Behavioral Health Workforce Report to the Oregon Health Authority and State Legislature

FINAL REPORT

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CENTER FOR HEALTH SYSTEMS EFFECTIVENESS

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Executive Summary

Oregon's behavioral health system is in a workforce crisis, with important implications for populations needing mental health or substance use treatment services. People of color are underrepresented among all types of behavioral health providers. Existing challenges in access to timely, affordable, and culturally specific behavioral health services make it difficult to address OHA's 10-year strategic goal of eliminating health inequities.

House Bill 2086, passed by the 2021 Oregon Legislature, required a study with recommendations for how to increase wages for behavioral health providers. The Oregon Legislature passed a number of other bills, with additional funding, to improve the behavioral health system. For example, House Bill 2949 includes $80 million to recruit and retain providers who are people of color, tribal members, or residents of rural areas in this state and who can provide culturally specific behavioral health services.

It is important to note that wage increases are a necessary but insufficient component to improving behavioral health workforce shortages. Additional measures that consider workforce recruitment and retention strategies, new models of care delivery, and reviewing competing state and organizational priorities will also be necessary. The findings and recommendations from this study can help inform the work from HB 2949 and other initiatives to improve outcomes for populations needing behavioral health services in the state of Oregon.

Listening to lived experience

This study used several methods to gather input from behavioral health service users and providers with a variety of lived experiences. We conducted key informant interviews with 24 providers, administrative and policy leaders, and others with knowledge of the behavioral health system, with approximately half identifying as people of color.

We conducted two focus groups with behavioral health consumers, including one conducted in Spanish, with Hispanic/Latinx participants. We conducted three focus groups with behavioral health providers, including one group consisting of providers of color. We conducted meetings with seven organizations (e.g., Latino Emotional Health Collaborative, Oregon Consumer Advisory Council Peer Support Committee) to provide additional perspectives for this study.

What we found

There is a gap between the need for services and the capacity of the behavioral health system. Oregon has the fourth highest rate of unmet need for mental health treatment in the country, and these needs have been growing. During the COVID-19 pandemic, the need for behavioral health services increased substantially, especially among communities of color. Populations in need of behavioral health services may have an even more difficult time finding providers, as the pandemic takes a toll on the workforce.

Because of the underrepresentation of people of color in the behavioral health workforce, it is difficult for service users of color to find culturally specific care. Consumers and providers of color echoed

this sentiment, emphasizing the importance of having providers who are members and understand the strengths and challenges of the communities they serve.

Lack of providers and workforce turnover harms those needing services. People needing behavioral health services had difficulties finding available providers and being seen in a timely manner. Wait times were reported to be very long and were exacerbated when the need for services required specialization, including bilingual or culturally specific training. Because of workforce turnover, people expressed frustrations with re-establishing rapport and reliving traumas to familiarize new providers with their social and medical histories. Provider turnover causes additional burdens with care coordination, transferring health records, insurance billing, delays in care, and challenges with finding a new provider with the right fit, especially when needing a bilingual or bicultural practitioner.

Under-resourced components of the behavioral health system make it more difficult for service users to transition between levels of care. Behavioral health professionals in inpatient settings described "log jams" whereby clients could not be discharged because of inadequate access to outpatient services. These bottlenecks create higher volume and acuity caseloads for outpatient settings, and these problems are even more acute in the behavioral health system that serves children.

Summary: Causes of the shortage of providers. Providers expressed agreement that low wages were a key issue in their struggles to recruit and retain workers. Many supported efforts to attain equity with wages for physical health providers. However, data from interviews and national studies suggest that wage increases alone may not be sufficient to resolve behavioral health workforce shortages. Career and educational barriers and work environment stressors contribute to burnout and frequent turnover among behavioral health providers. The most common reasons for burnout included higher client acuity and complexity over time, large caseloads, and high administrative burdens. These issues can be more significant for providers in community-based facilities, particularly those serving under-resourced communities, tribal communities, and communities of color.

Providers have been leaving the community behavioral health field for primary care, school settings, and hospital employment due to perceptions of better work environments and more robust compensation packages. The expansion of telehealth during the COVID-19 pandemic has been associated with increased recruitment of Oregon's providers to national telehealth companies who offer the prospect of working from home for higher wages.

Reimbursement rates are low for those serving behavioral health clients. Low reimbursement rates were a significant concern, with providers indicating that reimbursement was not commensurate with behavioral health providers' level of education, experience, or skillsets. Medicaid generally has lower reimbursement rates than Medicare or commercial insurance, although Medicaid often covers more behavioral health services than other insurers.

Challenges for service users with co-occurring disorders – mental health and substance use disorder. While mental health and substance use disorders (SUDs) are often co-occurring, services are usually provided in different settings, by different providers, and via different billing codes. These differences create barriers to effective, coordinated care. Generally, within a specific billing code, substance abuse disorder counselors receive reimbursement rates comparable to mental health counselors. However, data suggest disparities may arise because of the use of different billing codes. For example, reimbursements for the most commonly billed service for substance use treatment, lasting 60 minutes, were in the $40 to $45 range, approximately one-third the rate of reimbursement for 60 minutes of psychotherapy for mental health.

Administrative burdens reduce direct contact with service users and lead to provider burnout. Interviews with key informants suggest a number of administrative burdens inherent to working in the behavioral health system, such as burdensome treatment plan documentation requirements issued by the state and health plans. Those working on the residential treatment side reported administrative burdens with the level of service inventory (LSI), which is required every 45 days even when clients are not expected to change their level of service.

Gaps in career advancement opportunities. Providers highlighted a variety of challenges affecting the training and educational trajectories for behavioral health workers, including the absence of clear pathways for many behavioral health occupations and inadequate training opportunities. A lack of transparency and absence of clear opportunities for salary increases, additional certification and training, and leadership or administrative positions are significant barriers to provider recruitment and retention.

Selected recommendations

Direct adjustments to wages

- **Expand wage add-on programs.** There are various ways the state can fund "wage add-on" programs, which effectively increase wages for eligible providers. These programs could be modeled after an existing program in Oregon's Aging and People with Disabilities Program, which increases Medicaid fees for provider organizations who agree to pay a pre-specified minimum wage to certified nursing assistants or caregivers in home and community-based settings.
- **Consider retention and recruitment bonuses.** State-funded retention or recruitment bonuses may represent a short-term alternative to direct increases in wages. This approach may allow the state to target organizations with immediate unmet needs. However, this approach represents a short-term response to an underlying structural problem. Our interviews suggested that these temporary cash influxes were helpful but unlikely to motivate long-term retention of behavioral health professionals, particularly in under-resourced and community settings where case burden and demand for services continue to be high.

Direct adjustments to reimbursement

- **Reform the Medicaid fee schedule for services that are under-reimbursed.** The state could raise the fee schedule for behavioral health services in Medicaid's fee-for-service (FFS) program. About 10% of Medicaid beneficiaries are in Oregon's FFS ("Open Card") system, with the remaining 90% enrolled in Coordinated Care Organizations (CCOs). However, across-the-board increases in reimbursement may have unintended consequences. Some observers indicated that some services – such as psychotherapy – are already reimbursed at a reasonable rate, while others – such as psychiatric evaluation – are not reimbursed competitively. An increase in FFS rates for selected services could compel CCOs to increase their reimbursement rates for behavioral health care, though the exact impact would need further study.
- **Require or incentivize a fixed percentage of the global budget to be allocated to behavioral health.** CCOs work with a global budget, which integrates financing for physical, behavioral, and oral health. This model may introduce resource tradeoffs that favor physical health or procedural-based medicine. CCO requirements could be modified to incentivize increased payments for mental health and SUD services. For example, CCOs could be required to use a specified portion of the global budget on behavioral health treatment services.

- **Identify and remedy existing disparities in reimbursable activities.** Behavioral health providers in Oregon indicate that current insurance systems do not support billing for certain types of services, including care coordination. These systems also fail to support billing capacities for groups of providers, including peer support providers and case managers, reducing the funds available to support wage increases for these workers. An expansion of billable services, including code modifiers that offer reimbursement for language translation or culturally specific services, may be one mechanism for increasing wages to these workers.
- **Adjust reimbursement for social complexity.** Adjusting reimbursement rates based on client characteristics could increase wages for providers caring for the highest need clients. Reimbursement rates could be increased for services delivered to clients with significant social risk, such as housing instability and a history of trauma. Multnomah County includes culturally specific Knowledge, Skills, and Abilities (KSAs) in job descriptions that allow for increased pay for employees who can provide bilingual and bicultural services.

Additional adjustments to compensation

- **Reduce administrative burdens, claims delays, and denials.** A variety of evidence suggests that providers struggle with paperwork burdens and delays or denials in payments. Oregon has already engaged in efforts to reduce administrative burdens for behavioral workers during the COVID-19 pandemic. However, our interviews also suggest a need to revisit, simplify, and streamline CCO, state, and federal reporting and documentation burdens experienced by behavioral health providers.
- **Create robust recruitment and training pathways.** Providers reported under-resourced training environments, which could be bolstered through dedicated funds, either to provider organizations or to trainees directly. Additional funding could be used for internships and externships, professional development and mentoring, and specialized training pathways. Many people noted the need for diversity in leadership, which could help to support the recruitment and retention of a diverse workforce more broadly. It may be beneficial to adopt a wage or rate premium to support bilingual professionals, culturally specific positions, or other specialized services that often involve additional, currently unpaid work. A robust recruitment strategy needs to begin earlier in the career pipeline, including outreach to secondary schools, community colleges, and universities to strengthen interest in behavioral health professions.
- **Encourage transparent pay scales and promotion practices.** More transparent wage scales and promotion structures permit reliable salary comparisons within and across industries and have been shown to improve workforce retention and encourage further training and career progression. Career advancement and job promotion opportunities may have a more pronounced effect on job satisfaction and retention than a higher minimum starting wage.
- **Expand tuition reimbursement and loan repayment programs.** Oregon's Health Care Provider Incentive Program includes loan repayment programs for behavioral health providers. The 2021 legislature passed HB 2949, which included additional funding for loan repayment and tuition reimbursement programs, focusing on people of color, tribal members, or residents of rural areas who can provide culturally responsive behavioral health services. These programs can directly incentivize workforce pipeline development by reducing barriers to further training and indirectly increasing the amount of disposable income for behavioral health providers.

Additional recommendations

- **Improve the work environment.** Providers universally cited high case burden and acuity, intensive and inflexible schedules, frequent rotations on crisis calls, and insufficient supervisory

support as negatively impacting their job satisfaction. Improvements to the workplace could include expanded benefits such as health insurance, housing stipends, moving stipends, childcare, family leave and paid time off, and other options such as scheduling flexibility, rotating call, and occasional remote work. Creating the internal infrastructure to provide trauma-informed support for the workforce is likely to be essential for staff retention. Institutional and state guidance and oversight of these work conditions may help to reduce workforce burnout.

- **Review existing licensure requirements.** Oregon's approach to staffing behavioral healthcare needs has been to encourage the use of unlicensed professionals. This approach is intended to reduce barriers to hiring providers. However, large pay differences between unlicensed and licensed workers may exacerbate turnover, with unlicensed workers leaving their current employer when they obtain licensure to earn higher wages in a different setting. This structure creates scenarios where individuals with the least amount of training care for clients with the greatest needs.
- **Review regulations that inhibit recruitment.** Oregon could consider changing current licensing requirements regarding reciprocity with other states. State regulations require approximately six months for an out-of-state provider to obtain licensure to practice in Oregon. Requirements that employees pass background checks may reduce the opportunities to become peer workers for people with previous criminal justice system involvement.
- **Assess and remediate regional wage differences in Oregon.** There are significant regional variations in wages for substance use and mental health counselors. For example, the highest median wages occur in the South Coast area, with median wages ($32.07) that are almost 70% higher than the South Central area's median wage of $19.82. It is unclear why such large variations exist, though factors like regional competition and cost of living could contribute. Understanding the causes of these differences may create opportunities for addressing wage disparities in the state. The available data on wages did not allow for analysis by race/ethnicity, so these data sources should be augmented using OHA's REALD (race, ethnicity, language, disability) and SOGI (sexual orientation, gender identity) standard.
- **Commit to a diverse workforce and draw from the community.** Shortages of providers of color and others from underrepresented communities can be self-reinforcing. Increased representation can lead to greater success in recruiting diverse candidates. The state and health systems should include providers of color in developing their processes, policies, and outreach because these voices may have unique insights into challenges with work conditions, billing codes, and recruitment and retention. Many people noted the need for diversity in leadership which could help to support the recruitment and retention of a diverse workforce more broadly. To translate these priorities into action, it may be beneficial to adopt a wage or rate premium to support bilingual professionals or culturally specific positions.

Conclusions

A robust behavioral health workforce is necessary to address community needs regarding mental health and SUDs. Low wages are a barrier to recruiting and retaining behavioral health providers, including providers of color. This study provides context for the current landscape and offers suggestions for increasing wages and generally improving working conditions so that Oregon can address the growing need for timely, accessible, and culturally specific behavioral health services.

Overview

Oregonians report one of the highest rates of unmet need for mental health treatment in the nation. Population health needs are closely tied to longstanding concerns about the state's workforce's size, distribution, and diversity. These concerns have been particularly acute among lower-wage behavioral health providers. Lower-wage providers are more likely to be from historically excluded populations, including people of color and tribal communities. Thus, policies and programs designed to address behavioral health providers must consider the intended and unintended impacts on lower-wage providers of color. These approaches align with the Oregon Health Authority's (OHA) goals of creating a health care system where "all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances."

Aligning with the state's priorities and pursuit of equity, the purpose of this report is to provide recommendations to the Oregon State Legislature around:

(a) Achieving a living wage for behavioral health care workers, including additional treatment providers, peers, and family support specialists; and

(b) Providing more equitable wages between physical health care workers and behavioral health care workers;

House Bill 2086 was passed in 2021 to address behavioral health workforce shortages and access to care, particularly among people of color, tribal communities, and other historically marginalized groups. This project was conducted in the context of additional priorities of the Governor, Legislature, and Oregon Health Authority, including

- Eliminating health inequities by 2030;
- Diversifying the behavioral health workforce, including the activities outlined in HB 2949 (2021);
- Increasing access to behavioral health services, including by expanding the behavioral health workforce;
- Integrating the delivery of behavioral health, physical health, and oral health services;
- Priorities identified in the development of Oregon's next Medicaid 1115 waiver application;
- Improving population health outcomes; and
- Creating a sustainable and transformed health care system.

This report is intended to provide recommendations for achieving a living wage for behavioral health workers and providing more equitable wages between physical health care workers and behavioral health care workers.

Demand for Behavioral Health Services and Unmet Needs

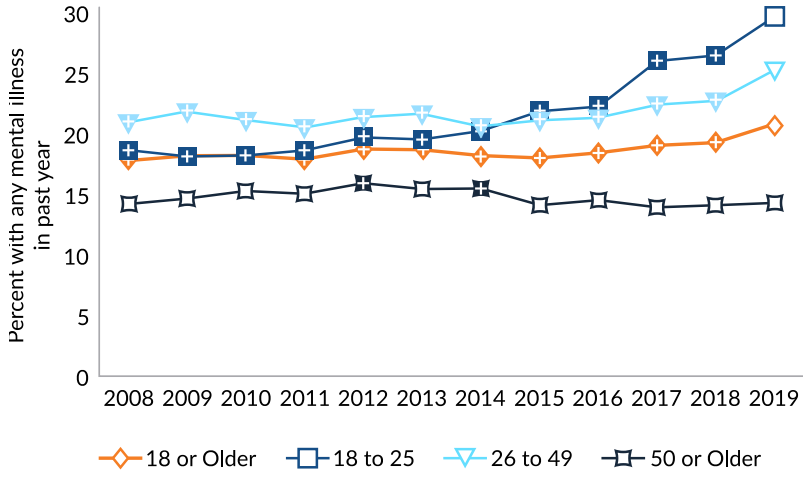
A rise in the prevalence of behavioral health conditions

The need for effective behavioral health services has increased across the United States, as demonstrated by rising suicide rates, increases in drug overdose deaths,[1] and substantially lower life expectancy among people with serious mental illness (SMI).[2] In 2019, approximately one in five adults ages 18 and over had a mental illness (Figure 1), and one in fourteen people ages 12 and older had a substance use disorder (SUD).[1] The percentage of young adults (ages 18 to 25) with any mental illness increased from 18.5% in 2008 to 29.4% in 2019.[1] The last ten years have been marked by a dramatic increase in mental health conditions for children and adolescents. Among adolescents aged 12 to 17 in 2020, 17.0 percent had a past year major depressive episode, more than double the percentage in 2010 (8.0%).[3] Trends in suicide attempts also have been increasing among adolescents[4] and the rate of U.S. adolescents and young adults dying of suicide has reached its highest level in nearly two decades, with suicide now the second-leading cause of death for people aged 15 to 24.[5]

Many indicators show inequities by race/ethnicity. For example, overdose death rates have been particularly high among American Indian or Alaska Native people (30.5 deaths per 100,000 individuals), non-Hispanic White people (26.2 deaths per 100,000 individuals), and Black people (24.8 deaths per 100,000 individuals).[6]

Trends in Oregon have generally followed the nation: among young adults aged 18–25 in Oregon, the percentage with serious thoughts of suicide has more than doubled over the last ten years, increasing from 6.5% in 2008–2010 to 14.7% in 2017–2019.[7] The prevalence of SMI in this group of young adults has also increased, from 3.9% in 2008-2010 to 10.4% in 2018-2019, similar to the regional average (9.7%) but higher than the national average (7.9%).[7]

Figure 1. Percentage of adults nationally with any mental illness, 2008-2019, by age group



Data source: Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration)

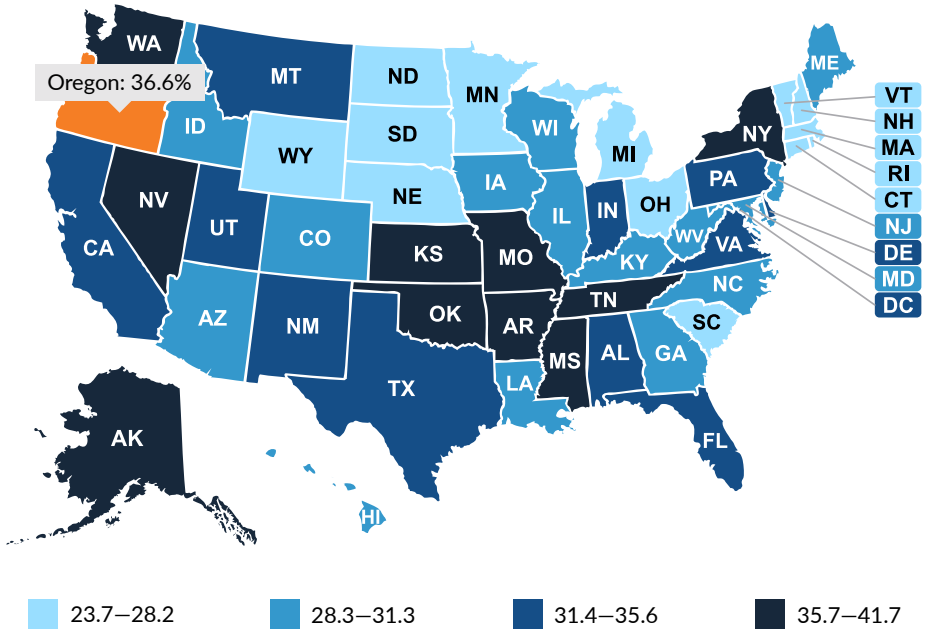
The personal and societal costs of behavioral health conditions are well documented. Individuals with mental health conditions and SUDs have significantly more chronic medical conditions, higher hospitalization rates, and higher mortality rates than individuals without behavioral health conditions.[8,9]

