Oregon Transforming Pediatrics for Early Childhood (OR TPEC)

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

April 16th, 2026

OREGON TPEC
Transforming Pediatrics and Early Childhood

- Context Setting & Overview of Oregon Transforming Pediatrics for Early Childhood
- Top Learnings from these Efforts Related to Behavioral Health
- Top Learnings to Consider for Next Oregon Waiver & CCO 3.0
- Key Implementation Considerations

Acknowledgement of Funding

- Transforming Pediatrics for Early Childhood (TPEC) is supported by Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS).

- The contents of this slide deck are those of the authors (OPIP staff) and do no necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the US Government.

OPIP's Broader Efforts Over Last Decade, Context on OR TPEC

- Proposal informed by decade of work across the state
- Meant to fund a pilot in largest, most diverse region to see fi this approach could yield improvements in care
- Leading work now to spread in rural regions and finding the exact same baseline finding and needs

- Work is aligned with incentive metric meant to ensure quality for young children and EPSDT aligned behavioral health services.
- Note: Despite accepting global budget on premise of network adequacy to provide these services, there is not network adequacy across the sectors it should exist in.
- Metric meant to ensure quality for those funds and stimulate investments.

Relevant National TPEC Objectives, In Oregon Speak & Specific to Focus of Today on Behavioral Health

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- Increase the **number of trained early childhood development (ECD) experts** in primary care settings that can serve birth to five
  - Integrated behavioral health providing interventions (aligned with metric)
  - In two sites, THW that addressed behavioras

- Increase the **number of pediatric practices** offering a **continuum of ECD services**, aligned with the EPSDT continuum, including screening, interventions and care coordination
  - Increase "EPS" aligned screenings
  - "D" and "T" Internal interventions conducted integrated behavioral health
  - Connections to "D" and "T" services, Priority on behavioral health

- **Identify and advance solutions** such as **policy and financing barriers**, ECD **workforce** needs and **service gaps**.
  - FFS Payment
  - VBPs/APM
  - CCO network adequacy related to specialty behavioral health

Early Childhood Continuum Aligns with EPSDT Continuum

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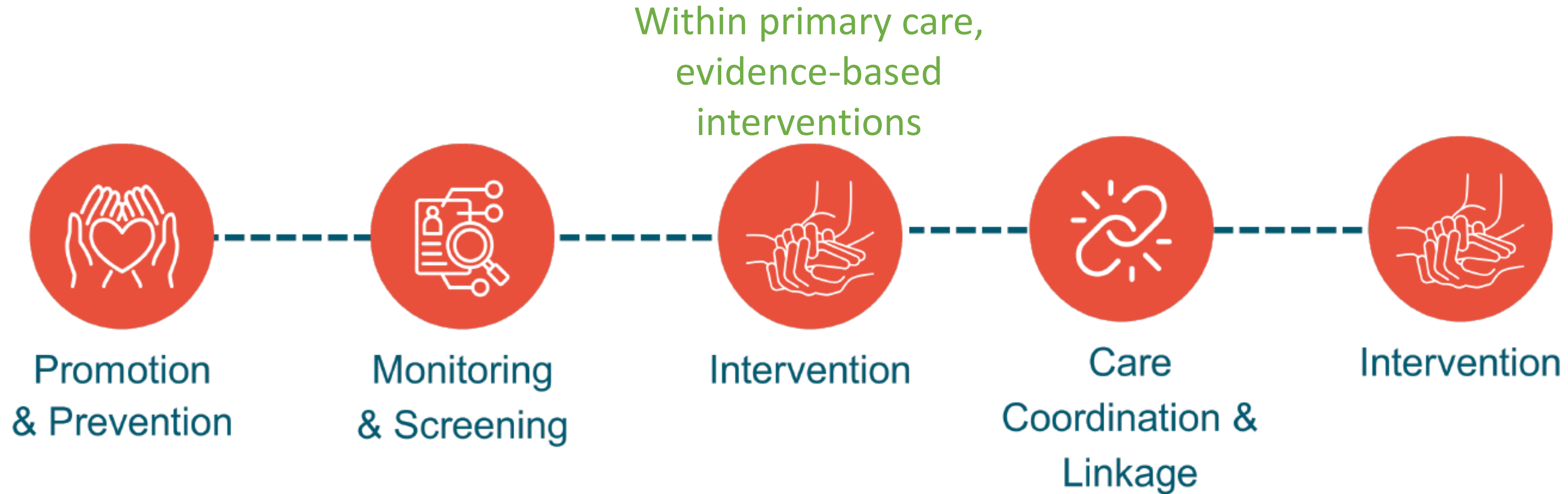
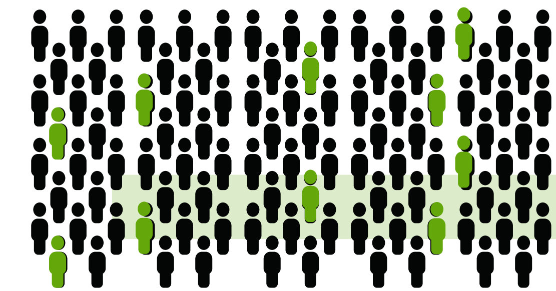


