May 6, 2022

Behavioral Health Stakeholder,

The purpose of this document is to outline tangible policy recommendations that will result in improving Oregon's publicly funded behavioral health system. The background information and recommendations offered in this document are intended to accomplish the following goals:

1. Promote clarity and transparency between the various partners that comprise the publicly funded behavioral health system,
2. Reduce unnecessary administration burden placed on behavioral health providers, Coordinated Care Organizations (CCOs), Community Mental Health Programs (CMHPs), counties, and the Oregon Health Authority (OHA),
3. Eliminate duplicative responsibilities between system partners,
4. Introduce regulatory solutions that improve access to behavioral health services, and
5. Improve the quality of care for people receiving behavioral health services in Oregon.

The intended audience for this document is the Oregon legislature, Governor's office, OHA, Association of Oregon Counties, CCOs, Association of Oregon Community Mental Health Programs, Oregon Council on Behavioral Health, National Alliance on Mental Illness, and anyone else who seeks to cultivate positive changes for Oregon's publicly funded behavioral health system.

Scope

This document focuses on recommendations for restructuring the regulatory framework of Oregon's publicly funded behavioral health system. While there are innumerable opportunities for system improvement that could be explored, the scope of this document primarily focuses on outpatient behavioral health services. Examples of future considerations include but are not limited to: examining roles and responsibilities between system partners for services provided at the Oregon State Hospital, licensing and payment reform for residential treatment services, and payment for services rendered by Traditional Healthcare Workers. The intent of this document is to provide historical context regarding the current regulatory framework, discuss the challenges presented by this framework, and offer solutions that may lead to system improvement and better outcomes for Oregonians. While this document critically examines the current construct, it is not the intent of this author to criticize any parties responsible for creating or perpetuating the design. Rather, it is the author's intent to identify opportunities for improvement that will ultimately result in a healthier Oregon.

Definitions

Community Mental Health Program (CMHP) means the 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 and operated in a specific geographic area of the state under an agreement with the Division pursuant to OAR chapter 309, division 014. OAR 309-019-0105 (27).

Local Mental Health Authority (LMHA) means one of the following entities:
(a) The board of county commissioners of one or more counties that establishes or operates a CMHP;

(b) The tribal council in the case of a federally recognized tribe of Native Americans that elects to enter into an agreement to provide mental health services; or
(c) A regional local mental health authority composed of two or more boards of county commissioners. OAR 309-019-0105 (74)

Note: The terms LMHA and counties may be used interchangeably through this document for ease.

Coordinated Care Organization (CCO) means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members. OAR 309-019-0105 (29).

Certificate of Approval (COA) means the document issued by the [OHA] that identifies and declares provider certification. A letter accompanying issuance of the certificate shall detail the scope and approved service delivery locations of the certificate. OAR 309-008-0200 (5).

Roles and Responsibilities

Understanding the historical and current roles of the entities comprising the behavioral health system is foundational to understanding how Oregon might reshape the system. Arguably, the most significant roles to examine are those of counties (LMHAs), CMHPs, CCOs, and OHA. Each of these entities plays a critical role in the development, provision, and oversight of behavioral health services in Oregon.

Community Mental Health Programs

Oregon Revised Statute (ORS) 430.610 proclaims that *"The State or Oregon shall encourage, aid and financially assist its county governments in the establishment and development of community mental health programs or community developmental disability programs, including but not limited to, treatment and rehabilitation services for persons with mental illness or emotional disturbances, alcoholism or drug dependence, and persons who are alcohol or drug abusers, and prevention of these problems through county administered community mental health programs or community developmental disability programs."* ORS 430.620 permits Oregon counties to operate a CMHP within the rules set forth by the Oregon Health Authority. *"(1) The county court or board of county commissioners, or its representatives designated by it for the purpose, of any county, on behalf of the county, may: (b) In conformity with the rules of the Oregon Health Authority, establish and operate, or contract with a public agency or private corporation for, a community mental health program."*

