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Impact Assessment: Certificate of Approval (COA) Requirement for Board-Registered Associates to Bill Medicaid

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Quick Explanation of Board-Registered Behavioral Health Associates:

For the purposes of this document, the word "Associates" is shorthand for Board-Registered Behavioral Health Associates. These behavioral health professionals have earned a master's degree and are registered with a state professional board, but are not yet licensed. Associates provide treatment services while receiving clinical supervision from a board approved licensed, experienced healthcare professional. Oregon Health Authority (OHA) is focusing on three types of Associates for the policy discussed in this document:

- Associate Professional Counselor (APC)
- Marriage and Family Therapist Associate (AMFT)
- Certified Social Worker Associate (CSWA)

Background:

OHA Director Sejal Hathi, MD, MBA, heard from Coordinated Care Organization (CCO) and Community Mental Health Program (CMHP) leaders during her 2024 regional listening tour about the challenges related to the 2016 policy change. The change allowed Board-Registered Behavioral Health Associates to bill Medicaid in private practice and in organizations without a Certificate of Approval (COA). During Dr. Hathi's trip to Southern Oregon and a roundtable discussion hosted by Jackson County in February 2024, partners indicated the 2016 policy change made it difficult for CMHPs to attract Associates and requested consideration of reversing the policy. Dr. Hathi visited Willamette Valley the next month and joined a roundtable discussion with Marion County, where partners described a "brain drain" effect as providers moved from CMHPs into private settings. Partners suggested exploring levers to incentivize new graduates to work at CMHPs. Lane County partners noted that private settings often involve lower-acuity cases and reduced administrative burden, and it was getting harder and harder to recruit providers into community-based roles. Yet it is community-based settings where new counselors develop essential skills in diagnosis, treatment and safety planning, and supporting members through clinical transitions. This is critical training for providers who desire to serve Medicaid members, with specific attention to working in team-based models of care supporting members with higher acuity. Other counties voiced similar concerns over the course of the tour.

Further OHA analysis and external feedback indicated the 2016 policy change, combined with the 2023 increase in Medicaid behavioral health reimbursement rates, contributed to a significant workforce shift from CMHPs to private

practice. This shift has presented substantial challenges to CHMPs working to provide services as well as to recruit and retain qualified staff.

CCOs concurrently raised concerns regarding the quality of care provided by independently practicing Associates. The reports, validated by the CCO BH Directors and subsequently shared with OHA, documented that some Associates were not completing safety assessments and planning and some Associates were also providing treatment exceeding medical necessity. In January 2025, OHA issued a memo announcing plans to begin rulemaking to prohibit Associates from enrolling as Oregon Health Plan (OHP) billing or rendering providers unless employed by a COA-approved agency.

OHA issues a COA to an outpatient behavioral health clinic after the clinic demonstrates their organization meets minimum regulatory requirements, including requirements for health and safety. COAs are granted to provider agencies and carry obligations that individual providers must meet to practice in Oregon. CMHPs are COA provider agencies designated by the Local Mental Health Authority (LMHA) county commissioners, or by OHA to ensure services and supports are available to serve people with more complex behavioral health conditions among the behavioral health outpatient providers.

Throughout 2025, OHA evaluated the impact of requiring Associates to work for organizations with a COA from OHA to bill Medicaid. This review included workforce recruitment and retention initiatives, supervision requirements for staff in COA settings and Associates seeking licensure, member and provider data, survey analyses, the Oregon Health Policy Board (OHPB) Health Equity Committee's Preliminary Health Equity Impact Assessment, and community feedback gathered through OHPB meetings, the Medicaid Advisory Committee (MAC), and correspondence from organizations, members, and providers. This impact assessment summarizes the extensive feedback that OHA reviewed before deciding to move forward with rulemaking to require Associates to work for organizations with a COA to bill Medicaid. The most prevalent concerns were related to continuity of care and member access and ensuring access to culturally specific services.