Context of Behavioral Health for Young Children and Why Primary Care-Based is Essential to EPSDT and Network Adequacy

OPIP Oregon Pediatric Improvement Partnership

Continuum of Social-Emotional Services

All Children as Part of Population-Wide Surveillance & Screening



Bright Futures Recommends **Social-Emotional** Screening as part of robust well-child care

Children with Identified Issues *(Delays, Behavior Concerns, Risk for Problem Behaviors)*

PCP-Provided Parent Guidance & Education

Behavioral Health: Issue-Focused Intervention & Treatment Services

Brief Intervention

40% of Children

Treatment Service

12-17% of Children

Infant and Early Child Mental Health is Dyadic: Two for One Bang for Your Buck and Potential Key to Adult Health

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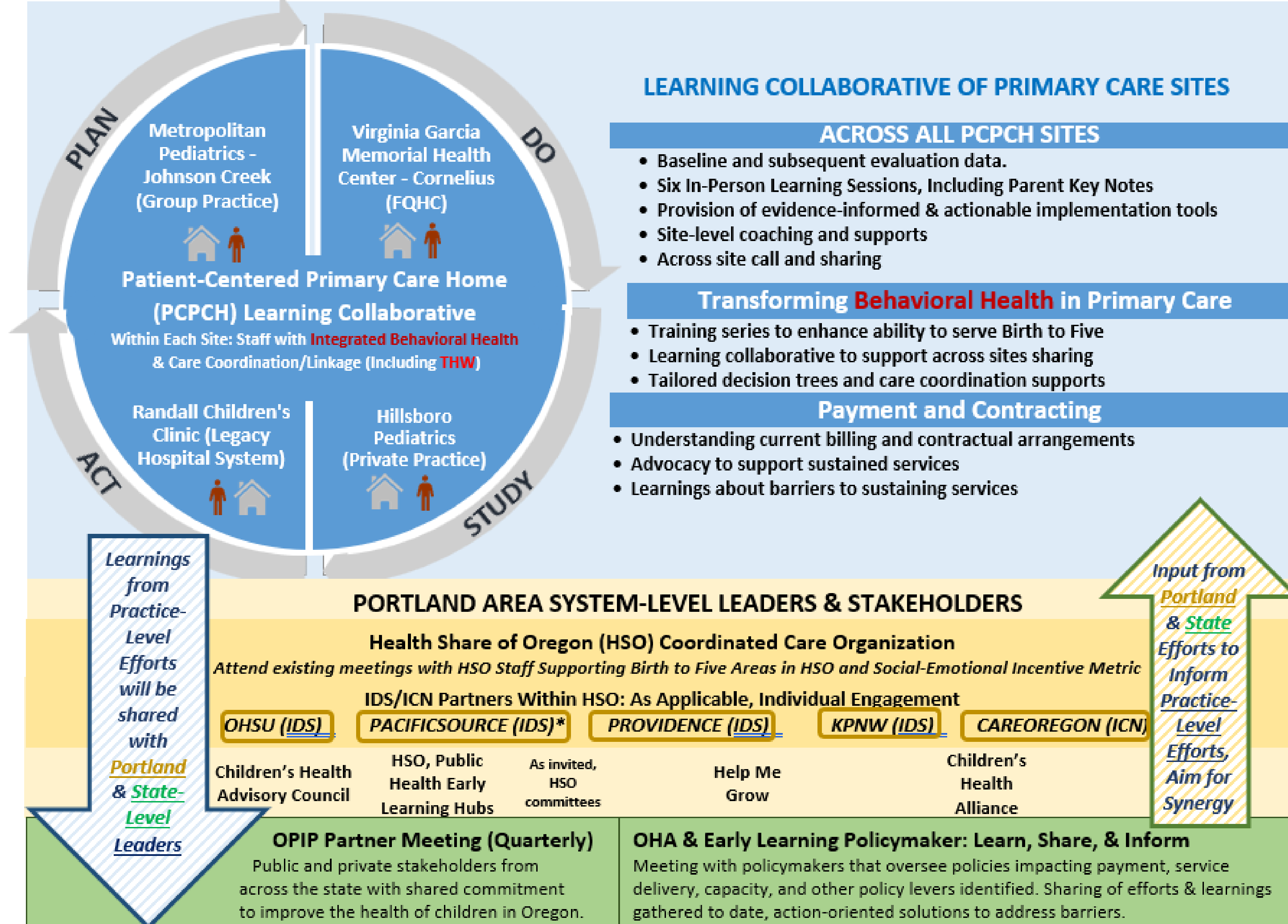
- Literature is strong on the impact of Adverse Childhood Experiences (ACEs) on adult health
- Prolonged exposure can rewire developing brains
- Early interventions can mitigate the effects of this toxic stress
- Build health in child AND family
- As parent may LOSE insurance and services, considering service for children may be a way to provide supports to the parent relative
  - Example: Maternal Depression

Figure 1: Overview of Learning Collaborative of Primary Care Sites Guided by & Informing Inform Local & State Leaders



