**DRAFT ONLY! Not Final. 1/10/2023. For discussion purposes only.**

# Key Recent Recommendations and Culture of YES, LC 0130

| Recommendation and Recommendation Source | Addressed by Culture of YES, LC 0130 | **Explanation** |
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| **Recommendations of Special Master, December 2023** | | *Dr. Marty Beyer was appointed by Federal Court Justice, Michael McShane, to make recommendations related to temporary lodging of children in the child welfare system* |
| 1. Guarantee of Placement Stability.<br>Set up an automatic alarm for child's impending 3rd placement that triggers interagency response. | No. | Although LC 130 does not create this alarm system, it will increase the funded options available to stabilize the current placement or develop a more stable alternative placement |
| 2. Universal intensive in-home child specific support for resource parents and kin caregivers beginning at placement.<br>Ensure full compensation for resource families and provide child-specific wraparound supports.<br>Achieve national target for permanency timeline. | Partially | LC 130 will address this in a couple of ways:<br>• Operationalization of K Plan services for eligible kids with mental health related needs will allow reimbursement for services and supplies needed to stabilize placements. These include, for example:<br>○ 1:1 attendant care available in a resource home or a family home<br>○ Home modifications to improve safety.<br>○ Training, including conferences and meetings, to support caregivers.<br>○ Paid respite to allow caregivers and youth to have a break without disrupting the placement. |

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| | | ○ Supplies such as incontinence supplies to address challenging issues that impact hygiene and comfort in the home.<br>○ Paid behavior support services, including evaluation and training.<br>• Because these services are tied to the child's need for home and community-based services to remain in the community, the child or youth will not lose eligibility because a placement changes from substitute care/resource care to a guardianship, adoption or reunification with family.<br>• As an alternative to 1:1 services coming into the home in the way we think of K Plan services today, smaller placement settings for 1 or 2 kids could be developed as a funded, specialized resource home model for high need kids. This would allow appropriate compensation for specialized, therapeutic foster care services (like DD system) |
| 3. Therapeutic homes with child specific in-home support throughout the state<br>Prioritize therapeutic kin homes with staff support and child-specific resources in every county. Leverage flexibility in Medicaid reimbursement. | Yes | • By opening door to Home and Community Based Services through the K Plan, we can leverage the highest possible Medicaid match to create funding models for child specific therapeutic homes. |
| 4. 1- and 2-child staffed homes throughout the state | Yes | • See the prior two bullets. Existing Home and Community Based service options can be used to create these child specific placement opportunities for kids at this highest level of need. |

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| Remove barriers to allow small 24-hour staffed homes to be operated for children who cannot be in group care. | | This will provide the same funding authorities and flexibilities available in the DD system to kids with high needs related to emotional disturbance, addiction, psychiatric issues and medical complexity |
| 5. Trauma treatment to fit every child/youth.<br>Invest in the mental health professional pipeline, offer competitive reimbursements, and remove systemic barriers for billing Medicaid | Partially | This proposal doesn't change provider rates. However, it creates a mechanism for kids in need of psychiatric and other mental health services to move to a fee for service model for services not available through their CCO. This has the potential of expanding access to psychiatric and other services by increasing the reimbursement rates available to providers serving Medicaid eligible kids.<br><br>This also will create more flexibility and more accountability for implementation of the existing EPSDT mandate by creating a rapid path to evaluations, treatment and continuity of care that allows kids to leap over barriers created by contracts, panels and preauthorization reviews |
| 6. Meeting child/youth needs due to delayed development.<br>Remove silos between mental health and DD systems. Leverage EPSDT through Medicaid to connect children with services. Enlarge in-school services and reimburse therapists. | Yes | • Clearly prohibits exclusion from services based on a co-occurring diagnosis and mandates that kids with dual diagnosis have access to the full range of services available in each service system for which they are eligible.<br>• Expands the number of kids eligible for Medicaid to create increased opportunity for Medicaid billing through schools. This will reimbursement at 100% for medically necessary services at school for things like nursing, personal care, certain behavior supports and interventions, PT, OT, Speech, equipment certain evaluations and assessments including behavioral assessments, some administrative fees and even transportation.<br>• Sets the stage to pursue needed investment, infrastructure and policy changes to support every district in the state to take full |

