Managed care enrollment figures, April 2026 (XLSX). April 2026.
[434] Minnesota Department of Human Services. Overview of Organization Chart. December 2025.

American communities, and state-run psychiatric hospitals.[435] Minnesota's mental health continuum of care is detailed in Figure 7.[436]

Figure 7: MDHS Adult Mental Health Continuum



The focus of this analysis on Minnesota's mental health residential services is on IRTS, which is the third highest level of intensity, according to Figure 7.

Mental Health Residential Services in Minnesota: Service Definitions and Licensure

MDHS covers residential treatment through IRTS as a Medicaid-covered service. IRTS uses "established rehabilitative principles to promote a client's recovery and to develop and achieve psychiatric stability, personal and emotional adjustment, self-sufficiency, and other skills that help a client transition to a more independent setting."[437] The intent of IRTS is to be time-limited and "directed to a targeted date of discharge with specific member

[435] Minnesota Department of Human Services. Adult mental health programs and services.
[436] Ibid.
[437] Minnesota Statute. 245I.23 Intensive Residential Treatment Services and Residential Crisis Stabilization. 2025.

outcomes."[438] IRTS treatment standards are prescribed by MDHS and must include all the services below:

- 24/7 awake staff providing rehabilitative services, supervision, and direct beneficiary activity that is aligned with treatment plans.
- Integrated services for chemical dependency, illness management services, and family education.
- Medical professional services, either directly or through a referral.
- Services provided by qualified staff, such as mental health, nursing, and rehabilitation services.
- Crisis prevention planning.
- Illness Management and Recovery or Enhanced Illness Management and Recovery.
- Weekly treatment team meetings.
- Immediate needs assessment.
- Initial individual treatment plan and abuse prevention plan development.
- LOC assessment to determine medical necessity.
- Diagnostic and functional assessment.
- Substance use screening and substance use assessment.

[438] Minnesota Department of Human Services. Provider Manual: Intensive Residential Treatment Services.

- Weekly review of treatment plan and individual abuse prevention plan.[439]

Providers are licensed by MDHS to provide IRTS or RCS, per statute, and must demonstrate that they do not meet IMD requirements. The facilities are defined as either a category I or category II program as defined below:

- **"Category I**: A mental health residential program which provides program services in which there is an emphasis on services being offered on a regular basis within the facility with the use of community resources being encouraged and practiced."[440]
- **"Category II**: A mental health residential program which provides either a transitional semi-independent living arrangement or a supervised group supportive living arrangement for persons who are mentally ill. This type of program offers a combination of in-house and community resource services with emphasis on securing community resources for most daily programming and employment."[441]

The IRTS facility must maintain a minimum treatment team staffing ratio of at least one staff member for every nine residents. Treatment team staff include program directors, treatment directors, RNs, mental health professionals, certified rehabilitation specialists, clinical trainees, mental health practitioners, mental health rehabilitation worker, and mental health certified peer specialists.[442]

[439] Ibid.
[440] Minnesota Administrative Rules. 9520.0510 Definitions.
[441] Ibid.
[442] Minnesota Department of Human Services. Provider Manual: Intensive Residential Treatment Services (IRTS).

IRTS Admission and Discharge Practices

To qualify for admission in an IRTS, individuals must be at least age 18 and qualify for MHCP. In addition, they must meet the following clinical criteria:

- Diagnosed with a mental illness.
- Functional impairment because of mental illness in three or more areas using the "functional assessment."
- Has one or more of the following:
    - History of recurring or prolonged inpatient hospitalizations in the past year.
    - Significant independent living instability.
    - Homelessness.
    - Frequent use of mental health and related services yielding poor outcomes.
    - Mental health needs that cannot be met through other available community-based services, or a documented risk of crisis or placement in a more restrictive setting without intensive rehabilitative services as determined by a QMHP.[443]

IRTS programs may admit individuals who are 17 years old if IRTS is determined to fit their needs better than a child-specific facility. Variances to rules apply, though the provider must ensure proper licensure before accepting a member in this scenario.[444]

[443] Ibid.
[444] Ibid.

There are three types of discharges that may occur from an IRTS: success, nonprogram initiated, or program initiated. Specific criteria for each of these discharge outcomes is outlined in Table 22.

Table 22: IRTS Discharge Criteria

Discharge Type	Discharge Criteria	Discharge Summary
Successful	A member must: • Meet the treatment goals and objectives. • Complete the discharge plan with the treatment team. • After discharge is arranged, continue care at a less intensive LOC.	A member's completed discharge summary in plain language that includes: • A review of problems and strengths during the IRTS stay. • The member's response to the treatment plan. • The provider's recommended goals and objectives that should be addressed during the first three months after discharge. • The recommended actions, supports, and services that assist the member with making a successful transition. • Crisis plan. • The member's forwarding address and telephone number.
Nonprogram initiated	• When a competent member does not meet the criteria for an emergency hold and withdraws consent for treatment. • Determined by a provider agency's written procedures for	Within 10 days, a member's completed discharge summary in plain language must include: • The reason for discharge. • What attempts did the provider make to engage the member to