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Impact of TPEC Efforts

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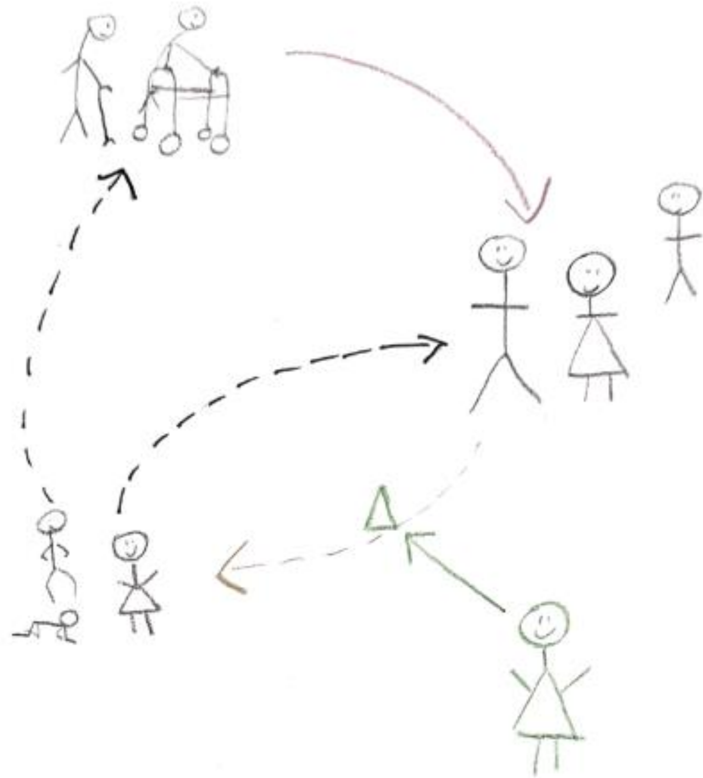
- Improved **Office Systems and Processes**
  - All four sites have improved early childhood development office systems and processes.
- Improved **Staffing with Early Childhood Development Experience to Provide Issue-Focused Interventions**
  - All four sites have **behavioral health** who attended trainings to enhance expertise in issue-focused interventions for young children
  - All four sites enhanced the FTE devoted to serving birth to five in **care coordination and system-navigation**.
  - All four sites have **at least one THW with enhanced birth to five** functions, some exclusively to birth to five.
- Improved **Services**
  - All four sites improved in at least one service tracked (screening, issue-focused interventions, referrals)



Behaviorist breaking cycle of generational trauma. Toddler referred for (+) PPSC, learned about naming feelings & deep breathing, and now she's helping older generations process their big feelings, too!

Behavioral Health Providers Lives Impacted

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Building expertise and focus around parenting support with TPEC has **increased job satisfaction**, [she] loves talking to parents-receiving support and knowledge around that helps her be more competent as a clinician.
-**Behavioral Health Clinician at Hospital Based Primary Care Clinic**

Learning about this project in the interview process and how [the clinic] prioritized this age group was a factor in her accepting this job.
-**Newly Hired Behavioral Health Clinician Hospital Based Primary Care Clinic**

A big success has been more support and focus on behavioral health support for kids ages 1-5. She has wanted to work with young children and "Now there is time set aside" for this age group. Before this work, she had to think "way, way back to even remember a young kid I worked with." But now she has time set aside for warm handoffs, and sees 5-6 young kids a month.
-**Behavioral Health Clinician at FQHC**

Children who Received Issue-Focused Interventions from Staff with ECD Expertise (Aligned with CCO Incentive Metric)