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| | | advantage of Medicaid funding for medically necessary services provided at school |
| 7. A developmentally-sound and trauma-responsive approach to substance use<br>Remove barriers to allow integration of trauma recovery and substance use treatment. Provide training to therapists and staff. | Partially | By providing clear support for rapid implementation of the EPSDT mandate, kids will be able to receive SUD treatment even while they also receive mental health treatment. They cannot be denied one service due to eligibility for another.<br><br>In addition, through the eligibility expansion with the waiver, more kids will be able to access these services before disrupting from home. Others will benefit from the upstream prevention that comes from early identification and treatment for mental health needs, reducing the number of kids turning to substances to address untreated mental health needs |
| 8. Supported transition to lasting homes.<br>Ensure continuity of services when children change placements, allowing for overlap. | Yes | This ties funding mechanisms to the child based on the child's needs-not based on the placement. Services and supports will follow kids from family home, to resource home to, to group home and to inpatient services. It will also provide continuity of services when kids move across CCOs or when they step down from higher levels of service or are reunified with their families. |
| 9. Supported independent living.<br>Remove barriers in housing, vocational education, and contracting for independent living. Require teaching of independent living skills in staffed homes and group care | No | This is not explicitly addressed. However, the waiver does require training in self advocacy for kids and for their families. Connection to services through our new 1115 waiver also means many of these kids will be eligible for ongoing, funded support related to housing and services as they transition to adulthood.<br><br>This will also provide youth access to funded job development and supported employment to help make the transition to adulthood |

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| 10. Right-sizing residential capacity<br>Conduct an interagency assessment of residential bed capacity. Work toward a statewide bed tracking and matching system. | No | This is not explicitly addressed. However, by providing robust home and community-based services to kids it will reduce the demand for residential beds. We've seen the success of this in the ID/DD system. Despite being identified as having among the highest needs, kids with ID/DD have a much lower rate of out of home placement, including placement in hospitals and nursing homes, due to the robust system of home and community-based services. We also have no institutions for adults with ID/DD because these services follow individuals into adulthood. With LC 130, we will create the same stability and support for individuals with significant medical or psychiatric/mental health needs |
| 10 sub 1. A new contract model for providers, adequately funded.<br>Do away with fee-for-service contracting and transition toward capacity-based contracts for providers | No | Not explicitly addressed. However, this is an important recommendation. In looking at the history of residential bed capacity, we can see that the crisis did not start with the enforcement of licensing regulations. Instead, it started when we changed from capacity-based contracts to fee for service contracts which makes it impossible for providers to hold capacity, maintain workforce and have available a variety of available service slots to ensure the right kids get the right placement at the right time. Fee for service arrangements means less stability in capacity and a crisis mentality that pushes kids into any available bed |
| 10 sub-2. Addressing the fear of unwarranted allegations<br>Reduce staff fear of unwarranted abuse allegations by shifting away from restraint and toward proven behavior response techniques. | Partially | This will provide funding for child specific evaluations and behavior support plans, including training for staff. It will also help fund trauma responsive services that allow kids to feel safe before their fear leads to challenging behaviors. |

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| 11. New approaches to managing flexible individual support.<br>Pursue innovative approaches to deploying individual support staff. Professionalize the role and develop postsecondary education programs. | Yes | LC 130 does this by opening the pathway to existing funding authority to pay for 1:1 in home support and attendant care services for kids with high needs in any non-institutional setting--- family home, family foster care, resource homes, host homes, specialized home and community-based settings, etc. |
| 12. Conduct monthly branch level interagency meetings for children with multiple placements.<br>Identify at least one child per month who is at risk of losing a placement without another lined up. Start prevention efforts early | Partially | This does not set this requirement for child welfare, but it does lay out a path towards developing collaboration between agencies for multi-system involved kids. |
| 13. Create transition homes for children who cannot be prevented from emergency placement.<br>Create an appropriate alternative to temporary lodging with adequate staffing in three largest counties. Collaborate with existing providers to build capacity and recruit staff. | No | It is unclear whether there would be HCBS funding available for this. In the interim we should explore how such homes can be structured to maximize Medicaid funds. |

