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Joint Task Force on Regional Behavioral Health Accountability

Meeting #4

Friday, May 2, 2025

Today's Agenda

- Welcome
- Perspectives on Oregon's Behavioral Health Funding Landscape
- Brief Break
- Task Force Discussion
- Task Force Goals and Next Steps

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Perspectives on Oregon's Behavioral Health Funding Landscape

PREPARED FOR: Joint Task Force on Regional Behavioral Health Accountability
DATE: May 2, 2025
BY: LPRO Staff

Overview

- Background
- Funding Conduits – Individually and as a System
- Perspectives on the System of Funds
- Discussion – Reflections and Takeaways
- Next steps

Background

Where this information came from

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Task Force Direction from January 2025

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

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

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

LPRO Research Aims

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

Activities and Outputs

LPRO activities included

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

Outputs

- **Today:** preliminary thematic analysis (system-level themes)
- **After Today:** compiling detailed information to share July 2025; opportunities for continued iteration on what information will help the Task Force complete its work

Preliminary Takeaways

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

Limitations

- Fast changing policy context
- First person perspectives vary and are incomplete
- Potential that LPRO misunderstood, misreported, etc.
- Analysis today is broad, not deep (details on individual conduits can be provided if useful)

Funding Conduits

Pathways to Funding Oregon's Behavioral Health System

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What is a “funding conduit”?

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

Why?

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

Conduits Reviewed

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

Topics Explored in Interviews

25 subject-matter experts were asked about these funding conduits, including

- purpose of the funds (what is required, preferred, and prohibited)
- funder decision-making roles and processes
- information and planning tools used in funding decisions
- mechanisms for distributing funds
- funder's emphasis (or not) on aligning award decisions
    - Across geographies
    - With other funding conduits ("braiding and blending" funds)
- funder's perceived challenges and opportunities

Individual Conduits and the System as a Whole

Each conduit has

- its own decision makers, restrictions, decision processes
- unique flexibilities and limitations
- details that can be compiled for future report-out

The conduits, in aggregate, form a **system of funds.**

There was agreement that the system of funds, *as a whole,* is not functioning as it should even when individual conduits may be perceived as well managed.

There are similarities in many of the challenges reported by interviewees.

Findings

What we heard from you and other system partners

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Findings

The financial “backbone” of Oregon’s behavioral health system is

Medicaid[1]

- theoretically sustainable; costs can be built into Oregon Health Plan rate development over time

County Financial Assistance Agreements[2]

- *subject to funding, a*ddresses court-ordered services (civil commitment, aid and assist, guilty except by insanity); alcohol and drug treatment; crisis response; limited inpatient psychiatric care in community hospitals, and provides coverage where Medicaid does not pay

Other coverage

- other public payers: child welfare, intellectual and developmental disabilities (IDD) systems
- commercial coverage

1. See ORS 414.766 oregonlegislature.gov/bills_laws/ors/ors414.html
2. See ORS 430.630 *et seq* oregonlegislature.gov/bills_laws/ors/ors430.html

Reported Challenges between Medicaid and CFAAs

Ambiguity about who is accountable for coordination of care at the local level

- Historically, the intent of the **Coordinated Care Organization (CCO)** model was to bring everything under a global budget. In practice there are still many actors involved, which can create unclear responsibilities (CCO, Local Mental Health Authority, other payers such as ODHS Child Welfare or IDD systems).
- OHA holds Community Mental Health Providers (CMHPs) accountable to work with CCOs to fill system gaps, promote equity. There is wide variation in CMHP size, as well as the degree of behavioral health integration in each CCO region. This can require different payment approaches across geographic regions.

Perceived lack of power or authority to take action to address challenges

- **CCOs** report they can't require some providers to share information, refer people to services, or participate in care coordination. **Providers** report that OHA is not directive to CCOs, which results in an unpredictable funding landscape for providers over time. **OHA** reports that CMS often will not allow them to be directive with CCOs without triggering a requirement for directed payments.