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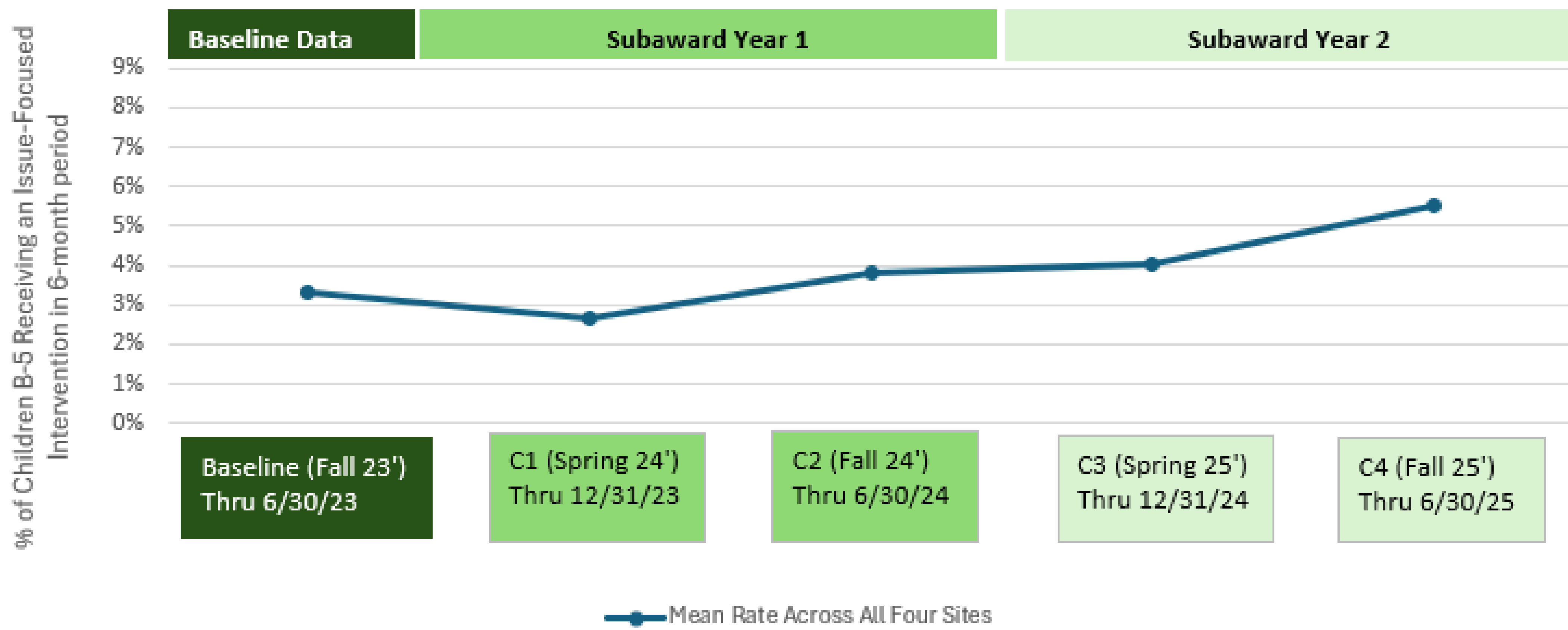


Metric 1.5: Aligned with Young Children Receiving Issue-Focused Interventions CCO Incentive Metric

