

FALL 2013 DHS|OHA CASELOAD FORECAST

Budget, Planning and Analysis

Office of Forecasting, Research and Analysis





FALL 2013 DHS OHA
CASELOAD FORECAST

DECEMBER 2013

Office of Forecasting,
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EXECUTIVE SUMMARY

The **Supplemental Nutrition Assistance Program (SNAP)** Biennial Average Forecast for 2013–15 is 432,231 households, 2.5 percent higher than the Spring 2013 forecast. The forecast average for the 2015–17 biennium is 393,716 households, 8.9 percent lower than the forecast average for 2013–15.

The **Temporary Assistance to Needy Families (TANF)** Biennial Average Forecast for 2013–15 is 33,591 families, 1.1 percent lower than the Spring 2013 forecast. The forecast average for the 2015–17 biennium is 30,212 families, 10.1 percent lower than the forecast average for 2013–15.

The **Child Welfare** Biennial Average Forecast for 2013–15 is 21,810 children, 2.6 percent lower than the Spring 2013 forecast. The forecast average for the 2015–17 biennium is 22,295 children, 2.2 percent higher than the forecast average for 2013–15.

The **Vocational Rehabilitation** Biennial Average Forecast for 2013–15 is 9,038 clients, 1.5 percent lower than the Spring 2013 forecast. The forecast average for the 2015–17 biennium is 9,681 clients, 7.1 percent higher than the forecast average for 2013–15.

The **Total Long–Term Care (LTC)** Biennial Average Forecast for Aging and People with Disabilities in 2013–15 is 29,231 clients, 2.9 percent lower than the Spring 2013 forecast. The forecast average for the 2015–17 biennium is 29,975 clients, 2.5 percent higher than the forecast average for 2013–15.

The **Developmental Disabilities Case Management** Biennial Average Forecast for 2013–15 is 22,045 clients, 2.0 percent higher than the Spring 2013 forecast. The forecast average for the 2015–17 biennium is 23,684 clients, 7.4 percent higher than the forecast average for 2013–15.

The **Total Medical Assistance Programs** Biennial Average Forecast for 2013–15 is 846,108 clients, 9.8 percent higher than the Spring 2013 forecast. The forecast average for the 2015–17 biennium is 956,807 clients, 13.1 percent higher than the forecast average for 2013–15. The caseload forecast for June 2015 represents a 38.3 percent increase over the same month in 2013. This growth is mainly due to implementation of the Affordable Care Act (ACA) starting in January of 2014. Otherwise, growth would have been 1.2 percent.

The **Total Mandated Mental Health** Biennial Average Forecast for the 2013–15 biennium is 5,237 clients, 2.7 percent lower than the Spring 2013 forecast. This change is due to a revision in how data is handled, not an indication of reduced need for services. The forecast average for the 2015–17 biennium is 5,372 clients, 2.6 percent higher than the Fall 2013 Forecast for 2013–15.

Introduction

This document summarizes the Fall 2013 forecasts of client caseloads for the Oregon Department of Human Services (DHS) and Oregon Health Authority (OHA). The Office of Forecasting, Research and Analysis (OFRA) issues these forecasts semiannually in the spring and fall. DHS caseload forecasts cover the major program areas administered by the department: Self Sufficiency, Child Welfare, Vocational Rehabilitation, Aging and People with Disabilities, and Developmental Disabilities. OHA caseload forecasts cover the major program areas of Medical Assistance Programs and Addictions and Mental Health. Forecasts are used for budgeting and planning and usually extend through the end of the next biennium. Forecasts are developed using a combination of time-series techniques, input-output deterministic models and expert consensus. Forecast accuracy is tracked via monthly reports that compare actual caseload counts to the forecasted caseload. An annual forecast quality report has also been created comparing forecast accuracy across programs and over time. ¹

1. Accuracy reports are available at <http://www.oregon.gov/dhs/ofra/Pages/index.aspx>. Methodology review is available from OFRA upon request.

Forecast environment and risks

Oregon's economy was severely affected by the Great Recession of 2008–09, and it has yet to fully recover. Oregon lost nearly 150,000 jobs between December 2007 and December 2009, more than half of which disappeared during the six months ending in March 2009. The large and sudden loss of jobs resulted in large and sudden increases in many DHS and OHA caseloads. This period is easily identified in many of the caseload graphs that follow. Post-recession job gains have been steady but slow. As of August 2013, Oregon's nonfarm employment stood at 1,670,700. This represents 71,000 more jobs than in August 2009, but 62,000 fewer jobs than in August 2007.