Discharge Type	Discharge Criteria	Discharge Summary
	when a member leaves against medical advice for an extended period. • A member is removed by legal authority. • A source of payment for the services is no longer available.	continue or consent to treatment. • The recommended actions, supports, and services that assist the member with making a successful transition.
Program initiated	• Multiple attempts to address the lack of participation must be documented when a competent member has not participated, or has not followed program rules or regulations, and the LOC is ineffective or unsafe. • There is neither a reasonable expectation that progress will be made at the IRTS LOC, nor does a member require the IRTS LOC to maintain current functions despite efforts to engage the member's progress toward the treatment goals and objectives. • The member is required to participate through a court order or legal status but leaves against medical advice.	A member's completed discharge summary in plain language that includes: • Discharge reason. • Discharge alternatives considered or attempted to be implemented. • The names of the individuals involved in the decision to discharge and a description of the member's involvement. • The recommended actions, supports, and services that assist the member with making a successful transition.

Discharge Type	Discharge Criteria	Discharge Summary
	• A more intensive LOC is needed and available. A discharge review process not exceeding five working days must be completed prior to a program-initiated discharge: • Review the program's decision to discharge in consultation with the member, member's family or other natural supports (with member's consent), and case manager (if applicable). • Evaluate whether additional strategies can be developed to resolve the issues leading to discharge to permit the member to continue services.	

Residents may continue a stay in an IRTS when specific criteria are met. This includes when an alternative, less-intensive community-based service cannot meet a resident's needs and when the member continues to meet admission criteria.[445]

IRTS Resident Rights

Minnesota administrative rule 9520.0630 outlines the resident rights that must be guaranteed in policies and procedures of the IRTS facilities. Each resident and their legal representative, if applicable, must be provided with

[445] Ibid.

a copy of the resident rights. Further, resident rights must be posted and accessible to all residents.[446]

IRTS Reimbursement

IRTS is reimbursed up to the first 90 days of service, based on a provider-specific per diem rate. Only "mental health service days" are billable; days in which direct services were not provided are unallowable costs.[447] PA is required if treatment in an IRTS exceeds 90 days. If an individual is readmitted to an IRTS within 15 days post-discharge, the readmission is included in the 90-day limit.[448]

New Mexico

The Medicaid program in New Mexico is administered by the New Mexico Health Care Authority (HCA), with primary operational responsibility housed in HCA's Medical Assistance Division (MAD). The HCA was established in 2024 to consolidate health and human services functions under a single agency to improve coordination across programs.

Medicaid plays a central role in New Mexico's healthcare system due to the large share of residents the program serves. As of 2024, the program covered approximately 36% of the state's population.[449] New Mexico uses its Medicaid authority to operate a comprehensive, managed care-based delivery system that emphasizes integrated, whole-person care. The

[446] Minnesota Administrative Rule. 9520.0630 Policies and Procedures Guaranteeing Resident Rights. October 2013.
[447] Minnesota Department of Human Services. Provider Manual: Intensive Residential Treatment Services (IRTS).
[448] Ibid.
[449] CMS. Medicaid and CHIP Scorecard 2024.

program is implemented through MCOs under the state's "Turquoise Care" model.[450]

Behavioral health services in New Mexico are structured through a regionally coordinated system within HCA, called the Behavioral Health Services Division (BHSD), that aligns closely with Medicaid financing and policy.[451] The state is organized into behavioral health regions, each tasked with assessing local needs and developing multiyear plans that inform funding priorities and service delivery strategies.[452]

Mental Health Residential Services in New Mexico: Service Descriptions and Licensure

HCA, MAD covers residential services through its AARTC for mental health.[453] AARTCs for mental health are separate and distinct from AARTCs for adults with SUDs and accredited residential treatment centers for youth, which are also covered by HCA, MAD.[454] AARTCs are structured to support residential or inpatient treatment for individuals with SMI based on three tiers structured around the LOCUS. Per the HCA Behavioral Health billing manual, "Members must be placed in the level of care appropriate to the most acute program identified in the assessment process…The level of service and level of care is determined by the progress and outcomes of treatment, rather than a predetermined length of stay."[455]

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[450] New Mexico HCA. Turquoise Care Overview.
[451] New Mexico HCA. Behavioral Health Services Division.
[452] New Mexico HCA. Behavioral Health Reform.
[453] NMAC. 8.321.2.11 Adult Accredited Residential Treatment Center (AARTC) for Adults with Serious Mental Health Conditions. December 10, 2024.
[454] NMAC. 8.321.2.10 Adult Accredited Residential Treatment Center (AARTC) for Adults with Substance Use Disorders. December 10, 2024.
[455] New Mexico HCA. New Mexico Health Care Authority Medicaid Behavioral Health Policy and Billing Manual. p. 14. April 1, 2025.

