OREGON HEALTH AUTHORITY

Medicaid Division

2024

Preliminary Report on K Plan Services and Supports

Contents

Executive summary

The Oregon Health Authority (OHA) provides this **preliminary** report in collaboration with the Oregon Department of Human Services (ODHS) as required by Section 4 of Senate Bill (SB) 1557 (Enrolled, 2024). This bill required an investigation of and report on the 1915(k) Community First Choice State Plan Option (K Plan) services and supports. This preliminary report includes background information, data, and initial recommendations. OHA is grateful to the youth, families, caregivers, and individuals with lived experience and expertise who contributed to the development of this report. OHA also appreciates the staff and teams across OHA, ODHS, Oregon Youth Authority, and Innovations Institute at the University of Connecticut School of Social Work whose combined efforts contributed to completing this preliminary report.

The K Plan is an optional federal Medicaid home- and community-based services (HCBS) state plan authority. It allows states to provide specific types of HCBS to individuals who meet institutional level of care (LOC) criteria with federal Medicaid reimbursement. In Oregon, an individual must currently meet one of three existing institutional LOC to be eligible for K Plan services. These three LOC are hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

Oregon uses the assessment tools and standards from a different Medicaid HCBS authority, the 1915(c) waivers, to determine if someone is eligible for the K Plan. Oregon's 1915(c) waivers have LOC criteria for hospitals, nursing facilities, and ICF/IID, but Oregon does not have a standardized set of criteria for individuals under 21 to receive psychiatric services under the "Psych Under 21" benefit. Therefore, anyone needing K Plan services must meet one of the other three LOC criteria. As a result, even though the Oregon's K Plan says that youth can be served if they meet Psych Under 21 LOC, no one currently qualifies under it since Oregon does not have standardized LOC criteria or an assessment tool for individuals under 21 requiring psychiatric services. Appropriate criteria are under development for this population.

In 2023, 9,023 individuals under age 21 received K Plan Services in Oregon. The majority (96%) of those individuals met the ICF/IID LOC criteria. A small number (593) of those individuals were youth with open child welfare cases in foster care. In state fiscal year 2023, Oregon received $329.5 million in federal Medicaid reimbursement for providing K Plan services to individuals under age 21.

OHA and ODHS engaged with families, youth, and caregivers with lived expertise about priorities for the K Plan. They shared the barriers and needs they are currently experiencing. They reported being concerned about access to services and supports that are timely, age appropriate, sufficient in duration, flexible, available from appropriately trained providers, and available when needed. They expressed a need for time away or respite for youth and families, a person to support youth at home and in the community that is not a family member, youth and family peer supports, training in de-escalation, access to crisis services, home monitoring and modification, and funding for socialization and/or skill-building activities.

There are children in Oregon with mental health, neurodevelopmental disorders, and disability needs whose needs are not being met. OHA and ODHS recognize that the K Plan could provide needed services for individuals under 21 who experience mental health challenges and require support related to activities of daily living (ADL), instrumental activities of daily living (IADL), and other health-related needs so they are able to remain in their homes and communities. OHA and ODHS are exploring opportunities to use the K Plan and other Medicaid authorities to expand and enhance the services that will support individuals under the age of 21 years who experience serious emotional disturbances or mental illness to live successfully in their family homes and avoid crises.

OHA and ODHS recognize it is important to improve communication with individuals, facilities, and organizations about the K Plan. Additionally, it is a priority to develop LOC criteria for institutional services under the Psych Under 21 benefit so that children and youth meeting those criteria can be served and supported by the K Plan to remain in their homes and communities.

OHA will continue to engage families, caregivers, and individuals with lived experience and expertise to inform the development of criteria and the design and implementation of the Psych under 21 LOC. OHA is committed to serving children and youth with complex needs in their homes and communities and looks forward to providing the final report as required under SB 1557 by March 1, 2025.

Introduction, purpose, and report organization

This is the **preliminary report** provided by the OHA in response to Senate Bill (SB) 1557 (Enrolled, 2024). Section 4 of SB1557 required an investigation and report on K Plan services and supports in collaboration with ODHS and with families and youth with lived experience. The 1915(k) Community First Choice State Plan Option, also referred to as the K Plan, is an optional federal Medicaid Home and Community-Based Services (HCBS) State Plan authority. Oregon's K Plan was approved by the Centers for Medicare and Medicaid Services (CMS) on June 27, 2013, with an effective date of July 1, 2013. State Plan Amendments (SPA) for the K Plan have occurred since the original approval date to address changing needs.*

Detailed information about feedback provided by individuals with lived expertise is provided throughout the report and summarized in Appendix 2. OHA and ODHS will continue to engage families and youth throughout the development of the final report and intend to change the system based upon report findings and recommendations.

There are three main sections in this report:

1. Section 1: Background, Requirements, and Context:
    a. This section provides background information on relevant Medicaid authorities.
    b. This section provides an overview of the current K Plan in Oregon, grounded in the federal requirements for K Plans.

* In 2018, Oregon submitted a SPA to include State Trained Assessors to conduct functional needs assessments for the I/DD population by ODDS. The SPA also included technical amendments to clarify required case management contacts, allowable use of electronic back-up systems, Long-Term Care Community Nursing requirements, payment restrictions for Home Delivered Meals, and non-payment for duplicative services. The 2018 version of the SPA is linked above. Other SPAs submitted since 2018 reflect non-substantive technical changes, including the 2023 SPA increasing reimbursement rates due to a cost of living adjustment.

2. Section 2: SB1557 Section 4(3)(a): Data:
    a. This section provides information requested in Section 4(3)(a)(A-H).
    b. This section focuses on providing information based on current eligibility, services, and related data.
    c. Data are provided on
        i. individuals eligible for the K Plan,
        ii. the types of services currently supported under the K Plan, and
        iii. estimates related to current service utilization.
3. Section 3: SB1557 Section 4(3)(b): Recommendations:
    a. This section provides recommendations as requested in Section 4(3)(b)(A-H).
    b. It explores opportunities to enhance and expand access to services and supports for children and youth with complex behavioral health needs and their families.

These sections are followed by appendices with additional information.

Section 1: Background, requirements, and context

This section provides information on the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit and current HCBS Medicaid Authorities. The purpose of this section is to provide context on Medicaid authorities that intersect with and relate to the K Plan. This section also provides background on the federal 1915(k) Plan requirements and Oregon's 1915(k) Plan, including level of care (LOC) and financial eligibility for the K Plan.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program

The federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit program provides access to comprehensive health care for youth and young adults 20 years old and younger.

EPSDT's goal is to ensure individual children enrolled in Medicaid receive the health care they need when they need it — the right care provided at the right time in the right setting. On January 1, 2023, Oregon fully implemented the EPSDT benefit.

OHA and coordinated care organizations (CCOs) are required to cover all EPSDT Medically Necessary and EPSDT Medically Appropriate services for Oregon Health Plan (OHP) members 20 years old and younger. Those services are covered regardless of whether they are on the Prioritized List of Health Services. EPSDT Medical Necessity and EPSDT Medical Appropriateness* are determined on a case-by-case basis, taking into account the individual's needs.

* See OAR 410-151-0001 for definitions of *EPSDT Medically Appropriate and EPSDT Medically Necessary.*

1915(c) Home- and Community-Based Services Waivers

Oregon operates seven 1915(c) HCBS Waivers. These waivers enable Oregon to support children, youth, and adults to receive necessary supports and services in their homes and communities instead of receiving services in an institutional setting.

Consistent with federal laws, **children and youth enrolled in 1915(c) HCBS waivers must meet the relevant institutional level of care (hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities [ICF/IID]).**

Federal rules also require that all individuals receiving 1915(c) HCBS waiver services:

- belong to a target group included in the waiver,
- meet applicable Medicaid financial and non-financial eligibility requirements, and
- require one or more waiver services to function in the community.

Individuals participating in a 1915(c) waiver:

- Have full access to and are expected to utilize Medicaid State Plan services, including EPSDT benefits.
- May receive State Plan Option benefits for which they are eligible, including the 1915(k). (1)
- May receive services from multiple State Plan Option HCBS authorities simultaneously, including 1915(k) plan services, as long as the service plan does not include duplication of services. (2)

Oregon's 1915(c) Waivers include the ODHS Office of Developmental Disabilities Services (ODDS)-operated Behavioral (ICF/IID) Model Waiver, Medically Fragile Model Waiver (hospital), Medically Involved Children's Model Waiver (nursing facility), Children's Extraordinary Needs (CEN) Waiver (hospital, nursing facility, ICF/IID), Children's HCBS Waiver (ICF/IID), and Adult's HCBS Waiver (ICD/IID)). Model waivers are federally capped at 200 participants at any point in time and may be further capped by states for a variety of reasons. The CEN waiver was effective July 1, 2024, and is currently capped at 155 participants at any point in time due to budget constraints. ODHS, Aging and People with Disabilities (APD) operates one 1915(c) waiver, Aged and Physically Disabled Waiver (nursing facility). Six of these seven HCBS Waivers have existed for many years, with all but one predating the 1915(k) Plan.