Workforce recruitment and retention

CMHPs are a major cornerstone in Oregon's behavioral health service delivery system, especially for populations that face serious and persistent mental illness, serious emotional disorders and who require acute and coordinated care. CMHPs, community-based organizations and behavioral health providers have described numerous challenges to OHA related to recruiting and retaining behavioral health professionals.

The state has invested over $80 million to strengthen Oregon's behavioral health workforce through initiatives funded by House Bills 2949 (2021) and 4071 (2022). These investments supported a broad range of incentives including loan repayment, tuition assistance, scholarships, exam fee support, housing stipends, and supervision related supports, and included more than $20 million in set asides for CMHPs to fund tailored strategies to recruit and retain qualified behavioral health providers. To date, CMHP grants have resulted in an average provider retention rate of 82.25% for all incentives across all 34 participating counties.

Supervision standards

Some CCOs and CMHPs raised concerns about the quality of care provided by Associates providing treatment in private practice and in organizations without a COA. The COA is one tool to ensure supervision. A COA from OHA's Behavioral Health Division ensures outpatient mental health and addiction programs (which treat substance use disorder and problem gambling) have met minimum requirements, including health and safety requirements, to operate a behavioral health program that serves Oregonians. This regulatory oversight includes but is not limited to facility inspections; review of policies and procedures; chart reviews; personnel record reviews; fire marshal inspections; liability coverage; and complaint and critical incident investigations. In addition, organizations with a COA can offer clinical support, ad hoc supervision, quality assurance of clinical records, and utilization review and management.

Clinical supervisors at an outpatient behavioral organization with a COA must meet a minimum of the Qualified Mental Health Professional (QMHP) requirements of completing two years of post-graduate clinical experience in a mental health treatment setting. Oregon Administrative Rules (OARs) describe standards for clinical supervision at COA agencies for all provider types[1]. The purpose of clinical supervision in a COA is defined in OAR 309-019-0125(4). Clinical supervision in a COA may include, but is not limited to: cultural responsiveness; oversight and evaluation of services; staff development; assessment; person-centered treatment planning; case management and coordination; utilization of community resources; group, family, and individual therapy or counseling; documentation and rationale for services to promote intended outcomes; and implementation of all provider policies.

[1] OAR 309-019-0125 (9-20)

In addition, all Associates are required by their licensing board to obtain licensure within five years of registration[2,3] regardless of where they work. Associates follow a clinical supervision plan approved by their licensing board before becoming eligible for licensure. The requirements for licensure and to be a board-registered Clinical Supervisor can be found on the webpages for the Mental Health Regulatory Agency and the Board of Licensed Clinical Social Workers.

With this background in mind, OHA engaged in additional analysis found below.

Key Findings

At the direction and under the guidance of OHA Behavioral Health, Health Policy and Analytics, and Medicaid Division executive leadership, OHA analyzed provider enrollment data and Medicaid behavioral health claims from July 1, 2023, through June 30, 2024, to assess how this policy change could impact members and communities. The date range was selected to capture the period prior to CareOregon's decisions to require associates to work for organizations with COAs in order to bill Medicaid and, subsequently, close its network to non-contracted providers and non-COA settings. It is important to note that the data OHA analyzed may include Associates who have since become licensed, and that more organizations now hold COAs.

OHA found 872 Associates provided services to 25,298 OHP members between July 1, 2023, through June 30, 2024.

Associates in settings with and without a COA

- A **total of 516** out of 872 Associates worked in an organization without a COA while serving 15,690 members.
- A **total of 159** out of 872 Associates worked in private practice (without COA) while serving 2,591 members.
- A **total of 197** out of 872 Associates worked at an organization with a COA while serving 7,452 members.

The chart below illustrates the types of settings at which OHP members receive services from Associates.

