2019 Joint Plan to Develop In-State Capacity and Minimize Out-of-state Placements of Children

SB 171 Legislative Report to the Interim Committees of the Legislative Assembly Relating to Children

Oregon Health Authority

DHS Oregon Department of Human Services

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Executive summary

The placement of Oregon children and youth in out-of-state treatment programs peaked in the spring of 2019. While it is not the desire of the DHS Child Welfare Program to place youth in other states, systemic issues have driven an increase in the use of these programs for intensive behavioral health services and other therapeutic supports that children and youth need. These issues include the reduction of Oregon treatment capacity, compounded by an increase in the complexity of child and youth individual needs.

The increase in the use of out-of-state placements has caused the Department of Human Services (DHS), the Oregon Health Authority (OHA), the Legislature and the Governor's Office, as well as child advocates, stakeholders and partners to examine the needs of this population and how they can be served in Oregon.

The programs utilized in other states for the care of children and youth involved with Child Welfare provide specific residential services such as;

- Psychiatric Residential Treatment Services (PRTS)
- Services for youth who exhibit sexually harmful behavior
- Services for survivors of Commercial Sexual Exploitation of Children (CSEC); and
- Behavioral support for aggression and safety risks related to elopement/runaway, suicidal ideation and self-harm

Progress

Ensuring Safety and Well-being

As the need for programs outside of the state peaked, DHS launched an effort to "Serve Youth in Oregon" in the spring of 2019. Initially, the effort focused on addressing internal and external concerns and gaps regarding the oversight and regulatory policies surrounding out-of-state placements. DHS in partnership with OHA are focused on facility safety, oversight of out-of-state contracted entities, the care for and contact with Oregon children and ensuring youth were placed in appropriate levels of care. Projects and completed work include;

- ✓ Contractually requiring licensing and regulatory standards equal to those in Oregon
- ✓ Implementing formal coordinated safety and abuse response and reporting as is done for Oregon programs
- ✓ Implementing policy and procedures for regular visitation of each youth placed out-of-state
- ✓ Centralizing safety and abuse data and reporting as is done for Oregon programs
- ✓ Increasing and standardizing evaluation of current and potential programs to assess for ability to provide services in accordance with Oregon rules and statutes
- ✓ Administering Level of Care assessments for current youth served out-of-state to review appropriateness of placement and treatment planning
- ✓ Analyzing individual needs of youth placed out-of-state including factors such as race, ethnicity, gender, placement history, Child Welfare history, diagnosis and other data to

better understand the needs of youth and current gaps in Oregon's system.

New policies and procedures resulting from this work were completed and implemented in August 2019. Contract amendments to raise regulatory standards will be executed October 2019. New policies will be included in the Child Welfare procedure manual and in October 2019 will be posted on the DHS Child Welfare Treatment Services website.

Serving Youth in Oregon

DHS and OHA are committed to the immediate reduction and planful elimination of the use of out-of-state programs. During Oregon's peak use of these programs (March 2019), 88 youth were in programs in other states. As of August 30, 2019, 37 children and youth remain out-of-state with a continued decline expected as capacity in Oregon is increased and youth are prepared to transition to Oregon into lower levels of care. DHS and OHA's shared goal of working to ensure Oregon's continuum of care can meet the needs of all Oregon children, youth and families will minimize the need for utilizing programs outside of Oregon. Efforts will include building necessary Oregon capacity as well as removing barriers to in-state services, supports and placements.

Through the direction of Executive Order No. 19-03, Establishing an Oversight Board to Address the Crisis in Oregon's Child Welfare System, the Child Welfare Executive Oversight Board with assistance from the performance improvement firm Alverez & Marsal (A&M), comprehensive plans and projects are underway across DHS and OHA to ensure Oregon has a continuum of care to meet the needs of Oregon children, youth and families. The focus of these projects and work streams are:

- ✓ Evaluating care capacity
- ✓ Partnering with Coordinated Care Organizations to address service authorization, utilization management and appeals
- ✓ Evaluating Coordinated Care Organization contracting (empaneling vs. contracting on a case-by-case basis)
- ✓ Ensuring equal access for youth served by Child Welfare
- ✓ Improving communication and collaboration between Coordinated Care Organizations and DHS field offices
- ✓ Improving Care Coordination

DHS – Child Welfare will continue to develop and implement individualized plans for the transition of children and youth to Oregon. In addition, measures are in place to ensure the prevention of youth being placed out-of-state which include; exhausting all other placement options and updated procedures for approval of placement out-of-state which include final approval by the Child Welfare Director. It is expected that these collective efforts will result in a steady decline in the total number of children and youth placed outside of Oregon.

Next Steps

Through research and analysis of child and youth needs and by collecting feedback from providers and system partners, DHS and OHA have identified barriers impacting Oregon

capacity and access to care and gained an understanding of in-state service gaps. Through partnership with our providers and Coordinated Care Organizations (CCOs), we expect to see progress and improvements in access and capacity are expected. Under the Governor's Executive Order, OHA and DHS are directed to increase PRTS capacity by 15 beds in calendar year 2019 and to further assess the potential for additional capacity in 2020. Community-based services, intensive in-home behavioral health services, interdisciplinary assessment teams, therapeutic foster care and specialized residential services to meet unique needs are all within the scope of DHS and OHA capacity-building efforts with the aim of serving all Oregon children, youth and families in Oregon.

Background

During 2018 and early 2019, an increasing number of Oregon children and youth served by the Oregon Child Welfare Program were placed in treatment settings in other states. At the peak of out-of-state placements (March 2019), 88 children and youth were receiving services in other states. Internal and external concerns increased as the number of placements grew. Several factors contributed to this increase, including Child Welfare experiencing a sharp decrease in in-state therapeutic options, as evidenced by reduction in licensed residential service capacity and the needs of children and youth growing in complexity. Additionally, some out-of-state programs were proving to have success with youth completing treatment objectives and discharging to lower levels of care while maintaining periods of stability and success.

OHA's intensive treatment system and Child Welfare's foster care system capacity have declined in recent years, resulting in inadequate services and placements for youth with specialized and complex needs. Several factors have contributed to or resulted from this decline, including:

- Since 2015, Oregon's Psychiatric Residential Treatment Services (PRTS) capacity has decreased by at least 67 beds, as outlined below. This equates to a 50% decline in Oregon PRTS capacity.
    - The closure of Youth Villages PRTS in 2016 resulted in the loss of 35 beds.
    - The closure of Looking Glass PRTS resulted in the loss of 12 beds in 2016.
    - Through a program restructure, Trillium Family Services reduced the Children's Farm Home capacity by 20 beds in 2016.
- Oregon entered its foster care crisis with an estimated loss of 400 caregivers in 2016 and 2017.
- In 2014 the Intellectual/Development Disability (IDD) system discontinued its use of proctor care which reduced placements by 60 beds.
- In 2015 and 2016 there was a Behavioral Rehabilitative Services (BRS) decline of approximately 100 beds within both therapeutic foster care and residential settings.

