Preliminary Health Equity Impact Assessment

Initial Evaluation of the Proposed Change to the Associate Provider Medicaid Billing Rules

Requested by:	Health Equity Committee (HEC) of the Oregon Health Policy Board
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Purpose of the Preliminary Health Equity Impact Assessment

Achieving health equity, and the elimination of health inequities by 2030, is a priority of the Oregon Health Policy Board (OHPB), the Oregon Health Authority (OHA), and the Governor. In 2017, the OHPB created the Health Equity Committee (HEC) as a subcommittee in order to coordinate and develop policy that proactively promotes the elimination of health disparities and the achievement of health equity for all people in Oregon, including using the HEC to provided enhanced attention to specific needs and decisions. Part of the HEC's work includes the development of the Health Equity Definition adopted by both the OHPB and OHA:

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

Consistent with that purpose, the HEC requested this preliminary assessment to evaluate the potential equity impacts of a proposed rule change that would disallow licensed board-registered associate providers[1] from providing behavioral health care and billing for services rendered to Oregon Health Plan (OHP) members unless employed by or contracted with organizations that have a certificate of approval from OHA (hereafter, COA agencies).

Through its fifth goal pillar of the agency's August 2024 Strategic Plan, OHA has committed to conducting prospective Health Equity Impact Assessments (HEIA) for all policies, rules, and practices considered by OHA, to ensure that the agency fulfills its goal of eradicating health inequities by 2030. However, the proposed change to the associate provider medicaid billing rule emerged prior to the roll-out of the HEIA tool.

Given the HEC's concerns about the significant likelihood of negative equity impacts of the proposed rule change, as well as the lack of adequate community engagement - particularly that of OHP members and associate providers - in the rulemaking process to date, the HEC requested this preliminary health equity impact assessment in light of the inability of OHA to use the HEIA tool to inform the decision to pursue this rule change before it was made.

[1] Board-Registered Associate Providers include associates from the following categories: marriage and family therapy, licensed professional counseling, and clinical social work.

The HEC hopes that the findings of this assessment will support OHA in achieving its goal of eradicating health inequities by 2030 and meeting it's Strategic Plan priority of "bringing community wisdom into the agency through realignment of power and accountability for agency action" by providing the agency with key information on 1) the equity impacts of the substance of this proposed rule change and 2) the harm caused by the process that was used to make this decision.

Summary and Drivers of the Proposed Rule Change

The proposed change will overturn a 2016 rule that allowed board-registered associate providers, under supervision of a board approved and registered supervisor, to provide care and bill for services rendered to Oregon Medicaid recipients (hereafter, associate provider medicaid billing rule). This 2016 rule was designed, in part, to 1) "reduce behavioral health workforce shortages in health professional shortage areas in Oregon", 2) "expand available opportunities for board registered interns to gain the post graduate experience required for independent licensure", and 3) "promote parity for board registered interns interested in providing services to Oregon Medicaid recipients." It was also designed to ensure alignment between administrative rules and state licensing statutes.

It is our understanding that the proposal to change the 2016 rule originated during the OHA Director's 2024 statewide listening tour. As outlined in the resulting report, community mental health programs (CMHPs) shared that they face difficulties recruiting and retaining mental health professionals in their organizations, and asserted that this was due to the 2016 rule change. In response to these concerns, OHA announced that it will issue rulemaking whereby associate providers will no longer be allowed to provide services to OHP members unless they are employed by or contracted with a COA agency, such as a CMHP, effective June 2026.

The primary justification provided for the proposed rule change (as listed in the OHA Director 2024 Statewide Listening Tour report) is to direct the early-career stage behavioral health workforce pipeline towards COA agencies by restricting allowable practice settings for associate providers. A secondary justification for this rule change, as provided in subsequent OHA communications, is "to ensure all behavioral health services meet the same standards across the state when public funds are being utilized."

Since first proposed, certain coordinated care organizations (CCOs) and health system partners have come forth as additional drivers of this proposed rule change, citing workforce development and/or care standards concerns. Of note, CareOregon, which serves more OHP members than any other health plan, announced an identical change to their reimbursement policies on December 5, 2024 - five days before OHA first announced their intention for this rule change.

To our knowledge, no Oregon Health Plan (OHP) members or patient advocacy groups[2] have come forth in support of this proposed rule change.