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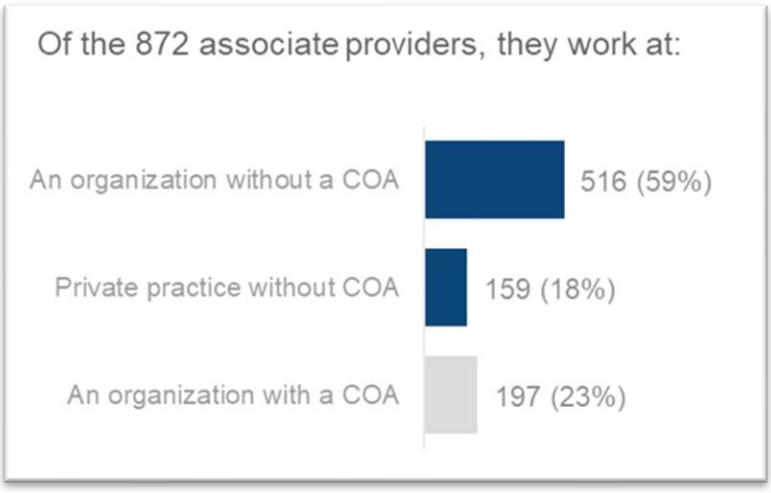
[2] 833-050-0021

[3] OAR 877-020-0010(3)(A)



Note: The 197 Associate providers serving members in an organization with a COA (gray bar) will not be impacted by the policy. Of the 25,298 distinct members served, 431 received services from multiple groups (organization without a COA, private practice without a COA, or organization with a COA). 321 members saw an Associate at a COA organization as well as one of the non-COA settings.

OHP members receiving treatment

Between July 1, 2023, and June 30, 2024, approximately 5% of all OHP members who received behavioral health treatment were served by an Associate working at an organization without a COA. Characteristics of the OHP members receiving treatment from Associate providers include:

- Ages 18-44 are the largest demographic of members served, followed by members under 18 years of age, and members 45-54 years of age.
- Members received treatment for reaction to severe stress and adjustment disorders most often, followed by anxiety disorders and recurrent major depressive disorders.
- Overall, Associates provided treatment most often for members that identify their primary race as Other White, followed by Mexican and Western European.
- 90% or more of members who only spoke English at home had received treatment from Associates working at practices with and without a COA.

The OHPB Health Equity Committee's Preliminary Health Equity Impact Assessment[4] stated that "requiring board-registered associates to work in organizations with a COA would likely disproportionately impact members who:

- are seeking culturally and linguistically appropriate care, including members who are BIPOC, LGBTQIA2S+, 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 health care shortage and rural areas, particularly those who live in areas outside of CMHP and other COA agency service areas;
- 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 health care 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.
- 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."

External Feedback

OHA has received substantial and often passionate feedback from a variety of perspectives on this issue. As of March 15, 2026, OHA Feedback Team had responded to 135 pieces of feedback, with 12 supporting the proposed rule change, 46 inquiring about the rule change's impact, timeline, and details, and 77 opposing the rule change. A mix of people have also supported and opposed the change at public meetings of the OHPB and its Health Equity Committee, whose members voted to oppose the change.

Arguments in support of the change have emphasized alignment with practices in other states, noting that most do not allow behavioral health associates to bill Medicaid. Proponents argue that the change would help ensure behavioral

[4] Preliminary Health Equity Impact Assessment

health professionals receive comprehensive training, supervision, and support — ultimately strengthening workforce competency and maintaining high standards of care across the system. Those who have expressed support include the National Alliance for Mental Illness (NAMI) Oregon, Oregon Council for Behavioral Health, CareOregon and other CCOs, various health systems, Association of CMHPs (AOCMHP), Community Behavioral Health Consortium (CBHC) of Lane County, Oregon Federally Qualified Health Centers (FQHC) behavioral health directors, Tri-County Behavioral Health Provider Association, Oregon Primary Care Association, and Oregon Psychological Association, among others.