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1. See HB 4092 CMHP cost report

Reported Challenges with Medicaid Reimbursement

Funding Adequacy

- Actuarial analysis indicated Medicaid and CFAA funding conduits do not cover the full cost to provide crisis intervention and court ordered services required of CMHPs

Payment Models

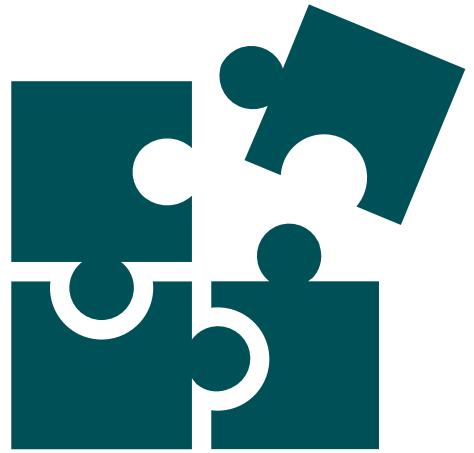
- Some services would ideally be paid through prospective per-member per-month (PMPM) payments to sustain system capacity over time but instead are reimbursed incrementally on a per-service basis

Payment Process

- The time and effort involved in Medicaid's eligibility and prior authorization processes are perceived to 1) drive high-risk, high-acuity clients to disengage early from treatment, and 2) drive providers to seek other (faster) ways of paying for services to keep clients engaged

Braiding and Blending Other Funding

Communities braid or blend other sources of funding with Medicaid and CFAA dollars to fully fund services, provide treatment to clients without coverage, and provide innovative or enhanced services not covered by Medicaid and CFAA dollars.



These other funding sources can be

- **highly restricted** for certain services or populations
- **one-time** funding or with no guarantee of renewal
- **competitive**, requiring preparation of custom applications and supporting documentation
- subject to **additional reporting requirements** that may be substantially different from Medicaid, CFAA, or other payer reporting requirements

Examples

- *Opioid Settlement grants
- *Drug Treatment and Recovery Services Fund grants, “access to care” grants (from M110 State Marijuana Taxes)
- *Alcohol Revenue Disbursements (sales, taxes, fees collected by OLCC and distributed directly to counties/cities or as grants through OHA; most reverts to the general fund)
- State Opioid Response grant (SAMHSA)
- Tobacco Prevention Education Program grants (M108 tobacco taxes, tobacco and vaping settlements)

*Some conduits are subject to a statutory distribution formula where cities and counties directly receive a portion of funds and other funds are distributed via grants

Varied Understanding of What it Means to "Fill Gaps in the System"

Grant-based conduits are commonly described as **intended to "fill gaps"** in the system.

There is not a shared understanding of what this means.

- **Providers** may consider "filling gaps" to mean bolstering revenue for existing services not fully covered by Medicaid or CFAA funding conduits (e.g. filling *funding* gaps)
- **Funders** may consider "filling gaps" to mean investing in services other than those funded by Medicaid or CFAAs (e.g. filling *network or service* gaps)

In some cases, funds are restricted in ways that may prohibit or discourage providers braiding/blending with Medicaid or CFAA funds over time.

- **SAMHSA block grants:** limited to services for which there is no other payer; must address SAMHSA priority areas
- **Measure 110 grants:** focus on providers who do not already access Medicaid or CFAA funding

Decision Processes Vary

Award processes for these **grant-based conduits** vary but generally operate very differently from Medicaid reimbursement and CFAA contracting.

Decision-making about funding distributions may be through

- **a governance body** that makes consensus-based decisions about grants
- **executive agency** processes that can involve multiple agencies and be subject to administrative rules

There are very few reported connection points across these decision-making groups and processes other than review of public-facing reports

Most of these conduits are subject to restrictions beyond those applied by the legislative assembly.

- e.g., SAMHSA requirements for federal grants; DOJ legal agreements outlining how settlement funds may be used

Missing Information: Capacity Needs

Despite desire to “fill gaps,” decision-makers frequently report they do not have the information needed to systematically identify *where* gaps exist in the delivery system.

- There is not shared understanding of which services ought to be in place or sustained over time as part of a “core” behavioral health system (e.g., methadone clinics or harm reduction programs).
- Capacity analyses that do exist are one-time or retrospective rather than ongoing caseload forecasts. There are concerns that bed registries do not capture wait lists or barriers to care.
- Where caseload forecasting exists, it is not always available in ways that support budget requests or distribution of grant-based funding conduits (e.g. forensic caseloads).

Funders may anecdotally perceive there are not enough funds available, in aggregate, to address all current gaps. Choosing **which gaps to fill** is often described as a state policy decision beyond the scope of individual governance groups or grant programs.

Missing Information: Existing Funds Flows

Funders reported needing, but not having, information about which entities are receiving which funds and where those can and cannot be braided.