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| 14. A developmentally-sound and trauma-responsive approach to teen choices<br>Train staff in respecting teens' preferences for placement while not enabling self-destructive choices by discussing pros and cons with them. | Partially | The waiver services would include self-advocacy training just as it does in the ID/DD system. It also would bring with it the HCBS settings rules which ensure age-appropriate choice for all individuals receiving services. |
| 15. Interagency services to stop juvenile department and hospital emergency department referrals to temporary lodging.<br>Leverage Medicaid to promote the use of DBT among therapists for self-harming teenagers before they reach hospitals.<br>Provide earlier intervention for families in crisis and intensive supports for youth known to juvenile departments and hospitals.<br>Expand the role of State System of Care to lead interagency services for at- | Yes | Kids who are in these situations are very likely to meet the institutional level of care. This, in combination with the mandate for rapid access to Medicaid covered assessments and services most critical to preventing disrupted placement, will allow for funded supports to follow a youth leaving detention, an ER or a residential program. It will also allow those supports to be provided before the child goes to the ER. Currently, too many families are advised that the only way to get services is to take their kids to the ER and leave them there OR to report their kids to law enforcement for disability related behaviors so that they can be charged and enter the juvenile justice system. Neither of these options are appropriate, safe or humane. LC 130 offers a different path that will no longer require the path to critical services to run through an ER or juvenile justice program. |

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| risk youth and their families. | | |
| **Recommendations of OHA Ombuds** | | |
| Require statewide networks. OHA should implement OHP policies requiring a statewide network for both inpatient and outpatient mental health services by requiring coordinated care organizations (CCOs) and OHA fee-for-service (FFS) programs to contract with all willing outpatient and residential behavioral health providers for children and adults in the state | Partially | This does not go as far as creating a statewide network. However, it is drafted to allow this to occur and creates alternative mechanisms that allow for the most critical services related to mental health for youth to be provided immediately as required by EPSDT without delays caused by preauthorization, pre service review or panel/contract restraints. This potentially could help with psychiatrist and other mental health provider availability by making available the higher FFS reimbursement rate. With most Oregon youth under the age of 25 on OHP, lower rates through CCOs compared to the relatively robust OHP FFS reimbursement rate means Oregon is not seeing the benefit of the investment/approval of higher rates. This means we have among the highest approved Medicaid reimbursement rates in the nation for MH, but this is no passed through to providers. As a result, we have among the lowest access to mental health providers. (Please see "Medicaid Reimbursement For Psychiatric Services: Comparisons Across States And With Medicare," April 2023.) |
| Prioritize funding of community-based children's mental health services | Yes | This is the entire basis of this proposal, and it unlocks existing funding authority to allow more kids to access home and community-based services that prevent crisis and institutional placement |
| Prioritize development and implementation of culturally specific services. Eliminate the racial and linguistic disparities in accessing mental health services, follow-ups from | Partially | Attendant care services and training accessed through the waiver and K Plan option are require by this proposed measure to be low barrier and allow self-direction. This means that youth and families can recruit attendant care and other non-clinical providers from among their communities and among people they trust. Empowering youth and families with the authority to select their providers and service design |