Conversely, those opposing the change raise concerns that it may reduce access to culturally competent care for communities of color, LGBTQIA2S+, and individuals with disabilities. They also warn that it may reduce workplace flexibility and create disincentives for professionals to enter or remain in behavioral health roles, particularly those serving OHP members. Additionally, critics contend that COAs do not guarantee quality supervision beyond what licensing boards already require, questioning whether the added requirement would meaningfully improve care. Those who have opposed the change include a variety of individual behavioral health providers (who are both licensed and unlicensed), several independent practices, OHP members, Oregon Therapists for Equity, Coalition of Oregon Professional Associations for Counseling and Therapy (COPACT), Oregon Heals Coalition (members are APANO, PCUN, and Family Forward Oregon), NAYA Action Fund, and Oregon Education Association, among others.

Member Survey Analysis

As part of its community engagement efforts, OHA released a behavioral health member survey that was open from Nov. 6, 2025, through Jan. 31, 2026. The goal of the survey was to obtain feedback from Oregon Health Plan (OHP) members to inform its planned policy change to require Associates to be employed by a provider with a COA from OHA in order to bill Medicaid.

The survey was designed to understand member perspectives on access to care, continuity of treatment, and cultural responsiveness — not to conclusively determine member support or opposition to a policy. This analysis presents the sentiment and themes that emerged from member responses, with particular attention being paid to the therapeutic relationship and potential barriers to care identified by those receiving services.

Survey respondents

A total of 261 members responded, including 252 through an English version of the survey and 9 through a Spanish version. Respondents identified receiving care across a diverse range of settings, including private practices, community mental health programs, and specialized clinics.

Provider Type Identified by Member	Number of Respondents
Associate Professional Counselor	62
Associate Professional Counselor & LPC	29
Clinical Social Worker Associate (CSWA)	17
Licensed Professional Counselor (LPC)	14
Licensed Clinical Social Worker (LCSW)	9
Associate Marriage and Family Therapist	7
I don't know / Unsure	16

Thematic analysis of member sentiment

OHA conducted a qualitative analysis of open-ended feedback from member respondents. The analysis utilized the same thematic framework as the provider survey to identify how member concerns align with broader systemic challenges. Approximately 79% of members who responded to the survey expressed direct opposition to the proposed COA requirement.

Theme	Member Feedback
Continuity of Care and Relationship	70.8% of open-ended responses emphasized the critical bond with their current provider. Members expressed fear that losing their therapist would “overwhelm” them or “hinder progress” made over years.
Access, Equity and Inclusion	30.2% of responses cited concerns about losing access to culturally specific care or choices in rural communities. Spanish-speaking members highlighted the difficulty of finding therapists who understand their culture.
Supervision and Care Models	24.5% of members expressed skepticism that COA requirements would improve quality, noting that private practice associates often felt 'more effective' than those in agency settings with a history of higher turnover.

Theme	Member Feedback
Process and Administrative Efficiency	17.0% of members identified waitlists at COA-approved entities as a major barrier, fearing that the policy would force them into systems with lower availability.
Financial and Provider Wellness	9.4% of responses linked the policy to potential cost-cutting or systemic barriers for providers of color, noting that licensing and certification costs are already a burden.

What members told us: Response summary

The survey gathered a range of perspectives on access and policy impacts. Consistent with the survey's design, results should be interpreted as member sentiment and input and not as a conclusive determination of member support for or opposition to a specific policy proposal.

Sentiment	Percentage of Respondents
Oppose (No)	79.3%
Undetermined / Unsure	10.8%
Support (Yes)	8.9%
Alternative Solution	1.0%

What this means:

Taken together, the responses of OHP members reflect significant concerns about care continuity and the potential loss of trusted providers. As part of OHA's community engagement efforts, the member survey is a critical input to help understand potential impacts on priority populations and to inform how OHA communicates and mitigates risks as related work continues.

Provider Survey Analysis

As part of its community engagement efforts, OHA released a behavioral health provider survey that was open from July 17, 2025, through Oct. 1, 2025. The goal of the survey was to get feedback on the planned Associates policy change.

The survey was designed to understand provider perspectives on workforce, organization, and policy considerations — not to conclusive determination of provider support or opposition to a policy. This analysis shares the themes and opinions from provider responses, with particular attention being paid to workforce recruitment and retention challenges that providers identified as impacting their organizations and communities.