% of Children 1-5 Receiving Issue Focused Interventions

10%
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%

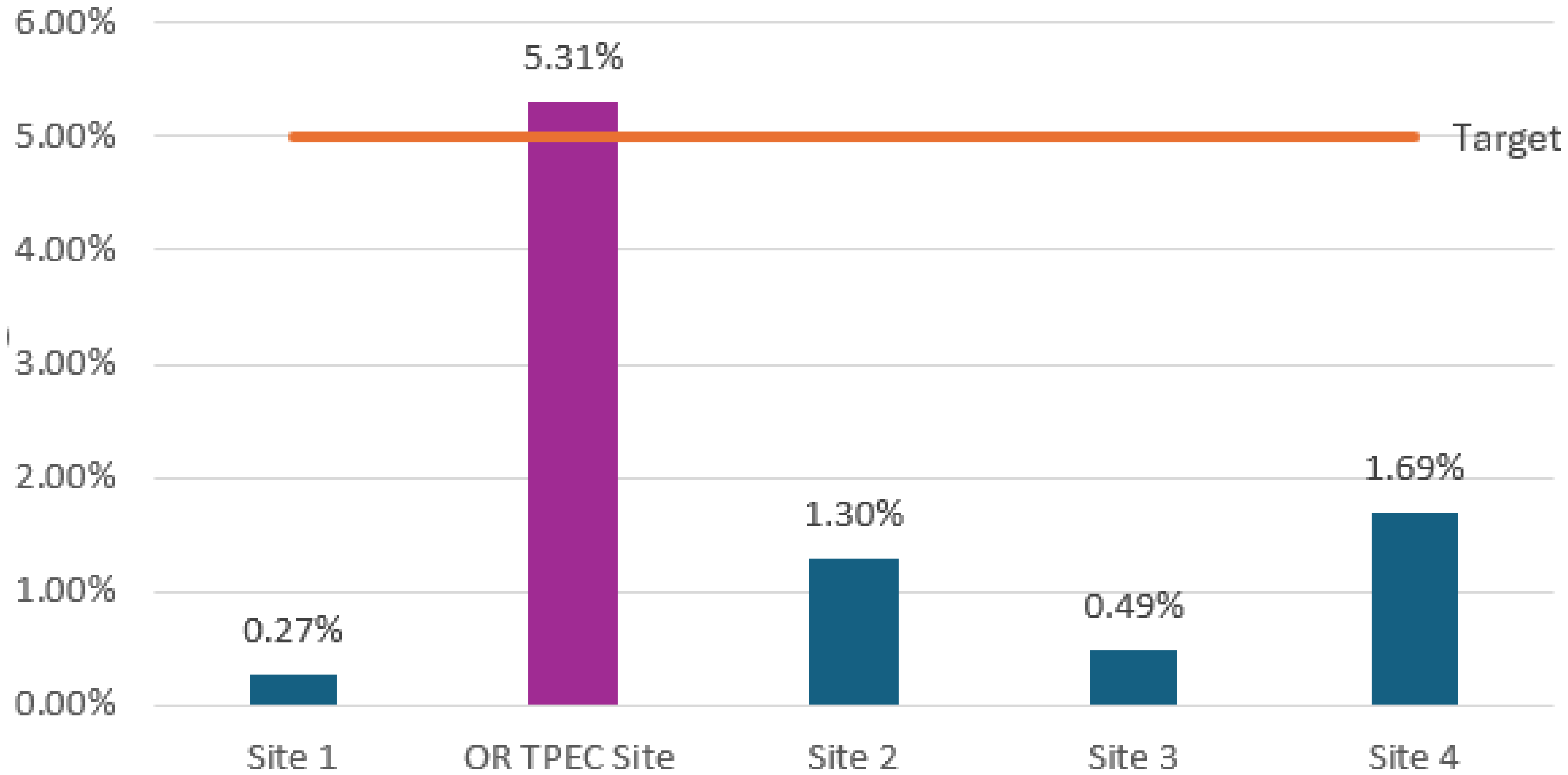
HSO Improvement Target for 2025

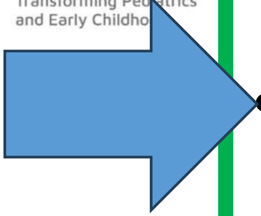
C3 (Spring 25')
Thru 12/31/24

C4 (Fall 25')
Thru 6/30/25

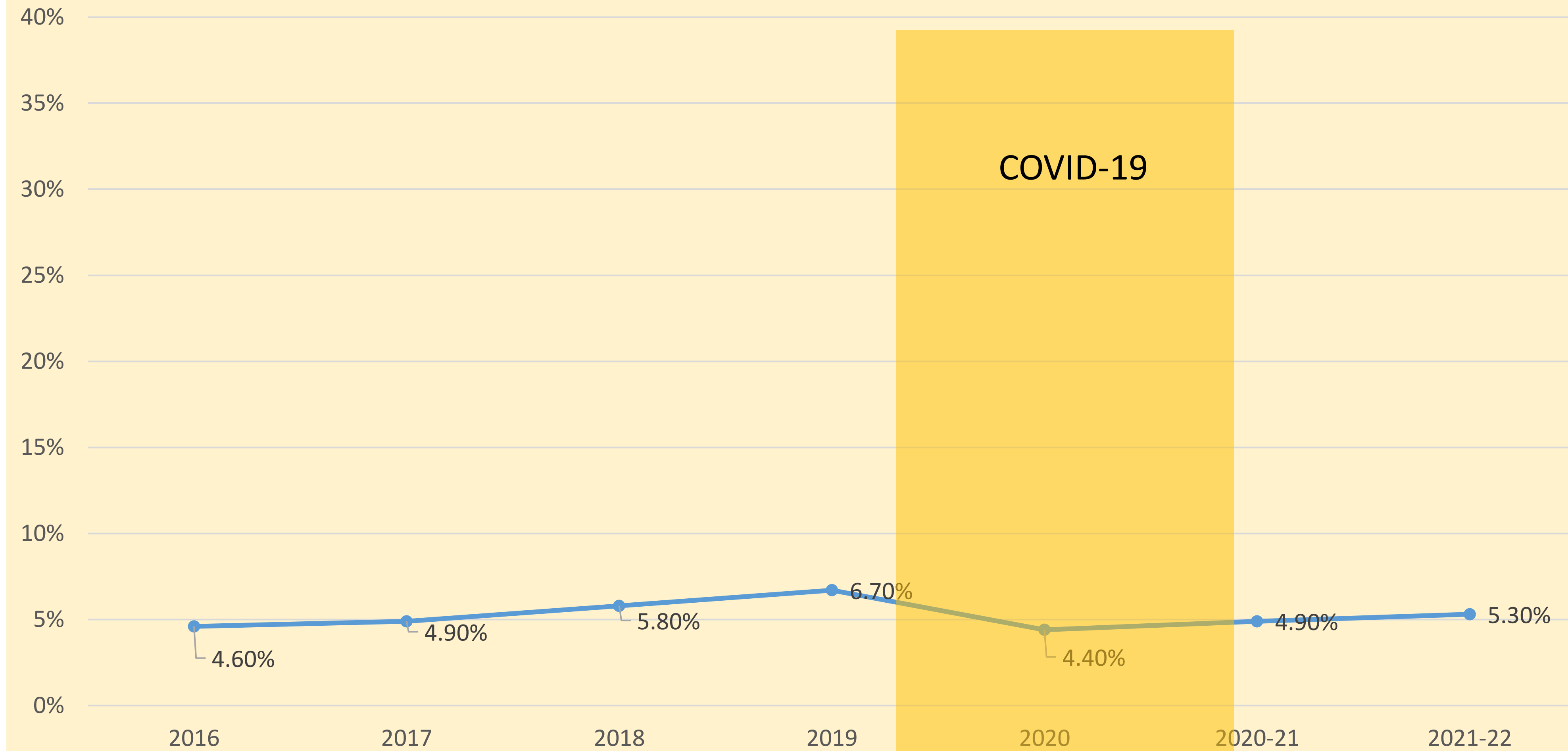
Site 1 Site 2 Site 3 Site 4

Example: OR TPEC Site Part of Larger Systems are Significantly Higher on CCO Incentive Metric Despite Same PCPCH Tier Levels (Current Dashboard)