Yet access to behavioral health services and treatment continues to be insufficient. Approximately 8.9% of adults in Oregon reported an unmet need for mental health treatment in 2018 and 2019 – the fourth-highest rate in the country and 2.7 percentage points higher than the national average of 6.2%.[10] Unmet needs in Oregon among adults reporting needing but not receiving treatment for alcohol use disorder was 7.0% (5.4% US average);[11] among adults for illicit drug use disorder was 2.9% (2.7% US average);[11] and among children aged 12-17 for illicit drug use was 4.1% (3.0% US average).[11] Unmet need for behavioral health services has been particularly high among those who are working-age, lower-income, reside in rural areas, and lack health insurance.[12] The prevalence of mental disorders or SUDs does not generally appear to be higher among people of color, but individuals in these groups are often less likely to receive treatment services.[13]

The COVID-19 pandemic may have exacerbated behavioral health conditions. Estimates from the Centers for Disease Control and Prevention's (CDC) Household Pulse Survey suggest that the prevalence of anxiety disorder or depressive disorder among adults in Oregon ranged from a low of 29.9% to a high of 50.2% between April 2020 and August 2021 (Figure 2).[14] During the pandemic, access to behavioral health services appears to have worsened, with up to a quarter of adults with depression and anxiety nationally reporting unmet behavioral health needs in 2020.[15]

People of color have been disproportionately affected by the COVID-19 pandemic,[16] with the prevalence of many behavioral health conditions becoming significantly higher for people of color during the pandemic.[14,17] For example, across the US in 2020, symptoms of current depression were reported more frequently by Hispanic/Latinx adults (40.3%) than by non-Hispanic White adults (25.3%). Estimates of self-reported suicidal thoughts/ideation among Hispanic persons (22.9%) were four times those of White persons (5.3%).[17,20]

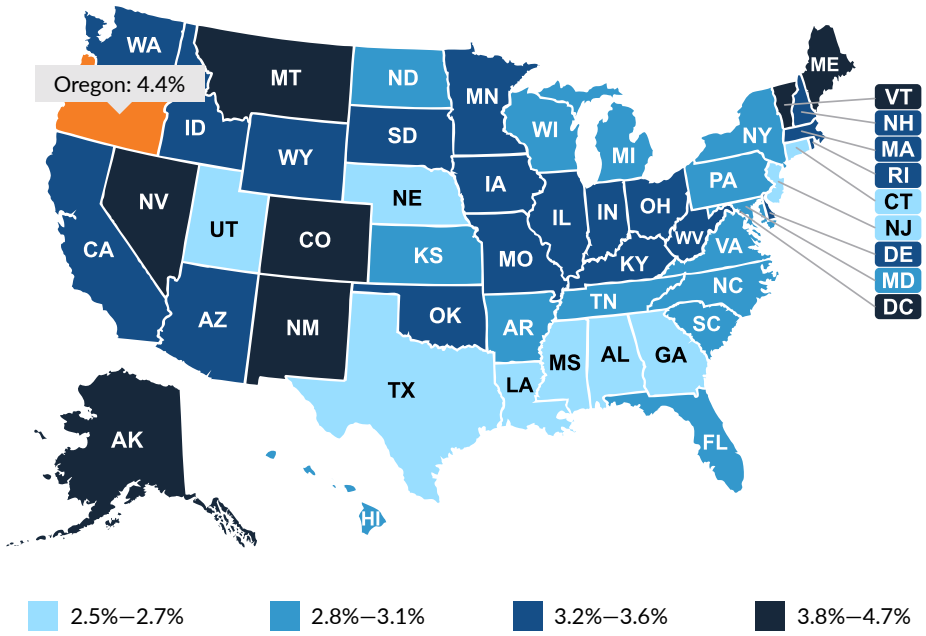
Figure 2. Percentage of population with symptoms of anxiety disorder or depressive disorder (September 15, 2021, to September 27, 2021) by state



Source: Anxiety and Depression: Household Pulse Survey. (National Center for Health Statistics)[14]

Substance use also increased overall at the onset of the pandemic (18.2% overall increase in substance use), with the greatest increase reported by Hispanic adults (36.9%).[17] More than 4% of adult Oregonians report illicit drug dependence or abuse in the last year, which is the 5th highest rate in the nation (Figure 3).[13]

Figure 3. Percentage of population reporting illicit drug dependence or abuse (2018-2019)



Source: Kaiser Family Foundation, January 13, 2021.[18]

Note: Number of individuals reporting illicit drug use disorder in the past year (time frame 2018-2019) are rounded to the nearest 1,000. Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine.

Asian Americans experienced an increase in discrimination and hate crimes at the onset of the pandemic; more than 40% of Asian Americans reported an increase in anxiety, and more than 50% reported an increase in depression when comparing their current mental health to pre-pandemic levels.[19] These patterns create an even greater demand for culturally competent care that accounts for factors such as discrimination, distrust of health care providers, and historical and racial trauma.[21]

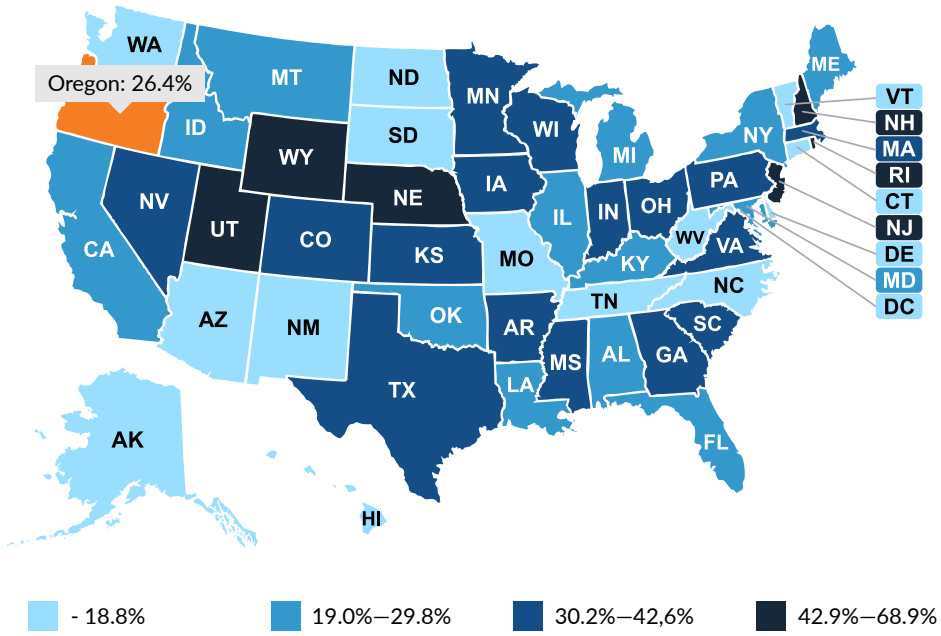
Shortages in the behavioral health workforce and unmet behavioral health needs

There are many historical, geographic, and socioeconomic reasons individuals may not receive the behavioral health treatment they need. There remains stigma associated with behavioral health conditions that may be particularly salient within communities of color, whose reluctance to engage in treatment may reflect the history of race-related abusive practices and mistrust.[22–25] In addition, a lack of health care coverage, insufficient availability of providers, travel barriers, challenges with care coordination, inadequate linkages among services, and other issues navigating the system may deter people from seeking care. Moreover, the Affordable Care Act (ACA) – alongside Medicaid expansion and legislation extending mental health parity coverage[26] – has increased demand for behavioral health services among those who previously were under- or uninsured.[27]

Shortages in the behavioral health workforce also contribute to unmet needs. Measuring these shortages is challenging, but various studies suggest that shortages in behavioral health workers are common across the country and are particularly acute in rural areas (Figure 4). For example, the number of psychiatrists per capita is almost five times higher in urban states such as Massachusetts

(24.7 per 100,000) compared to more rural states such as Idaho (5.2 per 100,000).[28] The number of psychologists varies tenfold across urban-rural geographies.[28] Within Oregon, workforce shortages are similarly geographically maldistributed, with all seven of Oregon's designated Health Professional Shortage Areas (HPSAs) located in rural areas.[29]

Figure 4. Percent of mental health needs met, by state

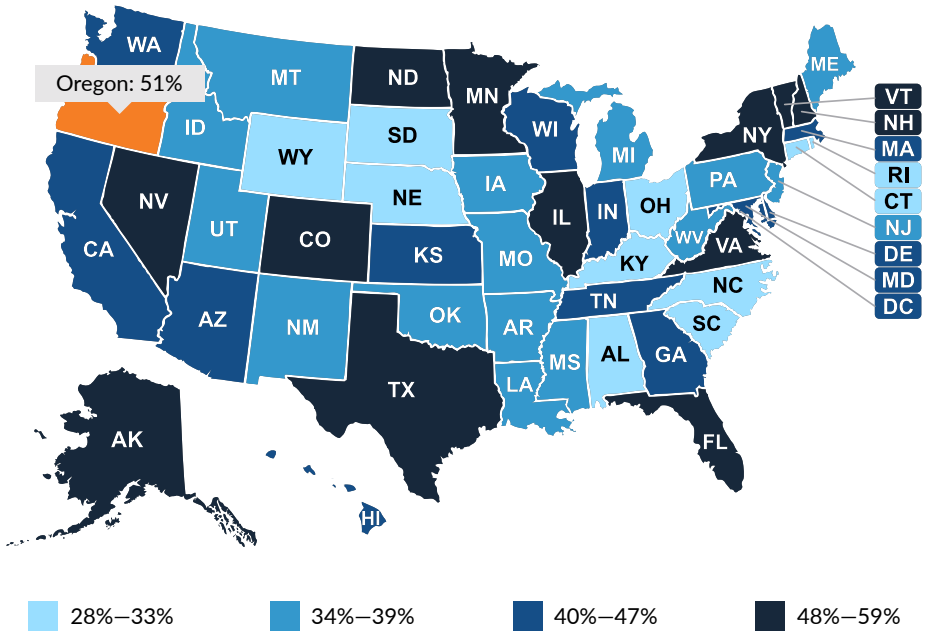


Source: Kaiser Family Foundation, Sept 30, 2021.[18]

Note: *Percent of need met is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health Health Professional Shortage Area (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated).*

Shortages in the behavioral health workforce may be particularly acute for children, with more than half of respondents of a national survey in Oregon reporting it was "somewhat" or "very difficult" to receive mental health care for adolescents and children, compared to a national average of 43% (Figure 5).[30]

Figure 5. Percent of children (ages 3-17) who faced difficulties obtaining mental health care, by state



Source: Kaiser Family Foundation, January 13, 2021.[18]

Note: The denominator of this measure is based on the response to the question which asks whether the child received a mental health care or not. The numerator represents respondents indicating it was "Somewhat" or "Very Difficult" or "Impossible to Get Care." Time span is 2020. Children whose response was "Did not receive care from a mental health professional, the child did not need to see a mental health professional" are not included in the denominator.

Unmet needs in Medicaid, the largest payer of mental health care in the U.S.

Medicaid is the single largest payer of behavioral health services in the U.S.[31] Individuals with behavioral health conditions are more likely to be covered through Medicaid than other insurance programs. The prevalence of any mental health condition among adults 18-64 is almost 50% higher for individuals in Medicaid relative to the commercially insured,[32] while the prevalence of SMI is more than 90% higher.[32] The prevalence of any SUD among Medicaid beneficiaries is approximately 40% higher than commercially insured or Medicare beneficiaries.[33]

Despite Medicaid's role in financing, behavioral health provider shortages are prevalent within the program. The implications of these shortages may be particularly acute among people of color, who are disproportionately represented in Medicaid enrollment. Nationally, only 35% of psychiatrists accepted new clients enrolled in Medicaid in 2014–2015, in contrast with 62% accepting new clients covered by Medicare and private insurance.[34] Variable acceptance of insurance may also disproportionately affect children and adolescents. In 2018, for example, only 27% of substance use treatment facilities that accepted Medicaid offered tailored programming for youth.[32]

Within Medicaid, there are significant racial and ethnic disparities in treatment access. Nationally, Black/African American and Hispanic/Latinx beneficiaries with mental health conditions receive treatment at lower rates than their White counterparts (52.3% for White beneficiaries vs. 35.5% for Black beneficiaries and 35.0% for Hispanic/Latinx beneficiaries).[32] Black/African American and Hispanic/Latinx beneficiaries are also less likely to receive treatment in a private therapist's office and less likely to take a prescription for their mental health condition.[32]

Nonetheless, Medicaid can be seen demonstrating success in important dimensions. Medicaid beneficiaries with mental health conditions receive treatment at similar rates as their peers with private coverage nationally[32] as well as in Oregon.[35] Medicaid beneficiaries often have access to a broader range of benefits than the commercially insured. They are also much less likely to have trouble

paying for care out-of-pocket, to have financial problems due to medical costs, or to go without needed care due to cost than privately insured or uninsured people.[36] Thus, the complete picture of Medicaid's role in meeting behavioral health needs may be nuanced, representing a mix of successes and clear opportunities for improving outcomes and the client experience.

Impact on service users

Across our outreach efforts, it was universally emphasized that populations in need of behavioral health services have been significantly impacted by workforce shortages. Focus groups with service users cited numerous challenges for clients dealing with behavioral health workforce shortages. As a consequence of frequent provider turnover, service users reported extended delays or discontinuities in care, often over months-long periods. Some consumers reported falling out of care entirely and experiencing setbacks or exacerbations of their behavioral health issues. Other consumers expressed frustrations with re-establishing rapport and reliving traumas to familiarize new providers with their medical and social histories; burdens with care coordination, transferring medical records, and billing; challenges with finding providers with the right fit; and diminishing provider choice over time.

> *"...it's based on where they accept health insurance, and the other thing is where they speak your language. Those places are very scarce. Especially in Marion county, finding those services is almost impossible."*
>
> *—Service user who speaks Spanish, on the main factors when choosing a provider*

> *"First, it's really hard to find a specialist who sees children younger than five. Then, I ran into problems with the language, because they didn't speak Spanish. And then when I found someone who spoke Spanish who could see my daughter, they didn't accept state insurance..."*
>
> *—Service user who speaks Spanish*

Interviews with services users identified a number of common barriers to finding appropriate providers. For example, clients most commonly cited insurance coverage as the most important factor they used to choose a provider, with coverage then limiting them to a small pool of providers. From the perspective of service users, providers were limited both in number and type and often accepted limited forms of insurance, if any at all. For the majority of service users, the specific type of provider mattered less so long as they were accessible and associated with low out-of-pocket costs. For some others, these provider shortages were also exacerbated by specific mental health conditions (e.g., need for specialization in trauma, or children and families) or cultural or language needs, which reduced the choice of providers further.

Some Spanish language service users described turning to online services to access mental health counseling from providers located in Argentina and Cuba and being more satisfied with that care than the care received locally. In addition to needing more providers who were able to communicate in Spanish, Spanish-language service users, in particular, cited ease of access and location as important factors when finding care, as they were more likely to report transportation challenges and reliance on public transportation than other service users. Service users of color also reported that providers who looked like them or could relate to and understand them were challenging to find.

Others reported appreciating peer support services but experiencing challenges having those services covered by insurance, particularly among enrollees with private insurance plans. Finally, while service users expressed appreciation for some bright spots in the system, they expressed a need for more services, including extra residential and inpatient care beds, increased crisis support resources, and additional help with navigating resources and services. For people experiencing crisis or requiring

immediate services, these areas were particularly important. One interviewee described how her son was eager to start a residential treatment for substance use, but a bed was not immediately available in their area. The mother found a hotel room for her son to stay in while they waited for beds to open. However, by the time a space opened up, her son had been sober for three days and thus was no longer eligible for the detoxification program. When service availability and accessibility are misaligned with acute needs, it leads to missed opportunities for treatment.

> *"My psychiatrist quit 14 months ago and my therapist quit 12 months ago, and I was told there would be a very simple transition in two to three weeks. Here we are, 13 and 14 months later, still without a psychiatrist or a case manager or therapist … it's very frustrating."*
>
> *—Mental health service user*

Composition of the behavioral health workforce in Oregon

Oregon's behavioral health workforce has been characterized by a lack of racial/ethnic diversity, with Hispanic/Latinx providers representing a particular shortage.[37] For example, in 2018, only 5% of prescribers identified as Hispanic/Latinx, although 13% of the state's population is Hispanic/Latinx. This finding is consistent with other studies that suggest that nationally, people of color account for only 21.3% of psychiatrists, 6.2% of psychologists, 5.6% of advanced practice psychiatric nurses, and 12.6% of social workers.[38] When physicians and clients share the same race, clients may experience greater satisfaction and better care.[39–44]

> *"[We need] access to culturally appropriate and well-trained [providers] … we have this myth that all behavioral health providers … [are] the same … We really have to think about the spectrum of specialists within behavioral health, in that the best quality of care is when somebody is well-matched with the type of professional that meets their need."*
>
> *—Psychologist*

In focus groups, providers and consumers of color echoed this sentiment, emphasizing the importance of available multicultural behavioral health providers who "look like their clients" and also understand the needs of the communities they serve. One Hispanic provider in Central Oregon noted that some cultures view mental health as "a weakness or vulnerability," requiring different approaches to providing care.

> *"Being in mental health for as long as I've been … I find that it's easier to relate to someone who looks like me because I feel like they can understand a little bit more of the struggle that I go through."*
>
> *—Service user who identifies as Black*

At the same time, consumers of color highlighted the current universal challenges of finding any qualified or available providers at all due to workforce shortages, with some experiencing wait times of a year or longer to find a provider who has availability and accepts their insurance.

Like many other states, Oregon's behavioral health workforce comprises licensed and unlicensed providers. Licensed prescribers include physicians and advanced practice providers like behavioral health nurse practitioners who provide prescription-based treatment for behavioral health conditions. Non-prescribing licensed providers, including psychologists, licensed counselors, and social workers, provide psychotherapy-based services under the authority of various professional boards.