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| emergency departments (EDs), and overrepresentation of youth of color in ED boarding | | (as in the ID/DD system) means that there are more opportunities to bring new people into the system that reflect the culture, language and values of the individuals accessing services. |
| Strengthen peer workforce within children's mental health | Yes | The waiver will provide access to training, self-advocacy and support. The requirements for low barrier entry to the workforce and self-direction in recruitment means there will be more paths and opportunities for funded peer support services. |
| Create pathways for expedited access to outpatient mental health services for youth accessing Mobile Response and Stabilization Services (MRSS) | Yes | Mobile Response and Stabilization Services are an entitlement to Medicaid eligible children and youth under our new EPSDT requirements. Expanding Medicaid eligibility through the parental income disregard for kids at risk of institutional placement will unlock funding for a broader population of children and eliminate concerns about who will pay the bill. This will lead to faster service and increased capacity due to this certainty related to payment. It also means these services will be funded for kids who currently must first go through an emergency room or juvenile justice to access Medicaid eligibility. |
| Fully implement Intensive In-Home Behavioral Treatment Services (IIBHT) within all CCOs and OHA's FFS program | Yes | Expanding Medicaid eligibility through the parental income disregard for kids at risk of institutional placement will unlock funding for a broader population of children and eliminate concerns about who will pay the bill. This will lead to faster service and increased capacity due to this certainty related to payment. It also means these services will be funded for kids who currently must first go through an emergency room or juvenile justice to access Medicaid eligibility. IIBHT is an entitlement under EPSDT for kids for whom this service is medically appropriate. Better communication and enforcement of this entitlement will come through the work related to implementation of SB 130. |

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| Fund and implement mental health respite care for the entire lifespan | Yes | This unlocks the door to funded respite for kids with high acuity behavioral health needs and their families or resource families. This will allow support, rejuvenation and stability to allow families to remain together and to prevent burnout among resource providers. |
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| Recommendations from Report on Barriers to Mental Health Care for Individuals with ID/DD (2022) | | This was a report generated following a budget note SB 5529 (2021) directing OHA and ODDS to look at barriers experienced by individuals with ID/DD seeking access to mental health services |
| Immediately issue a specific policy from ODHS and OHA, and improve enforcement of existing policies, to prevent discrimination in all treatment provider systems to ensure full inclusion of individuals with IDD... | Yes | This provision is explicitly included in LC 130 |
| Work to develop stronger communication pathways between APD, ODDS, OHA, and Community Mental Health Programs. | Yes | LC 130 directs the agencies to collaborate across systems to ensure that all of children's assessed needs are met with limited duplication. There is enhanced match available to support this under Medicaid. The measure directs that this work be done, but leaves flexibility to the agencies to better develop the most appropriate structure in rule. |
| Develop processes and procedures to ensure mental health services are delivered in a person-centered manner and are culturally and linguistically appropriate, including appropriate accommodations, | Yes | Unlocking the door to existing K Plan services for kids who are entitled by virtue of their needs and Medicaid eligibility will allow this to occur. The bill lays out the foundational values for this system that include self-direction and flexibility in accessing in home (including in resource home) support services as well as goods and supplies needed to support kids and families to be successful. |

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| interpreter services, and Activities of Daily Living supports, and provided where individuals are comfortable in receiving the services. | | |
| Support existing efforts to address the ongoing workforce shortage | No | This is not a bill that addresses workforce. However, it does unlock the door to more funding and creates more flexible pathways for a non-clinical workforce to be funded to provide critical home and community-based supports. |
| Develop methods to coordinate services for people with complex needs and facilitate local dialogue on coordination and integration. | Yes | This bill does speak to the importance of developing a cross system, child and family centered coordination process. However, it recognizes this is best developed by those directly involved (especially kids and families) which is why the details of the structure will be worked out by interested parties and established via rule rather than statute. |
| With community partners, explore strategies to coordinate different Medicaid authorities to ensure all individuals receive appropriate services and support through a person-centered plan that meets all their needs, and present those strategies for consideration by the legislature in 2023. | Yes | This bill is essentially a blueprint for leveraging all available Medicaid authorities for each eligible child and youth. The combination of expanded eligibility, intentional operationalization of our existing K Plan entitlements for kids and clear statutory prohibition on denying access to mental health services to kids and youth with ID/DD to receive services will create more flexible, comprehensive and integrated services to these kids and families to prevent crisis. |
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| Recommendations from NAMI Residential Care Report (Selected recommendations) | | *This report was developed by NAMI of Multnomah County based on interviews of children, youth and families who experienced residential* |