Employment levels, however, don't tell the whole story. The U.S. Bureau of Labor Statistics (BLS) reported that 112,000 (6.3 percent) Oregon workers had part-time jobs and could not find full-time employment for economic reasons in 2012. In 2007, prior to the Great Recession, 47,000 (2.6 percent) Oregon workers were in the same situation.² BLS also reported that the 2012 unemployment rate among Oregonians with less than a high school education was 11.8 percent and among those with a high school diploma it was 10.5 percent. At the other end of the education spectrum, the rate among those with at least a four-year college degree was 3.9 percent.³ This is consistent with the recent Oregon Office of Economic Analysis (OEA) report on job polarization in post-recession job growth.⁴ Most job growth has been in the high and low ends of the wage scale, rather than in the middle.

Most clients on economically-sensitive DHS/OHA caseloads do not have post-secondary education, and some lost middle-wage jobs during the Great Recession. That is, they are affected both by the higher unemployment rate among less-educated workers and by job polarization. For example, an analysis of 2012 SNAP recipients that were employed in construction or manufacturing in 2007 revealed that 1) most were not on SNAP in 2007, and 2) most were unemployed or working in another economic sector in 2012. For those with employment in both years, their earnings were 28 percent lower in 2012 than in 2007. These Oregonians were working and receiving SNAP in 2012.

In spite of these obstacles, some employment-sensitive caseloads have started to decline. OEA predicts a gradual employment recovery, but given anticipated population growth the ratio of employment to working-age population is not expected to approach its pre-recession level until well after the end of the DHS/OHA forecast horizon of June 2017. Many DHS/OHA clients have work history in the retail trade or leisure and hospitality sectors. These sectors depend on discretionary spending, and they tend to hire part-time workers. These factors and the structural changes mentioned above combined to cause the most economically sensitive DHS caseloads to increase rapidly at the onset of the Great Recession and decline slowly during the recovery. This dynamic has been incorporated into economically sensitive forecasts.

Forecasts are based on specific assumptions about the future, and an important part of forecasting is identifying the major risks to those assumptions. Caseload dynamics are influenced by demographics, the economy, and policy choices. Demographic changes have a long-term and predictable influence on caseloads. Economic factors can have a dramatic effect on some caseloads, especially during recessions. The most immediate and dramatic effects on caseloads result from policy changes that alter the pool of eligible clients or the duration of their program eligibility. Sometimes economic factors influence policy changes. For example, a poor economy will cause tax receipts to decline, which can in turn force spending cuts that limit eligibility for some programs.

The Office of Economic Analysis (OEA) identifies major risks to Oregon's economy in its quarterly forecasts. The third quarter 2013 edition lists contractionary public policies and economic weakness among Oregon's major trading partners as the major risks to the state's economy. Contractionary fiscal policies include the federal sequester and the potential for further tax increases or public spending cuts. Contractionary monetary policy means the potential for the Federal Reserve to raise the federal funds rate, a move that would increase borrowing costs for businesses and consumers.

Forecasts are based on current practices and policies applied to the expected state of external factors such as demographics and the economy. We do not attempt to anticipate future policy changes. Moreover, the effects of policy changes that have been adopted but not implemented sometimes cannot be quantified to the degree needed to accurately forecast outcomes. Future policy changes or uncertainty about the implementation of recent policy changes represent a major risk to the caseload forecasts.

2. http://www.bls.gov/opub/gp/pdf/gp12_16.pdf, <http://www.bls.gov/opub/gp/pdf/gp07full.pdf>
3. http://www.bls.gov/opub/gp/pdf/gp12_15.pdf
4. <http://oregoneconomicanalysis.com/2013/10/24/report-job-polarization-in-oregon/>