For additional detail on the 1915(c) authority, please see Appendix 3 for a chart comparing the 1915(c), 1915(i), and 1915(k) HCBS authorities.

Background on the federal requirements of the 1915(k) Community First Choice Option

The federal 1915(k) Community First Choice Option (K Plan) allows states to provide home- and community-based personal attendant services (PAS) and supports to eligible Medicaid enrollees under their State Plan in an allowable setting. This Medicaid authority gives states an additional six percent (6%) in the Federal Medical Assistance Percentage (FMAP) that they receive for 1915(k) services expenditures. Four other states, California, Maryland, Montana and Texas, utilize the 1915(k) option, which is designed to support community integration.

Federal rules require that all individuals receiving K Plan services:

- Meet an institutional Level of Care (LOC) for services in
  - a long-term care hospital,
  - nursing facility,
  - ICF/IID,
  - institution providing psychiatric services for individuals under age 21 ("psych under 21" benefit), or
  - an institution for mental diseases (IMD) for individuals ages 65 and older.
- Be eligible for Medicaid.
  - All Medicaid categorical eligibility groups must be included.
  - States may choose to cover medically needy eligibility groups.

States implementing K Plan services may not limit the number of individuals served. Individuals receiving K Plan services may receive services from multiple HCBS authorities simultaneously, including a 1915(c) waiver.

States providing 1915(k) services *must* cover:

- Assistance with activities of daily living (ADL), instrumental activities of daily living (IADL) and health-related tasks;*

* Oregon further defines ADL in OAR-411-015-0006 and defines IADL in OAR 411-015-0007.

- Acquisition, maintenance, and enhancement of skills necessary for the individual to complete ADLs, IADLs, and health-related tasks;*
- Backup systems or mechanisms to ensure continuity of services and supports; and,
- Voluntary training on how to select, manage, and dismiss staff. (3)

See textbox for federal definitions of terms.

Federal Definitions (42 CFR 441)

Activities of Daily Living (ADLs): Basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

Health-Related Tasks: Specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant.

Instrumental Activities of Daily Living (IADL): Activities related to living independently in the community, including but not limited to, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

Under the 1915(k), states may cover expenditures for

- transition costs (e.g., rent and utility deposits, bedding, kitchen supplies and basic household furniture) for an individual to transition from a nursing facility, IMD, or ICF/IID to a home and community-based setting where the individual resides and
- certain assistance devices and assistive technology services, medical supplies and equipment, and home modifications when these expenditures relate to a need identified in the individual's service plan that increases their independence or substitutes for human assistance. (4)

* Federal guidance clarifies that, while many states refer to these activities as habilitation services, section 1915(k) does not use that term and the services provided under this section must tie directly back to assisting in accomplishing ADLs, IADLs, and health-related tasks. These services may not be as broad as habilitation services under other Medicaid authorities. (3)

Under federal regulations, states may not cover the following under the 1915(k):

(a) Room and board costs for the individual, except for allowable transition services described in §441.520(b)(1) of this subpart;

(b) Special education and related services provided under the Individuals with Disabilities Education Act that are related to education only, and vocational rehabilitation services provided under the Rehabilitation Act of 1973.

(c) Assistive devices and assistive technology services, other than those defined in § 441.520(a)(3) of this subpart, or those that meet the requirements at § 441.520(b)(2) of this subpart.

(d) Medical supplies and medical equipment, other than those that meet the requirements at § 441.520(b)(2) of this subpart.

(e) Home modifications, other than those that meet the requirements at § 441.520(b) of this subpart. (5)

Additionally, respite care is not an allowable service under the 1915(k).*

Oregon's 1915(k) Plan

The Office of Developmental Disabilities Services (ODDS), a program under ODHS, and the ODHS Office of Aging and People with Disabilities (APD) operate Oregon's K Plan to support individuals who meet eligibility criteria to receive services and supports in their homes and communities instead of in institutional settings.†

* Confirmed through personal communication with the Centers for Medicare and Medicaid Services (August 27, 2024).

† Oregon has an ongoing commitment to engaging individuals with lived expertise, subject matter experts, and partners across agencies in the design, implementation, and assessment of Medicaid in Oregon. Consistent with the requirements of SB 1557, DHS and OHA are collaborating with the Medicaid/CHIP Operations Coordination Steering Committee to facilitate cross-agency coordination for children and youth involved across multiple systems who are eligible for K Plan or State Plan services.

ODDS serves children and adults with intellectual or developmental disabilities (I/DD) who meet the ICF/IID LOC (an institutional level of care). ODDS also serves children under age 18 with complex medical needs, with or without I/DD, who meet specified hospital or nursing facility LOC. All ODDS services are delivered in home and community-based settings, including an individual's own or family home, 24-hour residential settings, children and adult foster homes, supported living, and host homes.

APD serves individuals over the age of 18 who meet nursing facility LOC who have a functional impairment in one or more of the four core ADLs: mobility, eating, elimination and cognition. Services are provided in the individual's home or family's home, adult foster homes, assisted living facilities, and residential care facilities. Services are focused on supporting an individual's assessed ADL and IADLs.

Level of Care (LOC) eligibility for the K Plan in Oregon

Currently, an individual must meet one of three institutional LOC to be eligible for the K Plan: hospital, nursing facility, or ICF/IID.

Federal rules permit individuals to receive K Plan services as a result of meeting institutional LOC criteria for Psych under 21. Oregon's K Plan (6) states that individuals must meet the LOC "provided in a hospital, a nursing facility, an intermediate care facility for Individuals with Intellectual Disabilities (ICF/ID), an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over"(p.1). However, Oregon's approved K Plan (6) identifies the hospital LOC as the criteria to determine whether an individual meets the Psych under 21 LOC.

Individuals eligible for K Plan services under the hospital LOC criteria are those individuals who meet the criteria in the LOC assessment form and Medically Fragile Children's Unit (MFCU) Clinical Criteria tool: "The MFCU Clinical Criteria combined with the Level of Care Assessment Form are the complete level of care evaluation" (p.2).

Since the hospital LOC includes the MFCU clinical criteria, no individuals in Oregon are currently able to qualify based solely on their need for Psych under 21 services. **Oregon does not have standardized LOC criteria or an assessment tool for individuals under 21 requiring psychiatric services.**

Once it is determined that hospital, nursing facility, or ICF/IID institutional LOC criteria have been met, a person-centered service plan is developed through a person-centered service planning process. This process includes identifying services based on support needs identified in a functional needs assessment and documented in the planning process.

Appropriate criteria are under development for an assessment tool for individuals under 21 requiring psychiatric services, as discussed further in Section 3 below. Once these criteria are developed, they will need to be implemented in conjunction with

- providing training and technical assistance to assessors and teams to administer the LOC criteria;
- service design and implementation activities for this population, including rate development and provider network enrollment; and
- outreach and communication activities to children, youth, families, providers, and community partners.

The LOC assessment tools that Oregon uses for the existing 1915(c) waivers are also used to meet institutional LOC requirements under the K Plan. The table that follows provides an overview of eligibility criteria associated with each of the three existing institutional LOC established under Oregon's approved K Plan, which align with Oregon's existing 1915(c) HCBS Waivers.

Table 1: Institutional Level of Care eligibility for K Plan

	Hospital*	Nursing Facility	ICF/IID
Definition and eligibility requirements	• Defined in OAR 411-371-0000 (106): a) Has a documented medical condition and demonstrates the need for active treatment as assessed by the Clinical Criteria. (b) The medical condition requires the care and treatment of services normally provided in an acute medical hospital. • Must meet the Medically Fragile Children's Unit (MFCU) Clinical Criteria with an initial score of 45 or greater. The Clinical Criteria tool assesses and scores various care elements that the assessor expects to last six months or more. It measures nursing and other intervention needs, factoring in frequency and intensity of the care needed in the following: Skin/Physical Management; Metabolic: GI/Feeding; Neurological; Urinary/Kidney; Respiratory; and Vascular. • Individuals must have a physician's signature that hospital level of care is required.	• For ODDS: ◦ Meets criteria defined in OAR 411-371-0000 (147): (a) Has a documented medical condition that demonstrates the need for active treatment as assessed by the Clinical Criteria as defined in OAR 411-300-0110. (b) The medical condition requires the care and treatment of services normally provided in a nursing facility. ◦ The Medically Involved Children's Waiver (MICW) Criteria are used to determine Nursing Facility (NF) level of care for children and youth. Children must score 7 or greater on the ADL section in one (or a combination of) the areas of mobility, eating/feeding or elimination to be considered for eligibility (this is equivalent to a level 13 on the CA/PS tool). • For APD: Uses the Oregon Client Assessment and Planning System (CA/PS) and requires that individuals be eligible for Service Priority Levels 1–13, which is considered nursing facility LOC. The tool ranks an individual's need based on limitations in 6 ADL, which are clustered into Service Priority Levels (SPL), with SPL 1 indicating individuals with the highest need and SPL 18 the lowest. Currently, APD is allowed to serve individuals with SPLs 1 through 13.	• Defined in OAR 411-371-0000 (112): (a) The individual has an intellectual disability or a developmental disability as defined in this rule and meets the eligibility criteria in OAR 411-320-0080 for developmental disabilities services. (b) The individual has a significant impairment in one or more areas of major life activity as defined by federal regulation and assessed by the functional needs assessment, including: (A) Self-care; (B) Receptive and expressive language; (C) Learning; (D) Mobility; (E) Self-direction; and (F) Capacity for independent living. • Specific items on the ONA are coded as being used to determine the LOC.