Though care is tailored to meet individual needs, adult AAARTCs for mental health must perform at least the following to receive Medicaid reimbursement per New Mexico Administrative Code (NMAC) 8.321.11 (3)(a)-(f):

- "(a) diagnostic evaluation, necessary psychological testing, and development of the eligible recipient's treatment plan, while ensuring that evaluations already performed are not repeated;
- (b) provision of regularly scheduled counseling and therapy sessions in an individual, family or group setting following the eligible recipient's treatment plan, and according to LOCUS level five service descriptions the care environment, clinical services, support services, and crisis stabilization and prevention services;
- (c) facilitation of age-appropriate life skills development;
- (d) assistance to the eligible recipient in their self-administration of medication in compliance with state statute, regulation and rules;
- (e) maintain appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the eligible recipient, make referrals as necessary, and provide follow-up to the eligible recipient; and
- (f) consultation with other professionals or allied caregivers regarding the needs of the eligible recipient, as applicable."[456]

Additionally, AARTCs for mental health must provide MAT or make a referral for MAT for eligible individuals. AARTCs for mental health cannot refuse to

[456] NMAC. 8.321.2.11 Adult Accredited Residential Treatment Center (AARTC) for Adults with Serious Mental Health Conditions.

exclude individuals from receiving services in the AARTC for mental health facility as a result of an individual expressing a desire to receive MAT services.[457] Among the noncovered AARTC for mental health services are activity therapy, group activities, activities primarily for recreation or entertainment, educational, and vocational services.[458]

Eligible providers of AARTC for mental health must meet all 10 of the following requirements to receive Medicaid reimbursement:

- Accredited through the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities or the Council on Accreditation.
- Certified by BHSD. The certification process includes site visits conducted by BHSD.
- Have policies and procedures regarding utilization of the LOCUS evaluation parameters to determine eligibility into the treatment program.
- Meet LOCUS level five service definitions for the care environment, clinical and support services, crisis stabilization, and prevention services.
- Assess for and treat co-occurring SUDs.
- Provide or refer individuals for MAT.

[457] New Mexico HCA. New Mexico Health Care Authority Medicaid Behavioral Health Policy and Billing Manual. p. 13.
[458] NMAC. 8.321.2.11 Adult Accredited Residential Treatment Center (AARTC) for Adults with Serious Mental Health Conditions.

- Train all clinicians and practitioners in the LOCUS for psychiatric and SUD services. Training must be done by an approved LOCUS trainer and meet specifications outlined in NMAC 8.321.2.11.
- Ensure employees upon hire and at least every three years thereafter pass several screenings, including a criminal history and an abuse registry screening.
- Maintain appropriate drug and food service permit issued by state entities.
- Allow individuals the opportunity to notify family of an admission to the facility.[459]

AARTC for Mental Health Admission and Discharge Practices

Individuals are admitted to an AARTC for mental health following confirmation that they meet the LOCUS criteria for the LOC placement. There are three LOCUS LOC tiers associated with AARTCs for mental health, Tier 5C: Moderate Intensity Long Term Residential Treatment Program; Tier 5B: Moderate Intensity Intermediate Stay Residential Treatment Program; and Tier 5A: Intensive-Short Term Residential Services.[460] Table 23 summarizes the description of each LOCUS Tier level. Individuals must meet the criteria for at least one tier for admission to an AARTC for mental health.

[459] NMAC. 8.321.2.11 Adult Accredited Residential Treatment Center (AARTC) for Adults with Serious Mental Health Conditions.
[460] New Mexico HCA. New Mexico Health Care Authority Medicaid Behavioral Health Policy and Billing Manual. pp. 13-16.

Table 23: AARTC for Mental Health Tier Descriptions

Tier	Description	Typical Length of Stay
5C: Moderate Intensity Long Term Residential Programs	Facility has capacity to treat individuals with long-term and persistent disabilities requiring extensive rehabilitation and skill building. These facilities provide intensive treatment.	Two months to one year
5B: Moderate Intensity Intermediate Stay Residential Treatment Programs	Treats individuals who require rehabilitation and skill building following crisis stabilization or to prevent loss of functioning. These facilities provide intensive treatment environments and are sometimes described as "short term residential rehabilitation" facilities.	No more than 60 days
5A: Intensive-Short Term Residential Services	This facility acts as a "step down" facility for individuals discharging from acute inpatient care. They also provide crisis stabilization for individuals who do not require a secure facility during the crisis episode. 5A facilities are described as "subacute" or "respite" care facilities.	7-10 days[461]

Admission to an AARTC for mental health is allowable for up to five days without PA to facilitate immediate treatment of an individual. Facilities operating at a 5A level are exempt from PA requirements due to the short-term nature of their programming. The facility is required to notify HCA of the admission and is responsible for furnishing all medically necessary services during the five-day period.[462]

[461] New Mexico HCA. New Mexico Health Care Authority Medicaid Behavioral Health Policy and Billing Manual.
[462] New Mexico HCA. New Mexico Health Care Authority Medicaid Behavioral Health Policy and Billing Manual. pp. 16-17.

Discharge or transfer from an AARTC is driven by resolution of an individual's primary mental health concerns as informed by the LOCUS assessment. Discharge may occur to a different LOC, referral to a different type of mental health treatment program, or exit from treatment.[463]

Resident Rights

Myers and Stauffer was unable to verify through publicly available resources the resident rights applicable to AARTC settings.