A total of 2,180 providers responded, including licensed clinicians, Associates, supervisors, and other behavioral health staff across diverse organizational settings.

Provider Type	Organization with a COA	Organization without a COA	Unsure if Organization has COA	Total providers responding by provider type
Licensed Provider	399	689	225	1,313
Associate Provider	161	347	121	629
Clinical Supervisor	57	94	16	167
QMHA/QMHP	41	6	9	56
Administrative Staff	8	5	2	15
Total respondents	666	1141	373	2,180

Thematic analysis of provider sentiment

As part of the policy review process, OHA conducted a qualitative analysis of open-ended feedback from 2,180 behavioral health providers. This analysis was designed to capture prevailing sentiment regarding workforce conditions and organizational standards, rather than to generate a statistical mandate for or against a specific rule.

Out of 2,180 respondents, 834 (~39%) providers expressed that a change in the current rule is needed. The project team used a thematic framework to categorize responses, identifying six key areas that providers cited as critical to workforce recruitment and retention. It is important to note that these themes reflect broader system-level concerns identified by providers. OHA's analysis did not find that these areas of concern are isolated to the planned Medicaid billing policy change for Associates.

Theme	Provider Feedback
Category 1: Access, Equity and Inclusion	Providers emphasized the importance of ensuring OHP members — especially priority populations such as rural residents, people with disabilities, and culturally and linguistically marginalized communities — maintain equitable access, continuity of care, and culturally responsive services.

Theme	Provider Feedback
Category 2: Financial and Provider Wellness	Providers underscored that payment models and billing rules should support agency stability and provider well-being, ensuring the workforce can thrive while continuing to deliver consistent, high-quality care.
Category 3: Policy Rollout and Timeline	Providers identified the need for realistic timelines and meaningful engagement — including phased rollouts, pilot testing, and opportunities for communities to adjust without disruption.
Category 4: Process and Administrative Efficiency	Providers highlighted that the COA and billing processes should be simplified to reduce barriers for small, culturally specific, or innovative practices, so more providers can meaningfully participate in the system.
Category 5: Supervision and Care Models	Providers shared the importance of strong supervision structures and flexible care models that ensure client safety, provider growth, and consistent quality across practice settings.
Category 6: System-Level and Foundational Change	Providers stressed that true progress requires structural reforms addressing workforce pathway issues, equitable incentives, and accountability measures that advance Oregon's long-term 2030 health equity goals.

OHA's behavioral health initiatives

Analysis of themes and provider feedback allowed OHA to better understand how the policy decision aligns with ongoing work. The goal of the policy decision, to strengthen the behavioral health workforce, will not be achieved by one decision, but in coordination with other policies and initiatives. Based on the feedback received, see below for examples of ongoing work.

- Supervision and Care Models: Licensing and Credentialing Subcommittee (Governor's Office Behavioral Health Talent Council)
- Access, Equity and Inclusion: Culturally and Linguistically Specific Services (CLSS); School-Based Health Centers and Mental Health Expansion Grant
- Financial and Provider Wellness: Retention and Recruitment Subcommittee (Governor's Behavioral Health Talent Council, HB 2024 (2025): Behavioral Health Workforce Incentives — $4M grant program for recruitment and retention, including scholarships, loan forgiveness, and stipends

- Process and Administrative Efficiency: Stabilizing Oregon's Public Behavioral Health System (HB 2235)
- System-Level and Foundational Change: SB 2208 (2025) Community Health Improvement Plans

What providers told us: Response summary

The survey gathered a range of perspectives on workforce, organizational capacity, and policy considerations. Out of 2,180 respondents, 834 (~39%) expressed that a change in the current rule is needed, though the nature and scope of change that respondents recommended varied widely. Consistent with the survey's design, results should be interpreted as provider sentiment and input, not as conclusive provider support for or opposition to a policy.