- Introduction & Review of the Agenda
- Context Setting & Overview of Oregon Transforming Pediatrics for Early Childhood
- Top Learnings from these Efforts Related to Behavioral Health
- Top Learnings to Consider for Next Oregon Waiver & CCO 3.0


Oregon Medicaid-Covered Children:
Receipt of Social-Emotional Screening, Assessment, and Intervention
40%
35%
30%
25%
20%
15%
10%
5%
0%
COVID-19
4.60%
4.90%
5.80%
6.70%
4.40%
4.90%
5.30%
2016
2017
2018
2019
2020
2020-21
2021-22

Learnings Related to Transforming Behavioral Health

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1. Despite receiving a global budget since 2013 on the premise of network adequacy, Coordinated Care Organizations do not have network adequacy for birth to five 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. Training and investments in outpatient services and intensive therapeutic services will not address most of this gap.
3. Evidence-base and parent report emphasize the value of behavioral health within primary care, especially for young children and their families.
    - **That said, most current integrated behavioral health do not see young children.**
4. 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

Role of High Functioning Patient-Centered Primary Care Home in Child Behavioral Health

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Patient-Centered Primary Care Home

Surveillance & Screening Identifying Potential Delays For Full Population

Primary Care Provider
Response to Issues Identified in Visit or Screening Tool

- *Guidance & Education*
- *If Needed: Referral Internally or Externally*

For children who need additional supports

Integrated Behavioral Health
Assessments & Brief Interventions

Blue Boxes:
For Subset of Children Who Need It
Issue Focused Interventions

Referrals to External Services

- System Navigation Support

Subset: Children requiring ongoing therapeutic needs

External Behavioral Health Services
Therapeutic Interventions

OPIP Trainings to Transform Behavioral Health

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- With complementary support from Health Share of Oregon, led a **Multi-year Learning Collaborative** of Integrated Behavioral Health in Portland Metropolitan Region
- Over **60 behavioral health clinicians** involved in 1 or more trainings
- Reported it enhanced their ability to provide assessments and brief interventions for the birth to five population.
- Included:
  - Two In-Person Trainings
  - Monthly Webinars
  - Case Consultation
  - Listserv
- Provided CEU/CME Credit for attending.

- Assessment Models
- Intervention Model Tied to Parent Management Strategies
- Topic Specific Webinars:
  - Disruptive Behavior (two webinars)
  - Early Childhood Anxiety
  - Early Childhood Sleep
  - Toilet Training and Elimination Problems
  - Supporting children who experience autism or other developmental delays
  - Dyadic therapies in the context of parents with mental health challenges
  - Enhancing communication and coordination with primary care providers
  - Incorporating trauma-informed principles
- Connecting families to external services

Opportunities to Transform Behavioral Health

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1. **Invest in primary care trainings** specific to integrated behavioral health and anchored to principles of parent management strategies across different modalities and on specific strategies to engage parents in services
   - OPIP's model has been shown to be effective
   - Needs to include training of primary care providers on how to identify children, refer and engage families
2. Enhance future **CCO network adequacy requirements specific to populations** and settings of care that are evidence-aligned and acceptable to parents
3. Ensure that **behavioral health funds are appropriately allocated** to these behavioral health providers in primary care (Majority of global budget behavioral health money should go to primary care)
4. Address the **sustainable payment** barriers in future CCO contract requirements

Public Comment to the Early Learning Council on Addressing the Behavioral Health Needs of Young Children – April 2025

Opportunities to Transform Behavioral Health

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Address the sustainable payment barriers in future CCO contract requirements.

Examples OPIP recommends:

1. Ensure **service are covered** by applicable providers. (e.g. Some public payors didn't pay when in primary care)
2. Require **CCOs to pay DMAP rates**, for all provider types, for behavioral health service rendered, regardless of setting.
3. **Enhance VBP requirements to support PMPM or APMs** related to behavioral health to support non-billable activities
   - Warm handoffs
   - System navigation supports to external services
   - Team huddles with primary care

Unprecedent Back Slide We are Seeing in Last Six Months

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- Payment less than OHA FFS rates for behavioral health in primary care WHILE
- 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
- Restriction and Constriction of Behavioral Health Network
  - Prioritizing SPMI services, high risk
  - Prioritizing settings that are not young child friendly or focused
  - Not Aligned with EPS**DT**
  - For children/adolescents, want to intervene BEFORE

Learnings Related to THWs Doing INterventions

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- Primary care providers and behavioral health noted this THW enhancement was a key success of TPEC
- In two of the sites, on site THW's received specific training on birth to five services and interventions
  - No specific training models available right now for this population
  - Currently combined forces with Dr. Peterson's Kindergarten Readiness Work
  - Way to address gap in network adequacy

Barriers to Sustainability of THWs & Care Coordination

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- **As of right now, none of the OR TPEC sites can sustain their THW through FFS and PMPM payments (if received) and many are considering cuts.**
- **PMPMs don't cover time and were recently CUT.**
  - Recently HSO Health plans cutting THW PMPM
  - PMPM rates by PCPCH Tier not sufficient given what is provided
- **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

Considering Why this Back Slide is Happening

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- Young children who do not receive EPSDT aligned services don’t in the global budget period cost the CCO more money as a result of this lack of clinically recommended services.
- 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.
- Quality pool funds may be less than this increase in funds and as quality pool funds are further reduced, less of a focus on these EPSDT aligned services.