Preliminary Assessment Findings

Introduction

As stated by Governor Kotek in a news release from March 18, 2025: "Right now, depending on where you live or what help you need to address a mental health or addiction challenge, there are probably not enough people available to help you. At the same time, people considering a career in mental health and addiction care struggle to enter and stay in the field. "

Since learning about the proposed rule change during its December meeting, the HEC has expressed serious concern that, if implemented, it would directly undermine Governor Kotek's goal to improve access to behavioral health services, as well as OHA's goal of eradicating health inequities in Oregon by 2030.

Given the state's commitment to eradicating health inequities and increasing the behavioral health workforce, the HEC is struggling to understand why OHA is pursuing a rule change that would substantially decrease the number of behavioral health providers available to provide necessary care to OHP members, and risk exacerbating inequities in access to care across the state.

In particular, the HEC is concerned about the high likelihood of the following negative impacts of the proposed rule change:

- Disruption and discontinuation of care for OHP members currently receiving behavioral health services from associate providers not in COA agencies;

- Reduced access to behavioral health care for OHP members, particularly those who:

    - reside in healthcare shortage areas, including rural areas;
    - seek culturally and linguistically appropriate care, including those from BIPOC, immigrant, and LGBTQ+ communities;
    - have disabilities, chronic illnesses, and diverse access needs;
    - are children (and their families) who require:

[2] After the completion of this Preliminary Health Equity Impact Assessment, but before the Health Equity Committee's final vote, written comments in support of these proposed rule changes were received from NAMI Oregon, a family and patient advocacy group. Those comments named several caveats to that support: 1) the state should fast-track licensure in order to avoid major disruptions to the care provided by these associate providers and to their careers; and 2) the state must permit more group practices to become Certificate of Approval agencies. These comments were noted and considered by the committee prior to the final vote approving this preliminary health equity impact assessment.

i. significantly more time intensive and holistic behavioral health supports requiring case management and coordination through a larger system of care involving programs and services within the Department of Early Learning and Care (DELC), Department of Human Services (DHS), Department of Education (ODE), Oregon Youth Authority (OYA), in addition to those under OHA; and

ii. specialized training for behavioral health providers in didactic and multigenerational treatment models.

- Increased shortages of behavioral health care providers, including providers from marginalized and minoritized communities and those trained to work with children and families.

- Disruption in implementation of related state policies and service systems, such as the rollout of Every Child Belongs, the prevention program meant to support communities in the prohibition of suspensions and expulsions in early learning and care settings effective July 2026, which requires significant investment in infant/early childhood mental health consultants and providers most commonly working outside of COAs.

The HEC's concern about the negative equity impacts of the proposed rule change is based on the collective expertise of the committee members, extensive public testimony by those who would be directly impacted, research conducted by OHA's Equity & Inclusion Division, as well as data and reports published by OHA and other organizations.

Potential Health Equity Impacts

To better understand the likelihood and extent of the impacts that the proposed rule change may have on the state's equity goals and health care workforce priorities, the Health Equity Impact Assessment team conducted a review of relevant data and literature. These findings are summarized below.

I. Potential Negative Impacts on OHP Members

- 2,309 OHP members received care from an associate provider between July 1, 2023-June 30, 2024, according to a preliminary analysis conducted by OHA at the request of the OHPB.[3] Many of these members will experience care disruption or even care discontinuation as a result of the proposed rule change.

[3] These publicly reported numbers may not reflect the full extent of the associate provider workforce and the total number of OHP members who will be impacted by this rule change. According to an internal OHA analysis, **1,058 board-registered associates (nearly 80% of the associate workforce) provide care to 18,281 OHP members outside of COA agencies.** Many of these members would experience care disruption or even discontinuation as a result of the rule change.

- Marginalized and minoritized populations are disproportionately represented among OHP members, and thus will be disproportionately impacted by care disruptions and provider shortages stemming from the rule change. For example, based on available OHP enrollment data:

    - 55% of OHP members are BIPOC
    - 37% of OHP members have at least one disability
    - 17% of OHP members speak a language other than English

- Children make up a significant portion of OHP members and are frequently seen by behavioral health providers outside of COAs due to the additional case management and coordination required to navigate all child- and family-serving systems impacting their behavioral health, as well as the need for multigenerational treatment models working with the entire family; children and families who experience trauma or may be engaged in the child welfare or juvenile justice systems also require more specialized behavioral health treatments.