* Current hospital LOC criteria does not support Psych under 21

	Hospital*	Nursing Facility	ICF/IID
State Agency Responsible	ODDS	ODDS and APD	ODDS
Assessment Tool(s) and Criteria	MFCU Clinical Criteria	ODDS - Medically Involved Children's Waiver Clinical Criteria APD - Oregon Client Assessment and Planning System (CA/PS)	Oregon Needs Assessment (ONA)
Ongoing Eligibility Requirements	• Maintain a score of 45 or greater when re-evaluated every 6 months • Reside in the family home • Be capable of being safely served in the family home within the limitations of applicable administrative rules	A score of 100 on the MICW criteria must be reached to be initially determined eligible for the waiver. At a minimum of every 12 months thereafter, a reevaluation is conducted utilizing the MICW criteria. Eligibility is maintained if the MICW criteria score is 100.	Annual assessment conducted using the ONA

* Current hospital LOC criteria does not support Psych under 21

Financial Eligibility for the K Plan in Oregon

All Medicaid categorically eligible children meet financial eligibility for K Plan services. K Plan services are available to State Plan eligible groups as described in Section 2.2-A of the State Plan. These individuals are eligible for medical assistance under the State Plan and are in an eligibility group that includes Nursing Facility services or are below 150 percent of federal poverty level if they are in an eligibility group that does not include Nursing Facility services.

Children and youth who are not in a categorical Medicaid Eligibility Group may be eligible for K Plan services under an optional Medicaid Eligibility Group under 1915(c) authority. As noted above, children and youth who are eligible for a 1915(c) waiver are eligible to receive all State Plan services, including under the 1915(k). Those children and youth who are receiving medical assistance under the special HCBS waiver eligibility group defined at 42 CFR 435.217 and section 1902(a)(10)(A)(ii)(VI) of the Social Security Act must continue to meet all 1915(c) requirements and must receive at least one 1915(c) HCBS waiver service per month. This group would be eligible for Medicaid if residing in an institution, meet the LOC criteria for an institutional setting and are receiving at least one waiver service per month. This is also the authority through which ODDS disregards parental income for children under the age of 18 enrolled in 1915(c) waivers.

Section 2: SB1557 Section 4(3)(a): Data

This section provides data as requested in Section 4(3)(a). The timeframe was chosen to cover the specifications in Section 4(3)(a)(F) and expanded to provide a pre-pandemic baseline; all years are State Fiscal Years. **The data are disaggregated by the LOC that was met to be eligible for K Plan services: Hospital, Nursing Facility, or ICF/IID.** The current Hospital LOC criteria does not meet the need for children and youth under 21 who require psychiatric inpatient services so, as noted above, **no children or youth are receiving K Plan services based on meeting the Psych under 21 LOC.**

A. Count of individuals

Section 4(3)(a)(A): "The number of individuals under the age of 21 years who have or are receiving services and supports funded by the Community First Choice Option"

Table 2: Number of Individuals Under 21 Receiving K Plan Services

	2019	2020	2021	2022	2023
Hospital	56	56	70	90	97
ICF/IID	7307	7725	7924	8053	8698
Nursing Facility	239	230	206	233	228
Psych Under 21	0	0	0	0	0
Total	**7602**	**8011**	**8200**	**8376**	**9023**

B. Information about K Plan

Section 4(3)(a)(B): "How the authority informs the following individuals, facilities and organizations about how to access the services and supports"

The section below outlines how Oregon informs individuals, facilities, and organizations about accessing the K Plan services and supports for individuals under 21 who meet the current institutional LOC aligned with the 1915(c) HCBS Waivers. Currently, there are no specific activities focused on informing

individuals who might be eligible for K Plan services other than information about the current 1915(c) waivers. Additionally, Oregon recognizes that there is a need to improve communication with individuals, facilities, and organizations about the K Plan.

Feedback from families, caregivers, and individuals with lived expertise included specific recommendations to expand upon the strategies outlined below, including through

- use of additional print and electronic media, including videos, graphics, and materials in multiple languages;
- partnership with school, community and faith leaders; and
- more comprehensive materials online and in print that provide detailed information on what the K Plan is, who is eligible, how to access it, and what types of services and supports may be available through the K Plan.

(i) Individuals who are eligible for the services and supports and their parents, guardians, or caretakers:

Community Developmental Disabilities Programs (CDDP) are agencies in local areas providing case management services to help people access services. ODDS has a public-facing website that provides information on supports for children with I/DD. The website states that services are accessed through the local CDDP, with links providing the name and phone number for each CDDP. These CDDPs have public-facing websites on how to apply for services and what services are available. Most CDDPs are housed within county governments, while a few are contracted out to nonprofit organizations. A directory with multiple contacts within each CDDP is available online. ODDS also contracts with Support Service Brokerages to provide case management services to adults ages 18 and older who live in their own or family home. A directory of contacts is available online. Adults receiving services through ODDS can choose between a Support Services Brokerage or CDDP as their case management entity.

Additionally, ODDS has printed brochures distributed to each CDDP and Support Service Brokerage for use in the local area, such as in ODHS district office waiting rooms, school buildings, medical facilities, and with county programs like Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and CaCoon (CAreCOOrdinatioN). ODDS-contracted family networks promote developmental disability services in local communities, although they are not available in every county.

Referrals for services come from schools, health providers, other ODHS programs, and early intervention programs. Family members who participated in listening sessions in July 2024 stated that they learned about K Plan services from other parents or from their developmental disabilities service coordinators.

APD has public-facing websites. Additionally, APD supports the Aging and Disability Resource Connection, which helps individuals navigate access to services.

(ii) The Child Welfare Program within the Oregon Department of Human Services that have children in protective custody:

Chapter 5, Section 14 of the Child Welfare Procedure Manual provides a high-level summary of K Plan supports administered by ODDS and directs caseworkers to work with the CDDP case manager to determine a placement setting in the child's best interest, including consideration of the least restrictive setting with K Plan supports.

Child Welfare caseworkers may learn of K Plan supports through individual child consultation with the CDDP or when additional information is requested through the individual supporting ODDS coordination for child welfare.

(iii) Pediatricians:

Local CDDPs share printed materials with local area medical providers.

(iv) Children's mental health programs:

CDDPs are usually within county structures and, therefore, are connected to county mental health programs. They share resources about services and eligibility, both printed and electronic materials. They also provide direct referrals.

(v) Wraparound teams:

Fidelity Wraparound teams are expected to identify professional and natural supports to support individual plans of care. This includes resource development and outreach to partner organizations and agencies based on the strengths and needs of the children and families being served. As such, teams would be expected to outreach and engage with the local CDDPs and other partner organizations to be connected to information about the K Plan.

(vi) Schools:

Schools also have print materials and local relationships with CDDPs. CDDPs and schools participate together in resource fairs and special education teams refer children and youth to DD services. For transition-age youth,

the partnership between schools and ODDS/CDDPs and Support Service Brokerages is codified in the Lane vs Brown settlement agreement and employment first rules related to coordination of supports surrounding employment, transition of rights, and adult services.

(vii) Hospitals:

Local CDDPs share printed materials with hospitals and local area medical providers.

C. Setting Types

Section 4(3)(a)(C): "The types of home and community-based settings in which the individuals receive the services and supports"

The counts below include duplicate data because youth may receive more than one type of service or the same service in multiple locations. Definitions of the settings are found in Appendix 1. As noted above, currently no children or youth are receiving K Plan services under the Psych under 21 LOC.

Table 3: Number of Individuals under 21 Receiving K Plan Services, by HCBS Setting

	Setting	2019	2020	2021	2022	2023
Hospital LOC	Total Hospital	56	56	70	90	97
	In-Home	56	56	70	90	97
ICF/IID LOC	Total ICF/IDD	8,045	8,680	8,816	8,977	9,819
	Adult Day Support	102	90	56	44	67
	Foster Home	1,021	1,173	1,056	945	970
	Group Home	349	356	369	405	448
	Host Home	0	0	4	9	9
	In-Home	6,513	7,002	7,274	7,521	8,258
	SACU Group Home	41	38	46	35	40
	Supported Living	19	21	11	18	27

	Setting	2019	2020	2021	2022	2023
Nursing Facility LOC	Total Nursing Facility	239	230	209	233	229
	Foster Home	3	3	2	2	1
	In-Home	236	227	207	231	228
Psych Under 21		0	0	0	0	0
Total		**8,340**	**8,966**	**9,095**	**9,300**	**10,145**

D. Count receiving relief care

Section 4(3)(a)(D): "The number of individuals who received relief care utilizing funding available through the Community First Choice Option"

Relief care is defined as back-up providers or care setting alternatives in case the participant's primary provider becomes ill or is suddenly no longer available. Individuals may utilize alternate service providers such as contracted in-home care agencies that can be employed on short notice if an individual cannot locate a Homecare Worker or Personal Support Worker who can meet their needs. Other licensed community-based service providers may be used to meet immediate care needs when an individual is unable to find a suitable provider to employ directly. Individuals can utilize 24-hour, community-based settings if they are unable to locate an in-home provider to meet immediate care needs. (7)

(Note: Relief care should not be confused with respite. Respite services are described as providing planned time apart for primary caregivers of children and youth with complex needs, as well as a time apart for youth themselves.)