Reimbursement

Based on publicly available information found within HCA's Medicaid Behavioral Health Policy and Billing Manual, reimbursement is provider-specific and is negotiated with BHSD. Providers receive a negotiated amount per Tier level provided.[464]

Vermont

Vermont's Medicaid program is administered by the Department of Vermont Health Access (DVHA), which operates within the Vermont Agency of Human Services. Vermont has different Medicaid programs, as well as different types of Medicaid covering medical care and prescription drugs.[465] Vermont does not rely on private MCOs, instead, DVHA itself functions as a publicly operated managed care-like entity.[466] Recent figures indicate that Vermont Medicaid covers roughly 168,000 residents, representing approximately one-quarter of Vermont's total population.[467] This makes

[463] New Mexico HCA. New Mexico Health Care Authority Medicaid Behavioral Health Policy and Billing Manual. p. 14.
[464] New Mexico HCA. New Mexico Health Care Authority Medicaid Behavioral Health Policy and Billing Manual. p. 13.
[465] DVHA. Vermont Medicaid Programs.
[466] DVHA. DVHA Annual Report and Governor's Budget Recommendation (SFY26). p. 7.
[467] DVHA. Health Insurance in Vermont.

Medicaid one of the largest sources of health coverage in the state and underscores its central role in Vermont's healthcare system, particularly for low-income individuals, children, older adults, and people with disabilities.

The State uses federal Medicaid Authority through its Section 1115 demonstration waiver, known as the Global Commitment to Health Waiver. This waiver allows Vermont to encourage innovation in its Medicaid program with greater flexibility than traditional models.[468] Under this structure, DVHA is designated as a non-risk PIHP, enabling the State to manage Medicaid funds in a more unified and coordinated way.[466]

Behavioral health services within Vermont Medicaid are organized through a regional, community-based system rather than being centrally managed by DVHA alone. The Vermont DMH, along with other divisions of the Agency of Human Services, oversee the delivery of these services through designated community providers that serve specific geographic regions.[469]

Mental Health Residential Services in Vermont: Service Descriptions and Licensure

Per the DMH website, there are varying setting options offering mental health services. These settings ranged from shared living arrangements to secure residential programs.[470, 471] Though there is clear evidence that mental health services are provided in a variety of settings, information regarding licensure, reimbursement, and other standards were not verifiable. For this reason, review of Vermont's programming focuses on the IRR services offered as a subset of Adult Residential Services.

[468] DVHA. Global Commitment (1115 Waiver).
[469] Vermont Legislature. Department of Mental Health (DMH).
[470] Vermont DMH. Residential Treatment.
[471] Vermont DMH. River Valley Therapeutic Residence.

Per the approved Medicaid State Plan, components of rehabilitative treatment within an adult residential service like IRR may include:

- Rehabilitative skill building.
- Community integration activities.
- Psychotherapy.
- Psychiatry.
- Psychoeducation.
- Medication monitoring.
- Discharge planning.[472]

A review of information from DMH suggests that there are four private IRR programs and one state-run IRR known as River Valley Therapeutic Residence (RVTR). While the four private providers are "staff secured" settings, RVTR is labeled as secure residential facility of 16 beds.[473] Staff secure is distinct from a "secured" facility in that IRRs do not block egress, rather, staff are on site to "provide extra support" when required during the course of care.[474]

Admission and Discharge Practices: IRR

Vermont's IRR system represents a central component of the state's community-based psychiatric field. Admission and discharge practices are

[472] Vermont Medicaid State Plan. 3.1-A. Page 6e. p. 52. Eff. July 1, 2025.
[473] Vermont DMH. River Valley Therapeutic Residence.
[474] Vermont DMH. Intensive Residential Recovery.

structured around medical necessity standards. The program is designed for adults who:[475]

- Need more support than outpatient or community-based services can provide.
- Are transitioning from inpatient care or hospital settings.
- Are seeking structured support to stabilize and work toward recovery goals.

An individual may be initially admitted to an IRR program when they meet all the following five criteria noted in Table 24.[476]

Table 24: IRR Admission Criteria

Number	Criteria	Description of Criteria Requirements
One	Active eligibility for Medicaid mental health benefits for individuals with SMI.	Must have the following three: • Diagnosis. • Functional needs. • Treatment history.
Two	Symptoms of mental illness. **(two or more)*	• Impaired insight has led to treatment nonadherence resulting in hospitalization. • Current providers reasonably expect treatment nonadherence in a lower level of treatment. • Unsuccessful in meeting treatment plan goals in less intensive levels of treatment.

[475] Vermont.gov. Intensive Residential Recovery.
[476] Vermont.gov. IRR Treatment Medical Necessity Criteria Initial Prior Authorization Eligibility Criteria. March 2026.

Number	Criteria	Description of Criteria Requirements
Three	Impairment in functioning evident over past three months or more due to mental illness.	• Severely impaired interpersonal interactions requiring intensive intervention in group living model. • Inability to perform functional activities consistent with employment, caregiving, or independently structure time.
Four	Placement rather than residential.	• History or inability to manage symptoms at lower levels of treatment (i.e., residential, independent living) leading to hospitalization or incarceration. • Currently hospitalized or incarcerated with no less restrictive level of outpatient treatment available or appropriate, or at risk of hospitalization without IRR treatment. • Outpatient support system and other levels of treatment are unable to meet clinical needs. • Clinical improvement is reasonably expected with this IRR level of rehabilitative treatment.
Five	Necessary interventions.	• Clinical assessment. • Individualized goal-directed treatment plan. • Individual or group or family therapy. • Individual or support system psychoeducation. • Medication management as clinically indicated. • Targeted skill development as part of structured residential treatment.