Department of Human Services



Total Department of Human Services Biennial Average Forecast comparison

	Spring 13 Forecast 2013-15	Fall 13 Forecast 2013-15	% diff. Spring 13 to Fall 13 2013-15	Fall 13 Forecast 2013-15	Fall 13 Forecast 2015-17	% diff. Fall 13 2013-15 to 2015-17
Self Sufficiency						
Supplemental Nutrition Assistance Program (households)	421,674	432,321	2.5%	432,321	393,716	-8.9%
Temporary Assistance for Needy Families - Basic and UN (families: cash assistance)	33,947	33,591	-1.1%	33,591	30,212	-10.1%
Child Welfare (children served)						
Adoption Assistance	11,435	11,243	-1.7%	11,243	11,524	2.5%
Guardianship Assistance	1,325	1,385	4.5%	1,385	1,557	12.4%
Out of Home Care	7,893	7,482	-5.2%	7,482	7,542	0.8%
Child In-Home	1,746	1,699	-2.7%	1,699	1,672	-1.6%
Vocational Rehabilitation Services	9,177	9,038	-1.5%	9,038	9,681	7.1%
Aging and People with Disabilities						
Long-Term Care: In-Home ¹	12,387	13,394	8.1%	13,394	13,609	1.6%
Long-Term Care: Community-Based ¹	13,211	11,793	-10.7%	11,793	12,411	5.2%
Long-Term Care: Nursing Facilities	4,494	4,044	-10.0%	4,044	3,955	-2.2%
Developmental Disabilities						
Total DD Services	15,456	15,557	0.7%	15,557	16,444	5.7%
Total Case Management Enrollment	21,617	22,045	2.0%	22,045	23,684	7.4%

1. CBC: Relative Adult Foster Care was closed in June 2013, and the majority of the caseload transferred to In-Home Care.

Self Sufficiency Programs

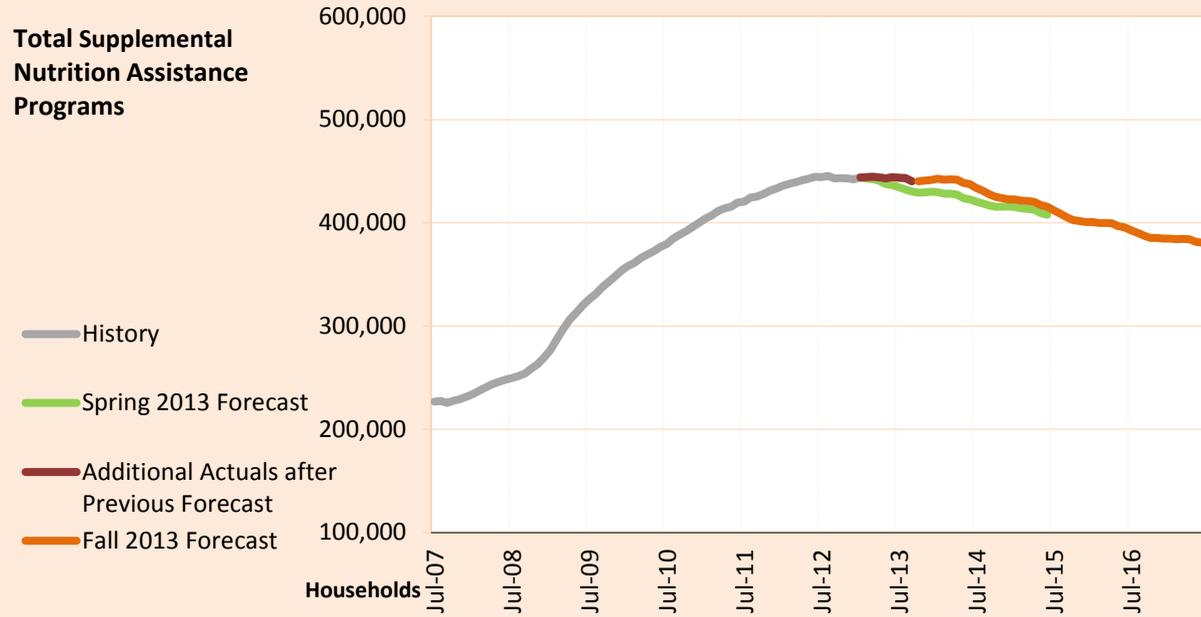
Supplemental Nutrition Assistance Program (SNAP) — There were 440,000 households (798,000 persons) receiving SNAP benefits in September 2013, one-fifth of all Oregonians. The SSP portion of SNAP rose rapidly at the outset of 2009 and continued to grow at a steadily decreasing rate until leveling off in mid-2012. The caseload has declined by 12,000 households since July 2012. The smaller APD SNAP caseload has been increasing steadily for several years. The combined SNAP biennial average forecast for 2013-15 is 432,321 households, 2.5 percent higher than the Spring 2013 forecast. The Fall 2013 Forecast average for the 2015–17 biennium is 393,716 households, 8.9 percent lower than the biennial average forecast for 2013-15. The major risk to the SNAP forecast is the eventual reauthorization of the federal farm bill that funds the SNAP program. Currently SNAP is operating on an extension of the 2008 farm bill. The final structure of the bill may change the way the SNAP program operates. Another risk is the implementation of the Medicaid expansion portion of the Affordable Care Act. This may increase the SNAP caseload if many more households enroll in SNAP during the Medicaid enrollment process. A third risk is the reduction in allotments that resulted when extra funds provided by the American Recovery and Reinvestment Act (ARRA) ended. Letters were mailed to clients in October to notify them of the reduction that took effect November 1, 2013. Some cases may close due to mail returned as undeliverable and others may close because clients whose allotments were small to begin with may decide that the transaction cost to an even smaller allotment outweighs the value of the allotment itself. Finally, the SNAP forecast could be affected by the issues stated in the “Forecast environment and risks” section, above.