    - 31.4% of OHP members are under the age of 18
    - 8.9% of OHP members are under the age of 6

- Reductions in the behavioral health care workforce resulting from this rule change would lead to lower service availability, reduced provider choice, and longer wait times for OHP members seeking care. These impacts are likely to disproportionately impact members who:

    - are seeking culturally and linguistically appropriate care, including members who are BIPOC, LGBTQ+, have a disability, or have lower English language proficiency, due to a reduction in the number of providers from marginalized and minoritized populations;
    - reside in healthcare shortage and rural areas, particularly those who live in areas outside of CMHPs' and other COA agencies' service areas;[4]
    - prefer to obtain care outside of CMHPs or COA agencies, particularly members from communities with whom public agencies have broken trust due to a history of healthcare discrimination, trauma, and abuse;
    - have lower acuity health care needs, as CMHPs and many COA agencies prioritize higher acuity clients, leaving those with lower acuity on waitlists for extended periods of time.

[4] It is also important to note that OHA has suggested that entities should apply for COAs as a way to mitigate any interruption or disruption to services offered to OHP clients by these providers. However. this solution, including providing additional technical assistance to organizations wishing to obtain a COA, is not sufficient due to several systemic concerns that must be reviewed. For instance, the COA application process has taken some existing COAs several years to complete, with extremely high and increased administrative burdens. Additionally, CCOs are not required to contract with COAs and often do not. In Eastern Oregon, for example, the CCO has solely contracted with the single CMHP provider in Malheur County, while consistently refusing to contract with other agencies who have received COAs from OHA - significantly narrowing client choice. Similar concerns regarding the narrowing of CCO networks to only certain CMHPs or COAs have been echoed across the state.

- require child and family treatment modalities provided in settings more tailored to their unique needs, including relief nurseries or private practice groups with special focus areas on early childhood or teen populations (but are settings that are not able to obtain COAs); these modalities are more time intensive and cannot be provided within many COAs or CMHPs because their caseloads are too high to allow for the level of care coordination required for child and family treatments.

II. Potential Negative Impacts on Associate Providers

The HEC and OHPB heard extensive testimony from associate providers and their supervisors, detailing the potential negative impacts of the proposed rule change on current and future associate providers. These impacts include:

- Loss of income, benefits, and reduced employment prospects.
- Being restricted to employment at COA agencies with poor working conditions, including unsustainably large caseloads of high acuity patients, inadequate supervision and professional development, non-competitive compensation and benefits, and chronically traumatic workplace environments (Hallett, et al. 2024).
- Being restricted to employment at COA agencies that do not provide adequate accommodations (e.g., part-time employment, lower caseloads) for associate providers with disabilities and chronic illnesses.
- Being restricted to employment at non-culturally specific COA agencies, limiting associate providers' ability to focus on providing care to marginalized and underserved populations (e.g., people of color, LGBTQ+ people, people with language access needs, people with disabilities).
- Being restricted to employment at COA agencies that are unable to serve the needs of children and families.

III. Potential Negative Impacts on the Behavioral Health Care Workforce in Oregon

- OHA reported 968 associate providers, representing approximately 10% of the behavioral health workforce in Oregon (source).[5] By severely restricting the settings in which these associate providers can practice, the rule change would result in a substantial reduction in the number of behavioral health providers available to care for OHP members.

- The proposed rule change is likely to negatively impact the diversity of the behavioral health workforce in Oregon, as associate providers are more likely to be from marginalized and minoritized communities.

[5] The publicly reported numbers provided by OHA around associate providers to date have been inconsistent; see footnote 3 for additional context based on internal OHA analyses.

  - For example, according to OHA's Health Care Workforce Reporting dashboard, 31.2% of clinical social work associates are people of color, compared to 15.8% of clinical social workers overall.

- The proposed rule change may reduce the number of people willing to pursue a career in behavioral health, due to reduced employment and income prospects for new graduates.

- The proposed rule change may result in fewer clinicians becoming trained to provide behavioral health services to children and families, particularly for early childhood.

- The proposed rule change may result in current and future associate providers choosing to practice in another state. There is particular concern that these providers will choose to work in Washington state, which began allowing associate providers to bill Medicaid for services on July 1, 2024.

Evaluation of Community Engagement to Date

Based on OHA's communications and public testimony at HEC and OHPB meetings, as well as at informational hearings before the Senate Early Childhood and Behavioral Health Committee, the proposed rule change appears to be primarily driven by health system organizations (most prominently CMHPs, other COA agencies, and CCOs), as well as the OHA Director and certain divisions of OHA. However, to our knowledge, there have been no proactive or intentional efforts to engage OHP members, associate providers, or other community members in the state's efforts to better understand the need for, and impact of, this proposed rule change.