To summarize responses in a consistent way, the project team grouped feedback into the sentiment categories below. This table reflects the set of responses that could be grouped using the survey's categories. "Alternative solutions" captures responses indicating that changes are needed, while also expressing concerns about how a proposed approach would work in practice and/or offering other policy areas for consideration.

Sentiment	Unlicensed Behavioral Health Providers	Licensed Providers	Total
Alternative solutions	13.07%	25.73%	38.81%
Oppose	11.97%	16.97%	28.94%
Undetermined	4.68%	15.96%	20.64%
Support	1.88%	7.84%	9.72%
Questions about proposal	≤ 1%	≤ 1%	1.42%
Alternative solutions *Uncategorized	< 1%	< 1%	0.46%

What this means:

Taken together, the responses reflect meaningful concerns about workforce sustainability, care continuity for OHP members, and equity impacts, alongside interest in quality and organizational standards. As part of OHA's community engagement efforts, the provider survey results offer one piece of input to help understand potential impacts on providers and members — including priority populations — and to inform how OHA communicates, sequences, and mitigates risks as related work continues.

OHA Recommendations

Increasing development and support of an independent provider model is in contrast to the OHA policy direction of moving toward team-based care for Medicaid members with complex and acute needs. With this change, OHA will ensure that providers serving Medicaid members are trained and supported to treat any clinical presentation and complexity within the population served.

Extensive feedback and engagement shaped OHA policy making and informed the decision to provide an exemption to the COA requirement to bill Medicaid when Associates work in the following settings.

- Clinics under Health Resource and Services Administration (HRSA), a federal regulatory agency. Such clinics include FQHCs, Rural Health Clinics, and Tribal Behavioral Health Clinics.
- State-certified School-Based Health Centers as defined by ORS 413.223
- Education Agencies participating in School-Based Health Services as defined by OAR 410-133-0040
- Higher Education settings such as 2-year community colleges, 4-year public universities, and career/trade schools that offer degrees, certificates, or workforce training.

Safety Net Clinics

There are also federal quality assurance requirements for Safety Net Clinics (SNCs) in Oregon. Oregon has 34 FQHCs and two look-alike FQHC clinics, operating more than 270 sites throughout the state, and 12 Certified Community Behavioral Health Clinics (CCBHCs).[5] Services provided at SNCs are based on community need and includes mental health treatment. SNCs must meet specific federal standards to receive funding and enhanced reimbursement. These standards include providing comprehensive integrated services, serving underserved populations, offering a sliding fee scale, and maintaining quality assurance programs. Federal policy requires that SNCs must have ongoing quality assurance programs to ensure the delivery of high-quality care. They must have adequate clinical staff or arrangements with other providers to deliver all required services and must have processes for credentialing and privileging staff. SNCs also have specific supervision requirements, particularly regarding physicians, physician assistants (PAs), and

[5] Federally Qualified Health Centers (FQHCs)

nurse practitioners (NPs). Physicians are responsible for medical direction, consultation, and supervision of healthcare staff, especially PAs and NPs. SNCs must also have policies and procedures in place for the services they provide, including those related to supervision.

School-Based Health Centers

School-Based Health Centers (ORS 413.223) are permanent spaces located on the grounds of a school in a school district or on the grounds of a school operated by a federally recognized Indian Tribe or Tribal Organization used exclusively for the purpose of providing primary healthcare, preventive health, behavioral health, oral health and health education services. School-Based Health Centers (SBHCs) are safety net clinics and all students in a school with an SBHC are eligible to receive services regardless of insurance or ability to pay.

As of Jan. 1, 2026, there are 89 state-certified SBHCs in Oregon. OHA Public Health Division's SBHC State Program Office is responsible for the certification of SBHCs. The SHBC State Program Office provides operating funds to all State-certified SBHCs and additional grant funding to support behavioral health services. Beginning July 1, 2026, SBHCs must be in compliance with the revised Standards for Certification (v.5). The revised standards will require all SBHCs to have a designated behavioral health sponsoring agency and that behavioral health staff be on site for a total of 10 hours each week, while not requiring the behavioral health staff to be licensed.