For concurrent processes (Table 25), the authorization is similar to the initial process. However, providers must regularly submit updated clinical information, treatment progress, risk factors, and discharge planning details to DMH reviewers who assess whether the individual still requires the

structured, recovery-oriented residential LOC.[477] Note, if criterion one is met, but full authorization criteria in numbers two through four are not met and discharge placement is not available, subacute status may be authorized for 30 days. Thirty-day periods can be reauthorized while discharge planning is occurring.

Table 25: Concurrent IRR Authorization Process

Number	Criteria	Description of Criteria Requirements
One	Same as #1 above.	Same as #1 above.
Two	Symptoms of mental illness. **(one or more)*	• Active safety concern without intensive, daily supervision. • Angry outbursts responsive to de-escalation by staff. • Low frustration tolerance with poor impulse control. • Hypervigilance or paranoia requiring assistance to self-manage behavior. • Psychotic or hypomanic symptoms requiring assistance to resist acting on impulses. • Suicidal or homicidal ideation without intent.
Three	Impairment in functioning evident over past month due to mental illness. **(one or more)*	• Socially withdrawn. • Unable to follow instructions or negotiate needs. • Unable to interact in a socially acceptable manner due to bizarre presentation or interpersonal conflict. • Unable to attend to or maintain gains in independent self-care without significant skill coaching from staff.

[477] Vermont.gov. IRR Treatment Medical Necessity Criteria Concurrent Prior Authorization Eligibility Criteria. May 2026.

Number	Criteria	Description of Criteria Requirements
Four	Ongoing interventions.	• Individual or group or family therapy at least weekly. • Individual or support system psychoeducation at least weekly. • Ongoing psychiatric evaluation or medication administration/ supervision. • Targeted skill development as part of structured residential treatment on a daily basis.

State-operated IRR capacity functions as part of Vermont's "no refusal" behavioral health system, meaning individuals who meet eligibility standards are intended to receive placement.[478] Vermont presently has one state-run IRR, RVTR. RVTR is a secure facility designed to provide treatment to individuals over the age of 18 coming from psychiatric inpatient units, corrections, or the community, who do not meet hospital LOC but are in need intensive mental health treatment within a secure setting.[479] Privately operated residential organizations also provide IRR services in Vermont and DMH provides oversight to their state licensing and Medicaid standards. The four contracted IRR programs for adults are:

- Meadowview Recovery Residence.
- Hilltop Recovery and Residence.
- Soteria House.
- Collaborative Solutions.[480]

[478] Vermont.gov. Vermont Statutes, Title 18: Health Chapter 174 § 7252.
[479] Vermont.gov. RVTR Policy and Procedure. May 2025.
[480] Vermont DMH. Intensive Residential Recovery.

The criteria to discharge an individual will be similar but depends on whether the organization is state or privately run. The state-run IRR, RVTR, has indicated that they, the individual, and their designated agency/support system, will actively work on appropriate housing and specific behavioral/ treatment goals. When those requirements are met, a discharge plan will be formulated and will include: [479]

- Expected date of discharge.
- Location and address of discharge.
- Name of receiving facility, if applicable.
- List of medications
- Pharmacy.
- Scheduled follow-up appointments.
- Name of designated agency.
- Name and phone number of designated agency case manager and psychiatrist.
- Name and contact information for the primary care provider.

IRR Resident Rights

Vermont's IRR programs are designed to support individuals with significant mental health needs as they transition from inpatient psychiatric care to more independent community living. Although both state-owned and privately contracted IRR facilities operate within Vermont's broader mental health system and emphasize recovery-oriented care, there are important differences in how resident rights, personal property restrictions, and safety procedures are implemented. State-operated programs tend to follow more

formalized DMH policies governing resident conduct, restricted items, and staff authority to conduct searches, while privately operated programs often rely on individualized residential agreements and program-specific rules within a more home-like setting. Comparing these approaches (see Table 26) highlights the balance IRR programs must maintain between resident autonomy, privacy, therapeutic recovery, and the responsibility to ensure safety within residential treatment environments.

Table 26: IRR Resident Rights

Topic	State-Owned (RVTR Policies[481])	Privately Owned (Second Spring,[482] Health Care and Rehabilitation Services [HCRS][483])
Legal Framework	Governed directly by Vermont DMH resident rights and state policies.	Governed by Vermont residential care home regulations plus contractual policies of the organization.
Core Resident Rights	Residents retain rights to dignity, privacy, humane treatment, communication, participation in treatment, and freedom from abuse or unnecessary restraint.	Same core protections apply under Vermont residential care regulations. Residents must be treated with dignity, respect, individuality, and privacy.
Room Privacy	Residents retain privacy rights, but those rights may be limited by safety monitoring requirements, room inspections, or searches authorized under policy.	Greater emphasis on residential/home-like setting, though staff supervision remains part of the program model.

