Oregon Pediatric Improvement Partnership:

Meeting with Oregon Health Authority Leaders Regarding Learnings Specific to Behavioral Health

April 24th, 2026

- Context on the **OPIP Partners** and our shared vision & commitment to support policymakers
- Examples of why we focused on our December Partner Meeting on Providing Input and Solutions
- Collective Agreement on Input from OPIP Partner: Overview of Our One Pager
- Other Context to Consider in Implementation
- Questions

OPIP

The Oregon Pediatric Improvement Partnership (OPIP) supports a meaningful, **long-term collaboration of stakeholders** invested in child health care quality, with the common purpose of improving the health of the children and youth of Oregon.

OPIP Partner Committee an invaluable component of our statewide focus

- Shared table of those committed the vision.
- Quarterly meetings.
- Shared agenda.

OPIP Partners & Functions

OPIP

A. **Sharing of successful initiatives and disseminating best practices:** The partners will share with each other the work they are doing to improve the health of children and youth, and the key learnings that are applicable to the other members

B. **Identify areas of synergy:** Partners will identify areas of synergy across their efforts and/or where there should be synergy in efforts, to ensure a meaningful impact on the health of children and youth in Oregon

C. **Build collaboration and consensus:** Through shared discussions, the partners will help to identify areas of collaboration and consensus about opportunities to improve the health of children and youth in Oregon

D. **Serve as a resource for policymakers in providing guidance and input:** The partners meetings will represent an opportunity for policymakers to share and discuss key policy efforts and gain input and insight from the collective group of stakeholders.

Why Now Is a Critical Time for Children

OPIP

- Critical time to acknowledge what has and hasn't worked for children in the CCO model.
  - Especially given a majority of children are publicly insured in Oregon.
- Need to ensure that children receive the set of EPSDT aligned services
- Need for assurances of contractual CCO obligations for children are met.
- Children are not little adults
  - Policies and systems need to be specific to children to account for their unique needs.
  - Outcome of child-focused priorities will be life-long health

OPIP

Two specific examples of worrisome trends OPIP Partners have Seen that Led us to This Shared Recommendation.

#1) Unprecedent Back Slide

Oregon TPEC Transforming Pediatrics and Early Childhood

Primary Care – a Key Place for Child Access and EPSDT Services – Funding is Not Sustainable

- **Payment less than OHA FFS rates** services within primary care WHILE
- **Reducing PCPCH PMPMs**
  - Limited Value in Higher Tiers from a PMPM Perspective Given Payments Not Higher
- **Removing behavioral health PMPMs to practices**
  - In primary care, this is critical as it supports:
    - ✓ Warm handoff
    - ✓ Clinic consults
    - ✓ Support to access external behavioral health
- **THW – Lack of Sustainability Despite State Priority and Way to Address Gap in Work Force**
  - As of right now, none of the sites can sustain THW through FFS and PMPM payments
  - PMPMs don't cover time and were recently CUT.
    - Recently Health plans cutting THW PMPM
  - Barriers to THW Payment Sustainability
    - Payment received is not always aligned with OHA THW Payment outlined
    - FFS payment quite small for services they can bill, doesn't cover their salary
    - Private payors don't pay (Unclear if there is any model of a workforce being sustained by one sector)
    - Barriers to billing in FQHCs

#2) Learnings Related to Behavioral Health

OREGON TPEC
Transforming Pediatrics and Early Childhood

1. Despite receiving a global budget since 2013 on the premise of network adequacy, Coordinated Care Organizations do not have network adequacy for **child focused behavioral health services.**
   - This is expected to get worse as CCOs are addressing cost and restricting their networks and prioritizing providers of high-cost care and patients with high complexity.
2. Evidence-base and parent report emphasize the value of behavioral health within primary care or in schools.
   - **That said, most current integrated behavioral health do not see young children.**
   - **Barriers to behavioral health in schools.**
3. Barriers to current payment models from CCOs to Primary Care to sustain and support behavioral health

Public Comment to the Oregon Health Policy Board on EPSDT and Behavioral Health Services for Children – September 2025

Considering The Why As We Think About Solutions

OREGON TPEC Transforming Pediatrics and Early Childhood

- Children, especially young children, who do not receive EPSDT aligned services don’t in the global budget period cost the CCO more money because of this lack of clinically recommended services.
  - In fact, if they increases these services, they have reported it negatively impacting their globally budget as children are getting services they were not before.
- Currently modelling based on past data and current risk adjustments, creates a situation where if the CCO invests in the network and services aligned with EPSDT recommendations, they will lose money.