ORS Chapter 430 lists a multitude of services and continuums of care that the Oregon Legislature has entrusted counties, and/or private CMHPs, to develop and operate. ORS 430.630 outlines a menu of behavioral health services that are required to be established and provided by CMHPs (subject to available funding). These services include, but are not limited to: Outpatient services, hospital aftercare, screening and evaluation, crisis stabilization, individual and group therapy, medication monitoring, prevention, and care coordination for housing and health and social service needs. More recently, ORS 430.628 requires CMHPs to provide crisis stabilization services to individuals contacting the 9-8-8 suicide prevention and behavioral health crisis hotline. It is clear that the Oregon Legislature's

intent in establishing these laws was to establish a behavioral health delivery system under the authority of Oregon counties and their CMHPs.

The OHA contracts with counties and CHMPs to accomplish their legislatively mandated duties. Examples of services that are funded through counties and CMHPs are crisis services, residential treatment services, civil commitment services, Assertive Community Treatment, Jail Diversion, Supported Employment, peer services, and safety net services. Another primary function of CMHPs is to render behavioral health services to people who are uninsured or underinsured. The number of people who are uninsured has drastically decreased since the implementation of recent legislation, such as the "Affordable Care Act" and "Cover All Kids." Added to the complexity of the structure is the fact that most of the CMHPs also contract with CCOs as part of their provider networks to serve the OHP population.

Coordinated Care Organizations

In 2012, Oregon lawmakers established Coordinated Care Organizations to become the managed care entities responsible for managing the Oregon Health Plan benefit on behalf of the Oregon Health Authority. ORS 414.572 defines the requirements for entities to qualify as a CCO. Oregon Administrative Rule (OAR) 410-141-3500 defines a CCO as *"a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members."*

In ORS 414.018 the Oregon Legislature declares "*its goals of improving health, increasing the quality, reliability, availability and continuity of care and reducing the cost of care requires an integrated and coordinated health care system in which: (b) Health care services, other than Medicaid-funded long term care services, are delivered through coordinated care contracts that use alternative payment methodologies to focus on prevention, improving health equity and reducing health disparities, utilizing patient centered primary care homes, behavioral health homes, evidence-based practices and health information technology to improve health and health care."*

The entirety of ORS 414 contemplates the responsibility for behavioral health services rendered to the Medicaid population being placed in the hands of CCOs. ORS 414.572 (1)(e) explicitly states that a requirement for CCOs is to *"Coordinate the delivery of physical health care, behavioral health care, oral health care and covered long-term care services."* It is important to note that the historical language in ORS 430 that contemplates the responsibility for establishing and coordinating a behavioral health system being placed in the hands of counties remains unchanged.

Local Assessments and Planning Requirements

Counties – Local Plans

With the responsibility for establishing and maintaining a delivery system for behavioral health services, the Oregon Legislature required both CCOs and counties to conduct a thorough assessment of community need and develop a specific plan of action to address those needs. Counties and CMHPs are required to complete a "local plan." ORS 430.630 (9) states that each "*[county] shall determine the need for local mental health services and adopt a comprehensive local plan for the delivery of mental health services for children, families, adults and older adults that describes the methods by which the local*

mental health authority shall provide those services. The purpose of the local plan is to create a blueprint to provide mental health services that are directed by and responsive to the mental health needs of individuals in the community served by the local plan. A local mental health authority shall coordinate its local planning with the development of the community health improvement plan under ORS 414.575 by the coordinated care organization serving the area. The Oregon Health Authority may require a local mental health authority to review and revise the local plan periodically."

Each "local plan" developed by a county must include information about coordination of care, mental health referrals, housing needs, transportation supports, coordination with the justice system, discharge planning from hospital settings, and peer support services. Counties are required to involve consumers, advocates, family members, service providers, and schools in their planning process. They are also required to conduct a population-based assessment to determine the types of services that are needed locally. The planning, funding and services must include community-based organizations (Social Determinants of Health), healthcare providers, and must demonstrate ways to integrate care with such providers and organizations.