These system-wide capacity constraints and additional barriers to behavioral health access and

care have resulted in Oregon lacking adequate placements, services and supports to meet the needs of a small group of children and youth. While this population is small in comparison to the total number of youth served by the Department, these children and youth have complex individualized needs that the current Oregon system of care is challenged to support in Oregon.

Purpose of this report

SB 171 SECTION 14 asks the Department of Human Services (DHS) and the Oregon Health Authority (OHA) to submit a joint report to the interim committees of the Legislative Assembly relating to children, summarizing the department's plan to develop appropriate in-state placements for Oregon children and wards and to minimize out of-state placements of children and wards.

This report addresses topics requested within SB 171 and provides an update on the progress DHS and OHA are making to ensure Oregon's children and youth have access to services and supports within Oregon.

DHS | OHA Joint plan to serve youth in Oregon

Programs and Services Needed to Serve Children and Youth in Oregon

Analysis of Youth Needs and System Gaps

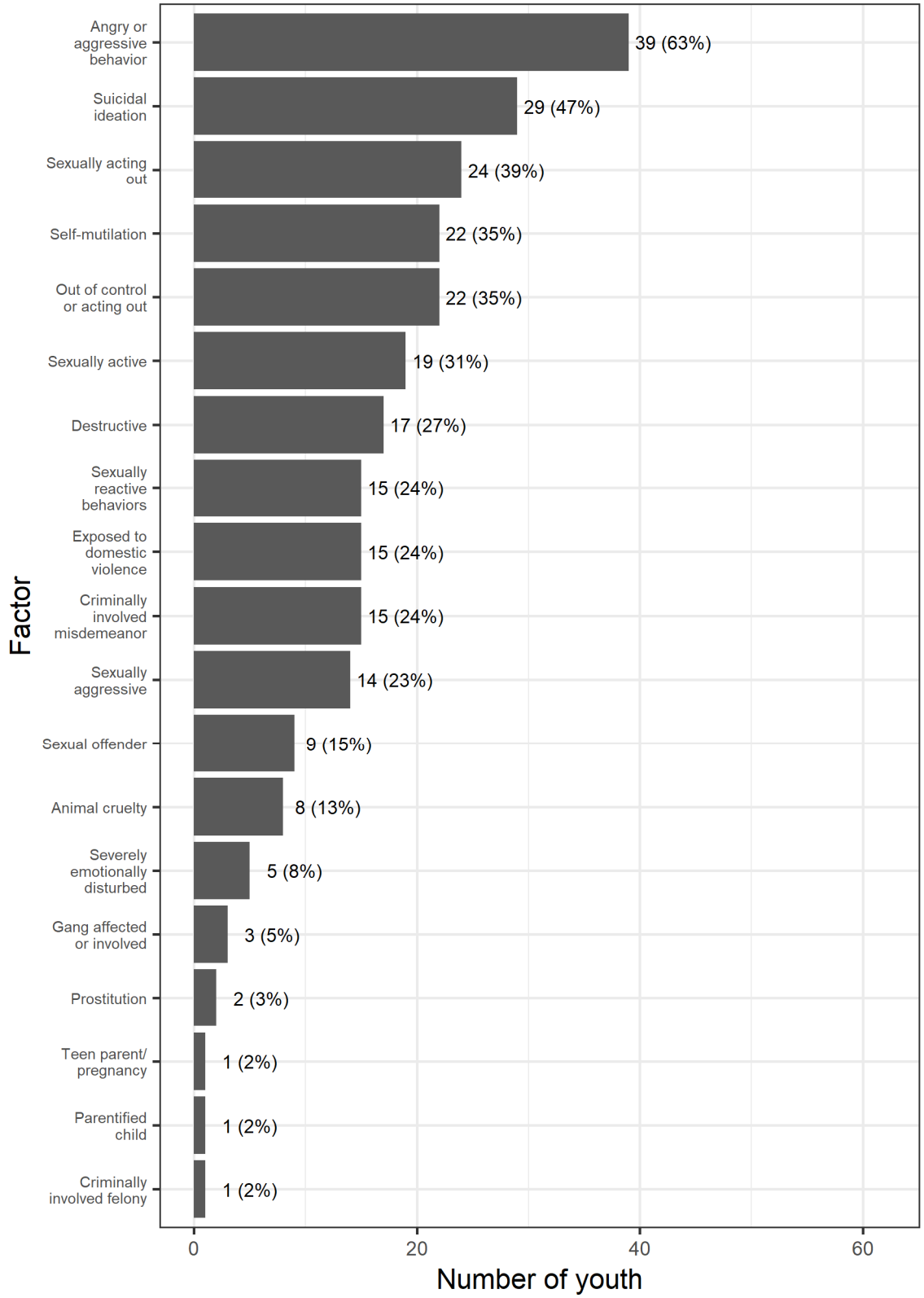
The DHS Office of Research, Reporting, Analytics and Implementation (ORRAI) is conducting research to better understand the needs of children and youth who have been placed in out-of-state programs. The research includes a review of prior placements, mental health diagnosis, reason for child welfare involvement, guardianship and/or adoptions status, race, ethnicity, gender and other relevant data points for each child in out-of-state care. This analysis is assisting the Department and its partners to better understand the presenting needs of youth and the corresponding areas of deficiency within the Oregon continuum of care that must be developed to best support the needs of children, youth and families. Further research and data analysis are underway to inform capacity-building and system improvement efforts.

A point in time analysis was conducted by the DHS ORRAI team for the 62 youth who were in out-of-state placements at the end of June 2019. The characteristics of these children, as outlined in the following bar graphs, were captured by performing case file readings for each youth. It is important to note the following regarding the data captured in the charts:

- The diagnosis that may have been recorded in the case files (OR-Kids) have not been verified with, for example, health system payment data or utilization data.
- Some of these youth may have diagnoses that were not counted here if it was missing from the case file.

