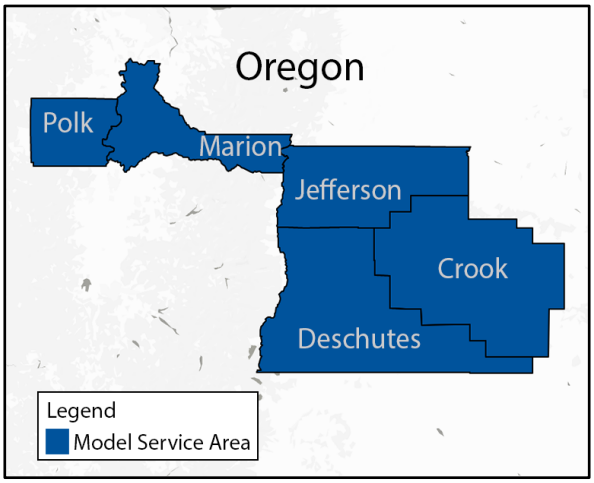
Oregon Health Authority
Integrated Care for Kids (InCK) Model
Oregon

State Medicaid/CHIP Agency: Oregon Health Authority (OHA) (Award Recipient)

Lead Organization: Oregon Pediatric Improvement Partnership (OPIP) based in the Department of Pediatrics at Oregon Health & Science University (OHSU)

Maximum Award Amount Over 7 Years: $15,460,593

Model Goals: Oregon InCK is led by OHA and OPIP, a public/private partnership and collaboration of stakeholders dedicated to building health and improving outcomes for children and youth. The OR InCK model will employ a regional and population-based improvement effort conducted in partnership with local core child services, providers, and region-specific Coordinated Care Organizations (CCOs). This will expand on existing efforts to promote coordinated and integrated care, patient-centered primary care homes (PCPCHs), and investments in Health Information and Community Information Exchange (HIE/CIE). With novel alternative payment models (APMs), Oregon will leverage and enhance the existing health complexity methodology to target children with the greatest health complexity.



Model Service Area & Population

Target population: ~88,235 Medicaid and CHIP beneficiaries from birth to age 21 in the Central Oregon Region (Jefferson, Deschutes, & Crook counties) and the more densely populated Willamette Valley Region (Polk & Marion County).

Highlights: Oregon's InCK model utilizes health complexity data, enhancements in social determinants of health screenings, care coordination and management services, including referrals, follow-ups, care provision, and HIE/CIE enhancements.

Implementation Strategy: The OR InCK approach to service integration is built on leveraging system-level data and the existing roles and responsibilities of CCOs and PCPCH and specialty providers to coordinate care and integrate services, with the support of a regional Service Integration Coordinator, partnerships with local core child service providers and funding through an APM. APMs will incentivize and support infrastructure for care coordination by providers that serve InCK attributed children who access multiple core child services. Early identification and risk stratification for the entire attributed population will rely on:

- Training and supports on access, prevention and screening of housing and food instability;
- Population-level risk stratification utilizing the child-level health complexity data based on indicators of medical complexity (including multiple hospitalizations and prolonged hospitalizations) and indicators of social complexity that account for: child or parent mental health, substance abuse, poverty; foster care; imminent risk for out-of-home placement; parent death, incarceration, or disability; child abuse and neglect, and limited English proficiency
- Region-specific Service Integration Coordinators who will support critical system navigation for the core child service providers and will facilitate enhanced data tracking and integration.

Alternative Payment Model: OR InCK includes three APMs that build on the CCO infrastructure and align with existing APMs and plans for future models: 1) Per member/per month (PMPM) payments to support PCPCHs in delivering screening and coordinated care for attributed children; 2) a combination of fee-for-service and prospective care management PMPM payments for children with medical complexity (includes retrospective shared savings based on total cost of care); and 3) case rates for parent/caregiver-child dyadic therapy and supports.

Community Partners: Oregon's partners include two regional Partnership Councils and the local core child services providers including CCO leaders, public health, educational service districts, local community action agencies Early Learning Hubs, and parent advocacy groups.

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