CCOs - Community Health Assessment and Community Health Improvement Plans

Like the direction provided to counties to develop a "local plan," the Oregon legislature directs CCOs to develop a "community health assessment and community health improvement plan. ORS 414.577 *"(1) A coordinated care organization shall collaborate with local public health authorities and hospitals located in areas served by the coordinated care organization to conduct a community health assessment and adopt a community health improvement plan, shared with and endorsed by the coordinated care organization, local public health authorities and hospitals, to serve as a strategic population health and health care services plan for the residents of the areas served by the coordinated care organization, local public health authorities and hospitals. The health improvement plan must include strategies for achieving shared priorities."*

Community Health Assessments and Community Health Improvement Plans must focus on primary care, behavioral health, and oral health; and the development of the plan must include community mental health providers.

In addition to the requirement for CCOs to develop a CHA and CHIP, the OHA now requires CCOs, by contract, to develop a "Comprehensive Behavioral Health Plan." The contract requires that CCOs meet the requirements set forth in ORS 430.630 (9). Again, the legislative intent of this statute applies to counties, not CCOs. Additional language in the CCO contract requires CCOs to collaborate with counties and other community partners to develop a plan that complies with ORS 430.630 (9). It is unclear if the OHA intended to alleviate counties of their responsibilities outlined ORS 430.630 (9)(b), however without legislative authority, the OHA does not have the authority to do so. Therefore, two entities are now responsible for submitting a plan to OHA that meets the requirements of ORS 430.630 (9)(b): counties, under statutory direction, and CCOs, under their contractual obligation to OHA.

These examples of duplication are not intended to be exhaustive. Lawmakers could examine the overlapping roles of Local Public Safety Coordinating Councils, Local Alcohol and Drug Planning Committees, Local Public Health Authorities, and the Alcohol and Drug Planning Commission, as well. They could look at the roles of counties, private contractors, CCOs, and the OHA regarding legal and paid responsibilities for coordination of services to people at the Oregon State Hospital. There are plenty of

opportunities to clarify role confusion, duplication, and administrative burden that are possible with these entities. However, the examples provided above highlight the need for the Oregon Legislature and the Oregon Health Authority to examine the current roles and responsibilities of the key behavioral health entities in the system, including their legislatively defined roles, their planning efforts in the community, and the opportunities for duplication and confusion at the local level.

Recommendation

Clarify the roles and responsibilities between the CCOs and the counties/CMHPs. This clarification is necessary in both the applicable ORS, and the contracts between OHA, CCOs and Counties/CMHPs, and providers. The OHA contracts with both counties/CMHPs and CCOs to provide many overlapping services to Oregonians. This overlap has led to role confusion and, ultimately, a lack of meaningful accountability for establishing a robust and intentionally designed behavioral health system. This lack of clarity has led independent organizations, hospitals, law enforcement, city governments, and community-based organizations to create siloed programs. While these entities may offer innovative and needed services, they are doing so because there is a lack of clarity, and therefore a lack of meaningful leadership and accountability to design a comprehensive behavioral health system at the local level.

Through collaboration, the counties (and CMHPs), the OHA, the CCOs, and the behavioral health provider community should convene a workgroup to discuss the various opportunities for role clarification throughout their work in the behavioral health system. Specific recommendations stemming from this collaborative process should be examined by leadership within OHA, the Oregon Legislature, and the Governor's office.

Some key questions that all parties should consider include, but are not limited to:

1) Should the CCOs be responsible for designing a comprehensive array of safety net services for their communities, even though the counties (and CMHPs) are statutorily responsible for these activities, and even though these services are intended to support entire communities, and not limited to the Medicaid population?
2) Should the language in ORS 430 be updated to contemplate the new and emerging role that OHA has assigned to the CCOs?
3) Should OHA attempt to reduce the duplicative regulatory requirements between CCOs, counties (and CMHPs), Public Health Departments, and Hospital systems? Or is there significant value in having each of these entities complete their own version of these similar processes?