APD does not track relief care separately from other services or supports; this count is provided only for those individuals served by ODDS.

Table 4: Children Receiving K Plan Services who Received Relief Care

	2019	2020	2021	2022	2023
Hospital	1	2	4	8	8
ICF/IID	2,648	2,553	2,351	2,259	2,445
Nursing Facility	40	40	40	44	40
Psych Under 21	0	0	0	0	0
Total	**2,689**	**2,595**	**2,395**	**2,311**	**2,493**

E. Count served by Child Welfare

Section 4(3)(a)(E): "The number of individuals receiving services and supports who are served by child welfare programs within the department"

For the purpose of this response, "served by Child Welfare" is being defined as "youth with open child welfare cases who are in foster care who are placed either out of home or in-home with family."

Table 5: Children with K Plan Services who were being Served by Child Welfare

	2019	2020	2021	2022	2023
Hospital	0	1	0	0	0
ICF/IID	638	651	626	619	592
Nursing Facility	0	0	2	0	1
Psych Under 21	0	0	0	0	0
Total	**638**	**652**	**628**	**619**	**593**

F. Federal funds generated

Section 4(3)(a)(F): "The total amount of federal funds generated to serve individuals under the age of 21 years through the Community First Choice Option in each of the prior three fiscal years"

Note: Some numbers may not sum exactly due to rounding.

Table 6: Federal Funds Generated through K Plan Services

	2019	2020	2021	2022	2023
Hospital	$1,866,241	$1,536,145	$2,073,711	$3,911,949	$6,217,002
ICF/IID	$144,775,186	$169,293,832	$223,042,812	$260,351,559	$309,238,012
Nursing Facility	$7,329,723	$ 7,188,935	$9,016,444	$12,106,032	$14,006,784
Psych Under 21	$0	$0	$0	$0	$0
Total	**$153,971,150**	**$178,018,912**	**$234,132,967**	**$276,369,540**	**$329,461,799**

G. Estimate of unmatched General Fund

Section 4(3)(a)(G): "An estimate of the total amount of unmatched General Fund expenditures that could receive federal matching funds through the Community First Choice Option and that were spent to meet the needs of individuals under the age of 21 years who are in the child welfare system"

Youth in the Child Welfare system receive services and supports that are the same or similar to those provided to individuals under the K Plan. If additional youth with ADL/IADL and other health-related needs meet an institutional LOC, including the Psych under 21 LOC criteria under development, and become eligible for and enrolled in the K Plan, there may be savings in the General Fund (GF) once those expenditures became eligible for the enhanced Federal Match under the K Plan.

The estimate of the total amount of funds is not yet available for this preliminary report. OHA and ODHS anticipate that the final report will include efforts to develop an estimate based on identification of current expenditures. This will be based on a calculation of the portion of those expenditures that could potentially be matched with federal funds in the future. Below is our initial, proposed methodology that will be further refined. The initial draft methodology would require Oregon to identify:

1) For calculating current GF Expenditures:
    a. Population of individuals under 21 in the Child Welfare system;
    b. The services and supports these individuals received that are coverable services under the K Plan; and,
    c. The total expenditures for these services and supports, identifying any costs that are already being matched with federal funds or covered through other federal mechanisms.
2) For calculating the portion of GF Expenditures that could potentially be matched with federal funds:
    a. The percentage of the population above that is in a Medicaid eligibility coverage group that would be eligible for federal K Plan services;
    b. An estimate of the percentage of those children and youth who might meet the Psych under 21 Institutional LOC based on claims data and behavioral health service utilization.

Since the Psych under 21 LOC criteria for the K Plan are under development, OHA and ODHS will have to use inpatient psychiatric hospitalization and PRTF claims or other related data to serve as proxy measures for this cost. Once LOC criteria are finalized, this estimate can be updated to align with the criteria more accurately. To provide the requested estimate, current GF expenditures as specified above will be reduced by multiplying by the percentages identified in the logic described above.

H. Estimate of children disrupted from their family homes

Section 4(3)(a)(H): "An estimate of the number of children disrupted from their family homes each year due to the children's unmet disability or mental health related needs"

There are children in Oregon with mental health, neurodevelopmental disorders, and disabilities whose needs are not being met. In some cases, the lack of sufficient, appropriate, and timely services and supports cause or contribute to the child being disrupted from their family home. As OHA considered the request for an estimate of the number of children disrupted from their homes and explored it with cross-agency partners, there was universal agreement that unmet needs contribute to the disruption of children from their family homes.

In the listening sessions, families described being frustrated with having to meet an institutional LOC in order to access services. One parent noted that there are long wait lists and "families are told they have to hospitalize their kids to get access to services." Another family member agreed, saying, "Early intervention means when the family asks for help."

Families described challenges associated with ableism, racism, and a lack of compassion and engagement, many of which were not specific to the K Plan itself. One parent said that she felt very powerless when she first hospitalized her child with psychosis and, even when she got into the programs for her child, she felt that the individuals providing care were judgmental and made families feel defensive. Another parent said that families need support that is provided in a more culturally responsive manner. She said that families experience discrimination and have trouble accessing services as a direct result of that discrimination.

Unfortunately, for the purposes of a sufficient response to this request, there was a corresponding inability to quantify this concern with a meaningful estimate. Current data tracking across systems is not consistent enough to clearly connect causal relationships in a way that would serve as a factual basis for such an estimate, especially without predetermined shared definitions of "need," "unmet," and "disrupt." While OHA is not able to make this estimate at present, it is aware of and working to address the problem at its root so that children's needs are appropriately identified and met.

All children in Oregon who are enrolled in OHP should have access to EPSDT Medically Necessary and EPSDT Medically Appropriate services without needing to access the K Plan or a 1915(c) HCBS Waiver. Additionally, Oregon continues to implement its Family First Prevention Services Act (FFPSA) plan and other individualized efforts to help children, youth, and families receive necessary services and supports to remain together in their own homes and communities without requiring them to enter the foster care system

Section 3: SB 1557 Section 4(3)(b): Recommendations

A. Opportunities to Expand Services

Section 4(3)(b)(A): "About opportunities to use the Community First Choice Option to expand and enhance the services that will support individuals under the age of 21 years who experience serious emotional disturbances or mental illness to live successfully in their family homes and avoid crises"

As discussed above, federal rules require that individuals served through the Community First Choice Option (K Plan) services meet an institutional LOC, which includes hospital, nursing facility, ICF/IID, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases (IMD) for individuals age 65 or over, if the cost could be reimbursed under the State Plan.

Inpatient psychiatric services for individuals under age 21 ("psych under 21" benefits) are defined at 42 CFR 440.160. These benefits may be provided in a psychiatric hospital, general hospital with an eligible psychiatric program, or a Psychiatric Residential Treatment Facility (PRTF).

The Community First Choice Option could provide needed support for individuals under 21 who have ADL/IADL and other health-related needs and experience mental health challenges so they may remain in their homes and communities. Children and youth meeting the institutional LOC may be eligible to receive K Plan services and supports in their home or community, and, when combined with medically necessary and appropriate behavioral health treatment, they may be able to avoid placement in one of the settings above.

OHA and ODHS are interested in exploring opportunities to use the Community First Choice Option to expand and enhance the services that will support individuals under the age of 21 years who experience serious emotional disturbances or mental illness so that they can live successfully in their family homes and avoid crises. However, as OHA and ODHS explore opportunities to support individuals under 21 with complex behavioral health needs to remain in their homes and communities, the State recognizes that federal limitations of

the K Plan. These limitations include the requirement for annual reassessment of LOC eligibility, which may constrain the ability of the K Plan to be the most effective approach to supporting children and youth with complex mental health needs. States are required to reassess LOC eligibility of K Plan enrollees at least annually unless they determine that there is no reasonable expectation of improvement or significant change in the individual's condition because of the severity of a chronic condition or the degree of impairment of functional capacity, (7) which is not typical for serious mental health conditions. This could limit the length of time when K Plan services could be provided to many children and youth experiencing mental health conditions and their families.

Additionally, The Ombuds Program 2023 Six Month Report, shared by OHA and families participating in the listening sessions, recommended Mobile Response and Stabilization Services (MRSS), Intensive In-Home Behavioral Treatment Services (IIBHT), and Respite Care as the priority strategies to address child, youth, young adult, and family mental health care in Oregon. While MRSS and IIBHT are already Medicaid-covered services in the process of implementation across Oregon, respite care is not covered under Oregon's Medicaid State Plan or Waivers and is not an eligible K Plan service. However, it would be beneficial to explore any potential coverage opportunities for respite care with CMS, building upon the efforts outlined in the OHA 2025–27 Agency Request Budget (p.1317–1337).