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| | | *care to meet their disability related needs. This is a population of children and families that would be covered by LC 0130.* |
| Follow IDD model for mental/behavioral health issues. | Yes | This bill expands what the community refers to as "K Plan" services to kids with complex mental and behavioral health needs. It is important to note that this is already an entitlement for Medicaid eligible kids and has been since 2014. It's also important to note that when these services are provided under the state Medicaid Plan there is an enhanced federal match. |
| Families should be able to gain access to support prior to crisis point (suicidal ideation, self-harm, harm or threat to others). | Yes | This bill uses existing funding authorities to provide home and community-based services to kids and youth before they enter crisis. The purpose of home and community services is to prevent institutional placement. |
| Create multiple paths to access services. | Yes | Yes. This will allow kids with complex needs to access a variety of services from different service systems. For instance, by prohibiting denial of access to mental health services because of an intellectual disability, a youth's attendant care services or other K Plan services can be approved to serve BOTH mental health AND ID/DD related needs. It also creates an intentional pathway towards leveraging federal funds to improve access to supports at school which can reduce trauma, improve graduation rates and most importantly provide meaningful support for the services needed for kids to successfully be at school all day. |
| Better crisis response that comes to the home without police involvement. | Yes | Yes. This will allow kids to access services without having to first go through the juvenile justice system, an ER or an out of home placement. |
| Provide meaningful support for exhausted parents so they can support their youth. | Yes | Yes. This clarifies access to funded overnight mental health respite care to allow kids and families to have a break from each other without permanent out of home placement or utilization of the hospital ER. It |

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| | | also provides ongoing support through waiver provider family training and support (which should include siblings and other household members) and through funded 1:1 in home supports that meet the assessed needs of the child to succeed at home. |
| Listen to and respect parents, and center their concerns from the start of intake. Take their experience and knowledge of the youth's history seriously and integrate this from the beginning of treatment. | Yes | Yes. Although the specifics of program design will be put together in statute, the bill does lay the foundational values for a child and family centered array of services and that allows low barrier, self-directed access to the services, supports, goods and supplies that best meet the needs identified by kids, youth and their family. |
| A child should never be discharged without a viable safety plan. | Partially | This bill does not create safety plans. However, it does create mechanisms for funding established safety plans that are necessary to prevent the child's return to an institutional setting. |
| Close gaps in service between residential treatment and next steps: warm handoffs prior to discharge to avoid lapse in care, particularly psychiatric care. | Partially | This bill ensures that services don't end when a child goes home. Children and youth will have access to the same robust set of medically necessary support services that are available to kids in residential placements and creates a funding mechanism for in home supports when a child returns home to maintain that placement. In addition, because of the proactive approach of the Culture of Yes, more kids and families should be able to access services before they are separated by a residential placement.<br><br>Finally, the provisions about immediate access to critical services to prevent institutional placement and to maintain continuity of care will help kids maintain access to psychiatrists, counselors, therapists, prescribers and medications, services and supplies that are successfully supporting them. This bill emphasizes the EPSDT mandate that these |

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| | | services are not disrupted or delayed due to preauthorization, panel or contract requirements. |
| Immediate and continuous support for family and youth after discharge | Yes | Yes. This creates the foundation and operationalizes existing funding authority to provide step down services consistent with the child's assessed need when the child returns to a home and community-based placement (family home, foster home, etc.) after an institutional or otherwise more restrictive placement. |
| Ask about family's and youth's culture, identities, and cultural needs. Find out what would make youth feel more nurtured, taking cultural considerations into account. | Yes | The broad values established in this bill, and the authority to self-select support services and move beyond the providers in a CCO panel, creates more flexibility to access child and family specific supports and services identified by youth and their families. |
| Kids need a voice in treatment at every stage. Ask them: "If this isn't working for you, what will work for you?" For African American kids, this is very seldom asked. | Yes | Again, this is embedded in the values outlined in this measure consistent with the implementation of HCBS services in the ID/DD system. This will also create an incentive to create more service rich HCBS service options (such as host homes and 24-hour comprehensive residential care in ODDS) that will be required to meet the person centered HCBS settings rules that maximize independence and self-determination. These settings will receive enhanced match which means our state general funds will go further while providing more individualized and self-directed services. |
| Provide family peer support with lived experience who know how to navigate systems alongside families. | Yes | Yes. The waiver includes training and self-advocacy development for individuals receiving services. |
| Treat families as allies and collaborate with them in all aspects of care – treatment | Yes | This creates a framework that affirms the ability of families or resource homes to successfully support kids with complex needs in noninstitutional settings. This means recognizing that kids are part of |