<u>Certificates of Approval/Letters of Approval</u>

<u>Background</u>

The regulatory system that governs Oregon's publicly funded behavioral system was created decades ago, at a time when the State of Oregon passed public funds to counties to administer CMHPs (the legislative intent and authority is described above). Prior to the adoption of managed care entities, OHA (previously DHS) funded counties to establish and deliver behavioral health services in their regions. With the adoption of the Oregon Health Plan, and the introduction of Mental Health Organizations (MHOs), the counties were still the primary provider of publicly funded mental health services across the state. OHA developed a regulatory process to ensure that counties were providing services in

accordance with minimal quality standards by creating set of standards outlined in OARs. When a county demonstrated substantial compliance, they were issued a "Certificate of Approval" that was valid for a period of three years. As the need for mental health services increased in some regions, and as capacity for delivering services changed at the county level, some counties sought to subcontract portions of their responsibilities to other providers in their communities. In response to this need, OHA developed a practice that required counties to perform a regulatory review of their subcontractors. Assuming the subcontractor passed the county's review, a Certificate of Approval was issued to the subcontractor. By the early 2000's, counties became the gatekeepers to providing mental health services to anyone on the Oregon Health Plan.

When the Coordinated Care Model was introduced in 2012, CCOs were under pressure to establish an adequate behavioral health provider network to meet the needs of their communities. The contracts for behavioral health services were rapidly changing; however, OHA did not update the regulatory framework. Counties no longer had to subcontract with providers in their communities because CCOs were now responsible for this task. However, counties still held the authority to issue a Certificate of Approval to providers wishing to contract with a CCO. This created a power dynamic between counties, CCOs, and providers that led to confusion. In response, OHA developed capacity to assume the regulatory functions that were held by the counties. Counties/CMHPs no longer held a regulatory responsibility over the CCO's provider network. These regulatory functions still reside with OHA today.

Another change to the regulatory process that occurred with the introduction of the Coordinated Care Model was the exemption of clinics that exclusively employed licensed practitioners from holding a COA. For example, if a mental health clinic that only employed Licensed Clinical Social Workers and Licensed Professional Counselors wanted to contract with a CCO and serve the Medicaid population, they did not have to obtain a COA. This is an example of OHA relying on the expertise of licensed practitioners to deliver quality care, without creating extraneous regulatory requirements.

Below is a partial list of program components that an outpatient behavioral health organization must demonstrate substantial compliance with to obtain a COA from OHA. It should also be noted that *each location* where an organization provides services must obtain a COA or be added to a master COA governed by OHA.

OAR 309-019-0100 through OAR 309-019-0320

Provider Policies

Individual Rights

Specific Staff Qualifications

Personnel Documentation, Training, and Supervision

Entry and Assessment

Service Plan and Service Notes

Co-Occurring Mental Health and Substance Use Disorders

Community Mental Health Programs (Crisis Services)

Quality Assessment and Performance Improvement

Grievances and Appeals

Questions for consideration

Why is behavioral health the only healthcare specialty with specific rules that govern the operations of a particular clinic through a COA process?

Could the behavioral health system rely on the training and expertise of the professionals and paraprofessionals who provide the services?

For fidelity-based services, such as ACT, Wraparound, and Supported Employment, should the achievement of an acceptable fidelity score suffice for State approval?

As this document begins to outline recommendations for improving the regulatory framework for the publicly funded behavioral health system, many of the recommendations will suggest changes that should be considered by OHA. It is not the intent of this document to paint OHA in a negative light, nor to criticize their historical regulatory practices. OHA's regulatory framework has resulted from the recent evolution of Oregon's healthcare delivery system.

