



1/7/22

To: OHA Health Policy and Analytics Medicaid Waiver Renewal Team  
From: Oregon Council for Behavioral Health (OCBH)  
Re: 2022-2027 Medicaid 1115 Demonstration Application

Oregon Council for Behavioral Health is the statewide member association comprised of behavioral health providers that serve and treat individuals with substance use disorders and mental illness. Our members provide the full continuum of behavioral healthcare from prevention to outpatient and residential treatment for both youth and adults living with the chronic diseases of addiction and mental illness.

We are grateful to the Oregon Health Authority for their work solidifying Oregon as a state at the forefront of healthcare transformation and health equity. OCBH members and partners are pleased to see many meaningful system improvements proposed in this waiver including network adequacy, documenting, and tracking services that improve health equity, improving access for those transitioning across multiple systems, formalized reporting, and auditing procedures to track and incentivize access for the larger healthcare system.

Robust and innovative healthcare policy proposals like these are part of Oregon's identity, and we are proud to stand alongside OHA in this work. Creating cutting edge healthcare policy is not without controversy and it is rare that Oregon's healthcare stakeholders reach unanimous agreement on anything. However, over the last several years, **we've found one aspect of our system in which this agreement exists: behavioral health rates are dangerously insufficient.** Across CCOs, hospital systems, state agency partners, legislators, and consumers we hear the same fundamental question: how can we improve behavioral health rates?

Current rates do not allow providers to pay a livable wage, much less a professional wage, to their workforce. Without a workforce to do this work, capacity is diminished and unscalable. We've seen this continue to play out for the last several decades. Short-term temporary infusions have provided stop-gap funding, preventing total collapse of the system. However, this incremental funding has been both inefficient and insufficient. Without ongoing, adequate, and stable resources that providers can anticipate, providers are unable to offer growth opportunities to current employees or consciously recruit underrepresented BH workforce and thus increase health equity and overall access. Thus, the workforce continues to churn, and experienced providers leave. Churn of the BH workforce increases overhead costs and causes disrupted, lower quality care for patients.

As mentioned, this cycle has hampered our behavioral health system's efforts to eliminate health inequity. Providing quality behavioral healthcare requires recruiting and retaining a workforce reflective of the population being served. However, recruiting a diverse workforce in a system that is unable to offer a professional wage is not only challenging, it undermines our equity goals.



**With far reaching agreement that behavioral health rate improvement is needed, we are left to ask: why hasn't it happened?** In asking this question we've received an incongruous series of answers from those with institutional knowledge of the waiver, our CCO model, and Oregon's history funding behavioral health. These responses have included the following explanations:

- We cannot, within the current waiver, require CCOs to raise rates for a specific sector, so the only option is to raise the OHA rate for those on "open card" and hope CCOs follow suit.
- The current waiver disincentivizes/prohibits a CCO from moving investments between areas of healthcare spend (i.e. moving money from physical health to behavioral health).
- Additional investment, above and beyond what is currently allocated to CCOs, is required to improve rates. However, this would put us above the 3.4%. This may jeopardize our ability to receive match on all these additional dollars and is therefore an untenable cost for the state/CCOs to absorb.
- Any additional investment in behavioral health rates would have to be funded using general fund up front. Actuarial soundness requirements are such that this investment would then take several years to be reflected in the rates from the federal government.

While we imagine the correct answer to this question may include aspects of several of the above theories, **Oregon Council for Behavioral Health is very concerned to see no clear evidence behavioral health rate improvement is being explored in this waiver.**

Furthermore, it is disheartening to see to see no mention of behavioral health rates in OHA's "Behavioral Health and Oregon's 1115 Medicaid Waiver" document. If behavioral health rates can be addressed outside the waiver, we see no reference to this on page four of the document (which mentions work being done on behavioral health outside the waiver but continues to point only to inefficient and insufficient stop-gap funding.)

We have broad agreement and willingness to improve behavioral health rates among our partners in Oregon. We are no longer tasked with the work of convincing partners *why* this work needs to be done; we are instead asking for direction from the experts about *how* this work can be done. We hope we can work together to seize this unique opportunity and make longstanding sustainable improvements to behavioral health access for the most vulnerable Oregonians.

Thank you,

Heather Jefferis, MA  
Executive Director, Oregon Council for Behavioral Health