The vast majority of licensed providers work in outpatient clinical settings. The number of licensed providers appears to be relatively stable, with most reporting no plans to change their clinical hours and less than 3% planning to retire in the near future.[37] Licensed providers typically use only 50-70% of their available hours on direct client care (with the remainder devoted to administrative or managerial tasks),[37] suggesting a smaller supply of clinical hours than would otherwise be available based on the number of providers alone. Furthermore, licensed providers often have a range of options in the clients they choose to see, and not all of them accept Medicaid.[35]

People of color comprise 13% of the licensed behavioral health provider workforce. Clinical social work associates are the most racially and ethnically diverse group, with 26% being people of color. Among licensed behavioral health providers, 8.2% have advanced proficiency in or are native speakers of a language other than English.[45]

Unlicensed providers comprise individuals that provide community-based counseling and supportive services for those with behavioral health conditions.[37] This group may include trained or certified addiction specialists, traditional health workers, crisis counselors, case managers, and community support personnel who vary in their formal training, as well as pre-licensed providers. For example, peer specialists or peer mentors have lived experience with a SUD or mental health issue; with training, they work as advocates for clients. A 2019 report by the Eugene S. Farley, Jr. Center of Colorado identified the unlicensed provider workforce in Oregon as more susceptible to turnover, with 22% of providers planning to leave their agency or retire and 23% reporting plans to advance within their field.[37] Unlicensed providers are the most racially and ethnically diverse segment of the behavioral health workforce, and comprise approximately 28% of the unlicensed behavioral health workforce.[45]

Geographically, there appears to be an overconcentration of licensed providers in Multnomah County. For example, adjusting for population size and need, Multnomah County has approximately twice as many licensed providers as other regions,[37] consistent with other evidence of the urban concentration of behavioral health providers. On the other hand, Eastern Oregon is consistently understaffed compared to other areas. The 2019 Farley Center report also noted the need for more accurate data and completion of the state's unlicensed behavioral health provider registry.[37]

Table 1. Licensed behavioral health occupations in Oregon

Occupation	Description	Minimum education	Licensing required?	Number practicing in oregon**	Direct patient care fte**
Psychiatrist (MD/DO)	Prescriber	MD/DO degree, internship, residency	Yes	750	498
Physician assistants (MH specialty)	Prescriber	Graduate degree	Yes	24	14
Nurse practitioners (MH specialty)	Prescriber	Graduate degree	Yes	534	362
Clinical nurse specialists (MH specialty)	Prescriber	Graduate degree	Yes	19	11
Psychologists	Provider	Graduate degree	Yes	1629	836
LCSW	Licensed clinical social worker; provider	Graduate degree	Yes	3684	1884
CSWA	Certified social worker associate; provider	Graduate degree	No	857	522
LPC	Licensed professional counselor; provider	Graduate degree	Yes	2616	1250
LMFT	Licensed marriage and family therapist; provider	Graduate degree	Yes	648	301
LPC LMFT	Licensed professional counselor, marriage and family therapist; provider	Graduate degree	Yes	87	45

*Source: An Analysis of Oregon's Behavioral Health Workforce: Assessing the Capacity of Licensed and Unlicensed Providers to Meet Population Needs, Farley Health Policy Center/Oregon Health Authority, 2019. **Data based on Board License Renewal Survey; Oregon Medical Board Licensure Renewal Data, 2016-2017; Oregon State Board of Nursing Licensure Renewal Data, 2015-2018; Board of Psychologists, Board of Social Workers, Board of Counselors and Therapists; Oregon Board of Licensed Professional Counselors and Therapists (2017-2018); Oregon Board of Licensed Clinical Social Workers (2016-2018); Oregon Board of Psychology (2016-2018).*

Table 2. Other behavioral health occupations without formal licensing requirements*

Occupation	Description	Minimum education	Certification requirements*	Number practicing in Oregon**
Addiction counselor	Identifies substance use issues and develops individual treatment plans	• High school/GED • 150 SUD education hours • 1,000 supervised experience hours, professional psychometric competency exam, or portfolio review***	Certification required in order to receive Medicaid reimbursement and be employed in State COA programs	4,206
Addiction peer	Professional with lived experience who supports a client through recovery	• High school/GED • 40-hour peer training, accredited by OHA	Certification required in order to receive Medicaid reimbursement and be employed in State COA programs	1,267
Addiction supervisor **(advanced SUD certification)**	Professional with lived experience who supports addiction peers	• High school/GED • Minimum 2-year degree or equivalent • 300 SUD education hours • 4,000 supervised experience hours, professional psychometric competency exam, or portfolio review	Advanced SUD Certification required and be employed in State COA programs	1,419
MH peer	Assesses and supports mh and sud service needs	• High School/GED • 40-hour peer training, accredited by OHA	Certification required in order to receive Medicaid reimbursement and be employed in State COA programs	1021
QMHA	Qualified mental health associate	• Bachelor's degree in related, behavioral health studies or 3 years of relevant education and experience	Pending new rules****: Certification required in order to receive Medicaid reimbursement and be employed in State COA programs	4,876
QMHP	Qualified Mental Health Professional	• Graduate degree in behavioral health	Pending new rules: Certification required in order to receive Medicaid reimbursement and be employed in State COA programs	1,965

Source: Table provided by Eric Martin, MHACBO, on Oct. 20, 2021

** Certification requirements are based on "outpatient rules" but are largely consistent with requirements for residential settings*
*** Numbers are based on the real-time MHACBO database registry and may be higher than those the Farley Report (An Analysis of Oregon's Behavioral Health Workforce: Assessing the Capacity of Licensed and Unlicensed Providers to Meet Population Needs), and the Oregon Health Authority (MH Peer count derived from Traditional Health Worker Credential Counts)*
**** Minimum requirements listed here as stipulated in Oregon Administrative Rule 309-019-0125 https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=278845*
*****Certification rules are currently pending from OHA*

Projections of workforce shortages in Oregon across provider types

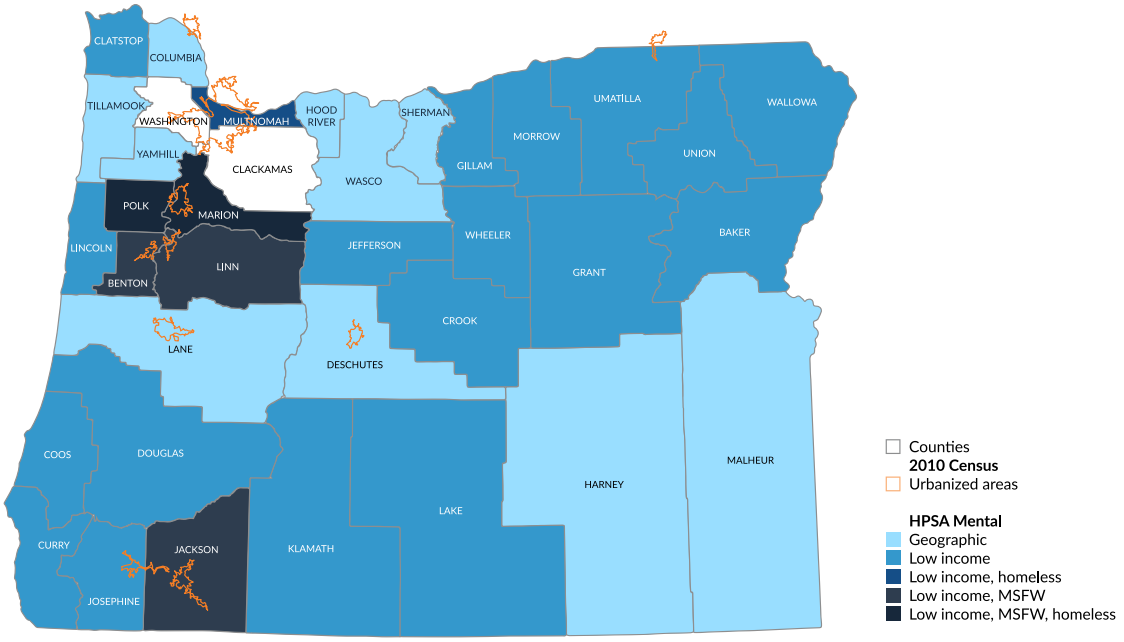
The federal Health Resources and Services Administration (HRSA) projects that by 2030, Oregon will have an estimated shortage of at least 240 FTE psychiatrists (a 48.2% increase from 2016) and 510 FTE addiction counselors (a 114.6% increase from 2016). In contrast, they project a relative surplus of 80 FTE psychiatric nurse practitioners, 340 FTE psychologists, 610 FTE mental health counselors, and 3,600 FTE social workers, based on faster growth in supply relative to demand (of note, these forecasts do not consider the impact of COVID-19 and the potential for provider turnover or reductions in the pool of providers).[46]

However, these projections may conceal disparities in providers specializing in children or adolescents and geographic disparities in the distribution of the behavioral health workforce (Figure 6). For example, of Oregon's seven designated Health Professional Shortage Areas (HPSAs) in 2021, the rural regions of East Columbia (Gilliam, Grant, Morrow, Umatilla, and Wheeler counties) and Lincoln, Klamath, and Lake counties are the highest priority in terms of the need for full-time behavioral health practitioners. In addition, areas with significant low-income, houseless, and seasonal/migrant worker populations – including parts of Marion, Polk, Lane, and Multnomah counties – also carry HPSA designations. In alignment with HRSA projections, a 2021 needs assessment by the Oregon Health Authority[45] concluded that Oregon's workforce suffered from a lack of diversity and critical shortages in rural and frontier areas.

> *"There's always been a deficit in rural areas, particularly of highly qualified professionals. When I practiced in Hood River, there were seven years that we didn't have a psychiatrist in the county."*
>
> *—Behavioral health director, psychologist*

In addition, the report noted a need for more trained behavioral health providers, among other health care professionals, as well as more data on unlicensed professions, including numbers of providers, demographics, and training needs. The assessment also noted the need for culturally-based practices, including equitable reimbursement for promising practices and practices outside of the conventional medical model.

Figure 6. Oregon mental health - health professional shortage areas, by county



Source: Health Resources & Services Administration

The COVID-19 pandemic has heightened these needs. A June 2021 survey by the Oregon Council for Behavioral Health, a trade group of behavioral health service providers, found that the workforce of its member groups shrank by 10-30% across various agencies and programs through layoffs, exits, and attrition.[47] One-fifth of provider groups reported a 6-month average delay to fill a position. Another 18% of provider groups reported perpetual job openings due to a lack of candidates. Oregon's largest behavioral health provider, Cascadia Behavioral Healthcare in Multnomah County, had 185 openings, including residential and direct support positions, peer support workers, and crisis counselors as of summer 2021.

> *"We're in dire straits … the system is imploding. It's a catastrophe. It's in crisis. None of this is hyperbole. I can't even find the work strongest. Decimated … means you lose 10%, we're up to, like, 40 to 60% of our kids' residential programs. It's way beyond decimated, it's a disaster right now."*
>
> *—Child and adolescent psychiatrist*

> *"What becomes a lot more burdensome is you're trying to make up for being short-staffed. We're critically low on psychologists, behavioral health specialists, therapists, drug and alcohol counselors. And then really trying to meet the institutional needs and the forensic needs of our patients … becomes a lot less about the actual work of psychiatry … and more about all the other bureaucratic and institutional tasks that we have to do."*
>
> *—Psychiatrist at state hospital*

Interviews with providers and provider organizations also revealed variation in workforce shortages across different positions. A common refrain was that provider organizations were in critical need of Qualified Mental Health Professional (QMHP) level clinicians (those with master's degrees in behavioral/social sciences, or bachelor's degrees in nursing or occupational therapy, and who work in counselor or program leadership capacities). Other key informants reported critical shortages of residential registered nurses and psychiatric nurse practitioners. A case manager at a community behavioral health center reported that positions often go unfilled for many months due to a lack of applicants, with staff in a constant state of turnover. This sentiment was echoed by other key informants, with a residential treatment director sharing that detox nursing positions usually remained open for months and workforce shortages exacerbated inherent difficulties in filling positions in residential facilities.

> *"It's really hard to find QMHPs right now. When I first started here seven years ago, we had five on staff, now we're down to two."*
>
> *—Addiction program supervisor*

Factors Contributing to Behavioral Health Provider Shortages

Although wages are important – and a focus of this report – there are a variety of other factors that contribute to shortages in the behavioral health workforce and have been well documented. Providers in community-based facilities, particularly those in underserved communities, are likely to experience burnout and turnover. Low reimbursement rates, payment delays, and administrative burdens may influence provider participation with health insurance contracts and contribute to shortages within specific health insurance networks. Licensure requirements, insufficient educational pathways, and inadequate career advancement opportunities may be barriers to recruitment. Workplace stressors, especially high acuity, more complex caseloads, along with inadequate resources across the full continuum of treatment, create additional challenges to provider retention.

Low reimbursement

Reimbursement is defined as payment from a health insurer. Higher reimbursement is often necessary to achieve increased wages, but the relationship between reimbursement rates and wages (the focus of this report) is not always one-to-one. Nonetheless, understanding the context and role of reimbursement is an important consideration in the efforts to increase wages for the behavioral health workforce.

Low reimbursement rates for behavioral health may make clinicians less willing to accept insurance,[34,48] a problem that may be particularly acute in Medicaid, which reimburses at a lower rate than Medicare or commercial insurance.[49–51] For example, in 2019, the national state-level ratio of Medicaid-to-Medicare physician fees was 0.72. This index varied from a low of 0.37 in Rhode Island to a high of 1.18 in Delaware, with Oregon's index at 0.83.[49] Interviews with providers revealed that low rates of reimbursement were a significant concern, with providers indicating that reimbursement was not commensurate with behavioral health providers' level of education, experience, or skillsets. In particular, key informants described "horrifically low" rates for behavioral health services, along with a perception that reimbursement rates might differ for behavioral health vs. physical health services (e.g., licensed clinical social workers) and between substance use vs. mental health services. Interviewees highlighted additional financial incentives that affected care delivery, including psychiatry codes that are relatively undervalued. In other words, provider groups often take a loss on psychiatrist-delivered care, even if psychotherapy codes may be relatively over-reimbursed (for example, at $151/hour for an unlicensed master's level therapist).

> *"The rate system does not match the vision of how to deliver care. [Rates] are horrifically low … we call that the non-profit penalty. You have to fundraise and use the charity care model or find other types of contracts, or just not pay people appropriately [for] very high education levels which are needed to deliver the care."*
>
> *—Behavioral health non-profit director*

A variety of studies find higher payments for Medicaid to be associated with increases in providers' willingness to accept Medicaid beneficiaries,[52–56] but policies that focus solely on reimbursement may have limited success. For example, the ACA required states to raise Medicaid payment rates to primary care physicians to the level of Medicare rates in 2013 and 2014, resulting in a 73% increase in Medicaid reimbursement for the average physician. However, the policy was not associated with any increases in the number of physicians accepting new Medicaid members.[57] However, additional studies suggest that these findings may have varied by state, with increases in appointment availability in states where the relative increase in reimbursement was high.[53] In New Jersey, for instance, the policy translated to a 109% increase in reimbursement,[58] but the study found no changes in Oregon, where the policy resulted in a 39% increase in Medicaid reimbursement.[58]

Many academic studies have assessed how workforce supply responds to changes in reimbursement. However, most studies have evaluated the relationship between reimbursement and the general physician workforce, with some focus on primary care. There is little direct evidence on the factors that may enhance the behavioral health workforce and its participation in Medicaid. Given that many psychiatrists do not accept commercial insurance,[59,60] it is not clear if significant increases in Medicaid reimbursement – e.g., rates comparable to those paid by commercial insurers – would lure large numbers of new providers to begin accepting Medicaid. However, our interviews with providers revealed that many believe Medicaid to be a more reliable source of revenue than commercial or Medicare insurance, which often reimburse for fewer behavioral health services.

> *"Medicaid pays for a wider service array, a wider provider type [than Medicare or private insurance]. So, we're very dependent on Medicaid [rates] to sustain our system."*
>
> *—Community mental health organization director*

Despite the interest in higher reimbursement, increased reimbursement might not translate to higher wages, particularly for providers who do not directly bill for services or who do a significant amount of work that is not billable. Peer workers, community health workers, and other counselors are often employed to provide behavioral health services but cannot bill directly for services. The link between reimbursement and wages may be murky in these situations depending on the extent to which organizations or intermediaries are willing or able to translate rate increases directly into higher wages for their workers instead of paying for administrative overhead and other costs.

Within the behavioral health community in Oregon, there is a strong sentiment from a variety of provider types that increased reimbursement, while critical to increased wages for behavioral health workers, needs to be accompanied by broader structural changes. Furthermore, there is a view that behavioral health services may be undervalued in the context of global budgets in the Coordinated Care Organization (CCO) model, with CCOs generally reimbursing procedural-based medicine at a higher rate.

"Wages don't increase unless payment increases, and payment doesn't increase unless you slice the pie differently. Until we see the whole cost of care, rather than 'Oh, here's the global budget. Let me take 15% and allocate it for behavioral health, and they will have to figure out what to do with it.' As if it had nothing to do with the other 85% of the cost of care."

—Behavioral health director, psychologist

"It's difficult for decision-makers to give us credit for saving money in the medical system. It's hard to prove, it's hard to track. And we certainly don't see the return on that investment. So in other words, we don't get those savings back in the behavioral health system."

—Community mental health organization director

Interviewees in community behavioral health settings commonly reported that reimbursable activities alone were unable to sustain necessary services and operations. This shortfall required provider organizations to rely on other sources of financial support. A dependence on institutional, state, and federal grants was also noted as unsustainable. Many key informants and focus group participants pointed to fundamental "infrastructure" problems, ranging from outdated or insufficient physical space to a lack of internal administrative and human resources support. Inadequate infrastructure funding created constant challenges in budgeting for higher wages or hiring more staff.

"We've become much too reliant on grants. We actually are using grant funds to backfill basic services. And this is a no-win pattern."

—Behavioral health nonprofit director

"So, in a capitated world with encountered data...it really only pays for the services rendered. It does not ever look at the infrastructure it takes ... Recruitment costs, HR costs, how many people does it take to run a business?"

—Certified Community Behavioral Health Clinic director

"I heard it from one of my legislators - he's saying what about all the new money? Well, it doesn't cover it. [The] infrastructure that hasn't been dealt with. You can slap a coat of paint on something that is not working well but ... you may need to replace it or you may need to take it down to bare wood."

—Community mental health program director

Administrative burdens and delays

Interviews with key informants identified several administrative burdens common in the behavioral health system. Behavioral health providers may face unique challenges in compliance or in working with electronic health records (EHRs). EHRs were traditionally designed for general medical care and often do not meet the needs of behavioral health providers.[61,62] For example, existing EHR systems may not have integrated user-friendly treatment planning or behavioral health screening tools. Furthermore, compliance with Title 42 of the Code of Federal Regulations Part 2 (42 CFR Part 2), which controls the release of patient information pertaining to treatment for SUDs, has been a source of confusion for providers and health systems, potentially adding barriers to the coordination and integration of substance use treatment with EHRs and the general medical system.[63] Overall, behavioral health providers are likely to face unique administrative barriers in a system primarily geared towards physical health care.