- This information would be used to inform grant decision making, if it was available.
- One suggestion was for a clearinghouse of state, county, local info that could be accessed across different decision-making groups to 1) avoid requesting duplicate info, 2) have access to info about other grant funds received, and 3) identify orgs in a given locality who could be potential program partners in offering or expanding a service

Both state and local partners reported gaps in fiscal information sharing

- Local partners and providers see opportunities for the state to better report out the information it collects from providers across funding conduits
- Governance groups and grant-based funding programs see a need for better insight into local governments' use of existing funds

Who should pay first, last, and in between?

Stakeholders offered varied perspectives.

- Oregon is in a pattern of making one-time investments (by the legislative assembly or grant funders) to create new BH services or capacity without a strategy to sustainably finance those services over time
- Funding conduits distributed as grants would ideally be for one-time, pilot, or innovation projects, with successful programs transitioning to Medicaid reimbursement or other sustained OHA payments over time
- Instead grant funds are relied on to sustain programs and services where Medicaid reimbursements are unavailable or Medicaid and the CFAAs are not covering costs

No communication or information sharing infrastructure exists across funding conduits that would support this type of systematic coordination

In Summary

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

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

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

Break

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Discussion

Where might there be opportunities to strengthen alignment across funding conduits to Oregon's behavioral health system?

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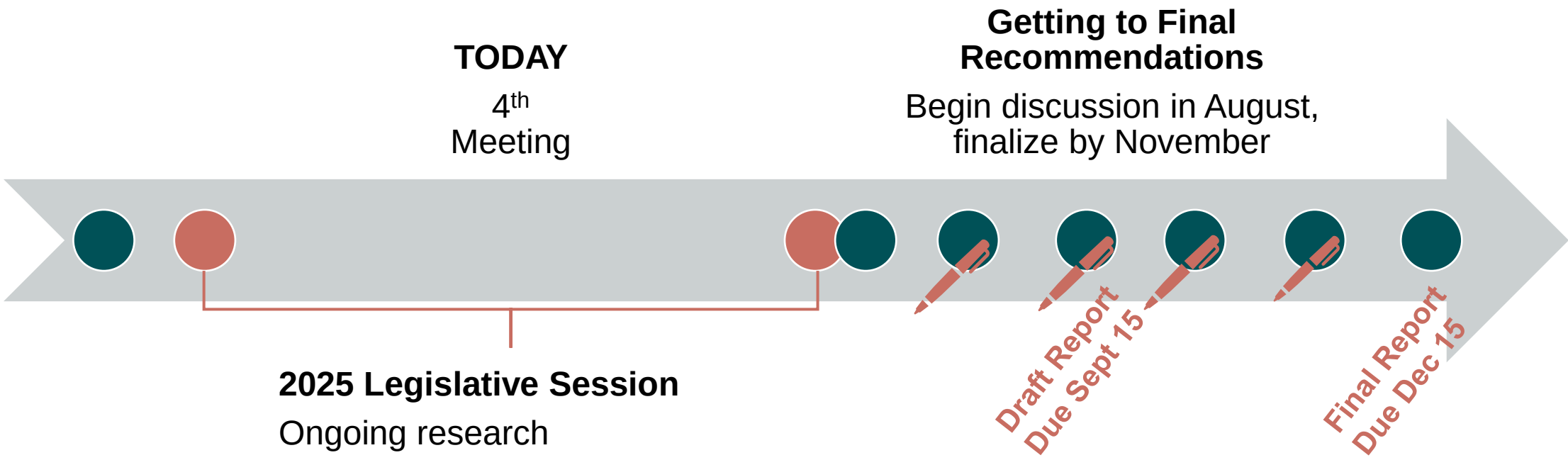
Task Force in 2025



As a starting point:

What questions or reactions came up for you?

What opportunities do you see to improve how funding conduits work together as a *system of funds*?

Where could the Task Force offer guidance?

Research Next Steps

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Activities and Outputs

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Details on Funding Conduits

- statutory, regulatory, and contractual characteristics
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- funder decision-making roles and processes
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Looking Ahead to July (and beyond)

How might the Task Force want to use more detailed information on individual funding conduits?

What discussions would you like to have?

What information would you want to support those discussions?

Task Force Goals and Next Steps

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Legislative Need (“Problem Statement”)

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

Next Task Force Meetings

Following 2025 Session

1st Monday* of each month

July 7, Aug. 4, Sept. 8*, Oct. 6, Nov. 3, Dec. 8*

Calendar invitations forthcoming

Thank You!

Contact LPRO Staff with questions

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