<u>Why are COAs Necessary</u>

The history of COAs is outlined above. Originally, the COA process served as a way for OHA to ensure that all providers of publicly funded behavioral health services met the minimum standards that are defined in applicable ORS and OAR. The rules historically defined the requirements for providing outpatient mental health services, civil commitment services, alcohol and drug treatment services, and different levels of residential care and treatment. Today, the OARs that govern the publicly funded behavioral health system have grown significantly in size and scope. While OHA continues to use the rules to ensure quality standards are met, they also use OARs to create new contract expectations for CCOs. For example, when OHA "creates" a new type of service, such as Intensive In-home Behavioral Health Treatment Services, the agency creates a new set of administrative rules and regulatory process to ensure CCOs establish a new level of care that is consistent with OHA's intent. It is important to note that this approach is used in lieu of establishing contract language. It is also important to note that CCOs are not service providers. CCOs do not require a COA. Their contracted provider network is regulated by the rules, but not the CCOs themselves. Rather, in addition to OHA's COA review, CCOs conduct quality and credentialing reviews of their provider networks to ensure certain Medicaid standards are consistently met. For example, CCOs review the same assessments and services plans that OHA reviews to ensure that OHP members meet medical necessity for the services they receive. Additionally, the External Quality Review process that is required for CCOs often mandates CCOs to review, or re-review, the same aspects that are covered in a COA review by OHA.

Recommendation

OHA should discontinue the practice of using the COA process and the 309 OARs to establish new levels of care. Rather, OHA should consider using the 410 OARs, and the CCO contract, to outline expectations for levels of care that CCOs shall fund. OHA should also ensure that there are appropriate ways to encounter these new services prior to requiring CCOs to fund them. The 309 OARs do not govern the CCOs, as the CCOs are not behavioral health providers.

Qualified Mental Health Professionals and Qualified Mental Health Associates

Perhaps one of the most significant aspects of the COA process and the applicable OARs is the creation of the Qualified Mental Health Professional (QMHP) and Qualified Mental Health Associate (QMHA). OHA has used the COA process to create qualifications for a workforce that is specific, and limited, to the publicly funded behavioral health system.

Outside of the publicly funded behavioral health system (specifically Medicaid and other funds flowing from OHA to communities), a person cannot render behavioral health services, or represent themselves as a behavioral health practitioner of any kind, without a license from a State of Oregon licensing board. The most relevant State of Oregon licensing boards include the following: the Oregon Board of Psychology; the State Board of Licensed Social Workers; and the Oregon Board of Licensed Professional Counselors and Therapists.

The practice of rendering mental health and/or addiction counseling services in Oregon is reserved for licensed practitioners of the healing arts. However, the applicable ORS for each licensing board offers an exception. Individuals who work for an agency that is certified by OHA are exempt from licensure requirements and the title protection laws. For example, ORS 675.523 states *"A person may not practice clinical social work unless the person is a clinical social worker licensed under ORS 675.530 or a clinical social work associate certified under ORS 675.537, except if the person is: (2) Certified to provide alcohol and drug abuse prevention services, intervention services and treatment in compliance with rules adopted under ORS 430.256 and 430.357, provided that the person is acting within the lawful scope of practice for the person's certification and does not represent that the person is a regulated social worker; (3) Employed by or contracting with an entity that is certified or licensed by the State of Oregon under ORS 430.610 to 430.695 to provide mental health treatment or addiction services, provided that the person is practicing within the lawful scope of the person's employment or contract;"*

It appears that OHA is well within the scope of the provisions afforded by ORS 675 to establish unique requirements for a unique workforce to meet the unique needs of the publicly funded behavioral health system. Unfortunately, the OARs that OHA has used for decades are full of requirements for *agencies* and not the *workforce.* OAR 309 Division 019 is the primary rule set that governs publicly funded outpatient mental health services in Oregon. These rules define the basic educational and skill requirements for the workforce. However, the rules do not define requirements for a standardized competency assessment, a standardized code of ethics, supervision requirements, or continuing education requirements. This is important for several reasons. First, there is no standardization across the system to ensure that the publicly funded workforce is capable of providing quality mental health services. OHA relies on each agency to evaluate the competency of their own staff (this verification process must be repeated whenever a provider is employed with a new agency). Second, there isn't a standardized code of ethics that this workforce uses to guide their actions. Third, there is no expectation for a training period to assess competency by a qualified supervisor. Last, there is no requirement for ongoing education and training.