During the 2023–2024 school year:

- SBHCs provided 51,427 behavioral health visits to school-aged clients.
- SBHC school-aged clients who saw a behavioral health provider had 7.9 visits per year on average.
- 52% of school-aged clients who saw a behavioral health provider also had a physical health visit at the SBHC.
- In 17 State-Certified SBHCs, more than half of the youth clients were Hispanic or Latino, Latina, Latine, African American or Black, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, or other youth of color.
- 40% of SBHC school-aged clients identified as youth of color.
- Medicaid was the payment source for 61% students at their first SBHC visit.

While the SBHC State Program Office does not collect demographic data on providers working in SBHCs, the above demographic data indicates that SBHCs

are a trusted source of care for many young people who belong to communities that are disproportionately affected by health inequities.

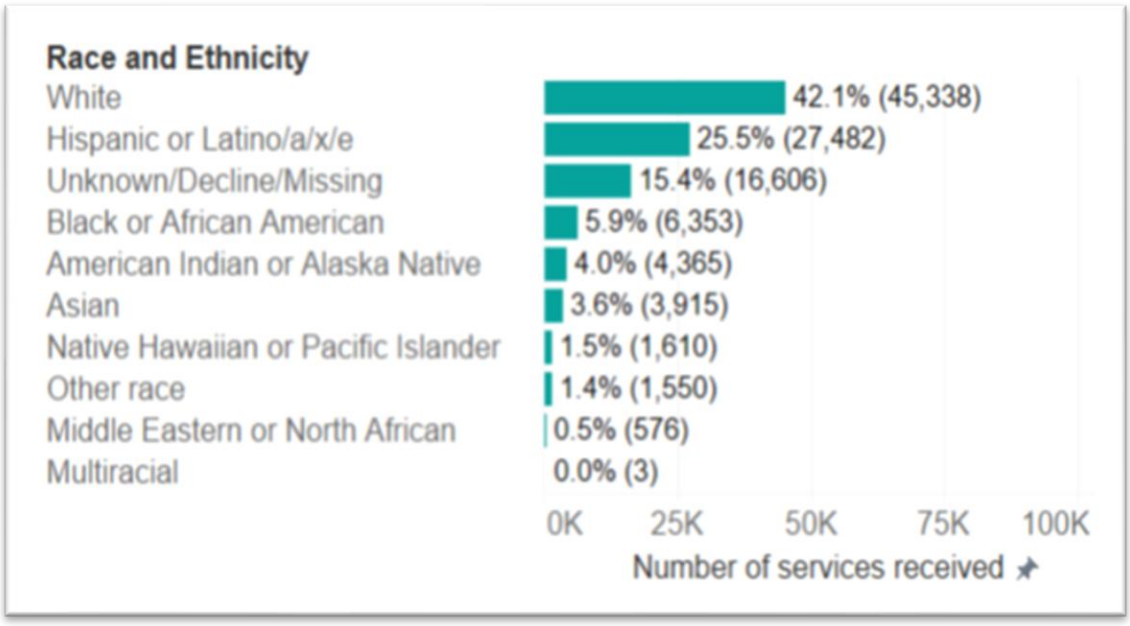
Each SBHC is supervised by a physician who is certified by OHA's Public Health Division and provides accessible behavioral health services to children and families. Therefore, OHA made the decision to exclude SBHCs from being required to obtain COAs in order for their Associates to bill Medicaid.

School-Based Health Services

OHA's School-Based Health Services (SBHS) Medicaid program provides partial reimbursement to Medicaid-enrolled education agencies for the cost of providing covered health services to Medicaid-enrolled children and young adults from birth through age 21. This includes services provided in compliance with the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act of 1973. Education agencies provide services at no cost to children, young adults, and families regardless of Medicaid enrollment. Medicaid-enrolled education agencies may bill for services provided by an Associate when the education agency employs both the Associate and a licensed, supervisory-level practitioner who supervises the services provided by the Associate.