[481] Vermont.gov. RVTR Resident Rights. July 2025.
[482] Collaborativesolutions.org. Resident Rights.
[483] HCRS. Residential Services Division. August 21, 2026.

Topic	State-Owned (RVTR Policies[481])	Privately Owned (Second Spring,[482] Health Care and Rehabilitation Services [HCRS][483])
Personal Possessions	Residents may possess personal property unless items are considered dangerous, contraband, or disruptive to safety/ treatment. State facilities maintain formal "restricted items" policies.	Residents may retain personal clothing and possessions as space permits unless items create safety or fire hazards or infringe on others' rights.
Search Authority	State-operated facilities explicitly reserve the right to search rooms, belongings, or incoming property when safety, contraband, or treatment concerns arise. Searches are tied to safety/ security rules and restricted-item policies.	Private IRRs generally rely more on admissions agreements and house rules. Search provisions may exist, but they are usually less formally articulated than in state-operated policies.

State-owned IRR facilities in Vermont allow residents to maintain personal possessions, but those rights may be limited when items create safety, security, or treatment concerns. The RVTR Resident Rights Policy states that residents may retain personal belongings unless the items create a "danger," "security risk," or "fire, health or safety hazard."[484] The RVTR Restricted Item and Search Policy further identifies prohibited or restricted items, such as weapons, sharp objects, flammable materials, contraband, and other potentially hazardous possessions that may threaten safety or interfere with treatment.[485] Some items may be temporarily restricted, supervised, or stored by staff depending on clinical need and risk level. Privately operated IRR programs, such as Second Spring North and South

[484] Vermont.gov. RVTR Resident Rights. July 2025.
[485] Vermont.gov. RTVR Restricted Items and Search. April 2023.

operated by Collaborative Solutions, maintain similar restrictions through admissions agreements and house rules rather than centralized state policies. These agreements prohibit residents from possessing weapons, illegal substances, or other dangerous items and authorize staff to remove prohibited property when necessary to maintain a safe therapeutic environment.[486, 487]

State-operated IRR facilities also maintain authority to conduct searches of resident belongings and living spaces when necessary to preserve safety and therapeutic order. The RVTR Restricted Item and Search Policy authorizes staff to inspect resident rooms, personal belongings, and incoming property when there are concerns involving contraband, dangerous items, substance use, or risks to residents and staff. Although residents retain rights to privacy and dignity, those rights may be reasonably limited when legitimate therapeutic or security concerns arise. Similarly, privately operated IRR programs establish search authority through admissions agreements and supervision policies. The admissions agreements for Second Spring North and South state that staff may review resident possessions upon admission, survey resident rooms for contraband, and inspect bags or belongings entering the facility as part of ongoing "monitoring activities to prevent harm." [488, 489]

IRR Reimbursement

IRR is paid on a capitated basis. Submitted encounters are billed on a daily basis, according to the 2023 DMH Provider Manual. Additionally, IRR costs

[486] Collaborativesolutions.org. Admissions Agreement Second Spring North.
[487] Ibid.
[488] Ibid.
[489] Ibid.

are included in the monthly adult case rates[490] that were developed based on a specific set of mental health services.[491]

Washington

Washington's Medicaid program, known as Apple Health, is administered by the Washington State HCA, which serves as the state's single Medicaid agency and is responsible for overall program governance, including eligibility coordination, managed care contracting, benefit design, and compliance with federal Medicaid rules.[492] Altogether, Apple Health serves nearly 2 million residents, including children, adults, seniors, and people with disabilities, representing roughly one-quarter of all people in Washington.[493]

The State uses Medicaid authority to structure its program as a predominantly managed care system in which most beneficiaries are enrolled in contracted MCOs that receive fixed payments to deliver comprehensive services.[494] Washington has also used its Medicaid authority to implement statewide integrated managed care (IMC), which fully integrates physical health, mental health, and SUD services under a single delivery system.[495]

Washington State has developed a comprehensive behavioral health delivery system designed to provide integrated care for its residents. This system comprises three primary components: IMC, Behavioral Health Administrative Service Organizations (BH-ASOs), and Behavioral Health

[490] DMH. Provider Manual. p. 54.
[491] DMH. Provider Manual. p. 6.
[492] Washington HCA. Apple Health is Medicaid.
[493] Washington HCA. H.R.1 impacts.
[494] Washington HCA. Apple Health managed care.
[495] Washington HCA. 60 years of Medicaid.

Services Only (BHSO) plans.[496] Together, these components aim to streamline the delivery of behavioral health services, integrate physical and mental healthcare, and ensure access to essential support for vulnerable populations.

At the foundation of Washington's behavioral health delivery system is IMC. This model ensures that all Medicaid recipients in the state are enrolled in an IMC plan, which provides coverage for both physical and behavioral health services.

Supporting the IMC framework are BH-ASOs.[497] These organizations manage the state's behavioral health crisis response system and ensure the availability of safety net services for individuals who are not eligible for Medicaid or who require urgent emergency care. BH-ASOs are addressing the immediate needs of Washington's most vulnerable residents by providing essential crisis intervention and support services. This ensures that critical resources are accessible to those facing behavioral health challenges, regardless of their insurance or Medicaid status.