One residential treatment manager highlighted the paperwork burden required to maintain fidelity standards and to meet reporting criteria required by state and federal regulators. Others noted burdensome treatment plan formatting rules that are part of behavioral health documentation standards issued by the state and health plans. Those working on the adult residential treatment side reported administrative burdens with the level of service inventory (LSI). This 54-item survey is used to develop supervision and case management plans and is required every 45 days even when patients are not expected to change their level of service.

> *"I love everything about my job but the documentation. The paperwork … has to go in before [patients] even get to their first assessment … they meet with me and they do an enrollment, and then they have a mental health assessment a week from now, and an [Alcohol and Drug] assessment two weeks from now. So [if] they come in and want treatment, I just don't feel like our state does well with getting them to what they actually need … it's more about technicalities."*
>
> *—Addictions and peer supervisor*

Others highlighted the specific challenges of keeping up with requirements to maintain Certified Community Behavioral Health Clinic (CCBHC) status, an integrated model for substance use and mental health services delivery. The CCBHC program was developed as a Medicaid demonstration program. Participants must meet stringent criteria regarding the timeliness of access, quality reporting, staffing, and coordination with social services, criminal justice, and education systems.[64] A behavioral health director of a rural CCBHC compared their requirements to those of primary care organizations in the area, noting that there was not parity in paperwork, compliance requirements, or standards for the delivery of services.

Administrative burdens may be higher for providers who cannot communicate in the language their clients prefer.[65] The cost of translation of clinical documents into languages other than English is carried by providers and is typically not reimbursed by CCOs. Additional barriers may arise when providers are required to navigate complex managed care or state bureaucracies to get reimbursed or be included in a plan's network. The overall fragmentation of the care delivery system creates additional challenges in communicating and coordinating care with providers of various types and fields. A study of residential treatment providers in Washington State found substantial communication barriers between substance use providers and Medicaid Managed Care Organizations (MCOs), including, for example, differences in payer and provider interpretation of the American Society of Addiction Medicine's (ASAM) criteria for residential placement.[66]

> *"There's so much administrative burden at this point that more than 70% of supervision is focused on completion of paperwork and not on clinical care, and what's going to be in the best interest of clients."*
>
> *—County mental health supervisor*

Within insurance systems, evidence suggests that providers may be particularly reluctant to accept Medicaid because of concerns about the medical and social complexity (e.g., housing instability) of those clients and the administrative challenges of working with Medicaid, including the costs of caring for Medicaid enrollees, delays in reimbursement, and high denial rates.[67–70] A study of primary care physicians in Washington State confirmed that willingness to participate in Medicaid was connected to reimbursement rates but suggested that other approaches to encouraging participation could be even more effective.[67] Those approaches include simplifying administrative processes, reducing the costs associated with caring for Medicaid enrollees, and speeding up reimbursement.[67,68]

Indeed, administrative burdens appear to be high on the list of reasons that physicians may not accept Medicaid. A recent study of claims denials and submissions concluded that physicians lose 17% of Medicaid revenue to billing problems, compared with 5% for Medicare and 3% for commercial payers.[71] Physicians were more likely to refuse to accept Medicaid beneficiaries in states with more severe billing hurdles. The study concluded that denials and payment hurdles were similar in importance to payment rates in explaining physicians' willingness to treat Medicaid beneficiaries.

Educational pathways, training, and licensure

There is a general consensus that the economic returns to pursuing graduate training in behavioral health have declined over the last fifty years.[72] Training, educational requirements, and supervision are highly variable within and across behavioral health occupations.

In addition, a shortage of providers of color can be self-perpetuating, as a lack of proper mentorship or visible role models may hinder recruiting new trainees to the field. In interviews for this study, providers of color reported more success and efficiency at recruiting diverse candidates when there was workforce representation. Educational programs may also be dismissive of different cultural approaches to wellness and behavioral health and may lack culturally responsive practices in undergraduate and graduate schools.

> *"I think it has to do with who's doing the recruitment. I can recruit young African Americans to this field because I can connect with them on what it's actually like on the patient level, but also on what it's like to be sitting in an agency."*
>
> *—SUD organization administrator who identifies as African-American*

Key informants also cited upstream challenges in expanding the behavioral health workforce, including the need to bring more people into the field earlier on. Informants noted the importance of creating awareness of and interest in behavioral health as a career path starting as early as high school. Providers also highlighted the absence of clear trajectories for many behavioral health occupations and inadequate training structures that require trainees to find their own internships and clinical opportunities. Key informants noted few internship spots in community behavioral health clinics. As a result, new graduates joined these sites without prior exposure to and understanding of the extremely demanding work environment. Furthermore, it may be challenging to train an adequate number of workforce members requiring certification and licensure supervision because supervision hours are not typically reimbursable under most payment methodologies and thus not incentivized.[45,73]

> *"When you have somebody who is supervising an intern they have to set aside time for them to do that which then takes them away from direct care, right? And for us who are primarily fee-for service, anytime you take somebody away from providing a service it's revenue that you are taking away…"*
>
> *—Community mental health program director*

Those already hired to behavioral health positions frequently cited concerns about a lack of supervisory positions and supervisor and training roles being undervalued and unfunded despite their importance to the workforce pipeline. These barriers may be particularly acute for people of color who may face systemic inequities and barriers to entry and advancement throughout the educational system.[45]

> *"...we don't have glide paths for training licensees in a robust way. We think we do, but we're not as systematic as nursing or medicine."*
>
> *—Behavioral health director, psychologist*

In addition, trainees may practice in rural areas to meet their licensing and student loan forgiveness criteria but soon leave these locations due to short-lived recruitment incentives, an absence of suitable housing, or challenges living in rural areas.

> *"Because we are a rural area, I think that people come here and meet the criteria for that and get their student loans taken care of partially, and then when they feel like they've gotten what they could out of that program is when they decide to move on to a different program that they feel more suitable, in a bigger town or something."*
>
> *—Addiction and peer supervisor*

Concerns about shortages are closely related to training and the need for training in evidence-based and community-defined, culturally specific treatments. However, training programs in the state have not necessarily grown, and current practices by providers in Oregon may not always be consistent with evidence-based or culturally specific treatment. Several Spanish-speaking providers noted the barrier created by using English as the sole language for most trainings, programs, and websites containing information about becoming certified and licensed as a behavioral health provider in Oregon.

> *"When I am helping a youth from Mexico or other [Latin] countries, I don't know how to explain things to them because all my training has been in English. I have to use my day ... finding out how to say it, so the youth understand what I am saying. Everything we have is in English..."*
>
> *—Youth support specialist who speaks Spanish*

Some interviewees highlighted a "schism" in curricula, with professionals trained in either mental health or SUD treatment, but not both, and little or virtually no access to education on integrated care and comorbid conditions. Although peer providers recognized the need for significant training, they also described these requirements as posing financial hardships. Some had to quit jobs or pick up additional shifts to pay for courses.

Licensure requirements, including national certification programs and state-specific training and standards, can also restrict the supply of providers. Behavioral health providers who have established licensure outside of Oregon may struggle with the state's licensing and credentialing processes, interstate variation in licensing requirements, and the lack of reciprocity across states.[74] Interviewees reported that for an out-of-state provider to get licensed to practice in Oregon, it could take up to eight months due in part to the state's current licensing reciprocity requirements.

Work environment

> *"There isn't much attention to behavioral health workers as people ... The net product is a lot of just revolving door cycles where they hire people, and they don't stay very long."*
>
> *—Professor of psychiatry*

Burnout, stress, emotional exhaustion, and a lack of organizational/social support have also contributed to turnover in behavioral health organizations.[75,76] In addition, career advancement opportunities and other issues related to the quality of life were highlighted as significant barriers to recruitment and retention among providers we interviewed.

Interviewees indicated that counselors, licensed clinical social workers, peer support workers, and other behavioral health workers experienced low wages and insufficient job-related benefits, including paid leave and hazard pay, health benefits, and inadequate or unclear pathways for career advancement. Providers highlighted poor long-term career prospects as a significant barrier to recruitment and retention. In particular, they cited an absence of career advancement opportunities – especially related to increased salary, access to additional certification and training, and leadership or administrative positions. Many providers shared a common opinion that an individual could make the same or more at a fast-food restaurant, with easier access to sign-on bonuses and the potential to move up a supervisory ladder. One Qualified Mental Health Associate (QMHA) reported that there were few incentives to move up in Mental Health & Addiction Certification Board of Oregon (MHACBO) certification categories because the work is similar, but there are additional educational requirements without guarantee of better pay. These factors, in addition to student debt, were cited as common reasons for leaving the field.

> *"There's generally no career path for peer support workers that enter … there may be a very limited number of supervisory or leadership positions available."*
>
> *—Professor of psychiatry*

Our interviews with providers suggested that a combination of low wages, inequitable reimbursement, career and educational barriers, and work environment stressors contribute to burnout and frequent turnover among behavioral health providers. The most frequently cited reasons for burnout were related to the work environment and included higher client acuity and complexity over time, high caseloads, and high administrative burdens. One LCSW described their work as "putting out fires every single day." While many providers described being drawn to the behavioral health profession out of passion, a common refrain was that passion was a limited resource.

Those working in the state mental health system described an over-reliance on strained emergency and crisis systems, requiring behavioral health workers to care for acutely sick clients without adequate support or sufficiently funded upstream preventive models.

> *"In other states … you generally have a lot more access to mental health care. Working on an inpatient unit in Oregon, I think the acuity we see is acuity that I haven't seen in other parts of the country … it's just way too high and it's hard to manage. There are not enough people to see them and people are not doing well. It's a sinking ship and there's not enough buckets to empty the water out."*
>
> *—Psychiatrist at state hospital*

Behavioral health professionals in inpatient settings universally described "log jams" arising from inadequate outpatient access, including assertive community treatment teams, intensive community treatment services, and school-based behavioral health services. Inpatient providers also described the need for more funding for shelter beds (especially for women), housing support, and other social support infrastructure to provide greater stability to patients discharged from the hospital or at risk for frequent readmissions.

Capacity problems in the inpatient setting were reflected in high acuity caseloads for outpatient settings. In consumer focus groups, these structural issues translated into the inability to access necessary care, inappropriately matched care, or long wait times.

> *"The State Hospital is not taking people because they just ran out of beds. So, the community is taking care of people who 10 years ago would be in a hospital. So, we're seeing a lot of people who are really truly very complex. As a new grad, for example, you can only do that for so long and you are going to be burned out."*
>
> *—Community mental health program director*

Providers frequently pointed out that the least-resourced settings, such as community mental health programs, often treat inappropriately high acuity clients. Individual providers with the least experience may be paired with the most complicated and high-need populations. This phenomenon has generated enormous barriers to retaining workers, with provider groups citing an average turnover period of 6-8 months. A substance use program supervisor described the challenges of caseloads of 50-75 or more for new hires, with the additional burden of significant documentation of their work.

A behavioral health clinic director in a frontier region recalled responding to a seasoned LCSW requesting to resign their position, citing that a primary care partner site had offered $30,000 more a year in salary, no crisis shifts, a Monday through Friday schedule, and no reports or documentation compliance requirements. In order to retain them, the clinic directors flexed the budget to give all clinicians a 48% pay increase, in addition to offering each clinician a month off in between crisis rotations.

Informants reported some bright areas, including some work environments that were improved by leadership committed to support and "lift up" staff who were "being inundated with other people's trauma." These experiences were important in improving morale but were highly variable across settings and provider groups, with many behavioral health professionals feeling devalued and underappreciated by leadership and management. Workers providing direct care noted a need for better access to mental health days, PTO, and time during their daily schedule to take care of themselves so they could better serve their clients.

> *"Our coworkers can see the kind of services we're providing. But the coworkers aren't the ones who make the budget and to feel that devalued by the higher-ups, it [is] demoralizing. That combined with not being able to pay bills … there was a period where I lost my housing unexpectedly and I was living in my car while working as a peer support specialist for a government agency."*
>
> *—Peer support specialist*

Recruitment practices

Within the peer workforce, background checks were frequently raised as barriers to recruitment practices. Individuals with lived experience with substance use or mental illness, who want to become peer providers, may have a history of criminal arrests or convictions. In Oregon, one in five behavioral health workers with a criminal history were denied employment because of that history, with people of color denied at twice that rate.[77]

> *"A lot of people are excluded because of background. And it can be something that happened 20 years ago. So [in terms of recruitment], who do you recruit? How you recruit? Are you going to the communities that you're trying to recruit? Are you asking the folks what they need? What type of person they need?"*
>
> *—Peer support services coordinator*

Key informants also described a "mass exodus" out of community behavioral health settings into private practice and telehealth, which attracts providers with promises of more flexibility (including the ability to work from home), higher pay, better benefits, and lower acuity cases. Interviewees also highlighted increasing competition to recruit providers away from community behavioral health settings. In some cases, behavioral health providers were recruited by CCOs away from counties where their roles involved less direct care, with a greater mix of administrative time. Overall, interviewees expressed concerns that these competitive dynamics reduced the total number of hours available for direct care, particularly for community behavioral health sites.

> *"I'm being recruited by private practices with numbers that are three times this [recent salary] bump. I feel like I'm supposed to be grateful, but I can do less work and make a whole bunch more money. But my passion is here in the community. So to keep me serving the population that I want to serve, I need to be compensated at, at least that rate, because I'm going to do the work."*
>
> *—QMHP at a culturally specific community mental health clinic*

National telehealth companies, for example, often have low overhead and can offer greater compensation than community-based facilities. Other providers were considering leaving the community behavioral health field for primary care and integrative behavioral health settings due to perceptions of better work environments and more robust compensation packages. In both focus groups and interviews, community behavioral health organization staff consistently discussed the challenges of competing with hospitals and private practices for skilled workers. At the same time, providers described being actively recruited for other settings. While demand for providers was high, interviews highlighted aggressive recruiting practices for residential and detox nurses, residential counselors, and QMHPs.

> *"[Other organizations] are aggressively recruiting for our people … I think clinicians are leaving because it's a lot easier to open up a private practice … And I can pay them what I can but I keep thinking in the back of my mind … quality of life is huge. And if we're constantly running short on clinicians, how am I going to keep [them] for much longer than another year or two?"*
>
> *—Certified Community Behavioral Health Clinic director*

> *"The payment structures don't incentivize people to work with acute [patients]. We have a system that incentivizes people to go to private practice, have all that flexibility and make more cash on hand. That's the way the system is designed. And if we look at the trends of younger workers coming into the field, that's what they want."*
>
> *—Behavioral health organization director*

Wage Disparities in the Behavioral Health Workforce

While the need for behavioral health services continues to rise, challenges remain to recruit and retain providers in the behavioral health workforce, particularly providers of color and those serving rural and under-resourced communities. Wage disparities between behavioral and physical health providers and across behavioral health occupations are often cited as one barrier to increasing workforce supply. Unfortunately, information on race and ethnicity is often not available in data on behavioral health wages. More detailed data are needed to understand how wages for behavioral health providers vary by race and the extent to which these inequities persist.

> *"I think we have to think about how are we engaging and bringing awareness to communities of job opportunities. How do we make it a living wage because it is a continuation of racism to recruit people into non living wage jobs. Sorry. I'm going to be blunt. That is an extension of racism in action to target populations to engage in jobs that are not competitive."*
>
> *—Behavioral health nonprofit director*

National data from the Bureau of Labor Statistics (2020; Table 3) suggests that the highest hourly wages in the behavioral health sector accrue to psychiatrists ($114/hour in Oregon) and psychologists ($47/hour in Oregon). Other therapists and counselors have average hourly wages of $25-$30/hour. These wages are lower than the average wages of registered nurses, nurse practitioners, physician assistants, and general social workers.

Table 3. Comparison of wages for selected occupations

Domain	Title	Mean hourly wage - national	Mean hourly wage - Oregon	Oregon vs. National
Mental health	Marriage and family therapists	$27.35	$27.68	1.2%
	Mental health and substance abuse social workers	$26.22	$23.90	-8.8%
	Psychiatric aides	$16.01	$20.82	30.0%
	Psychiatrists	$104.38	$114.03	9.2%
	Psychologists, all other	$48.14	$47.04	-2.3%
	Substance abuse, behavioral disorder, and mental health counselors	$24.78	$28.75	16.0%
Physical health	General internal medicine physicians	$101.42	$107.70	6.2%
	Licensed practical and licensed vocational nurses	$24.08	$27.56	14.5%
	Physicians, all other; and ophthalmologists, except pediatric	$105.22	$98.78	-6.1%
	Registered nurses	$38.47	$46.27	20.3%
Mental and physical health	Community health workers	$22.12	$21.79	-1.5%
	Healthcare social workers	$29.07	$36.41	25.2%
	Home health and personal care aides	$13.49	$14.78	9.6%
	Nurse practitioners	$55.05	$57.02	3.6%
	Physician assistants	$55.81	$57.24	2.6%

Source: Bureau of Labor Statistics, May 2020 National and State Occupational Employment and Wage Estimates

Table 4 displays data from surveys by the Mental Health and Addiction Certification Board of Oregon (MHACBO). These data capture more granular information on behavioral health positions in Oregon.

To address inequities, it is essential to understand how current wages for behavioral health providers vary by race and ethnicity. However, none of the identified data sources on wages for behavior health providers included data by race and ethnicity. While the MHACBO survey did include questions on race/ethnicity, the numbers of people of color who completed the survey were too small to allow for analyses that still protected the privacy of respondents.

Wages are generally lower among these community-based workers who are not currently eligible to bill insurance companies for their services. Among MHACBO survey participants, the highest median wages accrued to mental health supervisors ($33.55) and mental health professionals, including QMHPs and licensed mental health professionals ($30.45). Supervisors for SUD services earned median wages of $28.15, approximately $5 less than supervisors of mental health services ($33.55).

> *"The reason I left [my position], I was making so little that I had to work a second job. I'm working 60 hours a week, every week, six or seven days a week. And I wasn't sustaining. So I was willing to go all the way out to a position I didn't really want to take, leaving a team that I definitely didn't want to leave, leaving clients behind that I've had years of rapport with. It was heartbreaking, but I had to pay the bills."*
>
> *—Peer support specialist in rural Oregon*

A variety of counselors reported median hourly wages of less than $23 (Gambling counselor $22.65; SUD counselor $22.06; Qualified Mental Health Associate [QMHA] $21.10). Peer workers for mental health and SUD reported the lowest hourly wages (approximately $18). Some of these differences may be attributable to differences in educational level, years of experience, type of agency, and public vs. private employment. For example, wage differences across peer counselors were associated with differences in educational level, with higher percentages of mental health peers holding at least a bachelor's degree compared to addiction peers.

Table 4 also displays changes in mean wages for behavioral health occupations without formal licensing requirements between 2017 and 2021. In general, real wages have been flat for most of these occupations.