This is inconsistent with OHA's stated commitment to authentically involve Oregon communities in policy and program decisions, as outlined in its strategic plan in its commitment to bring "community wisdom into the agency through realignment of power and accountability for agency action." The current process appears to have done the opposite - 1) engaging only with the entities with the greatest access to OHA (CCOs, CMHPs, and Behavioral Health associations in support of this change) while ignoring those opposed to the change and who will experience the most negative consequences (non-COA agencies, associate providers, and OHP clients); and 2) lack of agency accountability or acknowledgment of the harm that has already been done to these communities since this proposed change was announced.

In response to the HEC's calls for greater community engagement in the process, and presumably an attempt to address the need to bring in the perspective of impacted communities and be accountable to that process, OHA stated that it will engage impacted community members in rulemaking starting in the Spring of 2025. OHA has also changed its stated predetermination that it *will* "prohibit practice settings" from employing associate providers (confirmed in its January 16, 2025 memo to CMHPs and CCOs) to the rule "*may*" change by June 2026 (as stated in their memo

to the HEC and in their comments before the Oregon Health Policy Board on April 1, 2025) - suggesting OHA has not decided it will make this change.

However, the HEC would like to point out two significant inconsistencies: First, according to OHA's own rulemaking process (as presented to the HB2235 Workgroup at their February 19, 2025 meeting), community engagement should have occurred before OHA's announcement of this intended rulemaking in order to evaluate all potential solutions.

Second, CareOregon has confirmed that it intends to make this change to its billing practices effective July 2025, *prior* to any rulemaking process or community engagement completed by OHA. CareOregon oversees three out of the sixteen CCOs - Jackson Care Connect, Columbia Pacific CCO, and Health Share of Oregon - and according to data on the percentage of OHP claims billed through a CCO by associate providers, 80.6% of those associate provider claims were administered under CareOregon. Thus, if CareOregon is allowed to make this change before the rulemaking process has even begun, a vast majority of these providers and their clients will already be impacted as of July 2025.

The harm will already be done, with services already interrupted and discontinued; thus, any community engagement process OHA engages in after CareOregon has already implemented this change is merely checking a box, significantly betraying trust between the community and OHA.

Given the lack of sufficient community input in the decision making process to date, there is a critical need for substantial, broad, and immediate community engagement. In particular, OHA must engage OHP members, associate providers, and behavioral health system experts, to accurately and fully understand whether this rule change is, in fact, an appropriate solution to the stated problems, and what potential impacts it may have, before any CCO is allowed to make this change.

Justifications for the Proposed Rule Change - Evaluating the Merits Through an Equity Lens

The HEC also requested that the HEIA team evaluate the provided justifications for the proposed rule change, namely that the rule change is necessary to: 1) address the recruitment and retention challenges reported by CMHPs, and 2) ensure care standards for OHP members.[6]

[6] A third reason was offered by OHA in an informational hearing before the Senate Early Childhood and Behavioral Health Committee on April 24, 2025, suggesting OHA is reviewing Medicaid billing rules in order to **support** the associate provider workforce (contrary to its previous positions that this was to support the community mental health system) and "assuring access and quality of care are addressed as [the board registered associate providers] workforce grows."

I. CMPH Workforce Shortages - the Wrong Solution for the Right Problem

The HEC recognizes the critical role CMHPs play in providing behavioral health care to Oregonians, and acknowledges the significant challenges these organizations face in meeting the needs of OHP members across the state. The HEC therefore calls on OHA to provide all necessary resources and support to CMPHs and other public behavioral health organizations serving OHP members.

However, the HEC is concerned that the proposed rule change is a misguided effort to address what are **systemic** and **institutional** workforce issues at the expense of associate providers by restricting their employment options. In essence, the proposed rule attempts to forcibly funnel early-career stage behavioral health providers into CMHPs and other public agencies, instead of pursuing solutions that would address the underlying systemic and institutional causes of workforce recruitment and retention difficulties these agencies face.

Beyond that, we believe that the proposed rule change is unlikely to meaningfully address provider shortages faced by CMHPs, especially in the short term. According to a 2024 study, community mental health centers "often had insufficient and inconsistent funding available to hire human resources, administrative, and supervisory staff." This was reported to result in "long delays in hiring and onboarding new employees." This begs the question: without systemic changes, would COA agencies have the capacity to recruit, manage, and supervise the large number of associate providers that the proposed rule change seeks to funnel into these organizations?