In the initial listening sessions, families reported they believed some youth with serious behavioral health needs who meet the LOC might benefit from supports that would qualify as ADL/IADL. In particular, they described the importance of having someone who can come into the home and assist with tasks that the youth needs to perform. Examples of activities that would benefit from individualized support included

- initiating and completing chores around the house related to cleaning and personal hygiene,
- practicing calling a medical or other office for an appointment and
- learning how and practicing finding out if a practice is covered by their insurance.

They also discussed the potential benefit of having someone support a youth prepare for school and help them after school. Families also reported that K Plan services would be helpful to support youth to participate in community activities by assisting with transporting the youth and going with the youth to a program, after-school activity, or event.

Several family members noted that it would be helpful to have support for door or window alarms or containers to lock away potentially dangerous objects. These supports may be available and would need to be based on an assessed need and follow the individually based limitations process to be in compliance with the Home and Community Based Settings federal requirements.

It may benefit Oregon to explore a combination of strategies, in addition to assessing the availability and accessibility of prioritized behavioral health services, including intensive care coordination using Fidelity Wraparound, intensive in-home behavioral health treatment, mobile response and stabilization services, peer support, and respite care, all of which were identified in the 2013 Joint CMCS and SAMHSA Informational Bulletin:

- Implement Psych under 21 LOC to enable provision of services related to ADL, IADL, and health-related tasks for children and youth meeting criteria;
- Implement 1915(c) Waiver for youth with serious behavioral health needs; and/or
- Implement 1915(i) SPA for youth with serious behavioral health needs.

The table in Appendix 3, excerpted from the CMS HCBS Technical Assistance website, outlines some of the requirements associated with each of these Medicaid authorities. As discussed above, 1915(c) HCBS waivers:

- Require participants to meet an institutional LOC.
- Do not include PRTFs as an eligible institutional setting, limiting eligibility to hospitals, ICF/IID, and nursing facilities.
- Require HCBS services to be cost neutral with those provided in an institutional setting.
- Include more expansive financial eligibility criteria, permitting states to specify the Medicaid eligibility groups that are served in the waiver.
    - In order for an eligibility group to be included in the waiver, it must already have been included in the State Plan.
    - States are permitted to use institutional income and resource rules for the medically needy (institutional deeming) and they may include the special income level group of individuals and may permit income up to 300% of SSI. (2)

The 1915(i) SPA enables states to offer HCBS to individuals who meet needs-based criteria, which can be less stringent than institutional LOC. Eligibility is limited to individuals eligible for Medicaid under the State Plan up to 150% of Federal Poverty Level. States may also include special income group of

individuals with income up to 300% SSI/FBR, who are eligible for HCBS under a §1915(c), (d), or (e) waiver or §1115 demonstration waiver. Individuals need to be eligible for and receiving services under one of these waivers in order to meet financial eligibility criteria. (2)

B. Opportunities to maximize federal matching funds

Section 4(3)(b)(B): "About opportunities to maximize federal matching funds to support services for individuals under the age of 21 years who experience substance use disorders"

Under the EPSDT benefit outlined above, all services that are EPSDT medically necessary and EPSDT medically appropriate are required to be provided with Medicaid reimbursement to youth and young adults 20 years old and younger, enrolled in Medicaid. Oregon's Substance Use Disorder (SUD) 1115 Demonstration Waiver, effective 4/8/21, enables OHA to use Medicaid funds to pay for SUD residential treatment in facilities with more than 16 beds and permits the use of Medicaid funding for prevention, outreach, and recovery support, in addition to treatment services.

C. How K Plan Can Support Resource Families

Section 4(3)(b)(C): "For how federal matching funds provided through the Community First Choice Option can be used to expand and enhance funding for and access to supports to foster parents serving children with serious emotional disturbances, mental illness or substance use disorders, including but not limited to relief care, training and in-home attendant care services"

Children in Oregon's Child Welfare system receive all Medicaid benefits, including through EPSDT. Federal matching funds provided through the K Plan could expand and enhance access to supports for child welfare foster parents of children and youth meeting the institutional LOC as outlined above, as relief care, training, and in-home attendant care services could be eligible under K Plan services if they are used to support ADL, IADL, or health-related needs. As noted above, relief care is back-up providers or care setting alternatives in case the participant's primary provider becomes ill or is suddenly no longer available. If the Child Welfare agency is responsible for paying for the foster parent, Medicaid could not pay for relief care for the foster parent. Relief care would only be applicable to cover personal attendant services or other services eligible under the K Plan.

D. Opportunities to create specialized out-of-home placements

Section 4(3)(b)(D): "About whether and how provisions of Medicaid and Medicaid funding streams may be utilized to create mental health resource homes, specialized homes for up to two children with behavioral health needs or treatment foster care that is accessible to the children served by child welfare programs in the Department of Human Services and to children, youth and young adults without requiring the children, youth or young adults to first access the child welfare system or the juvenile justice system"

While Medicaid covers some inpatient and other residential services, many types of room and board are not eligible for Medicaid reimbursement. The K Plan will not cover room and board costs and only reimburses specific services related to ADL/IADL and health-related needs, as noted above.

Oregon could explore opportunities to braid funding across federal and state sources to cover the costs of specialized behavioral health treatment and intervention homes. The specific clinical and behavioral health services provided through a mental health resource home or treatment home would need to be detailed, with rates set for those services and implementation activities associated with provider outreach, enrollment, and training. Examples of such services could include intensive in-home treatment, peer support, intensive care coordination, and psychoeducation. Oregon could include these homes as a treatment intervention under Rehab Option in the State Plan or through a waiver authority, but the room and board components would need to be covered through other, non-Medicaid funding. Although room and board costs may be covered by Title IV-E for some children in foster care, fewer than half (approximately 40%) of children in foster care in Oregon are eligible for Title IV-E (similar to national figures), due to the restricted eligibility criteria associated with those funds. (8)

OHA and ODHS are prioritizing making treatment and service interventions available to children and youth without requiring them to leave their own homes, which can be a traumatic experience. Oregon is focused on identifying opportunities to expand access to and availability of effective treatment supports and interventions in the home and community, including through EPSDT, as part of the State Plan (including under the Rehab Option), and/or through a waiver or 1915(i) SPA. Families described wanting access to services

and supports prior to their children meeting an institutional LOC and without them having to leave the home. As discussed above, Oregon is exploring possible mechanisms to access respite care to support families to maintain children in their own homes without requiring out-of-home care.

E. How K Plan can support children and youth with behavioral health needs

Section 4(3)(b)(E): "About how federal matching funds through the Community First Choice Option can be used to support children and youth with serious emotional disturbances, mental illness or substance use disorders and to provide services necessary for a successful transition from institutional placement or other restrictive placement to a family home, a foster home or another less restrictive environment"

As described in response to Section 4(3)(b)(A) above, Oregon is interested in opportunities to leverage the K Plan and other federal Medicaid authorities to support children and youth with complex behavioral health challenges. The Community First Choice Option could provide needed support for individuals under 21 who have ADL/IADL and other health-related needs and experience mental and behavioral health challenges so they may remain in their homes and communities. Federal matching funds through the K Plan could be used to provide supports to youth who meet the LOC criteria after:

- Psych under 21 LOC criteria are established and
- Training, provider outreach and enrollment, individual care pathway and enrollment, and communication and information system activities are implemented.

K Plan services would be appropriate to support a youth to transition from an institutional placement if the youth continues to meet institutional LOC but for the provision of the HCBS services. In that instance, if the services and supports available under the K Plan (such as skills training, positive behavioral supports, and attendant care services) are sufficient to support the youth in the community, they could be provided once the youth has returned to a home- or community-based setting. This may shorten the length of time the youth is served in an institutional setting.

F. How eligible children and youth have their needs met

Section 4(3)(b)(F): "For how multi-system involved children or youth who are eligible for services and supports under the Community First Choice Option or the State Plan for medical assistance have their assessed needs fully met while avoiding duplication of services and supports, including by using available natural and community supports"

Children and youth receiving I/DD services through ODHS receive service coordination. Community Developmental Disabilities Programs, Support Brokerages, or Children's Intensive In-Home Services Coordinators meet with children and youth to review their current situation, identify needs, and make referrals for services and supports. Many youth currently eligible for the K Plan receive DD case management services and have an Individual Support Plan (ISP). Additionally, children and youth enrolled in the K Plan receive service coordination as one of the K Plan benefits, which requires a person-centered service plan that is supported by a person-centered plan coordinator.

Youth who may be eligible for the K Plan using the forthcoming Psych under 21 LOC criteria may already have access to intensive care coordination using Fidelity Wraparound. As part of the design and implementation of the Psych under 21 LOC criteria, Oregon will be delineating the referral, engagement, enrollment, and care planning components of the K Plan to ensure no duplication of service or support.