Table 4. Wages for unlicensed behavioral health workers in Oregon

Occupation	Median hourly wage (2017)	Median hourly wage (2021)	2017-2021 change in median wage
Mental health associate (QMHA)	$22.04	$21.10	-$0.94
Mental health peer	$18.93	$18.24	-$0.69
Mental health professional (QMHP)	$29.96	$30.45	$0.49
Mental health supervisor	$33.60	$33.55	-$0.05
SUD counselor	$21.09	$22.06	$0.97
SUD peer	$16.82	$18.09	$1.27
SUD supervisor	$27.84	$27.11	-$0.73

Source: MHACBO (Mental Health & Addiction Certification Board of Oregon)-OHA Workforce Survey. Wages for 2017 reflect an adjustment of 11% to account for an average annual inflation rate of 2.2% between 2017 and 2021

ADVOCATING FOR HIGHER WAGES FOR PEER SUPPORT SPECIALISTS

Caroline Owczarzak began working as a peer support specialist at Deschutes County Behavioral Health in 2014, when the starting wage was $11.25/hour. She brings to her profession the experience of a trauma-induced eating disorder and alcohol use disorder. Working through these challenges and then being able to process her trauma, Caroline chose to become a peer support specialist. In this position, she uses the knowledge gained from her lived experience to work with and advocate for people using behavioral health services.

"Part of what peers do is advocate. It's appropriate and crucial that we advocate as strongly and passionately for ourselves as we do for the consumers we partner with," Caroline wrote.

During recent contract negotiations, Caroline worked with her union to advocate for all peers. She highlighted job descriptions of what peers do that were part of other positions that were paid significantly more. The new contract includes wage increases of over 20% for peer support specialists, with a wage range of $21 to $28 per hour.

Her lessons learned are, *"Be relentless and respectful. Be aware of misconceptions about peers that need clarification or exploration. And, appreciate your allies – you probably have more than you realize."*

— With permission from Caroline Owczarzak

Table 5 shows regional variation in the wages for SUD and mental health counselors, using data from the State of Oregon's Employment Department. These data suggest significant regional variations, with the highest median wages occurring in the South Coast area ($32.07), almost 70% higher than the South Central area's median wage of $19.82. Median wages in the Portland tri-county area ($29.74) were slightly higher than the state median of $27.10.

Table 5. Regional variations in wages for substance abuse, behavioral disorder and mental health counselors, 2021

Area	10th Percentile	50th Percentile	90th Percentile	Average Hourly	Average Annual
Oregon	$17.31	$27.10	$46.26	$29.38	$61,114
Clackamas	$19.71	$31.16	$50.75	$33.43	$69,538
Douglas	$16.80	$25.80	$39.30	$27.02	$56,191
Lane	$16.25	$24.11	$50.36	$29.38	$61,122
Linn-Benton	$18.33	$28.22	$38.69	$28.40	$59,075
Mid-Valley	$17.38	$27.45	$39.37	$28.12	$58,486
Northwest Oregon	$17.22	$26.62	$38.46	$27.13	$56,425
Portland Tri-County	$19.18	$29.74	$49.20	$31.64	$65,818
Portland-Metro	$19.06	$29.24	$48.49	$31.21	$64,910
Rogue Valley	$17.14	$24.55	$35.60	$25.36	$52,759
South Central	$15.92	$19.82	$31.54	$21.52	$44,746
South Coast	$14.90	$32.07	$47.14	$29.40	$61,164
Southwestern Oregon	$16.43	$25.82	$41.39	$27.39	$56,989

SOURCE: State of Oregon Employment Department[78]

In interviews, some workforce experts indicated that wage differentials between behavioral health and other sectors affected decisions to enter or retain positions in the behavioral health field. Table 6 shows the mean and median hourly wage for selected behavioral health occupations, compared to positions in the broader health care sector and beyond. For example, in Oregon, dieticians and nutritionists earned $35.32 per hour and dental hygienists $42.96 per hour, but substance use and mental health counselors earned only $27.10 an hour. Likewise, whereas a general healthcare social worker earned $36.90 an hour, a mental health or substance use social worker earned just $21.99 per hour, nearly 40% lower. A behavioral health nonprofit organization director noted that the job duties for an LCSW in the behavioral health sector were clinically intensive and often involved working at the top of their level doing treatment planning. However, LCSWs working on the medical side were sometimes paid up to three times more than those in the behavioral health sector.

One behavioral health workforce expert noted that some master's level providers with large amounts of debt enter a field where they may have wages similar to those of a bus driver. Low wages in behavioral health create incentives to enter other fields with higher earning potential.

> *"I make these comparisons all the time about what people are being paid for different types of services in contrast to the $22 we get for a Medicaid visit. [Studies] ... make the comparison that an assistant administrator in a behavioral health program would make less than an assistant manager at a fast-food restaurant."*
>
> *—Professor of psychiatry*

For providers of color and providers working in communities of color, current wages also insufficiently supported additional "silent" burdens of addressing stigma and getting clients connected to care. Providers who spoke languages other than English or provided culturally responsive care frequently reported higher caseloads and other communication and outreach duties because they offered those services. Some providers were compensated for those skills, although the extra compensation was generally small, and the burdens of the extra work remained.

> *"Large institutions] needs to loosen those purse strings and pay for these folks who are folks of color like us, who have second or third languages -who can get to the folks who need the help the most and don't even know how to ask."*
>
> *—Counselor at a culturally specific outpatient mental health clinic*

Table 6. Comparison of wages for selected behavioral health vs. other occupations, 2020

	Oregon			United States		
Occupation title	Employment 2020	Average (median) annual wage	Average (median) annual wage	Employment 2020	Average (median) annual wage	Average (median) annual wage
Clinical, counseling, and school psychologists	1,523	$44.18	91894.4	111,320	$38.37	$79,820
Industrial-organizational psychologists	19	$43.76	91020.8	780	$46.28	$96,270
Substance abuse, behavioral disorder, and mental health counselors	5,859	$27.10	56368	293,620	$22.91	$47,660
Counselors, all other	194	$25.24	52499.2	27,310	$22.00	$45,760
Healthcare social workers	1,800	$36.99	76939.2	176,110	$27.71	$57,630
Mental health and substance abuse social workers	1,708	$21.99	45739.2	116,780	$23.42	$48,720
Dietitians and nutritionists	623	$35.32	73465.6	66,330	$30.33	$63,090
Physical therapists	2,707	$44.24	92019.2	220,870	$43.75	$91,010
General internal medicine physicians	320	Over $100	Over $208,000	50,600	Over $100	Over $208,000
Psychiatrists	332	Over $100	Over $208,000	25,540	Over $100	Over $208,000
Dental hygienists	3,305	$42.96	89356.8	194,830	$37.06	$77,090
Radiologic technologists and technicians	2,046	$37.41	77812.8	206,720	$29.76	$61,900
Psychiatric technicians	595	-s-	-s-	85,330	$16.84	$35,030
Genetic counselors	15	$44.74	93059.2	2,280	$41.20	$85,700
First-line supervisors of food preparation and serving workers	11,181	$17.80	37024	891,540	$16.62	$34,570
Postal service mail carriers	3,763	$24.07	50065.6	333,570	$24.56	$51,080
Bus drivers, transit and intercity	2,610	$24.64	51251.2	162,850	$22.07	$45,900

Source: Bureau of Labor Statistics[71]

Tradeoffs with wage increases

The tradeoffs associated with increasing behavioral health wages for lower-income workers should be understood in the context of the economic literature on minimum wages. Historically, economists have expressed concerns that raising the minimum wage might lead to higher wages for some individuals but decrease overall employment. However, this hypothesis has not been supported by most research.

Less is known about the extent to which increased wages could lead to changes in employment (increases or decreases) within the behavioral health sector. Higher wages can lead to increased job satisfaction among behavioral health workers. For example, a MHACBO survey of providers concluded that those who made less than $23.09 per hour tended to be dissatisfied or very dissatisfied with their wages.

Nonetheless, increased wages can have unintended consequences, particularly when applied narrowly. In 2017, Vermont passed Act 82, which effectively increased the minimum hourly wages for select employees to $14 per hour and increased salaries for crisis response and crisis bed personnel. Retention rates improved for those specific jobs. However, two years after the policy, there were more vacancies among positions that did not receive increased funding.[80] Thus, there may be spillover effects associated with policies narrowly focused on wages for select groups instead of broader increases in wages. In particular, as minimum wages increase across states, workforce experts are concerned about the possibility of wage compression – whereby pay differentials shrink over time regardless of experience, skills, or career progression. In this case, employers faced with higher wage costs for low-wage workers may adjust for these costs by slowing the growth of or cutting the earnings of higher-wage workers.[81–83] There is also concern that these targeted wage changes could reduce morale, increase turnover, and restrict recruitment for positions that do not similarly qualify for increased wages. This may have the potential of creating a supply shortage of high-skilled workers, which may explain the experience in Vermont.

Reimbursement Disparities

A variety of issues within reimbursement create barriers to behavioral health workforce retention and satisfaction. These systemic challenges include disparities in what services are reimbursable across provider types and care settings, as well as differences in reimbursement rates between providers in physical and behavioral health roles and between providers in substance use and mental health occupations.

Disparities in reimbursable activities

One recognized strategy to increase behavioral health workforce capacity and indirectly raise wages is to ensure that behavioral health providers can receive reimbursement for common procedures and services, particularly when these services fall within the scope of practice. Studies indicate that behavioral health providers may experience challenges obtaining reimbursement from different payer groups.[59,84,85] These challenges may be unique to the behavioral health setting. For example, a recent study found that psychiatrists, clinical psychologists, and licensed clinical social workers are recognized as core behavioral health professionals by both Medicare and Medicaid and were able to bill for common Current Procedural Terminology (CPT) codes across payers, but that licensed marriage and family therapists and licensed professional counselors were reimbursed by Medicaid but not by Medicare.[86]

The same study also showed that Medicaid billing processes and procedures varied from state to state, particularly in reimbursement for clinical psychologists and licensed clinical social workers. Medicaid was also characterized by significant state-to-state variation in which settings were reimbursable and how scope of practice was defined.

The treatment of behavioral health providers also differs in how providers can bill or code for different intensities of service provision. For example, primary care and other medical providers can code for distinct levels of medical complexity via Evaluation and Management codes. However, psychologists can bill only for psychotherapy, based primarily on the duration of the visit.

Telehealth modalities have become increasingly accepted and are commonly used care delivery platforms for behavioral health services, raising questions about pay parity between telehealth and in-person visits. Due to the COVID-19 pandemic, telehealth now accounts for half of behavioral health visits, with expectations that this uptake will continue, even if the pandemic subsides. Telehealth flexibilities facilitated by the Coronavirus Aid, Relief, and Economic Security (CARES) Act have thus far allowed telehealth services to be reimbursed at rates equivalent to in-person care for Medicare enrollees, and many private insurers have followed their example.[87] Within Medicaid, most states expanded access to telehealth, with all states eventually covering behavioral health services. Oregon was among 42 states and the District of Columbia allowing telehealth services to be reimbursed at the same rate as in-person services.[88]

While there are calls to continue these mandates over time, some major insurers have already begun to pull back telehealth coverage for issues unrelated to COVID-19. In 2021, the Oregon legislature passed HB 2508, requiring that insurers reimburse for telehealth services for physical, behavioral, and dental

care. The bill also required insurers to provide meaningful access to telemedicine services, including auxiliary aids and services, and services that are culturally and linguistically appropriate. Future payment policies for telehealth may ameliorate or exacerbate disparities in reimbursement across care modalities. For example, expansion of telehealth may increase reimbursement opportunities for providers and clinical scenarios in which treatment plans can be managed appropriately at a distance. Such payment considerations may reduce the administrative costs associated with a full-service facility. On the other hand, greater reliance on telehealth has the potential to exacerbate existing disparities in care, given current demographic and geographic inequities in broadband access.[89,90]

Activities that add value but are not reimbursed

Providers also reported disparities in billing practices and capabilities, particularly for care coordination efforts that are labor-intensive in behavioral health. A common refrain among peer support specialists and other community-based clinicians was that current insurance systems did not support billing for care coordination or peer-provided services. One county peer services coordinator reported that less than 5% of their peer support services were paid directly through Medicaid billing. They noted that there were inadequate Medicaid billing codes and modifiers to cover the full scope of peer support services provided by their organization, which included talking to landlords, school administrators, and generally navigating complex societal systems.

> *"Clients with certain diagnoses, like schizophrenia, naturally require so much more [coordination]. It would be nice if there was a modifier to that claim to [reflect] a team-based approach … one of my staff spending two hours filling out this partial hospitalization form … is not billable, [but] it's what we need to do for care coordination."*
>
> *—County outpatient treatment program clinical manager*

Interviewees also highlighted that CCOs' capitated payment rates did not take into consideration non- encounter services, including treatment planning, team-based collaboration, and care navigation and coordination. These unreimbursed components of treatment can be even more complex and necessary in child and family treatment. Others highlighted a need for more reimbursable activities beyond care coordination. For example, a clinical services director at a rural community mental health program described challenges in implementing a new neurofeedback service without commensurate reimbursement. The service required high upfront costs for certification and equipment, along with the ability to schedule sessions weekly or bi-weekly for 60 minutes. However, only skill-building codes were available for providers to bill for, which did not reflect the significant investment of time or financial resources. These comments aligned with those from other provider focus groups, describing a separation between clinical standards of care and reimbursable activities.

> *"We know the best practice for youth SUD is day treatment with a whole family perspective. But we don't pay for family treatment. So we have [these] widgets that don't even match evidence-based, 21st century care … like paying a primary care doctor to do 1980s treatment."*
>
> *—Former behavioral health director*

Peer support specialists and community behavioral health workers in rural areas pointed to the need for billable "drive time," which often amounted to several hours a day trying to reach a client where they lived or worked and frequently overlapped with client care while in the car together. A rural clinic program manager noted their non-billable drive times were often quite lengthy, with frequent inclement weather.

Key informants also expressed a tension between wanting to supervise and train the next generation of providers and losing those hours as billable time. Some described community mental health programs as "training grounds" for interns fulfilling licensing requirements, but supervision was not typically reimbursable. In this sense, the supervisory role was disincentivized as a "no revenue generation position," which exacerbated funding difficulties in high-need community settings.

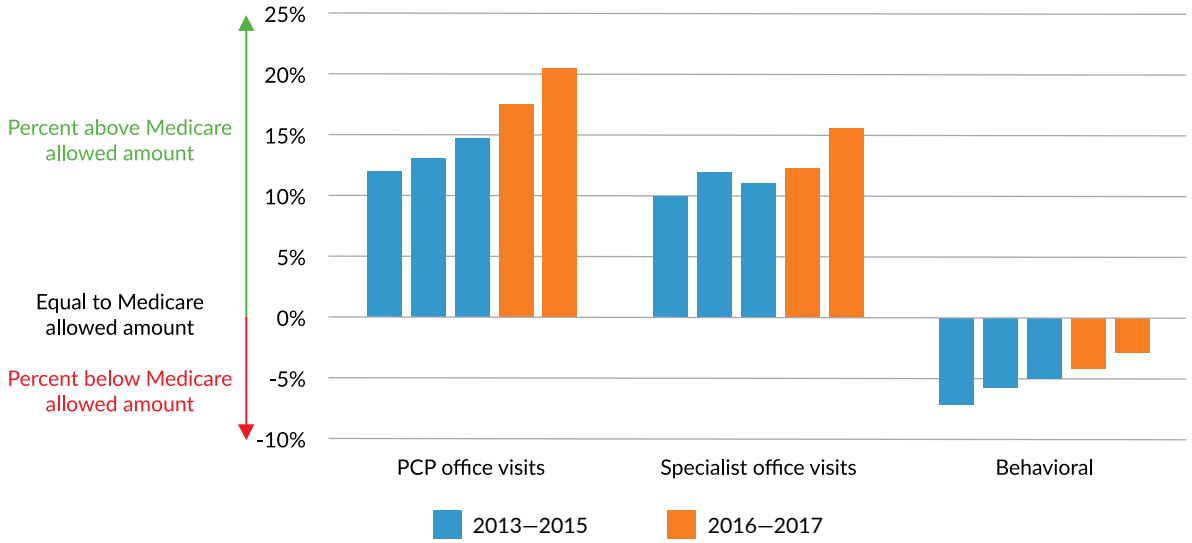
Potential differences in payment rates for behavioral and physical health providers

Differences in payment rates between medical and behavioral health providers appear to be inconsistent with federal mental health parity requirements set out by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.[26] In fact, guidance from the Centers for Medicare and Medicaid Services (CMS) discusses that disparities in provider reimbursements can lead to parity violations.[91] Specifically, the guidance identifies reimbursement rates as a type of "non-quantitative treatment limitation (NQTL)," with the parity law prohibiting states and MCOs from imposing an NQTL on behavioral health benefits more stringently than on general medical benefits.

In our analysis of Oregon's data, we do not find evidence of differences in payment rates between medical and behavioral health providers (described in detail below). However, these analyses were limited. Several studies suggest that these payment differentials exist, at least in some states. For example, a study of 2014 Medicaid claims from 11 states (a sample that did not include Oregon) found that, on average, psychiatrists were reimbursed less than primary care physicians when billing for the same procedural codes.[84] In comparison, within the commercial market, behavioral health providers often receive significantly higher reimbursement rates when treating clients out of a health plan's network, potentially reducing incentives for these providers to join Medicaid or commercial health plan networks.[85] It is no surprise, then, that out-of-network utilization for behavioral health services is now 3-6 times more likely than medical and surgical services.[92]

A 2017 analysis of commercial claims found that average in-network reimbursement rates for behavioral health outpatient visits were lower than for medical and surgical office visits, with this disparity increasing over time. For example, in 2017, primary care reimbursements were 23.8% higher than behavioral health reimbursements, compared to 19.7% in 2015 (Figure 7).[92]

Figure 7. In-network provider payment differences by provider type (relative to Medicare allowed amounts)



Source: Milliman Research Report, 2019[92]

In general, there is less empirical evidence regarding reimbursement differences for mental health care vs. substance use treatment. Our interviews highlighted, however, experience with these payment disparities.

> *"We have licensed clinical social workers and registered nurses … both in the substance use disorder and in the mental health side. There really [is] no difference in their job description and their duties. But the minute you put in that diagnosis code and the place where they're employed by, because of these funding streams that we're talking about, there's less money coming in for the activity that they perform."*
>
> *—Behavioral health nonprofit director*

Interviewees described existing payment differentials as a relic of the payment structure in residential treatment settings for SUDs.

> *"In residential [treatment], it's a day rate. So it doesn't matter who's providing the service, whether it's an addictions counselor or a mental health counselor or a nurse or all of the above, it's just a day rate that's happening in residential [settings]."*
>
> *—Rural community mental health clinic program manager*

While mental health and substance use conditions are often co-occurring, services are often provided in different settings, by different providers, and through different billing codes. This separation may create barriers to coordinated care and contribute to continued and longstanding fragmentation of care delivery systems.[93] Interviewees highlighted billing complexities related to clients with co-occurring disorders, with existing systems prioritizing payment for mental health over substance use conditions. A psychiatrist at the state mental health hospital reported a "perverse incentive" that existed to bill for a primary mental health disorder, even in patients who had substance use-induced symptoms. For example, coding for schizophrenia in an encounter could substantially increase reimbursement, even if substances were causing the psychosis.