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| planning, service delivery, discharge planning. | | families and the services are designed to support all who are impacted by these needs in order to prevent institutional placement. |
| Acknowledge parents/families as equal partners in the treatment process. Consider parents as an integral part of the team. | Yes | This creates a framework that affirms the ability of families or resource homes to successfully support kids with complex needs in noninstitutional settings. This means recognizing that kids are part of families and the services are designed to support all who are impacted by these needs to prevent institutional placement. |
| Make more information and education available for families. Explain and help them understand treatment (particularly related to medication), and help them understand needs and make decisions regarding their children's care. | Yes | The waiver includes access to funded training for parents. |
| Expand crisis-based programs like the Crisis and Transition Services (CATS) program to meet needs statewide and support youth and families by preventing long-term residential treatments. | Yes | The expansion of Medicaid eligibility through the parental income disregard will make these services available to kids who need them, and will hopefully prevent the need for the services through more proactive provision of supports and services to eligible children.<br><br>Once the children are Medicaid eligible, the EPSDT mandate to provide ALL medically necessary services without delay applies. This means that the clinically based services these kids need will be covered even after their commercial insurance limits. |
| Educate youth on their own mental health diagnoses, potential needs, means to self-care, and medication. Motivate | Yes | The waiver includes self-advocacy and training for youth. This is critical to preparing kids and youth to learn early on how to manage their mental illness and succeed in the community. This will benefit these youth not just now, but in the future which should reduce crisis, |

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| youth to continue supporting their own mental health (via positive supports and resources). Support youth in connecting to culturally responsive services and peer/family support in their communities. | | homelessness and justice involvement as adults. It will also ease the transition to adulthood as the service array will already be established to support the young person to succeed. |
| Make resources accessible to youth and families across mental health and DDS. Educate case managers to be a liaison across multiple services for families. DDS works much better than mental health care for youth and families. Make mental health care services work as well as DDS | Yes | This measure does this, as described elsewhere in this document, by ensuring the disability related needs of kids with mental health related disabilities are met with a similar set of services and supports as those provided to those in the ID/DD system. Again, this is not a new service but the operationalization of an entitlement that has been in place since 2014 for these kids. |
| Improve community mental health supports and access to same for BIPOC youth in an effort to avoid the trauma of residential services, if possible. Act before the point of crisis. | Yes | This measure is all about connecting kids to home and community-based services to avoid crisis, disruption and institutional placement. The parental income disregard will ensure that kids aren't forced into crisis and residential care because their commercial insurance doesn't cover community-based alternatives. |
| Create a new system to facilitate communication between mental health and DDS services. | Partially | This measure directs the agencies to develop a process to collaborate on meeting all the assessed needs of eligible kids with minimal duplication and with as few steps as possible for families. However, it allows the specific structure to be developed in the interim, in consultation with all impacted people, through rule. |

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| Model mental health systems after intellectual/developmental disabilities support system to facilitate successful discharge with reduced need for return to residential services. Trained and county-funded PSWs. Respite. Similar supports for individuals and caregivers requiring mental health services. | Yes | These are the values that underly The Culture of Yes. LC 0130 ends inequities that allow children with certain disabilities to access services before they go into crisis but denies that same effective strategy to others. LC 0130 will end this practice of creating populations of "haves" and "have nots" among kids with disabilities in our communities, reduce incentives to force systems to serve kids they are not designed to support, reduce the number of inappropriate assessments kids are subjected to in an effort to access funding authority and reduce the level of conflict and confusion among agencies about who is responsible to meet a child's assessed needs. These problems will be addressed through this new system that says YES to providing services and supports to meet the assessed needs of ALL kids at risk of institutional placement regardless of where they live, who they live with, the nature of their disability or whether they have commercial insurance. This is the Culture of Yes. |