- Why we have focused on quality metric for children and why they are critical in the QIP funding
  - However, quality pool funds may be less than the increase in costs of services

Version 4.1.2026

Oregon Pediatric Improvement Partnership (OPIP) Partners Commmitee
Recommendations *to OHA on Ensuring Quality of Care for Children in the Oregon's 1115 Waiver and CCO 3.0*

Background and Context

OPIP's Partners Committee is a group of leaders who share a commitment to improving the health of ALL children in Oregon. We meet quarterly with a shared focus on providing input to policymakers. We are eager to support and provide guidance to the Oregon Health Authority and other committees as they develop Oregon's next 1115 Waiver and the CCO 3.0 contracts, and work to address Medicaid sustainability. We appreciate OHA's longstanding commitment to ensuring quality of care for children and investing in upstream services that improve health outcomes and advance the state's health equity goals. **This is a critical time to acknowledge what has and hasn't worked for children in the CCO model. Adjustments are needed to ensure that children receive the set of EPSDT aligned services they are legally required to be provided and that contractual CCO obligations for children are met**. Children are not little adults: policies and systems need to be specific to children to account for their unique needs. And the goal and likely outcome of child-focused priorities will be life-long health and positive impact to society. This document summarizes key recommendations. We welcome your attendance at a future OPIP Partners meeting as we strive to provide partnership, collaboration and solutions needed during this complex time.

Partner Recommendations for OHA to Consider in the Next 1115 Waiver & CCO 3.0

1. Maintain Coverage Strategies for Young Adults with Special Health Care Needs.

2. Improve Rate Setting for CCOs to Ensure Federally Required EPSDT Services for Children Are Included in Global Budget as CCO Quality Incentive Pool Funding Decreases

- **2A. Increase OHA FFS Rates for Physical Care Services (Ex. Well Visits) to Ensure that Global Rates are Established in a Way that Physical Care Providers Serving Medicaid-Enrolled Children can Sustain Services.** Prioritize FFS rates for identified priority services, such as aspects of care included in the incentive metric pool like well-child visits, preventive services, and assessment within primary care
- **2B. Ensure that global budgets include prospective funds that would ensure EPSDT services are provided**, especially for priority topic areas aligned with metrics and priorities (e.g. behavioral health, dental services). We would be happy to provide quantitative data to inform budgeting scenarios.

3. CCO 3.0: Ensure Children are a Focus in CCO 3.0 and Receive All Required EPSDT Services, with Adequate Payment to Sustain the Providers Delivering Those Services

- **3a. Within CCOs, require that global budget funds for children are spent only on children and not shifted to adults.** *Example of Options: Within CCO budget, child vs. adult budget; Allow for a CCO focused only on children that may not be regional, but statewide.*
- **3b. Ensure that funds for child-level physical, behavioral and oral/dental services go to those services by requiring reporting of funds by type of service AND by population**
  - i. For school aged populations, require contracting for applicable services within schools to ensure network adequacy and services in places children can easily access.
- **3c. Ensure that CCOs Provide Sustainable Payments to Primary Care for EPSDT Services & Services Where Primary Care is the Dominant Place of Care and Ensures Network Adequacy**
  - i. Require in CCO contracts payment of Primary Care-Based Behavioral Health by OHA FFS rates and require PMPMs to sustain Integrated Behavioral Health in Primary Care
  - ii. Require in CCO contracts Traditional Health Worker FFS Payments and require PMPMs
- **3d. Improve CCO Reporting of Behavioral Health Network Adequacy for Children**
  - i. Require reporting of network adequacy for children in CCOs, and within children birth to 5 vs 6-21
  - ii. Address restrictions in CCO networks that limit access for low acuity, EPSDT-aligned behavioral health services for children, and services provided in schools.