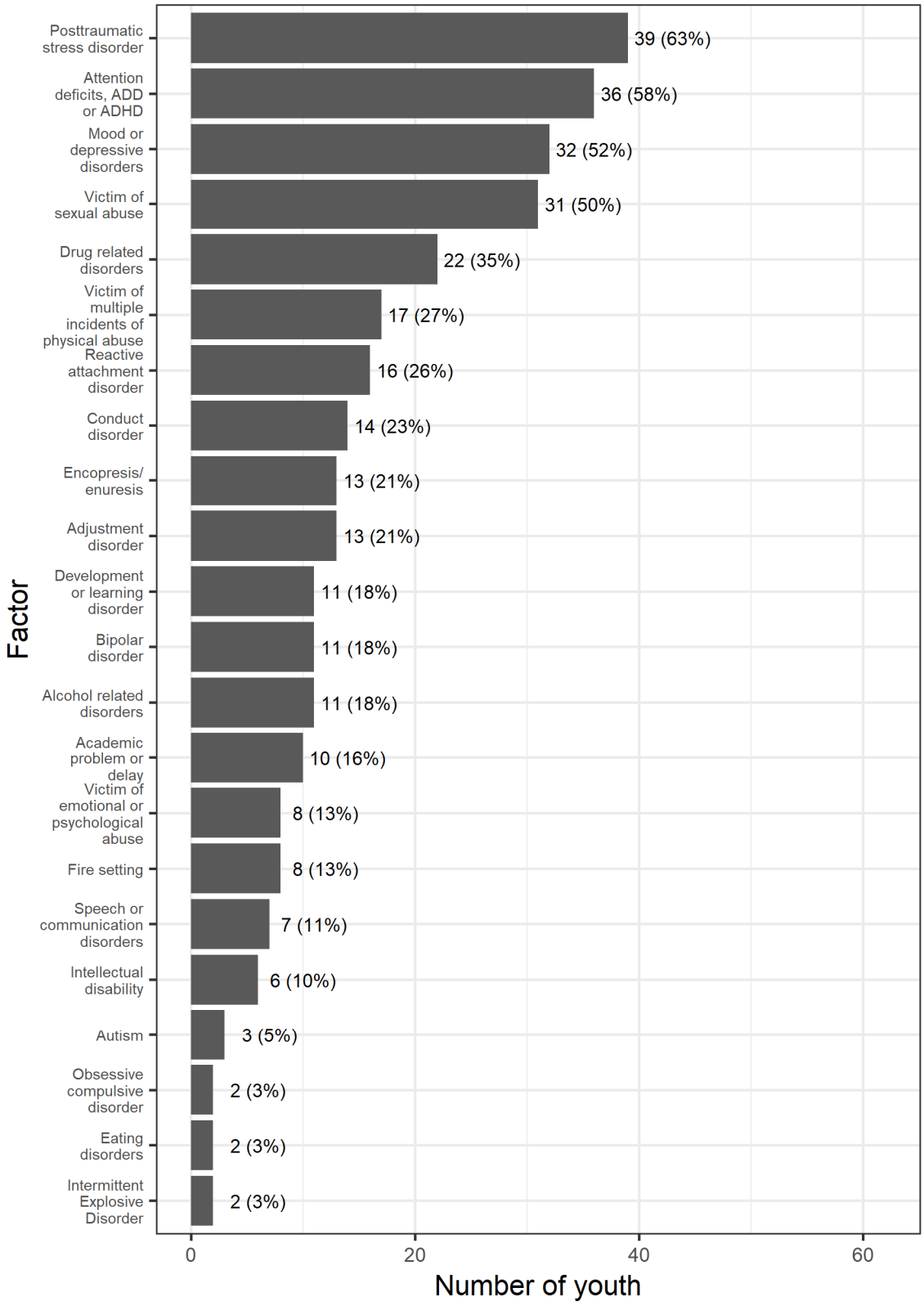
Emotional, behavioral, and mental health factors of out-of-state youth; Panel A

Factors were recorded for a youth only when documentary evidence was found within the youth's Child Welfare case history.
Based on the 62 youth in out-of-state placements at the end of June 2019.



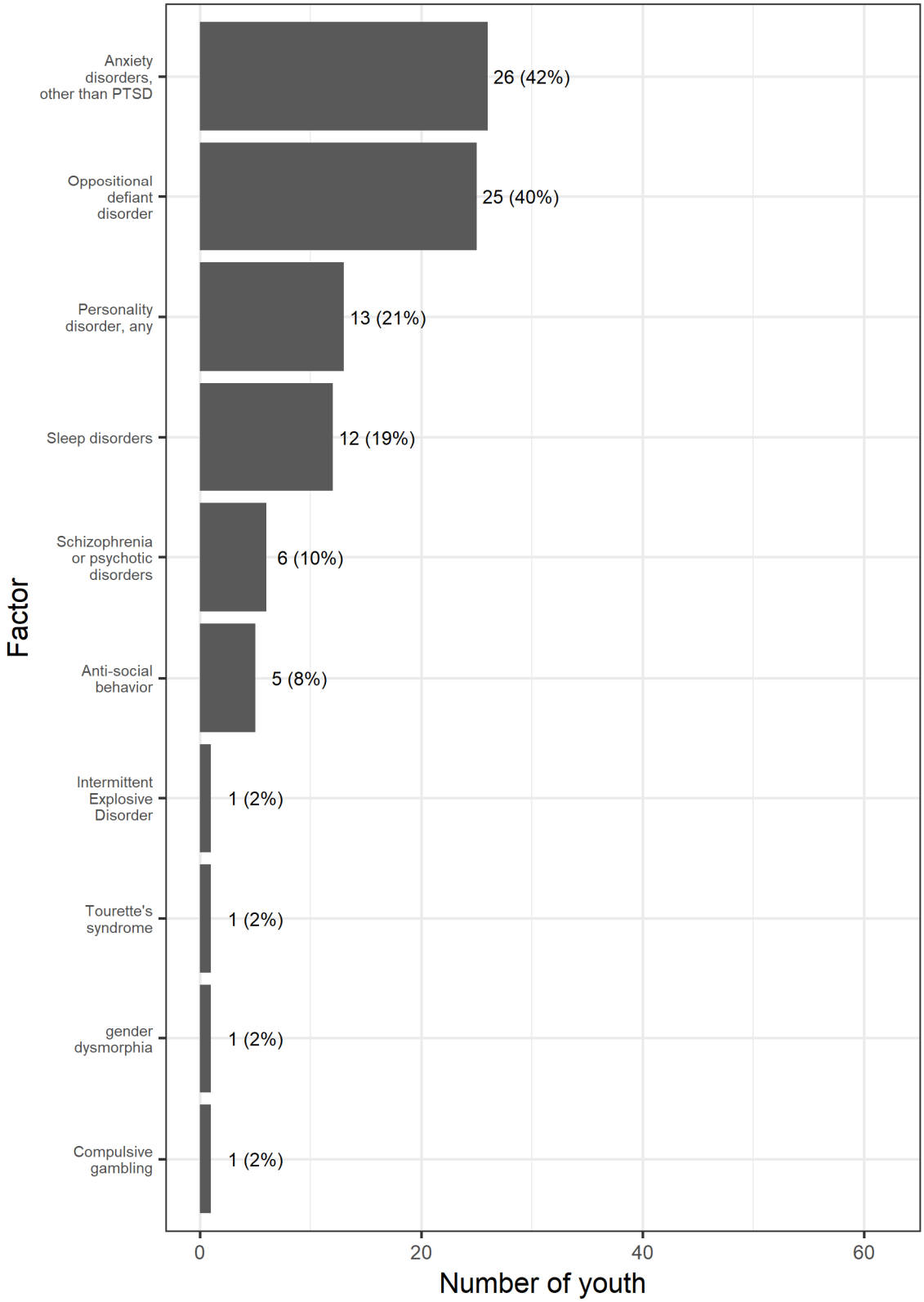
Emotional, behavioral, and mental health factors of out-of-state youth; Panel B

Factors were recorded for a youth only when documentary evidence was found within the youth's Child Welfare case history.
Based on the 62 youth in out-of-state placements at the end of June 2019.