During state fiscal year 2023-2024, most school-based health services (76.5%, or 82,464 services) were provided in relation to a primary behavioral health diagnosis. A majority (65%) of Oregon students who are eligible for Free and Reduced-Price Lunch (FRPL), which is often also an indication of Medicaid eligibility, are served by education agencies enrolled in Medicaid's SBHS program. Specifically, 56% of all FRPL-eligible students statewide attend K-12 school districts enrolled in Medicaid's SBHS program, and 28% attend schools served by education service districts that are enrolled in the program. This is important because it illustrates that even if some students attend a school district that is not participating in the SBHS program, they may attend a school in a region supported by an education service district that is participating in the program.

Of the school-based health services provided to children and young adults during state fiscal year 2023-2024, 42.1% were provided to members who identified as white, while 25.5% were provided to those who identified as Hispanic or Latino/a/x/e. In comparison, the U.S. Census found that 84.4% of Oregon's total population was white alone in 2024, while 15.5% of the state's total population that year was Hispanic or Latino/a/x/e.



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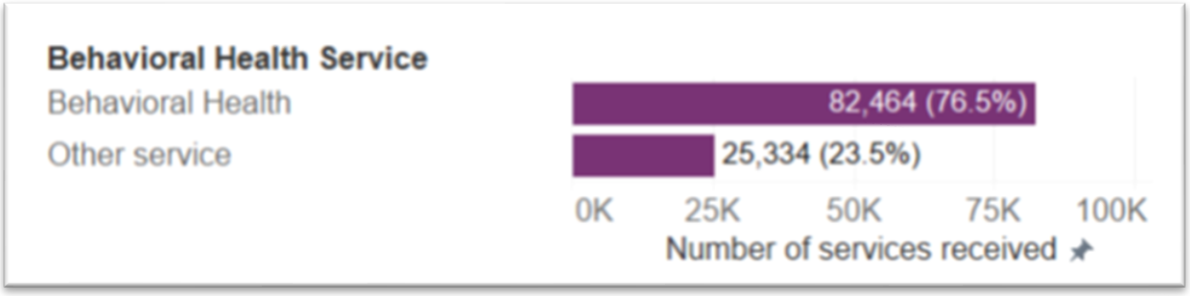

Conclusion

Across more than a year of analysis, engagement, and policy review, OHA has heard a wide range of perspectives from providers, members, community organizations, advocacy groups, committees, and trade associations. While these viewpoints differ in important ways, the volume of feedback by those already affected through recent network changes — including many providers and members impacted by the CareOregon policy change — illustrates the importance of taking clear and coordinated action. Evidence gathered through data analysis, surveys, listening sessions, advisory committees, and written feedback collectively demonstrates the complexity of Oregon's behavioral health system and the critical need to strengthen support structures for Associates serving Medicaid members. Providers emphasized workforce sustainability, the need for high-quality supervision, and the importance of team-based care for members with complex needs. Members highlighted the value of trusted therapeutic relationships, access to culturally responsive

services, and concerns around continuity. Collectively, these perspectives underscore why thoughtful implementation and ongoing risk mitigation will be essential as this policy and many other behavioral health efforts move forward.

OHA recognizes Oregon's behavioral health system must balance access, equity, quality, and workforce stability. After considering the full range of input, OHA believes that moving forward with rulemaking for this policy change is a necessary step toward a more consistent, reliable, and accountable treatment system for Medicaid members. At the same time, considerations of carve outs for appropriate exceptions are necessary for settings that already operate under strong federal or state oversight. This aligns with the state's broader goals to strengthen team-based care, improve clinical support for emerging professionals in the field, and ensure that all members – especially those with the most critical support needs – receive high-quality and well-coordinated services.

Continued collaboration will be essential to ensuring a strong, stable, and resilient behavioral health system for Oregon communities. As OHA proceeds, staff will continue to work closely with partners, prioritize clear communication, and apply lessons from this impact assessment to minimize disruption, support equity, and maintain access to culturally and linguistically specific care.

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