ACCBO/MHACCBO

In 2016, OHA worked with the Oregon Legislature and the licensing boards to draft a concept that would transition the responsibility for regulating the behavioral health workforce from the OHA's existing COA process to the licensing boards mentioned above. The licensing boards were working on consolidating

administrative functions into the Mental Health Regulatory Agency. OHA attempted to create a glide path for the existing unregulated QMHP and QMHA workforce to pursue an existing licensure path. For those QMHPs and QMHAs who could not qualify, a new State issued credential would become available through the Mental Health Regulatory Agency. The goal was to move individuals toward licensure whenever possible, ensure the development of a standardized competency assessment, adopt a code of ethics, ensure minimum supervision requirements, establish continuing education requirements, and implement a complaint investigation process. Not only would this create a sound regulatory practice, but it would also create portability for the behavioral health workforce. Individuals would be able to practice in a variety of settings (including integrated healthcare settings) and would no longer be tethered to the COA requirements for an agency.

By the end of the 2017 Legislative session, the concept was abandoned. Instead, OHA informally partnered with the Addictions Counselor Certification Board of Oregon (ACCBO) to develop a homegrown certification process for all QMHPs and QMHAs. (ACCBO had been issuing certificates to the addictions counseling workforce in Oregon since 1977. It should be noted that ACCBO is *not* a State of Oregon licensing board. ACCBO holds no statutory authority to regulate the addictions workforce other than permissive language in the OARs used by OHA.) ACCBO quickly rebranded to become the Mental Health and Addictions Certification Board of Oregon (MHACBO) and made plans to begin certifying the mental health workforce. This approach stirred confusion throughout Oregon and continues to be an incredibly controversial move by OHA.

While MHACBO may be seen as taking a step in the right direction to regulate the behavioral health workforce, the organization missed a huge opportunity to funnel all eligible practitioners to the appropriate licensing board. One of the biggest barriers facing the behavioral health system today is limited access. There has been a huge push to create maximum capacity in both specialty and integrated settings. Unfortunately, MHACBO's approach perpetuates the loophole around licensure requirements by allowing QMHPs to seek certification who would otherwise be eligible for a traditional licensure track. This is significant because QMHPs can still only practice in COA setting. Rather than developing a more meaningful streamlined approach to regulating the workforce, an additional requirement was simply placed on top of the archaic COA process. As with ACCBO, MHACBO does not hold any authority to regulate the mental health workforce other than permissive rule language and an agreement with OHA.

Recommendation

OHA should work with the Mental Health Regulatory Agency to complete the work that began in 2016. If the publicly funded behavioral health workforce were regulated by the licensing boards, the workforce would be governed in a way that is consistent with the rest of Oregon's behavioral health workforce. Due to the evolution of the COA process, OHA has unintentionally created a system that fosters an unlicensed, and often entry-level, workforce to serve the most vulnerable Oregonians who live with some of the most acute behavioral health needs.

Specifically, the regulatory solution for Oregon's publicly funded workforce should seek to accomplish the following:

- Require everyone who is eligible for a licensure path to pursue that existing path. In an effort to maintain the current capacity in the behavioral health system, a glidepath for these changes

should be considered that allows enough time for the existing workforce to complete a transition.