Emotional, behavioral, and mental health factors of out-of-state youth; Panel C

Factors were recorded for a youth only when documentary evidence was found within the youth's Child Welfare case history.
Based on the 62 youth in out-of-state placements at the end of June 2019.



Capacity Needs

According to research conducted independently by DHS and OHA as well as reports from DHS stakeholders, the current capacity for Psychiatric Residential Treatment Services (PRTS) is inadequate to meet the needs of Oregon's children. Without adequate capacity, children may be wait-listed for the service, further compromising PRTS access for children in Child Welfare custody. In addition, private insurers typically pay higher PRTS rates than the negotiated Medicaid rate and children with private insurance may not present with higher acuity than children in Child Welfare custody. The combination of higher rates and potentially lower acuity may make these youth more desirable for selection from a waitlist. Children in Child Welfare custody with high needs and without an appropriate residential placement are often unable to wait for an "in-state" PRTS opening to become available due to immediate safety needs. This results in the need for placement in programs outside of Oregon.

Oregon's Children and Youth Behavioral Health Intensive Treatment Services Array includes the following services offered in a residential or facility-based setting:

Psychiatric Residential Treatment Services (PRTS)
: A treatment program directed by a psychiatrist that provides a youth with treatment under 24-hour supervision that includes skills training, medication management, and regular therapy

Subacute Psychiatric Care
: A treatment program for youth who need 24-hour intensive mental health services and supports provided in a secure setting to assess, evaluate, stabilize, or resolve the symptoms of an acute episode that occurred as the result of a diagnosed mental health condition

Secure Children's Inpatient Program (SCIP) and Secure Adolescent Inpatient Program (SAIP)
: A highly intensive treatment program in a secure setting for children and adolescents to treat ongoing psychiatric needs which are not responding to treatment at lower levels of care. This level of care provides treatment, 24-hour supervision and nursing care, and is directed by a psychiatrist. This represents the highest level of care in Oregon

The research conducted in 2019 by DHS ORRAI provided Child Welfare capacity recommendations for each level of care across the continuum of services for youth in the Child Welfare system. The recommendations by bed count and level of care are represented on the next page.

https://www.oregon.gov/DHS/ORRAI/Pages/Projects.aspx

Additional Child Welfare Capacity Needs for Matching Services and Ensuring Access

LEVEL OF INTENSITY	PLACEMENT TYPE	CURRENT CAPACITY COUNT	AVERAGE LENGTH OF STAY *(in days)*[2]	ADDITIONAL CAPACITY NEEDED *w/buffer*
3 - 6	**ALL Family Foster Care** *(relative, general, tribal)*	7,215	441	1,553
7	**Medical Foster Care**	24	441	8
7 - 8	**DD Foster Care** *(includes enhanced)*	388*	506	124
9	**DD Residential/Group Home**	30*	506	46
11 - 17	**BRS Residential/Behavioral** *(all types)*	496	424	65
18	**Stabilization and Crisis Unit** (SACU)	15*	--	*community shared*
18	**Psychiatric Residential (PRTS)** – *ages 6-11*	45*	217	21
18	**Psychiatric Residential (PRTS)** – *ages 12-18*	56*	217	51
19	**Sub-Acute** – *ages 6-11*	12*	44	(3)
19	**Sub-Acute** – *ages 12-18*	28*	44	(6)
20	**Acute** – *ages 6-11*	6*	--	
20	**Acute** – *ages 12-18*	33*[1]	--	*community shared options*
21	**SCIP**	17*	--	
21	**SAIP**	28*	--	
			TOTAL CAPACITY GAP >>	**1,860**

** These community shared options are open to CW placements as well as other community placements (e.g. county-level placement). The beds available in these levels of care are not reserved specifically by contract.*

[1] The actual capacity number is fluid. These treatment beds can be adjusted at the hospital's discretion.

[2] Length of stay calculations include in state and out of state PRTS and Subacute placements. Calculations are based on current and true length of stay regardless of funding.

The above recommendations are based on a system that includes a "buffer," which means open bed capacity allowing for immediate access and flexibility within the system. Today, providers report they are unable to financially sustain vacant beds as the current funding model does not reimburse for open bed days.

OHA recently completed a year-long study of all referrals to PRTS and Subacute levels of care. A conservative estimate of need for increased PRTS and Subacute Capacity is based on one year of Medicaid and private insurance referrals submitted to OHA by the PRTS and Subacute programs.

The initial review of the data by OHA suggests the need for an increase in:

- 38 Psychiatric Residential Treatment Services (PRTS) beds and
- 29 Subacute beds

This OHA analysis is based on the need of the entire children's behavioral health system rather than limited to youth served by Child Welfare. Therefore, capacity recommendation and projections do differ between OHA and DHS due to focus, research modality and DHS' recommendation for excess or "buffer" capacity to ensure immediate access and appropriate

service matching with individual needs. When accounting for these differences, DHS and OHA recommendations for capacity are in alignment and the two agencies, as per direction from the Child Welfare Oversight Board, are conducting further analysis to determine additional PRTS capacity needs in 2020.

Additional OHA examinations of the continuum of care show that the state's highest level of care, the Secure Children's Inpatient Program (SCIP) and Secure Adolescent Inpatient Program (SAIP) show long wait times for services averaging 4 weeks for SCIP and 2 weeks for SAIP. Initial review suggests a need for an additional 4 SCIP beds and 6 SAIP beds.

C*urrent Capacity Expansion Efforts*

Oregon Health Authority

- ✓ Currently working jointly with DHS to increase PRTS in 2019 by requesting and reviewing proposals from known providers
- ✓ Publishing a Request for Proposals (RFP) in 2019 to receive applications on an ongoing basis to fund potential providers to increase capacity in 2020
- ✓ Increasing PRTS/Subacute capacity
  - 15 beds in calendar year 2019
  - 15 additional beds no later than June 30, 2020
- ✓ Developing a statewide Intensive In-Home Behavioral Health Treatment program to be implemented statewide. This program will provide a community-based service array with higher intensity within the community. This program is designed to decrease the demand on residential treatment and to support transition to the community following an episode of residential treatment or placement.