> *"Dual diagnosis clients are really difficult to bill because you either have to bill it on the SUD side or you have to bill it on the mental health side. My finance team really has to jump through hoops and correct codes, and it's just this constant battle with billing and clinicians."*
>
> *—Certified Community Behavioral Health Clinic director*

> *"Can we stop dividing substance use disorder and mental health at least? Can we start at the bare minimum and just call it a co-occurring behavioral health disorder, because we need to have people who are trained in both…we have no authority to make those changes. We can only operate under the burden of what we're allowed to do."*
>
> *—Behavioral health nonprofit director*

Medicaid reimbursement in Oregon

A goal of this report is to compare Medicaid rates for (a) behavioral health services to physical health services and (b) substance use treatment services to mental health services for providers with equivalent levels of education and training. In a fee-for-service (FFS) system, these analyses are straightforward and can be assessed through claims. However, a mix of payment models – FFS, capitation, sub-capitation, episode-based payment, or value-based payments – makes these assessments challenging, particularly when analyses include multiple payers and provider types.

Current Procedural Terminology (CPT) or Healthcare Common Procedure Code System (HCPCS) code, we do not discern stark differences in reimbursement rates for providers identified as mental health providers vs. those providing substance use treatment services. Generally, providers who identify as addiction or SUD counselors receive reimbursement rates comparable to other provider types within that CPT code. These data do suggest differences in overall reimbursement rates across CPT codes. For example, reimbursement rates for HCPCS Code H0005 (group counseling for alcohol and drug related services, 60 minutes) – the most commonly billed service exclusively for substance use treatment – were in the $40 to $45 range, approximately one-third the rates of reimbursement for 60 minutes of psychotherapy (90837).

We first assessed data from the CCOs' "Exhibit L" files, provided by OHA's Office of Actuarial and Financial Analytics, to understand the extent to which behavioral health services are paid through FFS arrangements versus other forms of payment. In reviewing these documents, we determined that a significant portion of behavioral health is paid in systems that are not claims-based (i.e., through capitation or episode-based models). Furthermore, reporting on Exhibit L includes some inconsistencies across CCOs. For example, Exhibit L lists broad categories of "Expenditures (not subcapitated)" and "expenditures (subcapitated)." However, "Expenditures (not subcapitated)" are not restricted exclusively to FFS payments. For some CCOs, these data also include reporting on FFS basis for claims that are actually paid through a subcapitated contract.

The net effect of these data and expenditure categories is that we could ascertain from Exhibit L that many behavioral health services are paid outside of FFS arrangements. Across all CCOs and behavioral health services, approximately 46% of services were included within the "expenditures (subcapitated)" category. This ranged from 0% in one CCO to 100% in another CCO. Within the area of outpatient services, the percentage included with the "expenditures (subcapitated)" category was 83%.

Thus, the claims data were limited in their ability to provide clear insights about the reimbursements and differentials between physical and behavioral health providers or mental health and substance use treatment providers.

Next, we used data extracted by the Office of Actuarial and Financial Analytics to conduct additional analyses using aggregated claims extracts from 01/01/2019 to 12/31/2019, which included data on (1) volume; (2) average paid amounts for each CPT or HCPCS code and (3) provider type for the codes of interest listed in the table below. We further restricted our analyses to exclude claims with $0 paid amounts (since these are clear instances of encounters where the provider is paid on a capitated basis). We also excluded FFS payments and payments from one CCO that had a high percentage of case rate payments to behavioral health providers. (Case rates, or bundled payments, represent a set payment to a provider organization to cover all services needed to achieve a successful outcome for a pre-defined episode of care.)

We analyzed payment rates for the CPT codes listed in Table 7. These codes represented a range of services that apply to physical health. For example, 99213, evaluation and management of an established patient, 30 min, is a common code among primary care physicians but can be used by substance use treatment providers or psychiatrists. The code 90837, for 60 minutes of psychotherapy, is used almost exclusively by behavioral health providers, but there are a variety of different provider types who are reimbursed for this service.

Table 7. Selected CPT codes and number of Medicaid claims, 2019

Code	Definition	Number of claims, 2019
99213	Evaluation and management of an established patient, 30 min	402,480
90837	Psychotherapy, 60 min	229,985
H0005	Alcohol and/or drug services; group counseling by a clinician, 60 min	229,217
90791	Psychiatric diagnostic evaluation without medical services	34,193
90847	Family psychotherapy, with client present	27,991
90853	Group therapy	25,401

Tables 8A-8E provide information on the 90th and 75th percentiles and the average reimbursement across specialty types. Data were restricted to 2019, with each provider type required to have at least 100 claims to be included in the analysis. We focused on the 90th percentile because this is most likely to represent a full payment on a FFS basis and not alternative payment methodologies, e.g., a partial payment from a capitated or episode-based arrangement. In some instances, the data represent unusual relationships. For example, licensed clinical social workers generally do not bill for CPT code 99213. The data represent what are reported by CCOs and may indicate data issues rather than contractual practices. Furthermore, CCOs may differ from the state's FFS plan in what is acceptable or allowed for coding.

Table 8A provides information on CPT Code 99213 (evaluation and management of an established patient, 30 min), a common service used by a broad range of providers, including a variety of physical health providers (family practitioners, obstetricians and gynecologists, and pediatricians), mental health providers (psychiatrists and psychiatric mental health nurse practitioners) and at least some providers who identify as substance use treatment specialists. At the 90th percentile, the highest paid providers were licensed clinical social workers ($123.09) and psychiatric mental health nurse practitioners ($120.32). These specialties also had the highest rates at the 75th percentile and were among the top three in average payments. There was not clear evidence of physical health providers (family practitioners, obstetricians and gynecologists, pediatricians, family nurse practitioners, or physician assistants) receiving notably higher reimbursement rates than mental health providers (psychiatrists and psychiatric mental health nurse practitioners).

Table 8A. Reimbursements for CPT code 99213 (evaluation and management of an established patient, 30 min)

Provider specialty	90th percentile	75th percentile	Average
Licensed clinical social worker	$123.09	$120.13	$118.47
Psychiatric mental health nurse practitioner	$120.32	$94.69	$81.34
Obstetrics & gynecology	$88.89	$81.41	$72.84
Pediatrics	$86.37	$78.38	$68.73
Physician assistants	$86.37	$74.14	$67.96
Alcohol/drug provider	$85.50	$85.50	$85.37
Family nurse practitioner	$83.64	$73.08	$64.43
Family practitioner	$81.95	$73.91	$67.12
Psychiatrist	$80.59	$80.35	$69.07

Table 8B provides information on CPT Code 90837 (psychotherapy, 60 min), a common CPT code for mental health services. At the 90th percentile, the highest paid provider type was psychiatric mental health nurse practitioners ($200). Perhaps surprisingly, reimbursement rates for psychiatrists and neuropsychologists were among the lowest across the 90th and 75th percentiles and average payments. To the extent that these data are generalizable, they do not suggest a large gulf in payment between MD and PhD providers and providers with masters' degrees. However, they may be an indication that CCOs are prioritizing recruitment and payment of masters-level providers over providers with MDs and PhDs. Table 8B does not support the hypothesis that mental health providers were routinely paid more than substance use treatment providers for similar services.

Table 8B. Reimbursements for CPT code 90837 (psychotherapy, 60 min)

	90th percentile	75th percentile	Average
Psychiatric mental health nurse practitioner	$200.00	$200.00	$180.52
Counselor - addiction / substance abuse disorder	$178.34	$152.87	$148.95
Social worker	$178.34	$174.74	$147.94
Licensed clinical psychologist	$174.74	$157.70	$150.92
Licensed clinical social worker	$174.74	$151.63	$145.45
Marriage and family therapist	$174.74	$172.16	$133.10
Licensed professional counselor	$174.74	$174.74	$145.80
Neuropsychologist	$157.70	$151.63	$149.55
Psychiatrist	$157.70	$151.63	$149.17

Table 8C provides information on HCPCS code H0005 (alcohol or drug services; group counseling by a clinician, 60 min), a common CPT code for substance use treatment. Overall, these payments were notably lower than those for 99213 or 90837, with the 90th percentile in the $40-$47 range, compared to $85 to $120 for 99213 or $157 to $200 for 90837. There was relatively little differentiation across provider types at the 90th percentile, with one exception: certified recovery mentors. Average payment rates were also fairly condensed, with the highest rates attributable to peer support adult mental health workers ($45.64) and the lowest to certified recovery mentors ($39.33).

Table 8C. Reimbursements for HCPCS code H0005 (alcohol and/or drug services; group counseling by a clinician, 60 min)

	90th percentile	75th percentile	Average
Peer support adult mental health	$47.95	$47.95	$45.64
Counselor - addiction / substance abuse disorder	$47.05	$45.61	$43.59
Licensed clinical social worker	$47.05	$45.61	$43.50
Peer support adult addictions	$46.80	$39.66	$40.95
Social worker	$46.80	$46.03	$41.39
Alcohol/drug provider	$46.08	$39.66	$41.25
Licensed professional counselor	$45.14	$41.28	$39.83
Certified recovery mentor	$39.66	$39.66	$39.33

Table 8D provides information on CPT code 90791 (psychiatric diagnostic evaluation without medical services). At the 90th percentile, the highest paid provider type is the psychiatric mental health nurse practitioner ($285.00). Reimbursement rates for psychiatrists are among the lowest across the 90th and 75th percentiles and average payments.

Table 8D. Reimbursements for CPT code 90791 (psychiatric diagnostic evaluation without medical services)

	90th percentile	75th percentile	Average
Psychiatric mental health nurse practitioner	$285.00	$133.99	$137.11
Counselor - addiction / substance abuse disorder	$188.96	$158.13	$138.99
Marriage and family therapist	$188.96	$157.77	$136.15
Licensed professional counselor	$188.96	$188.96	$136.20
Social worker	$162.66	$133.98	$113.11
Licensed clinical social worker	$151.52	$140.00	$117.48
Licensed clinical psychologist	$150.08	$132.84	$115.95
Psychiatrist	$143.15	$121.68	$107.36

Table 8E provides information on CPT code 90853 (group therapy). Three provider types (substance abuse disorder counselors, marriage and family therapists, and licensed professional counselors) appear to be paid similar rates ($58.18 at the 90th percentile). The lowest reported rates accrue to licensed clinical psychologists and licensed clinical social workers.

Table 8E. Reimbursements for CPT code 90853 (group therapy)

	90th percentile	75th percentile	Average
Counselor - addiction / substance abuse disorder	$58.18	$42.16	$38.94
Marriage and family therapist	$58.18	$58.18	$47.10
Licensed professional counselor	$58.18	$45.00	$39.51
Licensed clinical social worker	$49.18	$41.63	$38.81
Licensed clinical psychologist	$45.09	$37.24	$36.24

Overall, analyses of Oregon's Medicaid claims payments did not reveal stark payment differences in behavioral health providers and physical health providers for the same services. This stands in contrast to an analysis by Mark and colleagues who used FFS Medicaid claims data from 2014 for 11 U.S. states.[84] They found that, in 10 of the 11 states, psychiatrists were reimbursed less than primary care physicians for CPT code 99213. The 11-state average reimbursement rate for primary care physicians was $62.75, compared to $50.28 for psychiatrists – an approximate 25% differential.

Psychiatrists do not appear to receive the highest reimbursement rates across all providers in the data we analyzed. On the one hand, this may represent efforts by CCOs to ensure that other provider types receive adequate reimbursement for their services. On the other hand, it could mean that psychiatrist reimbursement rates are not high enough.

Furthermore, when confined to a single CPT or HCPCS code, we do not discern stark differences in reimbursement rates for providers identified as mental health providers vs. those providing substance use treatment services. Generally, providers who identify as addiction or substance abuse disorder

counselors receive reimbursement rates comparable to other provider types within that CPT code. However, these data do suggest differences in overall reimbursement rates across CPT codes.

The HCPCS Code H0005 is the most commonly billed service for substance use treatment and accounts for approximately 94% of all claims submitted by substance use treatment providers. Its reimbursement rate is in the $40 to $45 range, approximately one-third the rates of reimbursement for 60 minutes of psychotherapy (90837). In contrast, psychiatrists rarely use H0005 (with this code accounting for less than 1% of all claims submitted), and more frequently submit claims with higher reimbursement rates (99213, 99214, 99215, and 90832). Thus, reimbursement differentials may arise because of the types of services providers are billing for.

In summary, we did not find clear evidence of reimbursement rates in CCOs that – conditional on the CPT or HCPCS code - suggest systematic lower payments for behavioral health providers compared to physical health providers or SUD providers compared to mental health providers. However, we did observe different payments for different CPT codes. The reimbursement rate for HCPCS Code H0005 – the most commonly billed service exclusively for substance use treatment, lasting 60 minutes, ranged from $40 to $45 range, approximately one-third the of what was paid for 60 minutes of psychotherapy (90837). This analysis had substantial limitations. The absence of detectable differences in these analyses should not be considered conclusive evidence of the overall state of reimbursement across CCOs. A better understanding of payment differentials might require a focused audit of contracts between CCOs and their providers.

Fee-for-service schedules in Oregon and other states

In a separate analysis, we obtained data from publicly available FFS schedules from state Medicaid websites. We used the most recent available reimbursement rates for all seven procedure codes, including psychiatric diagnostic evaluation (90791), psychiatric diagnostic evaluation with medical services (90792), individual psychotherapy with patient or family member (90832, 90837), group (90853) and family (90847) psychotherapy, psychological testing and evaluation (96130), and telephone assessment by a non-physician healthcare professional (98966). The rates here represent professional (non-facility) physician rates, with the exception of 98966, which is an assessment by a non-physician professional.

Our analysis included 2021 data from all 50 states and DC, with the following exceptions: data from Hawaii were based on a fee schedule from June 2020, the most recent version publicly available. We excluded Tennessee because data were not publicly available and Wisconsin because base rates without modifiers for CPT codes were not available. For a substantial number of states, the rate for telephone assessment service (98966) was reported as zero, as result of either the service not being covered, or the rate not being reported in the FFS schedule.

Table 9: National Medicaid reimbursement rates vs. Medicaid reimbursement rate of Oregon for behavioral health services

Codes	National mean	25th percentile	National median	75th percentile	Oregon	Oregon relative to national median
98966	$10.11	$8.62	$11.82	$13.60	$10.77	9% below
90853	$25.77	$20.88	$23.81	$30.91	$36.54	53% above
90832	$58.38	$47.65	$57.65	$65.31	$73.29	27% above
90847	$90.91	$78.68	$90.23	$106.04	$120.11	33% above
96130	$97.57	$76.21	$89.97	$109.62	$94.84	5% above
90837	$117.04	$97.48	$111.16	$134.17	$150.19	35% above
90791	$128.85	$104.56	$125.05	$154.90	$99.25	21% below
90792	$142.69	$108.11	$125.91	$163.79	$146.58	16% above

SOURCE: Authors' own analysis of publicly available Medicaid fee for service schedules across 50 states

In general, Oregon's fees were above the national median. The two exceptions were 98966 and 90791. Oregon's fee schedule was above the 75th percentile for four of the eight codes we assessed. The most commonly used mental health code – 90837 (individual psychotherapy session for 60 minutes) – was substantially higher than the rates paid in most other states. In summary, these analyses suggest that Oregon's FFS schedule – which may serve as a "floor" for reimbursement rates – generally pays rates for behavioral health services that are higher than most paid in other states.

One interviewee noted that overall, psychotherapy codes are relatively over-reimbursed. In contrast, psychiatry codes, including the assessment and the follow-up evaluation and management codes, may be relatively under-reimbursed, making it more difficult to recruit psychiatrists. Such comparisons across behavioral health provider types may help target reimbursement adjustments based on specific service needs and workforce shortage patterns.

Approaches to Increase the Behavioral Health Workforce

While there are limited real-world examples that directly increase wages for behavioral health providers, a number of efforts have been implemented to address behavioral health workforce shortages. Here, we describe initiatives by the federal government, a variety of states, selected organizations, and Oregon.

Federal response

In the context of the COVID-19 pandemic, there has been a recent infusion of federal dollars to address continuing challenges in the behavioral health care delivery system.32 The American Rescue Plan Act of 2021 includes several provisions to address workforce shortages, including additional funding for training opportunities to improve the distribution and supply of the behavioral health workforce, including:

- Funding increases for the National Health Services Corps ($800 million) and Nurse Corps ($200 million).
- $80 million to HRSA for behavioral health training for health care professionals, paraprofessionals, and public safety officers, to be used to plan, develop, operate, or participate in evidence-informed strategies to reduce and address suicide, burnout, mental health conditions, and SUD among health care professionals.
- An additional $100 million for the Behavioral Health Workforce Education Training Program, administered by HRSA, to expand access to behavioral health services through focused training.
- An 85% enhanced federal matching rate for three years to states that opt to cover and scale mobile crisis intervention services, reduce unnecessary hospitalizations for people with behavioral health conditions, and reduce reliance on law enforcement.
- $122.8 billion in grants to state education agencies which can be used to support school-based mental health systems for children and youth.

While details about the allocation of these one-time funds are not yet clear in terms of proposed activities in Oregon, they are expected to have potentially large impacts on behavioral health funding in the state.

Initiatives by other states

Massachusetts expanded its behavioral health workforce with a large statewide investment in efforts to recruit, train, and retain licensed and masters-level unlicensed behavioral health professionals, particularly in community-based settings.[94] A number of student loan repayment programs are available, through a competitive application cycle, to repay a portion of student loans (between $30,000-$50,000) for behavioral health providers in exchange for a commitment to practice in a

community-based setting for four years.[95] Additional funding is available through MassHealth's Community Mental Health Center (CMHC) Behavioral Health Recruitment Fund. This program aims to increase the number of psychiatrists and nurse practitioners at CMHCs by offering provider organizations funds for recruitment incentives. These funds – up to $75,000 for psychiatrists and $55,000 for nurse practitioners – can be used for student loan repayment or for provider-led special projects. Additional state funds are available, on a competitive basis, to provider organizations to train and expand peer support specialists, community health worker supervisors, and recovery coach supervisors. These funds are one part of MassHealth's $1.8 billion Delivery System Reform Incentive Payment Statewide Investment program authorized under the Medicaid Section 1115 Waiver.