Opportunities to Address Payment Barriers

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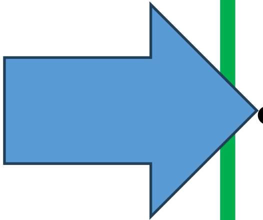
- ✓ Global budget for behavioral health for young children should appropriately go to **behavioral health in primary care** given the data shows that is 70% of services.

- ✓ FFS Coverage: Ensure **services are covered and require CCOs/Health Plans within CCO to pay DMAP rates**, for all provider types, for behavioral health service rendered, regardless of setting. (*Aligned with Primary Care Payment Reform Collaborative recommendations)*

- ✓ Ensure that primary care receives **BEHAVIORAL health PMPM** to support unbillable, but critical services, aligned with evidence-based services (*Aligned with Primary Care Payment Reform Collaborative recommendations)*
  - Warm handoffs, engagement in well-child visit
  - Engagement in external service, navigation
  - Huddles and training with PCPs to provide updates on who to refer



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- Top Learnings from these Efforts for Two OHA Strategic Priority Areas
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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.

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.*
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- **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**
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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)**
    - o Loss of continuous enrollment for birth to five and impact that will have
    - o Potential for pushback or innovation?
    - o Convene a small workgroup now
    - o 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**

Assurance of EPSDT: Opportunities

1. Payment Aligned with EPSDT
   - FFS Coverage of Claims for the D and T in **Primary Care**
   - Sustainable Payment Rates Aligned with OHA FFS Schedule
   - Addressing FQHC PPS Rates for Behavioral Health

2. Network Adequacy Aligned with EPSDT
   - Lack of behavioral health network adequacy for birth to five despite global funds going out
     - Likely getting worse in next few years, example – prioritizing providers for SPMI, complex diagnoses, settings that serve those patients
   - Progress on Autism Evaluation assessment, but then gaps in services

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

Rate setting to align with provision of care aligned with health equity

- OR TPEC practice with substantially higher medically complex and socially complex patients did not get higher payments
- Current rate setting continues health INequities and harms practices serving children with medical complexity and families with social complexity aligned with generational trauma

Public Comment to the Health Equity Committee on Ensuring a Focus on Children with Special Heath Care Needs – April 2025

Opportunities:

1. Enhance rate setting using PMCA
2. Consider methods to ensure that if EPSDT services provided, global rates would cover services
3. Consider OHA based social complexity factors
   - Foster care involvement – ever
   - Parent Medicaid Paid Use of Substance Use, Mental Health Services
   - Medicaid Eligibility and Alignment with TANF Use

Quality Metrics Program

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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

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- Data shows that we can improve services for children using the models used in OR TPEC. **Elements of this work can be spread to other sites and will be needed.**

- Population that should technically remain insured.
  - If young children are more likely to stay insured in changes, and there is an opportunity for dyadic support to parents who may have lost their insurance.

- Work is aligned with EPSDT Requirement and Incentive Metrics.