DHS – Child Welfare Program

Prior efforts:

The DHS Child Welfare Treatment Services Program actively works to increase treatment-based capacity through the onboarding and/or expanding of Behavioral Rehabilitative Services (BRS) as well as other supportive services. From July 2018 through July 2019 DHS Child Welfare Treatment Services Program has:

- ✓ Expanded BRS capacity by 67 beds ranging from Proctor Foster to Intensive Residential care
- ✓ Expanded Non-BRS Shelter capacity by 16 beds
- ✓ Expanded PRTS by 14 beds dedicated for Child Welfare youth
- ✓ Developed Supervised Independent Living (SIL) Plus, a new service for older and transitioning youth with specialized needs. This service was developed in collaboration with OHA and CCO's to assist youth with specialized needs gain independence.

Current efforts:

- ✓ DHS Child Welfare has a goal of expanding BRS Intensive Residential capacity by 12 additional beds by January 2020. This level of care has a specific focus on serving youth who may have otherwise been recommended for treatment out-of-state
- ✓ DHS Child Welfare has a goal of serving up to 28 transitional-aged youth with specialized needs through SIL+ services in calendar year 2019
- ✓ DHS Child Welfare has a goal of supporting targeted recruitment and retention efforts for BRS Proctor Foster Care in calendar year 2019

In addition to these efforts, DHS Child Welfare, in collaboration with the Oregon Health Authority, Oregon Youth Authority and Stakeholders are reviewing and updating the BRS Rate Model. This effort is targeted at increasing rates for BRS Providers.

DHS – Office of Developmental Disability Services

In 2020, the Office of Developmental Disability Services (ODDS) will implement provider rate increases for children's group homes, targeted at increasing staff wages, effective September 1, 2019. It is anticipated this will enable the expansion of children's group home capacity over the next 6 months. In addition, ODDS will initiate Host Home services with gradual building of capacity beginning in calendar year 2020. Host homes are home-based foster care settings for youth with intellectual and developmental needs.

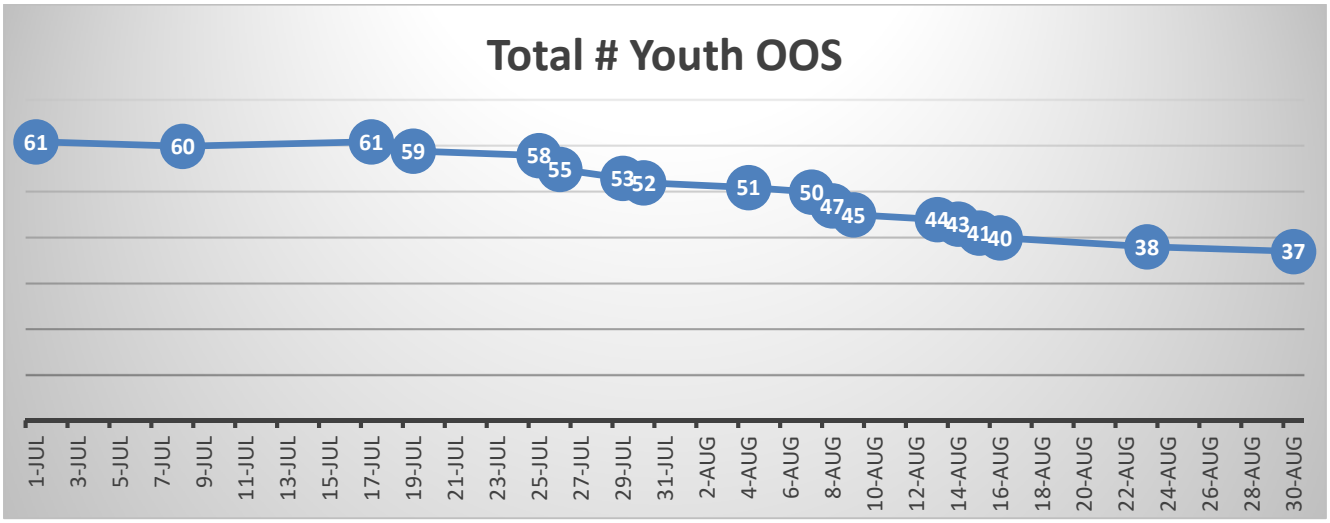
Recommended New Services

Data analysis has provided a better understanding of the children and youth placed out-of-state as well as the complexity of their needs. By comparing this information with the types of services that are accessed in other states and developing a comprehensive understanding of the current service array in Oregon, it can be confirmed that the following types of services either do not exist in state, or enough capacity does not exist to ensure Oregon children and youth remain in their state and communities:

- Programs for youth with sexually harmful and sexually aggressive behaviors
- Programs for survivors of Commercial Sexual Exploitation of Children
- Programs that manage aggressive and violent behavior
- Programs that can treat complex trauma

Proposed Plan for the Safe Return of Children to Oregon

When targeted efforts to minimize the use of out-of-state programs were initiated (March 2019), Child Welfare data and central office staff confirmed there were 84 children and youth placed in out-of-state care. DHS has committed to transition 45 youth back to Oregon by December 31, 2019. Steady progress has been achieved while ensuring youth are transitioned to Oregon when it is in the best interest of the child, youth and family and when appropriate program and placement options are available in Oregon.



As capacity is developed, the need for out-of-state placements will further decline. Current capacity-building efforts are focused on an increase in Psychiatric Residential Treatment Services (PRTS) and an increase in Child Welfare Behavioral Rehabilitation Services (BRS). In addition, Senate Bill 1, as well as new behavioral health investments from the 2019 session provided DHS and OHA with funds to develop needed services and supports across Oregon's children's continuum of care. The investments include:

- Therapeutic/Treatment Foster Care (DHS)
- Families First prevention services (DHS)
- Enhanced Services for youth with Intellectual/Developmental Disabilities (DHS)
- Interdisciplinary Assessment Teams (OHA)
- Intensive In-Home Behavioral Health Services (OHA)
- Crisis and Transition Services (OHA)
- Expansion of School-based Mental Health (OHA)
- Suicide Prevention (OHA)

Additional capacity building efforts are underway and will continue to identify available and required funding to create new types of services within Oregon that are needed to address the specific and unique needs of this population within Child Welfare.

Barriers to Implementing Programs and Services within Oregon

On May 15, 2019, DHS and OHA convened an array of children's system service providers including behavioral health, BRS (Child Welfare and the Oregon Youth Authority (OYA)), and intellectual/developmental disability service providers to listen and better understand the barriers to increasing service capacity in Oregon. Oregon providers shared the two primary concerns regarding expanding capacity for PRTS, which have also been identified and confirmed by Alvarez & Marsal (A&M) through their work under the Child Welfare Governor's Executive Order.