In Fidelity Wraparound, care coordinators collaborate with the youth, their family, and the Child and Family Team to complete a functional, strengths-based assessment and create a single, comprehensive plan of care across life domains. In Fidelity Wraparound, the goal is to have at least half of the Child and Family Team be composed of natural supports, with that amount increasing prior to discharge from services. A single plan of care is maintained and incorporates agency-specific plans of care, including plans from child welfare, juvenile justice, special education, and others. This reduces duplication of services and supports and streamlines service provision while maintaining accountability for outcomes. Oregon recognizes that there is currently limited availability for Fidelity Wraparound to ensure low caseloads necessary for fidelity to the model, and that non-OHP members may not currently have access to this support.

G. Identification of needed statutory and/or budgetary changes

Section 4(3)(b)(G): "For any statutory changes or changes to the authority's legislatively adopted budget that are necessary to implement recommendations that will maximize available funds through the Community First Choice Option and support children and youth to avoid crises and remain in the least restrictive environment"

In order for Oregon to come into compliance with its federal obligations and assurances to serve children and youth who meet the Psych under 21 LOC criteria, the continuing service level budget for OHA should be reset to include the necessary costs associated with both the design and implementation of the criteria.

OHA and ODHS have estimated that they would require up to eleven additional staff to design and implement these services. **When OHA and ODHS have a more detailed plan of action, the number of staff could be significantly higher,** to ensure compliance with federal and state rules, support effective and comprehensive communication and community planning and engagement, ensure comprehensive provider engagement and enrollment, and develop and implement robust data collection, oversight, and quality improvement plans. Once designed and implemented, **OHA and ODHS will require additional staff to effectively operationalize K Plan services and supports for individuals meeting Psych under 21 LOC.**

In the implementation of the Psych under 21 criteria, OHA will need to

- Develop a LOC and functional needs assessment process, which may include use of a standardized functional or clinical assessment tool
- Identify appropriate provider types
- Complete the SPA process, in compliance with federal laws to legally and equitably implement the assurances
- Establish infrastructure, referral processes, and access pathways for initial and ongoing determinations
- Develop and implement provider enrollment, oversight, and payment processes, integrated and aligned with existing protocols for the K Plan as well as those used currently to support youth with complex behavioral health needs

- Develop policies for the LOC assessment, functional needs assessment, person-centered planning activities (including goal setting and preferences), choice counseling, grievance procedures, risk management, critical event response and management, and outcomes and quality assurance
- Develop a data collection processes consistent with 42 CFR 441.580 and coordinate data collection with ODHS
- Develop a quality assurance strategy consistent with 42 CFR 441.585

Further costs would be associated with communication, marketing, and technical assistance activities associated with provider recruitment and enrollment and family and youth engagement and enrollment. Additionally, funds would be necessary to cover the costs of the ongoing coordination, reporting, and services provided to children and youth.

H. About implementing a parental income disregard

Section 4(3)(b)(H): "About implementing a policy to disregard parental income when determining medical assistance eligibility for children and youth with serious emotional disturbances, including the following information about the effects of the policy:"

(i) The estimated size of the population that is not currently eligible for medical assistance but that would be eligible for medical assistance due to such a policy:

A sufficiently accurate estimate has not yet been established.

(ii) The estimated cost to serve the entire eligible population:

A sufficiently accurate estimate has not yet been established.

(iii) Whether the number of children with serious emotional disturbances who are eligible to have their parents' income disregarded should be capped, and if so, at what number:

K Plan financial limits, without a 1915(c) waiver, is 150% of FPL for family income. As noted above, a 1915(c) waiver allows the parents' income to be disregarded and the child to have income up to 300% of SSI (217 group). Under a 1915(c) waiver, the number of eligible children could potentially be capped based on estimated population needing services. If Oregon utilizes a 1915(c) waiver to disregard parental income, the need to cap the number of enrollees

would be dictated by the amount of funding available through the legislature. Oregon could cap the number of enrollees and then monitor and identify whether that cap should be revised through an amendment in future years.

(iv) Criteria to use if the number of children described in sub-subparagraph (iii) of this subparagraph was capped:

Consistent with the response to (iii) above, criteria would need to reflect the availability of quality services, the resources available to support children and their families, and the funding available for services, coordination, infrastructure, training, data collection, oversight, and other functions already outlined. The criteria would be developed in partnership with other agencies and with engagement from families, youth, individuals with lived expertise and experience, provider organizations, and other key stakeholders.

(v) What impact the disregard of parental income may have on preventing the temporary lodging of children in the custody of the Department of Human Services, accessing Medicaid funding for school-based care for students with high needs and boarding children in emergency rooms due to the lack of available placements.

Preventing temporary lodging: Children in the care and custody of Child Welfare are already enrolled in OHP and are eligible for all medically necessary and appropriate Medicaid services and supports. However, a disregard of parental income may enable some children to access 1915(c) and K Plan services without needing to enter the custody of Child Welfare to get the services they need.

Accessing Medicaid funding for school-based care for students with high needs: K Plan services cannot supplant services required to be provided by schools or be used for services that should be covered under IDEA. They cannot be used to pay for room and board. Home, school, and community-based services for children with complex behavioral health needs can be provided with Medicaid reimbursement through EPSDT under the State Plan.* A disregard of parental income may enable eligible children and youth who are not otherwise eligible for OHP to be enrolled in a 1915(c) Waiver and the K Plan and have access to all State Plan services. This could be impactful for children and youth who have complex behavioral health needs, are not OHP-eligible, and have an identified need for school-based care available through OHP.

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* Recent CMS guidance provides comprehensive information on expanding Medicaid claiming for school-based services and leveraging Medicaid, CHIP, and other federal programs in the delivery of behavioral health services for children and youth.

Boarding children in emergency rooms due to the lack of available placements: Similar to the Medicaid funding in schools, a disregard of parental income may enable some eligible children and youth to be enrolled in a 1915(c) Waiver and the K Plan and gain access to State Plan services. This could be impactful for children and youth who have complex behavioral health needs, are not OHP-eligible, and who have not been able to access sufficiently comprehensive, individualized, and intensive interventions and supports through community-based services or private/commercial insurance.

Appendices

Appendix 1: Descriptions of Oregon's approved home- and community-based settings

Adult day: Attendant care supports in the community that happen during scheduled, intentional, structured activities in a non-residential setting.

Assisted living facility: An assisted living facility, which is licensed by APD, is a building consisting of fully, self-contained, individual living units where six or more senior or adult individuals with disabilities may reside in home-like settings. The assisted living facility offers and coordinates a range of supportive services available on a 24-hour basis to meet the activities of daily living, health, and social needs of the residents. Adults include individuals over the age of 18 in the APD program.

Foster home: A foster home is a home-like setting where care providers live with the individuals receiving services. An adult foster home is a home where residential services are provided in a home-like environment for compensation to five or fewer adults not related to the provider by blood, marriage, or adoption. It does not include any house, institution, hotel, or other living situation that supplies room and board only if no individual in the home requires any element of care. Adult foster homes are licensed by APD, ODDS, and OHA depending on the population served. A child foster home is a home certified by the Department that is maintained and lived in by the person named on the certificate. Foster homes are considered provider-owned, controlled, or operated residential settings.

Group home: A group home is a 24-hour residential setting (a home, apartment, or duplex) licensed by the Department under ORS 443.410 where HCBS are provided to individuals with IDD with shift staff who do not live in the home. It is a distinct method for the delivery of services. It is considered a provider-owned, controlled, or operated residential setting.

Host home: A host home is a residential training home (ORS 443.400) that is a community-based family home setting licensed by the Department to provide HCBS to children with IDD. They are community homes with an in-residence caregiver serving in a parental role with additional staff to deliver intensive care and support in a family home environment.

In home: A home that is the primary residence for an individual that is not under contract with the Department to provide services certified as a foster home for children under OAR chapter 411, division 346; licensed as a foster home for adults under OAR chapter 411, division 360; or a licensed or certified residential care facility, assisted living facility, nursing facility, or other residential setting. For individuals served by APD, in-home includes services provided in their own home or their family's home, which can also include services provided in shelters and hotels.

Residential care facility: A residential care facility, which is licensed by APD, is a building consisting of shared or individual living units in a homelike surrounding, where six or more seniors and adult individuals with disabilities may reside. The residential care facility offers and coordinates a range of supportive services available on a 24-hour basis to meet the activities of daily living, health, and social needs of the residents as described in Oregon Administrative Rules. Adults include individuals over the age of 18 in the APD program.

Stabilization and Crisis Unit (SACU): A SACU Group Home is a state-operated 24-hour crisis residential program licensed by ODDS under ORS 443.410 for individuals with I/DD, often with co-occurring mental health needs. The SACU Group Home provides support for individuals whose needs exceed what can be provided in other community residential programs.

Supported living: Supported living is a program that provides individuals with the opportunity to live in the residence of their own choice in the community, which could be their own home or a provider-owned and operated home.

