OFFICE OF THE DIRECTOR
Kate Brown, Governor

Oregon Health Authority

500 Summer St NE E20
Salem OR 97301
Voice: 503-947-2340
Fax: 503-947-2341
www.Oregon.Gov/OHA
www.health.oregon.gov

February 1, 2022

TO: Chair Gelser Blouin, Co-Chair Robinson, and Members of the Senate Committee on Human Services, Mental Health and Recovery
Chair Nosse, Co-Chair Moore-Green, Co-Chair Reynolds, and Members of the House Committee on Behavioral Health
FROM: Steve Allen, Behavioral Health Director, Oregon Health Authority
SUBJECT: HB 2086, Behavioral Health Wage Study

Dear Chair Gelser Blouin, Co-Chair Robinson, Members of the Senate Committee on Human Services, Mental Health and Recovery, Chair Nosse, Co-Chair Moore-Green, Co-Chair Reynolds, and Members of the House Committee on Behavioral Health,

HB 2086, passed in 2021, directs the Oregon Health Authority (OHA) to study Medicaid rates for behavioral health services compared to physical health services, and for addiction treatment services compared to mental health services. It requires OHA to report on the study to the behavioral health committees by February 1, 2022, including recommendations for achieving a living wage for behavioral health care workers and providing more equitable wages between physical and behavioral health care workers.

OHA contracted with the Center for Health Systems Effectiveness at Oregon Health & Science University to conduct this study. The full Behavioral Health Wage Study is available here.

The Behavioral Health Wage Study was conducted in the context of transformative legislative investments to improve the behavioral health system. The success of these investments relies on a robust behavioral health workforce that can provide culturally responsive care. Other sections of HB 2086 require the development of quality metrics to monitor and evaluate behavioral health services. Also, HB 2949 includes $80 million to develop, recruit, and retain providers who are people of color, tribal members, or residents of rural areas in this state and who can provide culturally responsive behavioral health services.

This study contributes to a growing body of important research on Oregon's Behavioral Health System. Two recent reports take the critical step of engaging broadly with communities in Oregon that have borne the brunt of gaps in access and inequities in outcomes: Crisis de Nuestro Bienestar: A Report on Latino Mental Health in Oregon by Oregon Commission on Hispanic Affairs, and Investing In Culturally And Linguistically Responsive Behavioral Health Care In Oregon by the Coalition of Communities of Color. This approach to research – one that honors lived experience and contributes qualitative as well as quantitative data – is critical for OHA to achieve its 2030 goal of eliminating health inequities in Oregon.

Listening to Lived Experience: The study used several methods to gather input from those with lived experience, specifically behavioral health service users and providers. Five focus groups were conducted, including one in Spanish. Key informant interviews were held with 24 participants, with approximately half identifying as people of color. In addition, data were analyzed on reimbursement rates, wages, and other workforce data. The available wage data did not allow for analysis by race or ethnicity, so these data sources should be augmented

using OHA's REALD (race, ethnicity, language, disability) and SOGI (sexual orientation, gender identity) standards.

What We Heard: The workforce crisis in Oregon's behavioral health system has severe implications for populations needing access to mental health, substance use, gambling addiction, and other behavioral health services. Communities of color, the LGBTQIA2S+ community, linguistically diverse, and intersections among rural communities with these and other populations harmed by health inequities have long struggled to access providers who can meet their culturally responsive and linguistically appropriate needs.

Providers expressed general agreement that improving workforce recruitment and retention is impossible without increasing behavioral health wages, thus moving towards equity with wages for physical health providers. Burnout and turnover are also fueled by work environment stressors, such as high client acuity, large caseloads, and high administrative burdens. Practitioners are leaving community behavioral health agencies for primary care, county employment, school settings, and telehealth-only agencies that can offer better work environments and more robust compensation packages.

Providers cited low reimbursement rates that are not always commensurate with a behavioral health practitioner's level of education, skills, and experience. Within billing codes, substance use disorder counselors generally received reimbursement rates comparable to mental health counselors. However, the most common substance use treatment service was reimbursed at about one-third the rate reimbursed for the most common mental health therapy.

Increasing Wages and Reimbursement: The study findings underline the need for direct increases in wages. Several providers cited the need to change wage structures to fairly compensate practitioners able to provide bicultural and bilingual care, navigate cultural complexities, and provide care to those with the highest needs. State-funded retention or recruitment bonuses may represent a short-term opportunity. Expanded benefits such as health insurance, housing stipends, and childcare support should also be considered.

Without increases in reimbursement rates, it will be difficult to create significant, sustained increases in wages for the behavioral health workforce. Reimbursement rate increases should be considered for most mental health and substance use disorder services, along with expanding the ability to bill for culturally responsive services. Raising the fee schedule for behavioral health services in Medicaid's fee-for-service program would compel Coordinated Care Organizations (CCOs) to increase their reimbursement rates.

Other mechanisms to incentivize CCO's to increase payments for mental health and substance use disorder services include requiring that a specified portion of the CCO global budget be spent on behavioral health services. Also, most insurance plans do not currently allow direct billing by the mostly lower-wage, unlicensed workforce; expanding the types of practitioners and services that can be reimbursed should lead to increased wages.

Improving the Work Environment and Advancement Opportunities: Interviews with providers as well as other evidence point to the importance of reducing the paperwork burden for practitioners. The state needs to continue efforts, initiated during the COVID-19 pandemic, to reduce administrative burdens. Employers should be supported in offering scheduling flexibility, rotating call, and flexibility around remote work.

Finally, improving provider recruitment and retention also depends on creating clearer pathways for salary increases and advancement into leadership or administrative positions. Pipeline programs, tuition reimbursement and loan repayment, and training opportunities focused on culturally specific care should be priorities for investments such as those in HB 2949. It is essential that wages increase and working conditions improve. Otherwise, people of color, tribal members, and residents of rural areas will be recruited into a behavioral health workforce that is underpaid and subject to burnout, thus perpetuating inequities in these communities.