The first concern identified by providers revolves around inconsistencies in CCO contracting and business processes. Because many providers contract with multiple CCOs, they face the challenge of navigating different contracts, requirements, rates, billing practices, and other processes. This is an administrative burden for providers to accommodate and frequently leads to rejected or denied claims. The second major concern is that CCOs are not required to empanel PRTS providers. This means that new PRTS providers must negotiate contract terms on a case-by-case basis, which is a time-consuming process that poses significant financial risk for a program starting up.

Identified Barriers to Behavioral Health Capacity Expansion

Limited providers

Oregon has a small number of intensive treatment providers with limited potential resources for increasing facility-based capacity. There is a limited appetite for new providers to offer intensive treatment services due to factors described below.

Administrative burden

For a PRTS or Subacute provider to be successful, they need to contract with several or each of the 15 CCOs. Each CCO has different policies and procedures. Providers have expressed excessive program costs associated with:

- Repetitive credentialing processes
- Different standards and timelines for Utilization Management
- Different reimbursement rates
- Lack of standards in reporting requirements

Array of services

Oregon does not have services or expertise necessary to meet the needs of youth who:

- Experience co-occurring intellectual/developmental and psychiatric needs
- Have a history of violent sexual behaviors
- Have a history of extremely aggressive behavior
- Have a history of experiencing severe and repetitive complex trauma

Licensing regulations

Providers have reported to DHS that they have stopped providing services or declined to develop new programs due to Oregon laws pertaining to Child Caring Agencies and required abuse reporting and investigation processes. Providers cite a large impact on their ability to retain and recruit staff due to the regulation standards.

Workforce

In discussions with providers, a continuous expressed concern is workforce and the difficulty in recruiting individuals who want to work within residential programs. This is compounded by high turnover rates, as direct care staff in residential programs earn a low wage and the work is stressful. Staff often experience vicarious trauma due to the demands of the work and the behaviors exhibited by children and youth.

Identified Barriers to Health Care and Mental Health Services

Alvarez and Marsal (A&M), through work to address priorities within the Governor's Child Welfare Executive Order, has identified the following barriers to health care and mental health services for children and families receiving services from Child Welfare:

1. There are not standard criteria for the authorization/utilization of PRTS services. For example, data indicates that practices vary significantly between CCOs regarding the average length of stay for PRTS. There are also reports of incidences in which CCOs denied PRTS services but were required to reverse the denial upon appeal.

2. Although CCOs are required to comply with Oregon Administrative Regulations (OAR) regarding processes for appeals, CCO are afforded some flexibility regarding processes, leading to, for example, different forms and contact information, and making it difficult for beneficiaries to understand and exercise their due process rights. After exhausting CCO appeal options, beneficiaries may seek relief through an administrative hearing process administered by OHA. This tiered approach can be time consuming.

3. According to research conducted by DHS ORRAI, the capacity for Behavioral Rehabilitation Services is inadequate to meet the needs of Oregon's children.

4. Child Welfare indicates they are experiencing access to care issues when a child is placed in an out-of-district Behavioral Rehabilitation Services (BRS) facility. The home district CCO is challenged with locating and contracting with the child's out-of-district providers.

5. Data indicates that there are a significant number of youth involved in Child Welfare that have been assessed for but do not meet level of care criteria for Intellectual and Developmental Disability (IDD) services. CCOs report that these youth can benefit from the types of services that are currently provided by IDD providers due to services being better tailored to individuals with intellectual and developmental delay, for example behavioral support planning and services.

CCOs are required to adhere to timely access standards and to ensure that members have access to evidence-based treatment and that treatment allows children to remain living with their primary parent or guardian. In addition, CCOs are required to ensure that children in the highest level of care continue family-focused treatment with their caregivers whenever possible.

Changes put in place in the implementation of CCO 2.0, effective January 2020, will improve the possibility of foster children participating in their parents' substance use disorder treatment, create an increased emphasis on trauma-informed training and care delivery by CCOs and their subcontractors, and require care coordination for complex behavioral health conditions. These efforts are intended reduce the number of children and wards leaving the

state for care and treatment and protect those who are vulnerable to health and behavioral health crisis and instability.

Identified Barriers and Recommendations Related to Coordinated Care Organizations

Included in the work that A&M is conducting is a comprehensive analysis of the children's system in Oregon to identify any barriers that may be contributing to the use of out-of-state placements. The barriers related to Coordinated Care Organizations are captured in the following categories;

- Service authorization, utilization and appeals
- Contracting (empaneling vs. contracting on a case-by-case basis)
- Ensuring equal access for children and youth involved with Child Welfare (reserved or prioritized capacity)
- Improving communication and collaboration between CCOs and DHS field offices
- Improving care coordination

Each category of barriers has resulted in work streams and projects within OHA in partnership with DHS and under the direction and support of A&M. Work areas to mitigate identified barriers include:

- DHS and OHA have worked collaboratively to modify protocols for CCO enrollment of children in out-of-district BRS placements. New protocols will provide children and youth in out-of-district placement with the same options as youth in the general population, allowing them to remain enrolled in or change CCO enrollment based upon an informed decision regarding the CCO best able to meet their medical and mental health needs.
- DHS and OHA are collaborating to identify process, training and technical gaps that create barriers for the Child Welfare population.
- DHS and OHA have convened a workgroup to identify existing state plan services that are comparable to 1915(k) Community First Choice State Plan Option (K Plan) services and could be used to serve youth involved with Child Welfare that do not meet IDD criteria.

OHA expects to see improvements across the behavioral health system and in services and access for children and youth. Improvements will be reflected in reduced wait times, increased choice and access and minimized need for out-of-state PRTS.

CCO 2.0 contract language requires CCOs to be fully accountable for the Behavioral Health benefit and care coordination in their service area. This includes provisions that CCOs must:

- Be responsible for providing Behavioral Health services for all members
- Provide care coordination for members accessing non-covered Behavioral Health services
- Ensure members have timely access to care (OAR has been updated to include timely

access to care standards for behavioral health services and specifically calls out priority populations)
- Ensure women with children, unpaid caregivers, families and children ages birth through five receive immediate intake and assessment
- Ensure that services and supports meet the needs of members and address the recommendations from the Behavioral Health assessment
- Arrange for provision of health-related services
- Comply with mental health parity

OHA is currently in the process of developing Behavioral Health reporting metrics which will be used to monitor compliance with the contract.

Out-of-State Programs

Cost of Out-of-state Placements

Annual costs of out-of-state placements are difficult to capture due to some expenses being within the Child Welfare central office budget while some are at the branch level. The following budget analysis provides a comparison of costs for out-of-state and in-state placements. DHS General Fund is utilized for the daily cost of care, including for PRTS levels of care, as out-of-state programs are not Oregon Medicaid certified and CCOs do not authorize behavioral health services for youth outside of Oregon.