Appendix 2: Feedback from families, caregivers, and individuals with lived expertise

In preparation for the preliminary report on SB 1557, OHA conducted five public virtual information and listening sessions for families and caregivers with lived expertise and engaged in a virtual information session with a mother and daughter with lived expertise. Four of the public sessions were in English and one was in Spanish. Additionally, OHA issued two surveys (available in both English and Spanish), requesting feedback and input. Finally, OHA facilitated a discussion with the Children's Services Advisory Group (CSAG), which primarily included professionals with lived expertise.

Engagement opportunity	Date	Language	Participants* and respondents
Virtual Information Session	7/9/24	English	25+ participants
Virtual Information Session	7/16/24	English	11+ participants
Virtual Information Session	7/19/24	English	3 participants
Virtual Information Session	7/26/24	English	2 participants
Feedback Survey	7/2024	English and Spanish	44 respondents
Virtual Information Session	8/13/24	English	28+ participants
Virtual Information Session	8/16/24	Spanish	13+ participants
Feedback Survey	8/2024	English and Spanish	7+ participants
CSAG Meeting	9/4/24	English	

The following is a summary of feedback provided through the virtual information sessions and feedback surveys in response to specific questions and prompts.

Have you heard about Community First Choice Option (K Plan) services? If yes, what have you heard?

Many participating family members whose children had intellectual and/or developmental disabilities (I/DD) were familiar with the K Plan. Some families mentioned that K Plan services have been very helpful to support their families, with one family noting that they have been "a game-changer for us…allowing our daughter to remain in the community." Some family members noted that it is very individualized, which means that they might be more or less helpful at different points in time and have the potential to be more confusing to access because it is so specific to the particular child or individual. One parent observed, "In my experience, K Plan services are appreciated by families, but it requires a strong and consistent services coordination team to fully utilize them."

* May include State Agency participants, some of whom also have lived expertise. Numbers are based on counts at a single point in the engagement session, which may have changed as individuals joined or left the meeting. Some individuals participated in multiple information sessions and/or also completed a survey.

When you consider who could access these services, how could a care provider or other professional assist a child with behavioral health needs at home or in the community? Which services and supports might be most helpful under the K Plan authority for youth with complex behavioral health needs who are at-risk of requiring an institutional placement?

In these initial listening sessions, families reported they believed some youth with serious behavioral health needs who meet the level of care (LOC) might benefit from supports that would qualify as ADL/IADL. One participant observed that non-mental health supports have the potential to dramatically improve and impact mental health symptoms.

Many participants described the importance of having someone who can come into the home and assist with tasks that the youth needs to perform. Examples of activities that would benefit from individualized support included initiating and completing chores around the house related to cleaning and personal hygiene, practicing calling a medical or other office for an appointment and learning how and practicing finding out if a practice is covered by their insurance. In one conversation, participants noted that one of the most commonly requested services among families whose children qualify for behavioral health services but not I/DD services is direct service professional or skills trainers.

Participants also discussed the potential benefit of having someone support a youth prepare for school and help them after school. Families also reported that K Plan services would be helpful to support youth to participate in community activities by assisting with transporting the youth and going with the youth to a program, after-school activity, or event. Some family members described a need for an awake individual at night to ensure that the child is supervised and someone is available if the youth wakes up.

Family members reflected that K Plan supports could be helpful to enable the family to feel safe in bringing the youth into the community to access services or engage in community events, including by joining the family to transport to locations. Others described a benefit that could come from having a person with specific skills to help the youth learn or practice strategies to support daily living because the youth's family may be unable to hear one another and how to communicate the specific need or task. Examples of tasks included how to transition between activities, doing laundry, taking showers, and participating in community activities.

Some family members described specific activities that could be supported under the K Plan, including helping the family to make sure the home is physically safe for a youth that may have suicidal ideation. Several family

members noted that it would be helpful to have support for door or window alarms or containers to lock away potentially dangerous objects. One participant noted that it would be helpful to have access to devices to support calming strategies and communication.

Many family members described a need for someone to provide additional supervision, including for safety and medication administration; support hygiene tasks; provide cuing, reminding, and modeling; and offer peer support to families. One family member explained that families who have experienced trauma can begin to heal when a trained individual can come into the home as a safe person and provide support.

One young person described that she could have benefited from having a person who was more of a coach or mentor than a therapist to help her learn how to schedule, advocate for herself, express herself, and communicate more positively. She noted that that person would have been a positive support for her to make plans, go with her to birthday parties, and find something creative to do outside of the home.

When you consider who could access these services, what specific skills training and/or behavior supports might a family need for a child with serious behavioral health needs?

Family members had numerous suggestions for the types of training and behavioral supports that could be provided to youth and families, including:

- How to develop natural supports and identify resources in the community, including for youth closer to adulthood
- Suicide prevention, preventing and addressing self-harm, lethal means training and support, and safety planning for the whole family
- Skills training for families to protect from identify theft
- Support for siblings and other family members
- Navigating social media
- Support for the youth to make phone calls requesting information or appointments
- Skills training related to driving
- Support before and after the school day to improve school engagement and success
- Sensory processing support tools and strategies
- Neurodevelopment and trauma, including the impact of trauma on physical health

- Understanding how different behaviors manifest and how to support the youth demonstrating them
- Collaborative problem-solving and de-escalation
- Supporting youth with changing identities
- Peer socialization
- Navigating and keeping up with multiple therapies and supports (e.g. physical, speech, occupational)
- Communication strategies and reading cues and body language
- Sensory accommodations in the home
- Advocacy and how to tell your story
- Intensive in-home behavioral treatment from a parent/family perspective
- Exit strategies for social situations
- Identifying how to advocate for yourself, including in selecting and maintaining providers and therapists
- Destigmatizing mental health

What are some of the challenges associated with accessing K Plan services?

Families described that it can be hard to know which services and supports are available through the K Plan because they are so individualized. One family member said, “Explain the K Plan, how it works and who it will cover, what the rules are for this process, and know how you qualify.” Another participant noted that families report services not being available but may not know which services are available that might meet their needs and how to access them.

They also discussed barriers to accessing the K Plan and a lack of providers who are well-trained to work with children and youth with I/DD and/or complex behavioral health issues and their families. They described a difficult time finding quality providers willing to come into the home to provide services. They also described a mismatch between the hours when services are available and when the youth actually needs them; children attending school need to have access to services before or after school and on the weekends and in the evenings. Some families also described what they felt was contradictions between the positive behavior support plans and mental health services needed; others expressed dissatisfaction with the therapies and interventions that focus on changing the child’s behavior.

Families described frustration with having to meet an institutional level of care in order to access services, with one parent noting that there are long wait

lists and “families are told they have to hospitalize their kids to get access to services.” Another family member concurred, saying, “Early intervention means when the family asks for help.”

Some families described challenges associated with ableism, racism, and a lack of compassion and engagement, many of which were not specific to the K Plan itself. One parent said that she felt very powerless when she first hospitalized her child with psychosis and, even when she got into the programs for her child, she felt that the individuals providing care were judgmental and made families feel defensive. Another parent said that families need support that is provided in a more culturally responsive manner. She said that families experience discrimination and have trouble accessing services as a direct result of that discrimination.

Families described challenges associated with maintaining their own employment and/or taking care of other members of the family while trying to support their child receiving K Plan services. Families described being isolated in their caregiving, with challenges exacerbated in rural communities with fewer resources. Others discussed the difficulty of always needing to bring people into your home and how providers do not always understand what it means to provide care inside the home, treating it as just a workplace. They discussed the difficulty of managing the individuals who come into the home to provide services, sometimes showing up late, not showing up at all, being disrespectful, bringing their pets with them, being on their phone, or otherwise not engaging professionally.

What would be most helpful in providing information about K Plan services and other supports for youth with complex behavioral health needs?

- Families provided recommendations for how Oregon might increase awareness of K Plan services, including:
- Continuing to provide information through pediatrician offices and family networks
- Advertising on news channels and providing public service announcements
- Disseminating information through faith-based and community-based organizations and libraries
- Creating a brokerage model for families
- Utilize family support providers who can help multigenerational families
- Using community leaders and community health workers
- Using school registration and other school events and communication networks
- Providing short videos

Family members emphasized the importance of information being shared in multiple languages and in a manner that is accessible for individuals with disabilities. Several emphasized the need for information to be shared in a variety of formats, including written materials that use visuals and not just text. They also suggested that written materials should outline the types of services and supports that can be provided under the K Plan, even if it is not an exhaustive list. Additional suggestions included utilizing distribution strategies that focus on reaching historically underserved and rural communities and ensuring that the materials explain how to access the K Plan services, in addition to what may be included and who might be eligible. Participants also recommended providing an online map of services and supports that provides information on what is available to families with private insurance, OHP, no insurance, or a combination of insurance.

What else is important for families to be able to access to support a child to remain in their home and community?

Many family members voiced a need for respite care, access to peer support, crisis services, and for family members to be able to be paid as caregivers. Several described challenges within schools and a need for there to be additional supports for youth during the school day. Many also described a need for funds for socialization and skill-building activities, as well as home monitoring and modification.

Families also described general workforce challenges across Oregon, including a need for more prescribers who will work with youth, behavioral health providers who are trained to work with youth with I/DD, and workers who are trained to come into the home and partner with the family.