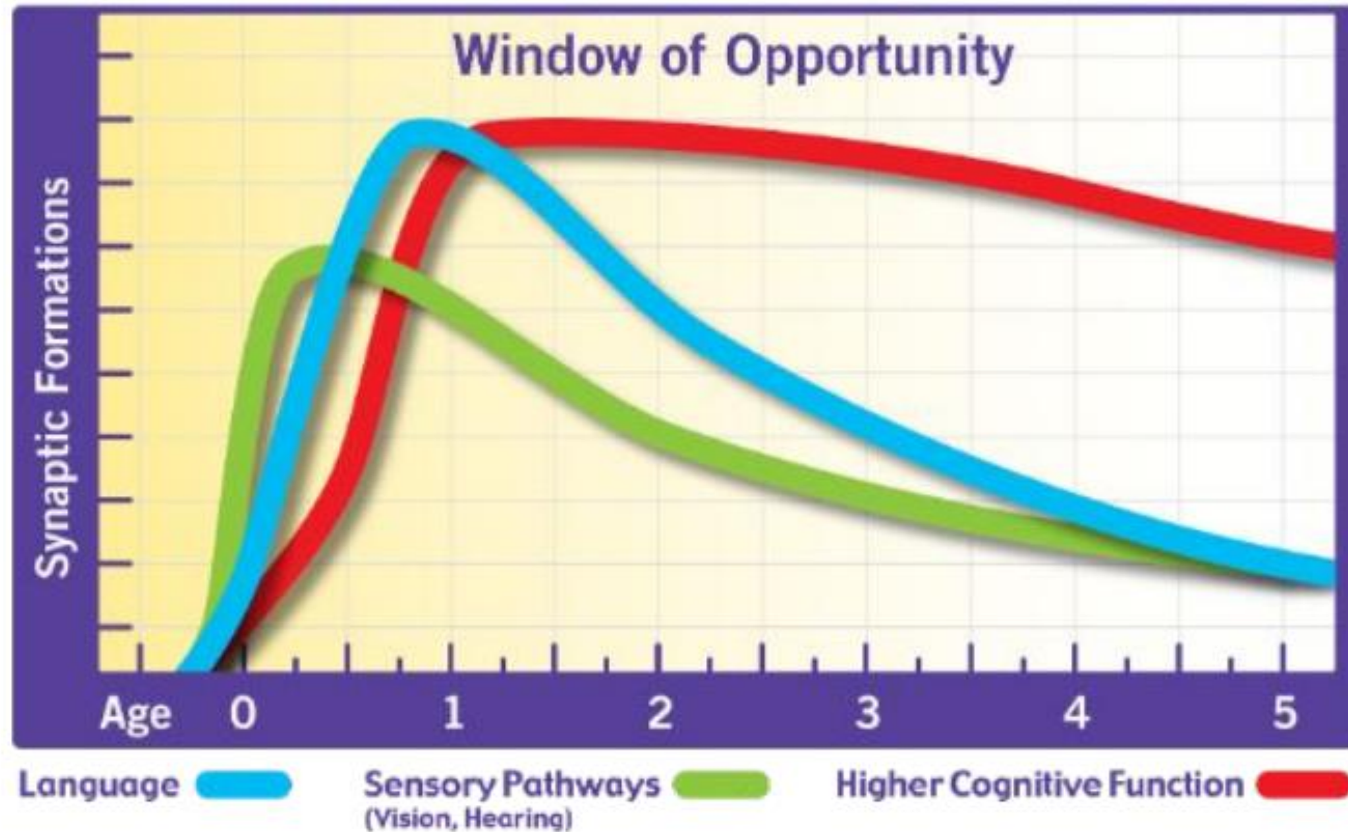
- Upstream work with young children may support behavioral health provider retention and balance in complex times

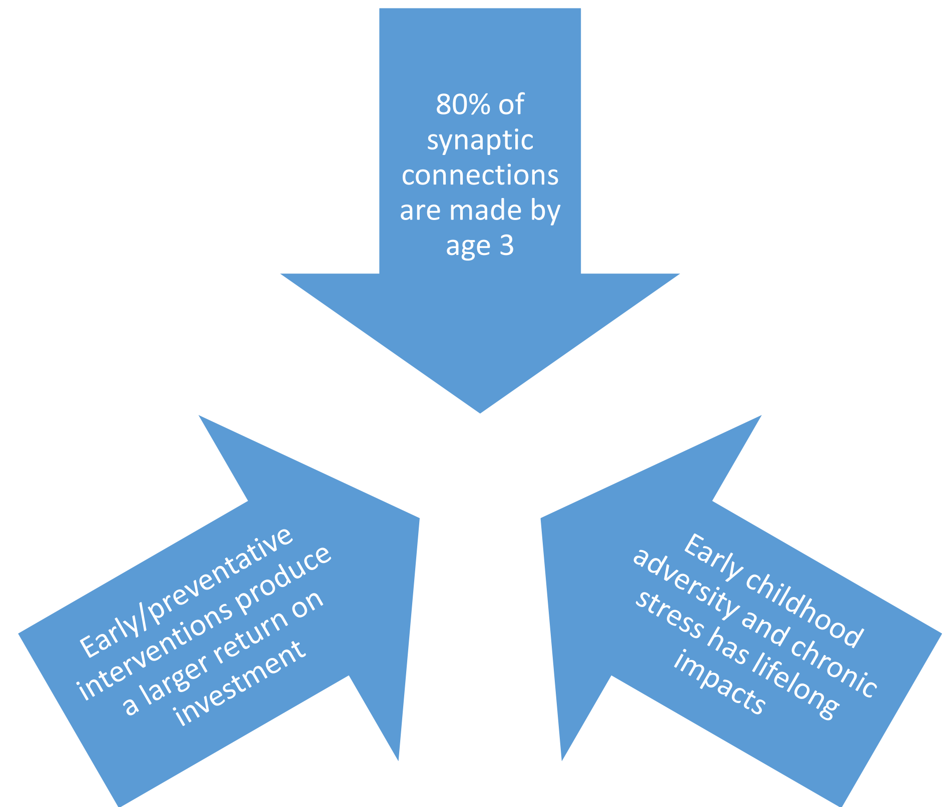
- Primary care-based solutions are cost effective relative to downstream consequences and intensive services.

We Can Make a Difference!

Addressing Issues BEFORE Crisis, While Synapses are Forming & **Families are Engaged**

OPIP Oregon Pediatric Improvement Partnership





Source: https://thescienceofearlylearning.com/tips/early-literacy-milestones-and-tips/milestone-3/brain-development-and-synaptic-formation-chart-2/

Shonkoff et al., 2012, *Pediatrics*
Racine, 2016, *The Economics of Child Development*

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THANK YOU