Annual expense per child/youth in a FOCUS out-of-state placement as compared to a FOCUS in-state placement

DETAIL AREA	OUT-OF-STATE	IN-STATE
Average placement cost per day[1]	$ 352	$ 526
Annual placement cost per kid	$ 128,611	$ 191,954
Monthly visitation and initial travel costs *(see breakout below)*	$ 1,784	$ 1,036
General Fund rate	**100%**	**94.6%**
General Fund Expense - per child/youth per year	**$ 130,747**	**$ 183,066**

The analysis shows average placement cost per day – also known as a daily bed rate – to be the primary driver in placement expense. The potentially high travel expenses are mitigated by using local contractors to provide monthly face-to-face visits.

Monthly visitation expenses	OUT-OF-STATE	IN-STATE
12 mo. visits - contractor paid (80% of placements)[2]	$ 520	$ -
12 mo. Visits - DHS staff (20% of placements)[3]	$ 127	$ 636
Initial placement travel expense[4]	$ 1,136	$ 400
	$ 1,784	$ 1,036

[1] Placement cost per day captured from OR-Kids FOCUS placement data. Future in-State FOCUS placements costs may range from QRTP ($500/day [estimate]) to PRTS ($600/day).
[2] Average per visit cost is 54.20, assume 12 visits/year. Approximately 80% of the out-of-state placements have contractors assigned. Calculation is multiplied by 80% to assume a total per kid expense.
[3] Assumes only Idaho placements require out-of-state visits by DHS staff and placements in all other states have assigned local contractors conducting visits. The Idaho placements represent approximately 20% of the total out-of-state placements. The in-state placements and Idaho placements use established fleet cars for travel and do not require airfare. Calculation assumes $53 per diem for one day a month for 12 months. Out-of-state calculation is multiplied by 20% to assume a total per kid expense.
[4] Assumes out-of-state placements require airfare estimated to be $400 per ticket + $60 baggage fee, one night hotel and per diem fee of $200 per traveler. Assumes two travelers for all trips (child and worker) and out-of-state placements have a second night stay for the worker only. Approximately 20% do not require airfare but will utilize fleet cars. These are related to the Idaho placements. The in-state placements do not utilize airfare but assume fleet car travel with hotel and per diem added.
*Out-of-state calculation: ((400 + 60 + 200)*2)*80%) + ((200*2)*20%)*
*In-state calculation: (200*2)*

Out-of-State Programs Utilized

Programs Utilized Any Time January 2014 to Current

Program	Parent Agency	City	State
Acadia Montana	Acadia	Butte	Montana
Detroit Behavioral Institute- Capstone Academy	Acadia	Detroit	Michigan
Clarinda Academy	Sequel	Clarinda	Iowa
White Deer Run/ Cove Prep	Acadia	Torrance	Penn
Youth and Family Centered Services of New Mexico/ Desert Hills	Acadia	Albuquerque	N. Mexico
CARE Schools - Falcon Ridge Ranch	Sequel	Virgin	Utah
Woodward Youth - Forest Ridge Academy	Sequel	Estherville	Iowa
Innercept LLC	N/A	Coer d'Alene	Idaho
Sequel Schools LLC- Kingston Academy	Sequel	Kingston	Tennessee
Lakeland Behavioral Health Systems	N/A	Springfield	Missouri
Lakeside for Children	Sequel	Kalamazoo	Michigan
CARE Schools - Lava Heights	Sequel	Tocqueville	Utah
Habilitation Center Millcreek of Arkansas	Acadia	Fordyce	Arkansas
Mingus Mountain Estates - Mingus Mountain Academy	Sequel	Prescott Valley	Arizona
Sequel Three Springs Inc - Mountain Home Academy	Sequel	Mountain Home	Idaho
CARE Schools - Mt Pleasant Academy	Sequel	Mt. Pleasant	Utah
Northwest Children's Home	N/A	Lewiston	Idaho
Northwest Children's Home- Triumph House	N/A	Clarkston	Wash
Northern Illinois Academy	Sequel	Aurora	Illinois
Normative Services Inc	Sequel	Sheridan	Wyoming
Sequel Schools LLC - Norris Academy	Sequel	Andersonville	Tennessee
Summit Youth Academy- Patriot Center	N/A	Emmett	Idaho
Piney Ridge Treatment Center	Acadia	Fayetteville	Arkansas
UHS of Provo Inc - Provo Canyon School	UHS	Provo	Utah
CARE Schools - Red Rock Canyon	Sequel	St. George	Utah
Resolute Acquisition Corporation	Acadia	Indianapolis	Indiana
Resource Acquisition Corporation	Acadia	Indianapolis	Indiana
The Anchor at Rolling Hills Hospital	Acadia	Ada	Oklahoma
Starr Commonwealth - Starr Albion Prep	Sequel	Albion	Michigan
Success Acquisition Corporation	Acadia	Indianapolis	Indiana
Woodward Youth	Sequel	Woodward	Iowa
Youth Development Inc	N/A	Phoenix	Arizona

Recommendations for Implementation of Federally Qualified Residential Programs

Rate Adjustments Required to Fund Newly Required Services

The BRS Rate Review Update Committee commenced in July 2019 to explore specific BRS rate model adjustments and additional contract funding provisions required to implement Qualified Residential Treatment Program (QRTP) mandates. The committee is composed of representation by OYA, OHA, DHS, Disability Rights Oregon and Child Caring Agency (CCA) leadership. The committee will propose rate recommendations by the end of September 2019. Currently there are four specific components of QRTPs that are being explored for financial impact on programs:

Nursing Services

Child Welfare - At this time, several CCAs do not hire or contract for nursing services (either on-site or on-call) as access to medical, dental and physical health services are covered by the Oregon Health Plan, whether through Oregon Health Plan (OHP) open-card or CCO enrollment. OHP members also have access to 24/7 nursing advice lines. While this may meet the federal Family First guidelines, Oregon statute in SB 171 specifically requires facility staff to include licensed or registered nurses. The additional cost for adding nursing positions is currently being analyzed and will be complete by the end of September 2019.

Oregon Health Authority- It is not anticipated that the revised BRS rates will cover nursing services. Counties that need to certify as QRTPs will be required to cover the cost of nursing services through their own General Fund, unless other funding is provided to them by the Legislature.

Oregon Youth Authority- If the costs for nursing are not bundled into the BRS rates, OYA will be required to determine how to pay for nursing services on a fee-for-service basis.

Aftercare Services

Child Welfare - Child Welfare Treatment Services proposes to model aftercare services around current OYA "transitional" services, helping to align contracting and service requirements across OYA and DHS BRS programming. Post discharge, children, youth and families will be provided individualized, in-person and by-phone ongoing support and skills training. These services will be authorized at a level to meet the youth and family's need, funded separately from the BRS rate model, and will utilize general and Title IV-E funds.