Appendix 3: Comparison of HCBS Authorities

Table 7: Comparison of HCBS Authorities (excerpted from CMS HCBS TA Website)

HCBS Authority	1915(c)	1915(i)	1915(k)
Purpose	The 1915(c) waiver authority permits a state to offer home and community-based services to individuals who: (a) are found to require a level of institutional care; (b) are members of a target group that is included in the waiver; (c) meet applicable Medicaid financial eligibility criteria; (d) require one or more waiver services in order to function in the community.	1915(i) permits states to offer HCBS to Medicaid-eligible individuals who meet state-defined minimum needs-based criteria that are less stringent than institutional criteria, and state-optional target group criteria. May also provide services to individuals whose needs exceed the state's minimum needs-based criteria including those who meet an institutional level of care.	1915(k) permits states to provide individuals meeting an institutional level of care the opportunity to receive necessary personal attendant services (PAS) and supports in a home and community-based setting. The CFC option expands Medicaid opportunities for the provision of home and community-based long-term services and supports (LTSS) and is an additional tool that states can use to facilitate community integration while receiving enhanced Federal match of six (6) additional percentage points for CFC services and supports.
Requirements that may be waived or disregarded (for State Plan options)	State-wideness Comparability Community income rules for medically needy population	Comparability Community income rules for medically needy population	Community income rules for medically needy population.

HCBS Authority	1915(c)	1915(i)	1915(k)
Medicaid financial eligibility	The state may specify the Medicaid eligibility groups that are served in the waiver. In order for an eligibility group to be included in the waiver, it must already have been included in the State Plan. States are permitted to use institutional income and resource rules for the medically needy (institutional deeming). May include the special income level group of individuals and may permit income up to 300 percent of SSI. For individuals eligible under section 1902(a) (10)(A)(ii)(VI) of the Act who continue to meet all of the 1915(c) waiver requirements and who are receiving at least one 1915(c) waiver service a month, excess income determined under 42 C.F.R. 435.726 is applied to the cost of 1915(c) waiver services, to the cost of 1915(k) services.	Individuals eligible for Medicaid under the State Plan up to 150 percent of Federal Poverty Level. States may also include special income group of individuals with income up to 300 percent SSI/FBR, who are eligible for HCBS under a §1915(c), (d), or (e) waiver or §1115 demonstration waiver.	State must cover all categorical eligibility groups and may elect to cover medically needy. Individuals eligible for the CFC benefit are either: in an eligibility group entitled to nursing facility services under the State Plan; or are not in an eligibility group entitled to nursing facility services but whose income is at or below 150 percent of the Federal poverty level. For individuals eligible under section 1902(a) (10)(A)(ii)(VI) of the Act who meet all of the 1915(c) waiver requirements and who are receiving at least one 1915(c) waiver service a month, excess income determined under 42 C.F.R. 435.726 is applied.

HCBS Authority	1915(c)	1915(i)	1915(k)
Target groups (if applicable) and other eligibility criteria	Individuals must meet institutional level of care. Waivers are limited to one or more of the following target groups or any subgroup thereof: • Aged or disabled, or both; • Individuals with Intellectual Disabilities or a developmental disability, or both; • Persons with mental illnesses. • States may also specify age ranges within the target groups and/or subgroups served. • Additional targeting criteria may include but are not limited to: • Nature or type of disability; • Specific diseases or conditions; • Functional limitations (e.g., extent of assistance required in ADLs or IADLS.	A state may elect not to apply comparability requirements set forth in the statute. This provision enables states, at their election, to target the HCBS State Plan option. These target groups must be defined on the basis of any combination of the following: Age; Diagnosis; Disability; Medicaid Eligibility Group And may not have the impact of limiting individuals' choice of provider and/or living setting. NOTE: See approval section above for 1915(i) benefits that include targeting. Regardless of whether a state elects to target the 1915(i), each 1915(i) must include need-based criteria which are factors used to determine an individual's requirements for support and may include risk factors. The criteria are not characteristics that describe the individual or the individual's condition. A diagnosis is not a sufficient factor on which to base a determination of need. Needs based criteria must be less stringent than institutional level of care criteria. In addition to needs-based criteria for eligibility for HCBS as a State Plan option, the state may establish needs-based criteria for each service.	States may NOT target 1915(k) benefit. Services must be provided on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community- based attendant services and supports that the individual requires in order to lead an independent life. Individuals must meet institutional level of care. Individuals eligible for Medicaid under 42 CFR 435.217, must continue to meet the eligibility requirements for the 1915(c) waiver in order to maintain eligibility for Medicaid and CFC.

HCBS Authority	1915(c)	1915(i)	1915(k)
Other unique requirements	States may operate multiple 1915(c) HCBS waivers **Cannot cover:** Room and board costs. Habilitation does not include special education and related services provided under IDEA that are education related only and vocational services provided under Rehab Act of 1973.	Multiple State Plan amendments covering different target groups permitted. **Cannot cover:** Room and board costs. Habilitation does not include special education and related services provided under IDEA that are education related only and vocational services provided under Rehab Act of 1973.	MOE requirement for 1st fiscal year for services provided under 1115, 1905(a), and 1915 of the Act. Must establish and consult with a Development and Implementation Council with majority representation from consumers. **Cannot cover:** Certain assistive devices and assistive technology services; medical supplies and equipment, home modifications, unless it meets the requirements in 42 CFR 441.520(b)(2). Room and board costs. Special education and related services provided under IDEA that are education related only and vocational services provided under Rehab Act of 1973. **Increased FMAP:** 1915(k)(2) provides that States offering this option to eligible individuals during a fiscal year quarter occurring on or after October 1, 2011, will be eligible for a 6% point increase in the Federal medical assistance percentage (FMAP).
Limits on numbers served	Allowed	Not Allowed	Not Allowed

HCBS Authority	1915(c)	1915(i)	1915(k)
Waiting lists	Allowed	Not Allowed	Not Allowed
Allowable services	Statutory Services: • Case management services • Homemaker/home aide services and personal care services • Adult day health services • Habilitation services • Respite care • Other services requested by State as Secretary may approve" • Day treatment or other partial hospitalization services* • Psychosocial rehabilitation services* • Clinic services* *For individuals with chronic mental illness Settings where individuals receive support must comport with the settings requirements as set forth in 2014 final rule.	Same as §1915(c) services. Settings where individuals receive support must comport with the settings requirements as set forth in 2014 final.	**Must cover:** • Assistance w/ ADLs, IADLs, and health related tasks. • Acquisition, maintenance and enhancement of skills necessary for individual to accomplish ADLs, IADLs, and health-related tasks. • Back-up systems or mechanisms to ensure continuity of services and supports. • Voluntary training on how to select, manage and dismiss staff. **May cover:** May include, but not limited to:1) Expenditures for transition costs such as rent and utility deposits, bedding, basic kitchen supplies, and other necessities linked to an assessed need for an individual to transition from an institution to an home and community-based setting; 2) Expenditures relating to a need identified in a person-centered service plan increasing independence or substitutes for human assistance, to the extent that expenditures would otherwise be made. Settings must comport with the requirements in 2014 final rule.

HCBS Authority	1915(c)	1915(i)	1915(k)
Goods and services	Permitted as a waiver service.	Permitted as a covered service.	Permitted as a covered service at the state's election for expenditures relating to a need identified in an individual's person-centered service plan that increases an individual's independence or substitutes for human assistance, to the extent that expenditures would otherwise be made for the human assistance.
Cost requirements	Cost-neutrality. Average annual Medicaid costs per waiver participant cannot exceed average institutional cost per person for each level of care.	N/A. State must submit CMS 179 including estimated FY impact on federal budget.	N/A. State must submit CMS 179 including estimated FY impact on federal budget. For the first full fiscal year in which the State Plan amendment is implemented, a State must maintain, or exceed, the level of expenditures for services provided under §1115, §1905(a), and §1915, of the Act, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year.

HCBS Authority	1915(c)	1915(i)	1915(k)
Interaction with State Plan services and waivers	Participants have access to and must utilize State Plan services provided under 1905(a) (including all EPSDT benefits) before using identical extended State Plan services under the waiver. Waiver services may not duplicate State Plan services. Individuals may be eligible for and receive services from multiple HCBS authorities simultaneously, so long as the person-centered service plan ensures no duplication of services. HCBS waivers may be operated concurrently with other authorities, for example 1915(a) or 1915(b).	Participants have access to and must utilize State Plan services provided under 1905(a) (including EPSDT) before using identical services covered through 1915(i). 1915(i) services must not duplicate services available under the State Plan. Individuals may be eligible for and receive services from multiple HCBS authorities simultaneously, so long as the person-centered service plan ensures no duplication of services. HCBS as a State Plan option may be operated concurrently with other authorities, for example 1915(a) or 1915(b).	Individuals may be eligible for and receive services from multiple HCBS authorities simultaneously, so long as the person-centered service plan ensures no duplication of services. 1915(k) may be operated concurrently with other authorities, for example 1915(a) or 1915(b).

Endnotes

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