Additionally, the State offers BHSO as a form of Apple Health (Medicaid) coverage for individuals who are eligible for behavioral health services but are not qualified for full medical managed care plans.[498] BHSO plans specifically serve populations, such as those who have Medicare as their primary insurance, individuals with tribal health medical coverage, and foster care recipients who receive medical care through Apple Health on an FFS basis. BHSO ensures access to behavioral health benefits, including mental healthcare and SUD treatment. Washington HCA automatically

[496] Washington HCA. BHSO and BH-ASO comparison.
[497] Washington HCA. Behavioral Health-Administrative Service Organizations.
[498] Washington HCA. Behavioral Health Services Only Enrollment.

enrolls eligible individuals in BHSO coverage.[499] This ensures that those who qualify for Apple Health behavioral health services but receive their physical health coverage outside the managed care system can still access the behavioral healthcare they need.

Mental Health Residential Services in Washington: Service Descriptions and Licensure

Mental health residential services in Washington encompass a wide range of housing options and support systems authorized by resource management services. These services may involve dedicated facilities, designated units within larger facilities, or community-based support programs. They are designed to assist individuals with acute mental illness, adults with chronic mental health conditions, children with severe emotional disturbances, or adults facing significant mental health challenges who are identified by the behavioral health organization as being at risk of developing acute or chronic mental illnesses.[500] The services shall include at least evaluation and treatment services, acute crisis respite care, long-term adaptive and rehabilitative care, and supervised and supported living services, and shall also include any residential services developed to service persons who are mentally ill in nursing homes, RTFs, ALFs, and adult family homes and may include outpatient services in a supported housing model.[501] In Washington State, residential mental health services are delivered through a variety of settings, including RTFs and IBHTFs.

RTFs operate under the provisions of the Revised Code of Washington (RCW) 71.12 and must meet the requirements set forth in Washington

[499] Community Health Plan of Washington. Behavioral Health Services Only Plan.
[500] Cornell Law Institute. Legal Information Institute. Washington Administrative Code (WAC) 388-865-0238.
[501] RCW. RCW 71.24.025(48) Definitions.

Administrative Code (WAC) 246-337 to be licensed by the Washington State Department of Health (DOH). These facilities can provide SUD and mental health services for adults and children. The RTF is a facility in which 24-hour on-site care is provided for the evaluation, stabilization, or treatment of residents for substance use, mental health, co-occurring disorders, or for drug exposed infants.[502] There are over 100 RTFs in Washington that provide 24-hour behavioral health, psychiatric, or substance use treatment in a residential setting. Most of the facilities are publicly owned and all are regulated by the Washington State DOH.[503, 504] There are two specific facilities that are state-owned and operated by the Behavioral Health and Habitation Administration: Olympic Heritage Behavioral Health[505] and Maple Lane Campus.[506]

IBHTFs are a specialized type of RTF. These facilities are designed for individuals who no longer require care in state hospitals but are voluntarily seeking continued treatment and support to aid their reintegration into the community. IBHTFs operate under a person-centered treatment philosophy, incorporating person-first, strengths-based, recovery-oriented, and trauma-informed approaches. Each facility accommodates up to 16 residents and provides live-in care tailored to meet individual needs. Services include on-site behavioral health interventions, psychosocial rehabilitation, and skill-building programs to support individuals in successfully transitioning back into their communities.[507] This setting is characterized by a higher staffing ratio compared to the RTFs, limited egress, and the expectation that

[502] WAC. WAC 246-337-005(27) Definitions.
[503] Washington DOH. Residential Treatment Facilities List.
[504] Washington DOH. Residential Treatment Facilities.
[505] Washington State Department of Social and Health Services (DSHS). Olympic Heritage Behavioral Health.
[506] Washington DSHS. Maple Lane Campus.
[507] Washington HCA. Intensive behavioral health treatment facilities.

residents will return to the facility following hospitalizations of less than 30 days. IBHTFs are designed to function as LTC programs, offering a LOC that is greater than an RTF. IBHTFs have enhanced staffing levels and on-site treatment services, as well as limited egress requirements. Unlike other facilities, IBHTFs do not accept individuals under involuntary detention. These facilities primarily serve as step-down programs for individuals who have achieved stabilization in an inpatient setting and are transitioning to community reintegration. The typical length of stay at an IBHTF is estimated to be approximately one year.