1. Maintain Coverage Strategies

- Young children and considering cont enrollment.
- Young Adults with Special Health Care Needs.

2. Improve Rate Setting to Ensure Federally Required EPSDT Services for Children Are Included in Global Budget as CCO Quality Incentive Pool Funding Decreases

- **2A. Increase OHA FFS Rates for Physical Care Services (Ex. Well Visits) to Ensure that Global Rates are Established in a Way that Physical Care Providers Serving Medicaid-Enrolled Children can Sustain Services.**
  - Prioritize FFS rates for identified priority services (e.g. Well-child visits, preventive services)
- **2B. Ensure that global budgets include prospective funds that would ensure EPSDT services are provided**
  - Especially for priority topic areas aligned with metrics and priorities (e.g. behavioral health, dental services)

CCO 3.0: Ensure Children are a Focus in CCO 3.0 and Receive All Required EPSDT Services, with Adequate Payment to Sustain the Providers Delivering Those Services

- **Within CCOs, require that global budget funds for children are spent only on children and not shifted to adults.** *Example of Options: Within CCO budget, child vs. adult budget; Allow for a CCO focused only on children that may not be regional, but statewide.*
- **Ensure that funds for child-level physical, behavioral and oral/dental services go to those services by requiring reporting of funds by type of service AND by population**
  - For school aged populations, require contracting for applicable services within schools to ensure network adequacy and services in places children can easily access.
- **Ensure that CCOs Provide Sustainable Payments to Primary Care for EPSDT Services & Services Where Primary Care is the Dominant Place of Care and Ensures Network Adequacy**
  - Require in CCO contracts payment of Primary Care-Based Behavioral Health by **OHA FFS rates and require PMPMs** to sustain Integrated Behavioral Health in Primary Care
  - Require in CCO contracts Traditional Health Worker **FFS Payments and require PMPMs**
- **Improve CCO Reporting of Behavioral Health Network Adequacy for Children**
  - Require reporting of network adequacy for children in CCOs, and within children birth to 5 vs 6-21
  - Address restrictions in CCO networks that limit access for low acuity, EPSDT-aligned behavioral health services for children, and services provided in schools.

As Oregon Implements New Waiver, CCO 3.0
Some Key Factors to Consider Not Included in OPIP Memo

OPIP

- **Maintaining Child Insurance, Considerable Worry About Impact on Birth to Five (Historically a stable populations)**
  - Loss of continuous enrollment for birth to five and impact that will have
  - Consider proposing two year eligibility aligned with federal CMS and CMMI Priority on early childhood
  - Convene a small workgroup now
  - CHIPRA Demonstration Findings

- **Convene a workgroup with OHA and Education to Address Barriers to and Opportunities for School Based Services**
  - Administrative burden
  - Leveraging federal match

- **Add PMCA and Other Medicaid Paid Social Complexity Indicators to Metric and Risk Stratifications**

Quality Metrics Program

OREGON TPEC
Transforming Pediatrics and Early Childhood

1. Parsimony of metrics **across the <u>sectors</u> CCO** are meant to serve
   - Physical
   - **Behavioral (NOT JUST PRIMARY CARE BEHAVIORAL HEALTH SCREENING)**
   - Oral separate from Dental
2. ***Limitation of downstream being narrowed to CHIPRA Core Set and gaps in metrics related to non-primary care based behavioral health***
3. Equitable support & technical assistance to CCOs, especially for metrics that are brand new
   - In first of the metric, No TA being provided for the Young Children Receiving Issue-Focused Intervention/Treatments

Looking forward with hope and opportunity

- Data shows that we can improve services for children using the models and levers in Oregon.
- Population that should technically remain insured (at least up 18)
- Work is aligned with EPSDT Requirement and Incentive Metrics.
- Upstream work with young children may support behavioral health provider retention and balance in complex times
- Primary care-based solutions are cost effective relative to downstream consequences and intensive services.

OREGON
TPEC
Transforming Pediatrics
and Early Childhood

THANK YOU