Oregon Health Authority - OHA will be working with Child Welfare and OYA, where applicable, to help design required aftercare services.

Oregon Youth Authority – Federal Family First legislation requires expanded transitional services, increasing the current three-month aftercare expectation to six months. If this becomes a requirement for youth in a QRTP, General Fund resources would need to be utilized for this cost. The fact that residential programs are not necessarily located in the geographic area where youth will receive aftercare will pose additional challenges in allocating funding.

Accreditation

Child Welfare - Grant awards up to $50,000 have been received by 12 Child Welfare-contracted programs to support with initial costs related to accreditation. The BRS rate group is considering how new agencies will receive initial grant funding to achieve accreditation. The fiscal impact of ongoing accreditation and renewal on each QRTP program is unknown currently, as accreditation is new to many agencies and the related staffing requirements are undetermined. Analysis is underway and will be included in the group's recommendations.

Oregon Health Authority - Since OHA has historically been a pass-through for the counties to leverage federal Medicaid funding, no OHA General Fund grant awards are currently available to achieve accreditation. The BRS rate review will determine whether ongoing staffing costs for accreditation are recommended to be included in the rates. However, it is not anticipated that the Medicaid Service portion of the revised BRS rates will cover any accreditation costs.

Oregon Youth Authority – At this time, accreditation is not required of OYA therefore it is assumed that the cost will not be included in OYA BRS rates. However, this is subject to change if it is determined that all providers must be accredited.

Evidence Based Supports and Services

Child Welfare - The current rate model provides funding for training; however, it may not fully cover the training costs associated with many evidence-based programs. For example, the initial and ongoing training costs for models such as Collaborative Problem Solving (CPS) and Crisis Prevention Institute - Non-violent Crisis Intervention (CPI) are likely to exceed the rate model.

Oregon Health Authority - Some evidence-based programming is already a requirement for BRS. However, some of Oregon's OHA-contracted county BRS programs will be subject to the QRTP requirements, which may require additional funding for training on evidence-based models. OHA is participating in the rate model workgroup with DHS and OYA. It is undecided whether any funding in the rates for additional training will come from Medicaid. If so, a part of that will be reflected in the Medicaid Service portion of the daily rate paid to OHA-contracted counties.

Oregon Youth Authority – OYA does not foresee any changes in evidence-based programming

due to Family First legislation, as it is also a requirement of SB 267. OYA is involved in discussions about evidence-based programming in the rate model workgroup, along with OHA and DHS.

Costs for Financing Bed Vacancies to Ensure Availability and Crisis Access

Costs

OYA, DHS and OHA have explored funding options to offset the significant financial impact Child Caring Agencies face when bed capacity is vacant. Aside from the program costs, DHS' research recommends building in "buffer" capacity or a number of excess beds to allow for service matching based on individual child needs and to ensure immediate access when needed.

One proposal being evaluated in September 2019, is the use of General Funds to provide a BRS absent day rate for up to 10 percent of billable care days each year. This would allow CCAs to invoice for 36.5 vacant days per year. The potential General Fund fiscal impact for DHS is $3.7 million per biennium. Funding will help maintain staffing and bed availability to achieve contracted bed capacity. Moving forward, this information will be presented to the BRS Rate Review Committee and be incorporated into overall recommendations for funding priorities and the proposed rate model.

Crisis access

SB 171 has limited the placement duration (60 days max) of placement within non-QRTP Licensed transitional programs for runaway and homeless youth. Today, these programs are frequently used as crisis placement resources or transitional placements. Six of these contracted programs serve youth beyond 60 days. Frequently, a period of 60 days is needed to transition youth to longer-term placements that can be expected to best support and meet their needs.

Under SB 171, a total of 32 beds across Oregon will have length-of-stay limitations which has the potential for increasing the need for readily-available QRTP placements. Non-QRTPs, as described above, are part of the continuum of services for Child Welfare and the time restriction may limit options for crisis placements which are necessary to avoid temporary lodging and other inappropriate placement settings.

It is unknown at this time if providers will continue their contracts with OYA or DHS under the new length-of-stay criteria and other changes. The changes could impact which providers and service levels are available upon implementation of SB171 on July 1, 2020.

Potential Impact of Policy and Rate Adjustments on County Juvenile Programs and The Oregon Youth Authority

There remain several unanswered questions for OYA regarding policy and rate adjustments and county juvenile programs. While OYA does not currently accept Title IV-E payments, there are several requirements in SB 171 that, if not implemented by both DHS and OYA, would create difficulty for providers. For example:

- The extension of aftercare services from three to six months would be a change in current practice for many OYA BRS providers. OYA currently provides transitional services for only those youth who are in higher levels of care or transitioning to independent living. If this becomes a requirement for all youth, OYA would need to find a mechanism to pay providers for these additional services.

- Certain legislative requirements that cover both DHS and OYA will not have a direct impact on OYA. For example, as stated above, while supports for evidence-based programming are part of the Families First Act, it is also a requirement of earlier legislation, SB 267, which sets implementation standards for the use of validated programming.

- For OYA to continue contracting with providers that DHS also contracts with, those provides will be required to become a QRTP. This will result in an increased General Fund cost to the state of Oregon. OYA cannot receive additional federal funds, as OYA is not subject to Families First legislation, according to the federal legislation and Oregon SB171.

- The current rate review process will result in a recommendation for changes in rates. It is unknown at this time what the impact will be, or whether the state of Oregon will fund the recommended increase. If additional General Fund will be required to fund increases for OYA youth due to Family First and SB 171, the increase in General Fund will be required for youth placed by Child Welfare as well as OYA.

Ongoing activities and next steps

DHS and OHA will continue to partner and address system need while working to build a continuum of care that supports all children, youth and families. The following efforts will continue with the assistance and support of our partners, stakeholders, communities, the Legislature and providers:

- Develop and monitor individualized transition plans for current youth out-of-state
- Measures to prevent further placements of youth out-of-state through tightened procedures, ensuring all other in-state resources are exhausted and final approval by the Child Welfare Director in consultation with the ODDS director as appropriate
- Capacity building of PRTS, BRS, therapeutic foster care, community-based services and other services identified
- Further analysis of capacity needs to include proposed new services and related budget recommendations for the costs of adding new services to the Oregon continuum of care
- Implementation of new behavioral health investments from the 2019 session
- Improvements in mental health access, community-based services and care coordination through work with Coordinated Care Organizations
- Increased CCO accountability to provide prevention services, behavioral health access, reduce administrative burden on providers and remove other barriers to access and care each monitored and measured by OHA
- Analyze and plan for BRS system cost and capacity impacts resulting from Families First legislation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