- Work with the Mental Health Regulatory Board of Oregon to create a paraprofessional certification/license for those clinicians who do not meet current licensing eligibility requirements. Two levels of licensure/certification should be created: one for QMHPs, and another for QMHAs. The new credential should incorporate the following at a minimum:
    - Develop standardized competency assessment
    - Develop minimum supervision requirements
    - Adopt a standard code of ethics.
    - Adopt a complaint investigation process.
    - Require CEUs to maintain credentials.
- Create portability for the behavioral health workforce that allows people to carry their credential with them from employer to employer and setting to setting.
- Create pathways for the behavioral health workforce to render services that will be reimbursed by both public and commercial funds. This is critical to assist with the expansion of integrated healthcare services.
- Eliminate the burden and limitations placed on integrated settings (e.g. FQHC, PCPCH) to acquire a COA in order to hire paraprofessional level staff and maintain compliance with applicable Medicaid billing practices.
- Consider the notion that the current regulatory framework is designed to allow people without credentials to serve the most vulnerable Oregonians with the most significant behavioral health needs.
- Assuming a new regulatory process focuses on individuals, rather than organizations, OHA should consider whether there is any value in maintaining the COA process. Many of the organizational requirements could be moved to contracts and managed through performance expectations.

Parity

Mental health parity has been a major focus of state and federal legislation for the past three decades. Laws and policies have extensively focused on the requirement to provide the same coverage levels between behavioral health services and other medical services. While these protections require insurance companies to adopt similar payment and utilization practices between behavioral health and medical services, the regulatory structure between the two service types are completely misaligned. Insurance coverage for medical services relies on licensed and certified medical professionals to deliver services in accordance with their training and licensure. As outlined above, the behavioral health system relies heavily on a complex COA process that has varying standards depending on the specific type of service to be rendered, and the type of professional/paraprofessional rendering the service.

For all other types of healthcare services that CCOs are required to cover, there are billing codes and contract language to guide the provision of care. However, for specialty behavioral health, OHA uses the OARs to create new service types and then requires CCOs to develop capacity and fund those services. This practice would be akin to OHA developing rules for a specific Physical Therapy intervention, rather than relying on the training and governing body for Physical Therapists, or

requirements for each primary care office to receive a specific certification from OHA prior to serving OHP members.

Recommendation

OHA should consider the impact that the current regulatory structure has on CCOs' ability to create parity between the physical healthcare system and the behavioral healthcare system. Furthermore, OHA should consider the challenges that the existing structure creates for healthcare providers to develop an integrated approach to patient care. Navigating the complexity of the OARs is a barrier to clinics that are striving to incorporate behavioral health services into their service array. OHA should work with counties (and CMHPs), CCOs, behavioral health providers, and other healthcare professionals to thoroughly examine the current language in the OARs used for the COA process. Requirements that are not specifically tied to a federal or state statute, or Oregon's state Medicaid plan, should be evaluated. If the collective goal in Oregon is to increase the availability of behavioral health services (including integrated services) it is counterintuitive to simultaneously increase the administrative barriers associated with the provision of these services.

COA Requirements for Fidelity-based care

Behavioral health services such as Assertive Community Treatment (ACT) and Supported Employment (SE) are grounded in fidelity models that are based on years of research and proven success. OHA requires providers of these fidelity-based services to pass a fidelity review conducted by a Center for Excellence. Each provider must demonstrate compliance with the fidelity requirements evidenced by a compliance review. Additionally, OHA has created requirements for providers that exceed the standards of the fidelity model. These standards must be met in order to gain a COA for the specific service type (e.g. ACT and SE).

Recommendation

OHA should evaluate the added value of imposing extraneous requirements on providers of fidelity-based services. If value is found, OHA should consider whether those requirements are appropriate for a COA, or if they would fit better in a contract.

Summary

The information and recommendations included in this document are intended to highlight some of the existing barriers in Oregon's publicly funded behavioral health system, and to offer recommendations for addressing these barriers. As the need for behavioral health access continues to increase across the state, it is imperative that Oregon adopt a regulatory model that is reflective of the growing need for access. This document makes specific recommendations that, if implemented, could address many of these barriers. Some of the core values that should accompany any action items associated with these recommendations are to increase service access, clarify roles and responsibilities between system partners, reduce unnecessary administrative burden, eliminate duplicative requirements between system partners, and improve the quality of care for people receiving services.