In an effort to increase access to behavioral health services among children and young adults, **Pennsylvania** leveraged Medicaid dollars to bring mental health providers to schools. The state is expanding pathways – including new certification pathways – to increase the number of highly qualified social workers who can provide treatment services and support in school settings.[96]

In **Virginia**, the Department of Behavioral Health and Development Services requested $75 million in American Rescue Plan Act funding to pay for salary increases for employees currently at five state-owned mental hospitals due to critical staff shortages (including vacancies of up to 54% in some facilities). These requested increases would push salaries to the 75th percentile of market compensation scale. In August 2021, the Virginia state legislature approved $121.9 million to increase employees' wages at state behavioral health facilities by 5% in the hopes of attracting and retaining more QMHPs. Another $40 million was appropriated to expand community-based mental health and substance use services to provide interventions before emergencies that would require hospitalization.[97,98]

North Carolina recently passed House Bill 914 in June 2021, directly increasing pay for long-term care workers through a Medicaid rate increase in a variety of settings, including workers at residential behavioral health facilities.[99,100] Providers would have to use at least 80% of this rate increase to increase wages paid to direct care employees and would be required to provide verification of the use of these funds for this purpose. The remaining 20% would be eligible for increases in supervisor salary, pensions, health benefits, and facility maintenance, among other needs. While these changes are expected for the 2022-2023 fiscal year, there are some concerns about the possibility that wage compression may lead to a loss of supervisors who will not be eligible for a wage increase under this bill.[99]

These state-level approaches have accelerated, in part due to mounting behavioral health demands and critical workforce shortages during the COVID-19 pandemic. However, little empirical evidence currently exists regarding the effects of various state policies to address workforce wages. One exception mentioned previously in this report was Vermont's 2018 allocation of increased funding to raise salaries for crisis response and crisis bed personnel, including some behavioral health professionals. While workforce retention improved for those specific jobs, there were more vacancies among positions that did not receive increased funding two years later.[80]

Organizational initiatives

A variety of other approaches have been implemented in organizational settings to attract and retain workers. Some research suggests that several concurrent strategies may be beneficial to reduce workforce turnover. These strategies include wage increases, transparent pay scales, improved job-related benefits, flexibility in job design, and opportunity for advancement.[101] One study of community mental health workers found that a higher maximum hourly wage was associated with lower turnover,

but no association was found between turnover and minimum or average hourly wages. These findings suggest the potential benefits of career advancement and higher salary opportunities over time.[102]

In recent months, several large behavioral health organizations across the country have raised wages for their behavioral health workforce. Most often, these raises have occurred across all positions.

- In Providence, Rhode Island, Lifespan recently announced that behavioral health specialists would be among those who would begin receiving either a minimum wage of $20/hour or a 3% raise, whichever would be greater. In addition to wage increases, the organization offers referral bonuses of $1,000 to $7,500 to employees who can successfully refer other health care providers. Lifespan operates multiple medical centers in Rhode Island, including psychiatric emergency, inpatient, and outpatient behavioral health services, and is the largest workforce in the state.[103]
- MaineHealth, northern New England's largest health system and Maine's largest private employer, invested $61 million in July 2021 to increase wages across its system, setting a minimum wage of $17/hour from $14/hour for the entire organization, focusing on non-executive, non-physician roles. Additional salary adjustments were implemented for hard-to-fill roles.[104]

Recent efforts to address behavioral health services in Oregon

The Oregon Legislative Assembly passed numerous bills during the regular 2021 session that involved funding for and investment in behavioral health services. Bills covered a range of approaches to support behavioral health infrastructure in the state, including funding culturally responsive programs[105] and staffing new substance use crisis centers.[106] Legislation also focused on addressing shortages in the behavioral health workforce by investing in the recruitment and retention of diverse providers,[107] and directing insurers to set reimbursement rates for behavioral health providers using the same methodology as rates for physical health providers.[108]

Table 10. Select 2021 Regular legislative session bills

Bill	Effective Date	Summary
HB 2086	Aug. 6, 2021	Requires OHA to establish peer and community-driven programs that provide culturally specific and responsive BH services to people of color, tribal communities, and people of lived experience. Gives OHA authority to establish minimum Medicaid reimbursement rates for addiction treatment providers.
HB 2949	Aug. 6, 2021	Diversifies the BH workforce by requiring OHA to provide incentives to increase recruitment and retention of diverse professionals. Activities include pathway development, scholarships and stipends, loan repayments, and other retention activities. Expands funding to increase access to culturally responsive BH services.
SB 755	Jul. 19, 2021	Modifies and provides for the implementation of Ballot Measure 110, including the establishment of Behavioral Health Resource Networks and the staffing requirements of those networks.
HB 3046	Jan. 1, 2022	Details parity compliance and reporting requirements for insurers and further specifies which BH treatment must be provided by CCOs and covered by insurers. Establishes network adequacy parameters for BH services in both commercial and CCO plans.

The 2020 recommendations of the Governor's Behavioral Health Advisory Council were codified in HB 2086. The bill required OHA to establish behavioral health programs that are responsive to and guided by people of color, tribal communities, and people of lived experience. HB 2086 also directed

OHA to conduct a study of Medicaid reimbursement rates and provide the Legislative Assembly with recommendations for achieving a living wage for behavioral health workers and providing more equitable wages between physical health and behavioral health care workers. Section 8 of the bill allowed OHA to establish minimum rates of reimbursement paid by OHA or by CCOs to addiction treatment providers. Passed in tandem with HB 2086, HB 2949 focused on diversifying Oregon's behavioral health workforce and allocated $80 million for incentive programs that increase the recruitment and retention of diverse providers through scholarships, loan repayments, and other activities like stipends for intern supervision.

SB 755 detailed processes for the implementation of Measure 110, which was passed by Oregon voters on November 3, 2020. Notably, this bill funded the creation of Behavioral Health Resource Networks and substance abuse crisis centers in all Oregon counties. Staffing provisions in the bill stipulate that each Center must have at least one certified alcohol and drug counselor or other credentialed addiction treatment professional, one intensive case manager, and one peer support specialist.

Steps to enforce federal mental health parity requirements were addressed in HB 3046, which shifted the responsibility of parity compliance to insurers. This bill instructed insurers and CCOs to set reimbursement rates for behavioral health providers using the same methodology as rates for physical health providers and undertake regular parity compliance analyses between physical and behavioral health services. The results of these analyses, including analyses of network disparities, are to be reported regularly to OHA.

Examples of recruitment and retention strategies

Key informants within Oregon highlighted additional strategies to improve wages for behavioral health workers, relieve work-related pressures, and reduce burnout and attrition (Table 10). These strategies included additional financial incentives, such as loan repayment programs and scholarships to support additional workforce training and capacity. For example, employees at sites that qualify to participate in Oregon's Health Care Provider Incentive Program can qualify for up to $150,000 in student loan forgiveness. The Oregon Behavioral Health Loan Repayment Program (OBHLRP) was established to support rural and urban underserved communities in recruiting and retaining high-quality mental and behavioral health providers. The OBHLRP is available to QMHAs, QMHPs, pre-licensed and licensed mental and behavioral health care providers. Participants receive funds to repay qualified educational loan debt in exchange for service at a qualifying practice site. Awardees can receive up to $50,000 per year for three years.

In some interviews, providers described organization-specific sign-on and retention bonuses of several hundred to a few thousand dollars to stay competitive with higher-paying hospitals, health systems, and outpatient services. Provider organizations also reported referral fees, whereby employees were paid up to $2,000 for recommended hires that meet certain employment duration thresholds. Others provided relocation and housing stipends of a few thousand dollars with unrestricted use. Some organizations located in areas with tight housing markets offered housing assistance as a recruitment strategy. However, by and large, interviewees reported that these strategies were short-term "band-aids" rather than long-term, sustainable solutions to improving workforce retention. Other community-based providers pointed to the need for a guaranteed pay scale that would allow for improved income predictability year over year. They also expressed a need for better benefits, including health care, paid leave, childcare support, and housing support.

Although it has not been extended to behavioral health, Oregon's approach to improving wages in long-term care could serve as a model for the behavioral health workforce. Through its Aging and

People with Disabilities Program, Oregon has also recently implemented a temporary Medicaid rate add-on for caregivers working in skilled nursing facilities (SNF) and home and community-based services (HCBS), with a primary goal of raising wages. This program includes a 4% temporary enhanced Medicaid rate add-on, funded by general fund dollars with a significant federal match, to ensure starting wages of $17/hour for certified nursing assistants (CNAs). To be eligible, SNF provider organizations must agree to pay a starting wage of $17/hour and a pay scale of $17.50/hour the second year for all CNAs. Similarly, the wage add-on program provides a 10% temporary Medicaid rate add-on – through general fund dollars, with a federal match – to increase wages for direct caregivers in HCBS settings. HCBS organizations are eligible for this increased rate only if they agree to pay caregivers a minimum of $15/hour ($15.50 during the program's second year).

Other strategies to recruit new workforce members included improving the education and training pipeline, including early efforts to encourage interest in behavioral health professions. One counselor described early exposures to career and job recruitment fairs at local high schools, community colleges, and universities. She recalled never seeing behavioral health organizations recruiting or educating young adults about this potential career. Efforts to expose people to behavioral health careers early in their development could enhance recruitment opportunities. Other interviewees suggested more funding for internships, career development, and other training for those already pursuing behavioral health positions, citing a lack of current opportunities.

> *"We were able to recruit the last two hires because we promised training. We wanted them to learn a specific modality in trauma treatment. And then we put money into it. We couldn't do it without that extra money."*
>
> *—Faith-based counseling center manager*

Beyond incentive structures, front-line providers pointed to the importance of low-intervention, low-cost strategies to boost morale. Successful strategies included frequent communication, recognition and praise, employee input in implementing and assessing changes, non-work team-building activities, flexible work schedules and team-oriented approaches to sharing challenging caseloads, and providing food in the workplace. To address workplace culture concerns, one organization implemented wellness funds, funded by their contracted CCO, paid time off certificates, employee of the month, celebration committees, and appreciation bonuses to provide staff encouragement. Supervisors cited the importance of training and promoting healthy workplace cultures but also pointed to the additional unpaid burden of this work.

> *"We try to make it where it's not just a place to work to live out a passion, but a place to work [where] you're being appreciated and you're worth something. If the trainings at MHACBO and Daystar were in Portland, we provide [employees] with company credit cards and a company vehicle. They travel there and we cover their training, their food, and their hotel, the whole entire time that they're there."*
>
> *—Addictions and peer supervisor*

Table 11. Frequently suggested initiatives to increase workforce recruitment and retention
Financial incentives for recruitment and retention
• Loan repayment programs • Tax credit programs and scholarships • Sign-on and retention bonuses • Benefits like health care, paid leave, childcare and housing support
Education and training programs
• Increasing training program slots • Increasing opportunities for culturally specific training • Changing hiring requirements • Education programs that are inclusive and culturally responsive • Funding for federally qualified health centers (FQHCs) and other under-resourced settings to support internships • Elevate the value of careers in substance use and mental health services
Practice-oriented tactics
• Supporting telehealth infrastructure and reimbursement • Licensure, certification, and scope of practice changes • Broadening potential for reimbursement across provider and payer types • Reducing administrative burdens and delays • Paperwork parity with primary care and other practice specialties and settings

Recommendations

The purpose of this report is to provide recommendations to the Oregon State Legislature for (a) achieving a living wage for behavioral health care workers, including additional treatment providers, peers, and family support specialists and (b) providing more equitable wages between physical health care workers and behavioral health care workers. The focus on increasing wages, per legislative direction of this report, represents a narrow set of policy options intended to improve population behavioral health and advance health equity. Increases in wages for behavioral health workers may be a partial solution but are unlikely to resolve existing disparities or suboptimal outcomes. We focus our recommendations on the issue of behavioral health wages but close with additional considerations for broader policy efforts.

Direct adjustments to wages

A small number of policies can directly increase wages for the behavioral health workforce or specific types of providers.

Expand wage add-on programs. The state could adopt a "wage add-on" program for behavioral health providers, similar to the packages passed recently by the Oregon legislature that were focused on long-term care. Under this legislation, assisted living, residential care, and in-home care who pay caregivers $15 or higher (in year one; $15.50 or higher in year two) receive a 10% enhanced rate. Skilled nursing providers who pay certified nurse aides a starting wage of $17 or higher (in year one; $17.50 or higher in year two) receive a 4% enhanced rate. These efforts were further supported by a package of bills, including SB 266 and SB 714 (2021), requiring the state to evaluate whether assisted living communities, residential care facilities, or other long-term care facilities have sufficient staffing; SB 703 (2021), which focuses on transparency; and SB 800 (2021), which ensures that long-term care workers have access to affordable healthcare. These new regulations and incentives are designed to address workforce shortages, with some policies directly increasing wages, others focusing on the larger compensation package, and others ensuring that increased wages are not offset by reductions in staffing. North Carolina's model offered an alternative approach for long-term care, increasing Medicaid reimbursement rates with the requirement that at least 80% of the rate increase be passed to direct care employees in the form of wage increases, with the remaining 20% eligible for increases in supervisor salary, pensions, health benefits, facility maintenance, and other needs.[99,100]

Consider wage floors or targeted minimum wage approaches. The state could consider legislation analogous to minimum wage legislation, requiring employers who employ specific job types (e.g., QMHAs, or mental health or SUD peer providers) to pay a minimum wage. This approach could be unfunded, which is typical of many minimum wage laws. However, an unfunded mandate could strain the financial resources of existing behavioral health systems. Another approach could be to rely on taxes or general state funds to subsidize wage increases. Wage floors should be approached carefully, however, as there is some evidence that wage compression may worsen retention for higher wage workers.[80]

Consider state-funded retention or recruitment bonuses. State-funded retention or recruitment bonuses may represent a short-term alternative to direct increases in wages, with the state potentially

offering grants to organizations experiencing or anticipating shortages for specific workers. This approach may allow the state to specifically target organizations that can identify unmet needs for priority populations or the ability to recruit or retain providers of color and rural providers. Retention and recruitment bonuses are often a short-term response to an underlying structural problem. Our interviews suggested that these temporary cash influxes could be useful in the short term. However, they may be limited in their effects on the overall retention of behavioral health professionals, particularly in under-resourced and community settings where case burden and demand for services continued to be high.

Direct adjustments to reimbursement

The state could also consider efforts to increase reimbursement for behavioral health services. Reimbursement is an indirect channel: increases in reimbursement may not translate directly to a 1:1 increase in wages. However, without increases in reimbursement rates, it will be difficult to create significant, sustained increases in wages for behavioral health providers.

Reform the Medicaid fee schedule for services that are under-reimbursed. The state could potentially raise the fee schedule for behavioral health services in Medicaid's FFS program. The fee schedule could serve as a "floor" that could be useful for providers in their negotiations with CCOs. Oregon's Administrative Rule 410-120-1295 (Non-Participating Providers) provides additional support to ensure that providers are not contracted with CCOs below the state's FFS rate. However, across-the-board increases in reimbursement may have unintended consequences, with some observers indicating that some services – such as psychotherapy – are already reimbursed at a reasonable rate, while others – such as psychiatric evaluation – are not reimbursed competitively. Thus, adjustments should consider existing levels and attempt to rebalance rates accordingly.

Require or incentivize a fixed percentage of the global budget to be allocated to behavioral health. A hallmark of the CCO model is its global budget, which integrates financing for physical, behavioral, and oral health. While this approach may improve the integration of services, it may introduce tradeoffs that favor physical health or procedural-based clinical services. One of the rationales of traditional "carve-out" models is that they preserve a portion of funding for behavioral health services that might otherwise be ceded to physical health providers. Some key informants suggested that CCOs have under-allocated funding to behavioral health. Increased allocation of the global budget towards behavioral health – including substance use prevention and treatment – might direct higher funding streams to behavioral health organizations, allowing them to raise wages for their workers downstream. It might also be beneficial to devote dedicated resources to adolescent and child mental health, given the growing needs in these communities. Alternatively, the state could consider a more targeted approach, requiring, for example, that some percentage of the CCO budget be used explicitly to fund residential treatment or peer-provided services.

Using national parity laws to enforce pay equity between behavioral and physical health providers. Many interviewees indicated that behavioral health providers were paid less than physical health providers for comparable work. Because many providers are paid outside of claims, (e.g., through capitation, episode-based treatment, or other value-based payment mechanisms) the existing financial and claims data make these assertions difficult to confirm. The state could assess these differentials through an audit of CCO contracts and payments. To the extent that differentials appear, the state could leverage the federal behavioral health parity requirements from the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA). CMS has indicated that reimbursement rates are included in consideration of non-quantitative treatment limits (NQTLs),[91] and the MHPAEA requires parity within NQTLs. Oregon's HB 3046, which goes into effect Jan 1, 2022, requires insurers and CCOs to

evaluate compliance with federal mental health parity requirements. These findings may help to target new guidance and regulations.

Identify and remedy existing disparities in reimbursable activities. Behavioral health providers in Oregon indicate that current insurance systems do not support billing for certain services, including care coordination. These systems also fail to support billing capacities for groups of providers, including peer support providers and case managers, reducing the funds available to support wage increases for these workers. Another difficulty is the lack of reimbursement for language translation or culturally specific services. An expansion of billable services, including code modifiers that offer reimbursement for language translation or culturally specific services, may be one mechanism for increasing wages for these workers. Expanding both billing capacity and billing provider types within the state's Medicaid program is one lever to reduce reimbursement disparities where they exist. However, there may be benefits from encouraging commercial insurers to adopt similar changes to incentivize labor-intensive, high-value services like care coordination and care navigation.

Adjust reimbursement for social complexity. Traditional risk adjustment provides increased payment for more clinically complex clients. Behavioral health providers are likely to engage with clients that have significant social risk, including, for example, housing instability, trauma, or particular challenges that intersect with behavioral health needs and language or cultural support. Behavioral health providers also are called upon to care for children and adolescents, engaging in complex family dynamics that require additional skills and time that are not typically reimbursed. Interviews with behavioral health providers suggest that many of these providers offer services that accommodate these needs (managing finances, keeping an apartment clean, or searching for a counselor with a good cultural and linguistic match), even though these activities are uncompensated. Multnomah County includes culturally specific Knowledge, Skills, and Abilities (KSAs) in job descriptions that allow for increased pay for employees who can provide bilingual and bicultural services. The state could consider similar approaches that are designed to increase reimbursements for behavioral health providers who care for more socially and clinically complex clients.

Additional adjustments to compensation

Various programs and initiatives can make it easier for people to enter and advance in the behavioral health field. More robust recruitment and training pathways that are inclusive of a diverse array of people with various educational and lived experiences and financial needs can help expand the workforce and encourage people of color to become behavioral health providers.

Reduce administrative burdens, claims delays and denials. Nationally, Medicaid has been characterized as a program that makes it difficult for providers to get paid for their work. A variety of evidence – including interviews with clinicians from Washington State – suggests that reducing paperwork burden, delays, or denials may be even more beneficial than raising reimbursement rates.[67,68,71] Furthermore, there is some evidence to suggest that these denials or delays may be more substantial for behavioral health providers, particularly when coordinating with a payer or administrative body that is most comfortable in the physical or general medical health setting.[66] Oregon has already engaged in efforts to reduce administrative burdens for behavioral health workers.[109] However, our interviews also suggest a need to revisit, simplify, and streamline CCO, state, and federal reporting and documentation burdens experienced by behavioral health providers. These barriers increase the work burden in an already strained system and are often cited as reasons for attrition to private practice and telehealth settings.