Admission and Discharge Practices: RTF and IBHT

Washington RTFs are regulated through a combination of state licensing laws and facility-specific policies. These facilities may be either state-operated or privately owned. Admission to RTFs is determined based on medical necessity for inpatient care. This includes treatment aimed at diagnosing, correcting, curing, alleviating, or preventing the progression of a mental disorder or SUD.[508] Admission is restricted to individuals who are at least 18 years old and whose primary care need is the treatment of a mental health disorder.[509]

The discharge process requires the RTF to develop and provide a discharge summary that must include a continuing care recommendation and scheduled follow-up appointments. Additionally, the discharge summary will also include either a discharge statement if the individual left without notice or the discharge information of an individual who did not leave suddenly, that is completed within seven working days of the discharge. The seven-day

[508] RCW. 71.34.020 Definitions.
[509] WAC. 246-341-1137 Intensive behavioral health treatment services-certification standards.

notice will include the date of discharge, continuing care plan, and prescribed medication, if applicable.[510]

To meet the needs of the populations served by the IBHTFs, they adhere to strict guidelines for admission and service provision.[511] Admission to IBHTFs is limited to individuals age 18 and older whose primary care need is the treatment of a mental health disorder. However, individuals diagnosed with dementia or organic brain disorders are not eligible as their needs are better addressed in enhanced service facilities. Exceptions can be made for individuals with secondary diagnoses of intellectual or DDs, provided their main treatment focus remains on their mental health condition. Those admitted must be capable of performing daily living activities independently without the need for direct assistance from facility staff.[512]

Discharge planning constitutes a fundamental element of the service plan for individuals admitted to an IBHTF and is initiated promptly upon a resident's admission. There are three phases involved in discharge planning. The first phase involves ongoing collaborative discussions between the resident and their MCO to ensure care objectives are aligned with addressing and overcoming barriers to the resident's successful reintegration into the community. Establishing individualized goals is the foundation for an effective transition from the facility. The second phase of the discharge planning process becomes increasingly focused when it is anticipated that the resident may be ready for discharge within 6-12 months. At this stage, emphasis is placed on the resident's recovery journey

[510] WAC. 246-341-0640 Individual service record content.
[511] Washington HCA. Intensive Behavioral Health Treatment Facilities FAQ for Managed Care Organizations.
[512] Washington State Legislature. WAC 246-341-1137 Intensive behavioral health treatment services—Certification standards.

beginning with the identification of appropriate post-discharge accommodations and the support systems necessary to enable a successful transition. During the final phase, efforts are concentrated on equipping the resident with skills essential for their long-term stability and well-being within the community. This phase prioritizes reinforcing the competencies acquired during the resident's tenure in the facility and collaboratively establishing robust support networks. Facility staff work alongside the resident to ensure they possess the necessary resources, strategies, and connections to thrive independently in their post-discharge environment.[513]

RTF and IBHT Facility Resident Rights

RTFs are required to establish and maintain processes that protect resident rights. These processes must ensure that residents or their representatives are informed, in an understandable manner, of all rights, treatment methods, facility rules, estimated treatment costs, DOH's contact information, and how to file a complaint without fear of reprisal. The use of emergency interventions, such as behavior management, restraint, or seclusion, special treatment interventions, restrictions of rights, and confidentiality limits based on admission or confinement terms must also be communicated. RTFs must treat each resident with respect for their identity and dignity, fostering self-esteem, and guaranteeing freedom from abuse, deprivation of necessities, and unnecessary restraint or seclusion. Residents have the right to participate in or abstain from social and religious activities, be involved in planning their own care, review their personal files, refuse to perform services for the facility unless agreed upon and documented, live in a safe and clean environment, and be free from invasion of privacy except for reasonable safety measures. Upon or before admission, RTFs must

[513] Washington HCA. Intensive Behavioral Health Treatment Services A toolkit for implementing WAC 246-341-1137.

document that residents or their representatives have received a written copy of these rights. Strict confidentiality must be maintained regarding treatment and personal information. Additional safeguards apply for those receiving SUD services. Facilities must comply with mandatory reporting requirements for suspected child or adult abuse and neglect, account for each resident's assets, and, upon request, assist residents with notifying others of their commitment. Collectively, these requirements ensure that RTFs provide care environments that prioritize the dignity, autonomy, and safety of all residents.[514]

IBHTFs, as specialized residential treatment settings, are held to the same standards as RTFs in establishing and maintaining processes that safeguard the rights of their residents. However, IBHTFs bear an added responsibility to actively protect and promote everyone's rights, ensuring that residents are empowered to exercise those rights both as individuals and as citizens or residents of the United States and Washington State.[515] Fulfilling this obligation requires the agency to implement comprehensive training for staff, specifically focused on resident rights and effective methods for assisting individuals in exercising those rights. This commitment upholds legal and ethical standards and fosters an environment in which residents are respected and supported in every aspect of their care.[516]

RTF and IBHT Facility Reimbursement

Medicaid payment for RTF services is provided to eligible individuals when care is medically necessary and delivered in licensed facilities. The HCA sets specific reimbursement rates and billing procedures. The Washington

[514] WAC. WAC 246-337-075 Resident Rights.
[515] WAC. WAC 246-341-1137 Intensive behavioral health treatment services-Certification standards.
[516] Ibid.

Medicaid State Plan outlines covered residential services and reimbursement methods. For short-term mental health services in a residential facility, the payment rate is $272.23 per day. Long-term mental health residential services are reimbursed at $156.62 per day. Room and board expenses are billed separately.[517, 518] The current Medicaid fee schedule establishes the maximum allowable reimbursement for IBHTFs as $854 per diem.[519]

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[517] HCA. Washington Apple Health (Medicaid) Mental Health Services Billing Guide April 1, 2026.
[518] HCA. Provider billing guides and fee schedules.
[519] HCA. April 1, 2026, to present – Specialized mental health fee schedule. March 31, 2026.