Furthermore, the HEC is deeply concerned about the state's reliance on associate providers to meet the behavioral health needs of CMHP clients, many of whom are high-need and high-acuity, requiring a significant level of provider experience and expertise. Associate providers are usually within their first three years of practice, and may not yet have the skills and experience necessary to care for clients with complex needs. However, according to a survey by the Coalition of Oregon Professional Associations for Counseling and Therapy, associate providers working at CMHPs and other public agencies report not being able to choose the clients they feel competent working with, and instead are assigned large caseloads of high-acuity patients, often without adequate supervision or support. As reported by Hallett, et al, in their 2024 study, these early-career stage providers "often were not prepared for the level of patients' symptom severity or complexity in their caseloads and quickly became overwhelmed."

Given that high-acuity and high-need clients should receive care from providers with the appropriate level of experience and skills, it is unclear why OHA is seeking to address provider shortage issues by pursuing a rule change that would exclusively funnel early-career stage providers into these acute behavioral health care settings.

This represents a systemic inequity, whereby CMHP clients are served primarily by providers with less experience (i.e., associate providers), while people with private insurance or who can afford to pay out of pocket are able to obtain care from providers with more experience.

Instead of pursuing a rule change that is highly unlikely to address the recruitment and retention difficulties faced by CMHPs and other COA agencies, the HEC calls on OHA to implement solutions that address the underlying systemic causes of provider shortages in community mental health settings. In fact, there are already efforts underway to develop such solutions at OHA, specifically the work being done by the legislatively-mandated HB 2235 Workgroup, which has developed a comprehensive report with evidence-based recommendations to address behavioral health workforce shortages in Oregon. Importantly, the Committee's report does not include a recommendation to change the associate provider medicaid billing rule and in fact, contradicts many of the assertions made through public comments about associate providers (i.e. that associate providers do not receive proper supervision or quality control while the HB 2235 shows those claims are actually true with CMHPs and COAs). Another claim made is associate providers work in unstructured settings, while our preliminary review shows many associate providers work within large practice settings employing over 100 clinicians serving clients that are majority OHP members throughout Oregon, including more rural areas such as Central and Eastern Oregon.

II. The Missing Evidence of Differences in Care Quality

OHA argues that the rule change is necessary to ensure consistent care quality and standards for OHP members across the state. The HEC strongly agrees that Oregonians on OHP are entitled to the same standard of care and the same care quality as Oregonians not on OHP. However, to our knowledge, the state has provided **no evidence** of differences in the care received by OHP members from associate providers in COA agencies versus those in non-COA agencies or private practice. In fact, in the nearly decade since this rule has been in effect, OHA and CCOs have established alternative protocols for documenting and assessing care in these settings. If there are any quality issues, a more appropriate first step would be to review these existing protocols to determine how they may be adjusted.

Furthermore, it is important to note that this proposed rule change would not prohibit associate providers from providing care in general, it only restricts the settings in which such care can be provided **to OHP clients**. Associate providers are fully credentialed to render care by state licensing boards and are required to practice under the supervision of a registered supervisor regardless of practice setting. By restricting access to associate providers for OHP members, but not for other patient groups (e.g., higher-income clients who can pay out of pocket), OHA risks exacerbating existing inequities in access to care between higher- and lower-income Oregonians.

Due to the lack of evidence of differences in care quality rendered by associate providers in different practice settings, along with the potential for increased inequities in provider access by income, the HEC believes that care standards is not a valid justification.

Summary of Preliminary Health Equity Impact Assessment Findings

The findings of this preliminary health equity impact assessment are summarized in the table below.

Likelihood that the proposed rule will increase health inequities	**High**
Extent of community engagement in the rulemaking process to date	**Low**
Equity merit of justifications provided for the proposed rule change	**Low**

The Health Equity Committee calls on the Oregon Health Authority (OHA) to pursue equitable, community-driven, and evidence-based solutions to the behavioral health workforce shortages in Oregon, including those developed by the HB 2235 Workgroup, to lead OHA toward eliminating health inequities by 2030.

Therefore, based on the findings of this preliminary health equity impact assessment, the Health Equity Committee of the Oregon Health Policy Board strongly opposes the proposed changes to Medicaid billing rules around associate providers providing care to OHP clients outside of CMHPs or COAs, and calls on OHA to suspend its rulemaking process.