Create robust recruitment and training pathways. Outside of health care, traditional efforts to improve wages and income have often focused on job training programs. These programs are based on

the expectation that improved skill and productivity should lead to higher wages from employers. In our interviews, we heard several concerns that the training pathways were not robust. Providers were generally trained in either mental health or SUD treatment, but not both. There was little opportunity to receive education or instruction on integrated care or approaches that incorporate other common comorbidities. Providers also reported under-resourced training environments. Training resources could be bolstered through dedicated funds for provider organizations, supervisors, or trainees. These funds could support behavioral health internships and externships, professional development and mentoring, and specialized training pathways. Providers also identified difficulties in obtaining training that focused on culturally specific care. Recruitment strategies should include dedicated outreach to secondary schools, community colleges, and universities to strengthen interest in and early exposure to the behavioral health profession, a practice common in Science, Technology, Engineering, and Mathematics (STEM) fields.

Encourage transparent pay scales and pay practices. Salary or wage ladders generate transparent future expectations of salaries and promotion structures and permit reliable salary comparisons within and across industries. Opportunities for career advancement and job promotion may have a more pronounced effect on job satisfaction and retention than a higher minimum starting wage. Pay transparency, whereby institutional and state pay practices are established and communicated, can also support more equitable wage outcomes, particularly for people of color.

Expand tuition reimbursement and loan repayment programs. Oregon's Health Care Provider Incentive Program includes loan repayment programs for behavioral health providers. The 2021 legislature passed HB 2949, which included additional funding for loan repayment and tuition reimbursement programs, focusing on people of color, tribal members, or residents of rural areas who can provide culturally responsive behavioral health services. These programs can directly incentivize workforce pipeline development by reducing barriers to further training and indirectly increasing the amount of disposable income for behavioral health providers.

Additional recommendations

Improve the work environment. Institutional and state guidance and oversight on behavioral health work conditions may help to reduce workforce burnout. Research suggests that high job demand and low job control drive burnout. Providers universally cited high case burden and acuity, intensive and inflexible schedules, frequent rotations on crisis calls, emotional trauma, and insufficient supervisory support as negatively impacting their job satisfaction. Providers who spoke languages other than English and who could provide culturally specific care appear to have particularly high caseloads and administrative burdens, especially when they were among a limited number of providers in an organization who can offer those services. Investing in supervisory roles, workplace culture development, and shared or collaborative clinical duties may help to reduce job strain. In interviews, providers cited these factors as dominant considerations in moving from community health settings to private practice, telehealth, and large health systems. Additional improvements could include expanded benefits, such as health insurance, housing stipends, moving stipends, childcare, paid time off, scheduling flexibility, rotating call, and occasional remote work.

Review existing licensure requirements. Oregon's approach to staffing behavioral healthcare needs has been to encourage the use of unlicensed professionals (e.g., QMHP and QMHA) to meet the needs of its population with behavioral health conditions. On the one hand, this approach reduces barriers to hiring providers and may help address the workforce shortage. On the other hand, it may introduce unintended consequences, particularly if unlicensed workers face depressed wages. For example, differences between unlicensed and licensed workers may exacerbate turnover, with unlicensed workers leaving their current employer if they complete required training and obtain licensure. As

a result, individuals with the least amount of training were often those who cared for clients with the greatest needs. The state could consider using licensure for behavioral health in the same way as physical health, where providers are expected to follow licensure tracks with board supervision requirements.

Some observers suggested that the state was under-resourced in the support provided to people with interest in obtaining licensure or certification as a behavioral health provider or peer support specialist. Online guidance documents were described as difficult to navigate and not accessible to people who prefer Spanish or another language. As a result, some candidates may have dropped out of the application process.

It may be beneficial for the state to review its current policies and identify the tradeoffs associated with continuing with the current model.

Review regulations that inhibit recruitment. Oregon could consider relaxing its current licensing reciprocity requirements. The current regulations require approximately six months for an out-of-state provider to obtain licensure to practice in Oregon, placing constraints on the potential workforce available outside of the state. Similarly, requirements that employees pass background checks may reduce the opportunities for peer workers with previous contacts with the legal system. Overall, the state may benefit from a broad consideration of any licensing requirements that could be relaxed or eliminated without leading to adverse outcomes or reductions in the quality of care.

Additional research

Assess and remediate regional wage differences in Oregon. There are significant regional variations in wages for substance use and mental health counselors. The highest median wages occur in the South Coast area, with median wages ($32.07) that are almost 70% higher than the South Central area's median wage of $19.82. It is unclear why such large variations exist, though factors like regional competition and cost of living could contribute. Understanding the causes of these differences may create opportunities for addressing wage disparities in the state. The state could also consider incentivizing working in higher-need areas by varying salaries with the level of need in an area (e.g., creating a type of "community need loan").

Enhance the availability and accuracy of REALD (race, ethnicity, language, disability) and SOGI (sexual orientation, gender identity) data for the provider workforce. Information on race and ethnicity is often not available in data on behavioral health wages. More detailed data are needed to conduct research on how wages for behavioral health providers vary by race and the extent to which these inequities persist.

Creating a more diverse workforce

Commit to a diverse workforce and draw from the community. Interviewees noted the need to "do more than talk" and encouraged the state and health systems to develop stronger partnerships with communities of color. Shortages of providers of color can be self-reinforcing; increased representation can lead to greater success in recruiting diverse candidates. The state and health systems should also include providers of color in the development of their processes, policies, and outreach. These voices may have unique insights into challenges with work conditions, billing codes, and recruitment and retention.

Develop diversity across the pipeline. Many people noted the need for diversity in leadership which could help to support the recruitment and retention of a diverse workforce more broadly. In order to translate these priorities into action, it may be beneficial to adopt a wage or rate premium

to support bilingual professionals or culturally specific positions that often require additional unpaid work. The state could fund professional development opportunities, including certification fees and continuing education, especially for diverse, up-and-coming leaders in the field. Funds could also support community partnerships and pathways in the community to receive both general and specialized behavioral health training. Multiple interviewees expressed a strong appreciation for the skills and qualities that providers of color can bring to the table to meet the needs of Oregon's diverse communities.

Conclusions

A robust behavioral health workforce is necessary to address community needs regarding mental health and SUDs. Low wages are a barrier to recruiting and retaining behavioral health providers, including providers of color. Higher wages are a necessary but insufficient component of addressing the behavioral health workforce shortage and the growing need for timely, accessible, and culturally specific behavioral health services. Accomplishing these goals is an essential part of the state's effort to eliminate health disparities

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Methodology

This report was conducted by the Center for Health Systems Effectiveness (CHSE) at Oregon Health & Science University, in partnership with OHA. In alignment with OHA's equity priorities, the methodology centered around reaching out to people of color, tribal communities, people with lived experience with mental health and/or SUDs, and providers who are affected by non-competitive wages, including community-based behavioral health workers who are most affected by disparities in behavioral health wages.

Key informant interviews and focus groups

The insights and findings generated in this report are drawn from a number of sources, including a review of the academic and grey literature, key informant interviews and focus groups, and analyses of reimbursement and wage data. CHSE staff conducted 24 one-on-one key informant interviews and 5 focus groups of 4-11 individuals to survey challenges facing behavioral health workforce recruitment and retention; wage and reimbursement barriers; effects of these barriers; and institutional and other policy responses to improve behavioral health workforce supply, diversity, and equity. Key informants included members and leadership of provider organizations, policy experts, consumer advocates, government officials, and academics, representing a multitude of care settings, communities, perspectives, and backgrounds. These individuals were identified in partnership with OHA, with purposive oversampling for individuals from or serving rural regions, FQHCs, tribal communities, Black/Indigenous/people of color, and people with lived experience. Each identified key informant was contacted up to two times via email from August-October 2021, with the assistance of OHA contacts where appropriate and feasible. The response rate was 58.5%, with a total of 41 individuals contacted. Service users were recruited via National Alliance on Mental Illness (NAMI) Oregon listservs and with support from the Oregon Consumer Advisory Committee, or directly through the community in the case of the Spanish-language focus group members. Overall, across 57 interview and focus group participants, 29.8% served or lived in a rural/frontier region; 59.6% were behavioral health providers; and 33.3% were service users.

Appendix Table A1. Participant characteristics across all interviews and focus groups (N=57)

	n(%)
Clinician/provider	34 (59.6%)
SUD provider or service organization	17 (50.0% of providers)
Service user	19 (33.3%)
Serves or lives in rural/frontier area	17 (29.8%)
Counties in Oregon represented	Benton, Clackamas, Columbia, Coos, Deschutes, Douglas, Harney, Hood River, Jefferson, Lane, Marion, Multnomah, Polk, Sherman, Tillamook, Wasco, Washington, Wallowa

Key Informants completed a full REALD and SOGI questionnaire, provided by OHA.[110] English-speaking focus group participants were asked about their race/ethnicity in compliance with REALD

methodologies, but the language, disability, and sexual orientation and gender identity information was either not collected or was not in compliance with REALD standards. For that reason, only race/ethnicity data was reported and aggregated across all participants. The Spanish-language focus group was recruited by a separate entity and REALD data was not collected from that group.

Appendix Table A2. Racial/ethnic identity across all participants*

	n**
American Indian and Alaskan Native	**2**
American Indian	2
Asian	**1**
Asian Indian	1
Black/African American	**10**
African American	9
Caribbean	1
Hispanic/Latino/a/x	**9**
Mexican	7
South American	1
Other Latino/a/x	1
White	**30**
Slavic	1
Eastern European	1
Western European	17
Other White	11
Identifies as more than one race/ ethnicity	6
Did not respond	5

** The Spanish-language consumer focus group did not receive a REALD questionnaire, so their information is also not included in this table.*

***These data are reported according to the "alone or in combination" concept110 meaning that people who respond to multiple categories will be counted in each of the categories they list, making the total number of races reported will exceed the total number of participants reporting (n = 44)*

Appendix Table A3. Position characteristics of key informant interviewees (n=24)

Interview	Work/Practice setting	Community served	Position category	SUD vs. mental health
A	Hospital system	Urban	Director	Mental health
B	Academic	Statewide	Director	N/A
C	Academic	Statewide	Director	N/A
D	CCBHC*	Urban	Manager	Both
E	Non profit association	Statewide	Director	Both
F	CMHP**	Urban	Coordinator	Both
G	CCBHC, CMHP	Rural	Director	Both
H	CMHP	Urban/rural	Coordinator	Both
I	Government agency	Statewide	Director	Both
J	Non profit association	Statewide	Director	Mental health
K	Health plan	Urban/rural	Director	Both
L	CCBHC, CMHP	Rural	Manger	Both
M	CMHP	Urban/rural	Manager	Mental health
N	CMHP, FQHC***	Urban/rural	Manager	Both
O	CCBHC, CMHP	Rural	Coordinator	Both
P	Outpatient mental health services	Urban	Manager	Mental health
Q	Recovery support services	Urban	Director	SUD
R	CMHP	Rural	Director	Both
S	CCBHC, CMHP	Rural	Director	SUD
T	Recovery support services	Urban	Manager	SUD
U	CMHP	Urban/rural	Manager	Mental health
V	Government agency	Statewide	Analyst	SUD
W	Government agency	Statewide	Director	Mental health

**CCBHC – Certified Community Behavioral Health Clinic*
***CMHP – Community Mental Health Program*
****FQHC – Federally Qualified Health Center*

Three of the five focus groups were directed towards

1. Behavioral health providers of color
2. Rural and frontier behavioral health providers, including those working in clinics, hospitals, residential treatment settings and community health centers
3. Psychiatric prescribers and RNs (Appendix Table A4).

We conducted two separate focus groups with service users who experienced the impact that provider shortages and turnover have on access, quality, and experience of care, one with English-speaking and the other with Spanish-speaking service users, the latter facilitated by a Spanish-language moderator contracted through OHA (Appendix Table A5). Service users had broad geographic representation (representing 4 metro areas and 11 non-metro counties in Oregon) and sought care in a wide range of treatment settings, including outpatient clinics, inpatient hospital settings, residential treatment facilities, VA mental health ward, private practices, and counseling centers. Finally, we participated in "listening sessions" with seven additional community or OHA-led committees and workgroups, including the Behavioral Health Wage Study Project Advisory Group at OHA, the Central Oregon

Health Council, and the Latino Emotional Health Collaborative to further increase the range of perspectives (Appendix Table A6).

Appendix Table A4. Characteristics of non-service user focus group participants (n=14)

	# of participants	Identifies as person of color (n, %)	Rural/ frontier provider (n, %)	SUD provider (n, %)	Community health setting (n, %)	Mean years in practice	Descriptors
Providers of color	5	5 (100%)	0 (0%)	0 (0%)	2 (40%)	13.2	Therapist (LPC, NCC); psychiatrist; marriage/family therapist (LMFT, LMFT-Associate); LPC associate (QMHP, CADC I, NCC); Clinical supervisor, CADC III, LPC
Rural and frontier BH providers	5	1 (20%)	5 (100%)	2 (40%)	5 (100%)	8.2	CADC I outpatient counselor; peer support specialist; program director, LPC residential treatment; program director CADC III, LPC; Director of clinical services – youth programs, LPC
Psychiatric prescribers and RNs	4	0 (0%)	0 (0%)	0 (0%)	3 (75%)	19.5	3 psychiatry MDs, 1 psychiatric RN

**LPC- licensed professional counselor; NCC-National Certified Counselor; LMFT-licensed marriage and family therapist; LPC-certified licensed professional counselor; QMHP-qualified mental health professional; CADC-certified alcohol and drug counselor (I-III depending on education, duration of experience, coursework, and examinations)*

Appendix Table A5. Characteristics of service user focus group (n=19)

	# of participants	Identifies as person of color	Geographic representation	Treatment settings	Participant descriptors
Spanish-speaking service users	8	8 (100%)	Clackamas, Deschutes, Jefferson, Marion, Multnomah, Polk, and Tillamook counties	Specialized child therapy, SUD residential treatment, SUD outpatient, community counseling, individualized therapy, support groups, community clinics	3 parents of pediatric/youth patients, all with lived experience seeking services for themselves and/or their children, 2 SUD care and dual diagnosis
English speaking service users	11	3 (27.3%)	Portland metro (n=6); 1 each from Clackamas, Deschutes, Douglas, Coos, and Lane counties	Outpatient clinics, inpatient hospital, SUD residential treatment, VA mental health ward, private practice, community counseling	2 family members of youth patients; 7 with lived experience seeking mental health or SUD care; 2 with dual diagnoses

Appendix Table A6. Workgroup and meeting listening sessions

Group	Description	# of participants
Latino Emotional Health Collaborative	Collaborative with 9 service organizations in the Portland metro area, seeking to address service gaps for the Latino/Latina community	7
Behavioral Health Collaborative Workforce Community Forum, Oregon Health Authority	OHA workgroup that assesses workforce gaps and develops training standards	~50
Oregon Consumer Advisory Committee Peer Support Subgroup	Consumer sub-committee which reviews, evaluates, and provides feedback to the OHA Director on peer-support related behavioral health services	6
Workforce Workgroup: Rapid Engagement, Oregon Health Authority	OHA workgroup supporting a pilot project around possible rule and fee schedule changes to support a wide array of provider services	~20
Central Oregon Health Council Behavioral Health Workgroup	Workgroup of providers, program managers, administrators, non-profit leaders, and community members in Central Oregon focused on increasing equitable access to behavioral health services	13
Oregon Health Authority Behavioral Health Project Advisory Group	Advisory group for this report and its activities, consisting of OHA agency staff and leadership	14
Meeting with Oregon Health Authority youth and family peer staff	Group of OHA Child and Family Behavior staff and Youth and Family Peer Experts	3

Medicaid claims reimbursement analysis

As outlined in HB 2086, the study team conducted a descriptive cross-sectional analysis of Medicaid administrative claims data to assess the extent of reimbursement differences between behavioral health vs. physical health services, and between mental health vs. SUD services. An analytic dataset was prepared by OHA's Office of Actuarial and Financial Analytics, using Medicaid professional service claims from 01/01/2019-12/31/2019. The dataset was aggregated to the CCO-year level, providing data on (1) volume; (2) average paid amounts for each CPT (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Code System) code and (3) provider type for the codes of interest. We assessed (1) volumes and paid amounts (exclusive of $0-paid amounts) and (2) volume for $0 paid amounts. For all non-zero paid amounts, additional dispersion measures included interquartile range, median, 10th/90th percentile payments, and standard deviation. We also used the OHA Office of Health Analytics' Payment Arrangement File from the All-Payer All Claims database to estimate the proportion of expenditures to each CCO that are reimbursement-related vs. non-claims related payments to take into account additional bonus payments negotiated by CCOs for meeting certain quality and performance incentives. These proportions were estimated for percentiles of behavioral health revenue earners to shed light on the extent to which fee for service reimbursement reflects total payments to select CCOs.

A number of data limitations restricted further systematic study of reimbursement disparities, including the high proportion of zero paid amounts in the claims data from which we were unable to discern additional information. Zero-paid amounts are charges in which the payer remits a payment at $0 for a given procedure, typically because the payer claims that the service is part of a bundled or capitated service for which it has already paid. In addition, claims data had overlapping provider organization and type categories which made it difficult to compare service reimbursement for specific types of providers. Therefore, this analysis was undertaken as a case study to provide some targeted examples of how behavioral health services are reimbursed in Oregon's Medicaid program.

Glossary of Terms

Behavioral health	Includes mental health and substance use disorders. As a discipline, encompasses a continuum of prevention, intervention, treatment and recovery support services
Community mental health program	Organization of various services for individuals with a mental health diagnosis or addictive disorders operated by or contractually affiliated with a local mental health authority. Operates in a specific geographic area
Mental health	Holistic term that includes emotional, psychological and social well-being
Peer support specialist	An individual providing services to a current or former consumer of mental health or addiction treatment who shares a similar life experience with the peer support specialist. The four categories of peer support specialists are: family support specialist, youth support specialist, recovery peer, and mental health peer
Peer wellness specialist	Individual who has lived experience with a psychiatric condition(s) plus intensive training, who works as part of a person-driven, health home team, integrating behavioral health and primary care to assist and advocate for individuals in achieving well-being
Provider	An individual who delivers services, as opposed to agencies or group practices
Qualified mental health associate (QMHA)	A person who delivers services under the direct supervision of a QMHP who meets the minimum qualifications as authorized by the local mental health authority (see Table 2)
Qualified mental health professional (QMHP)	A licensed medical practitioner or any other person meeting the minimum qualifications as authorized by the local mental health authority (see Table 2)
Serious mental illness (SMI)	A diagnosable mental, behavioral, or emotional disorder that results in substantial impairment in carrying out major life activities or functioning in different contexts
Substance use disorders (SUD)	Mental disorders that affect a person's brain and behavior, leading to a person's inability to control their use of substances such as drugs, alcohol, or medications
Traditional health worker	In Oregon, umbrella term for frontline public health workers who work in a community or clinic under the direction of a licensed health provider. The five specialty types are: birth doulas, community health workers, personal health navigators, peer support specialists, and peer wellness specialists

**For the purposes of this report, terms were defined as listed here.*