Temporary Assistance for Needy Families (TANF) — There were 34,600 families receiving TANF benefits in September 2013. The TANF caseload underwent nearly uninterrupted growth starting in January 2008 until leveling off in mid-2012. After a seasonal increase in the winter of 2012-2013, the caseload declined consistently and is currently 2,000 cases below its February 2013 peak. Over the next two biennia, the caseload is expected to decline overall but with small seasonal increases during the winter months. The TANF biennial average forecast for 2013–15 is 33,591 families, 1.1 percent lower than the Spring 2013 forecast. The current forecast average for the

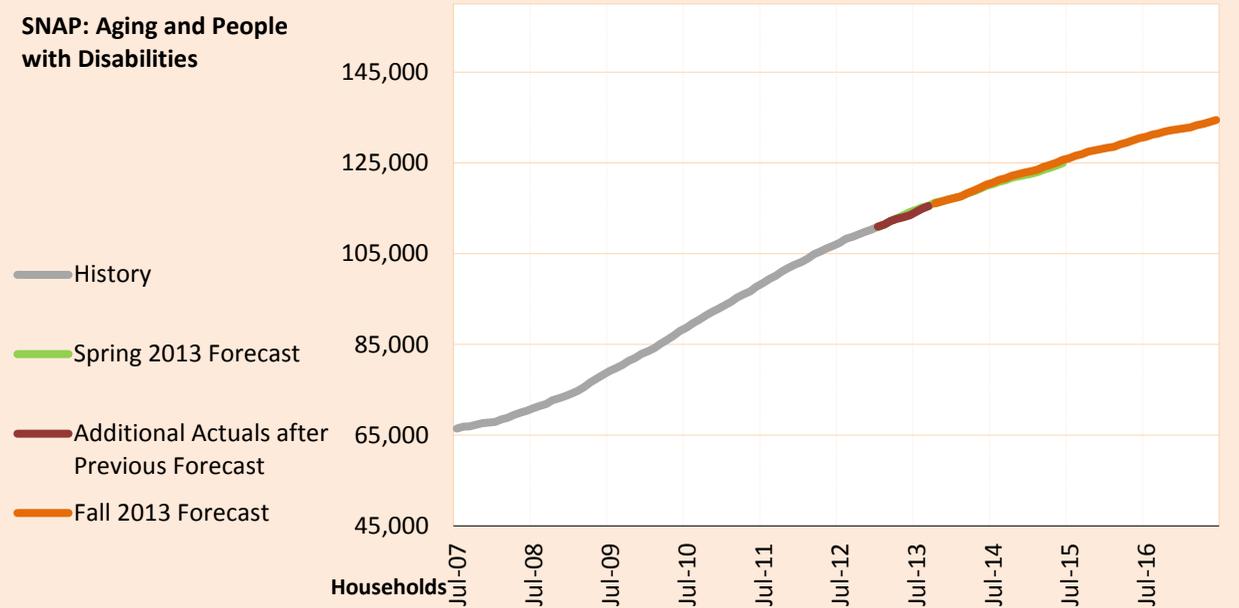
2015–17 biennium is 30,212 families, 10.1 percent lower than the forecast for 2013-15. The major risk to the TANF forecast is a series of management actions designed to refocus staff from eligibility work to case management. These actions may cause the caseload to decline more quickly than forecast. Finally, the TANF forecast could be affected by the issues stated in the “Forecast environment and risks” section, above.

Temporary Assistance for Domestic Violence Survivors (TA-DVS) — This is a relatively small caseload that experiences regular seasonal fluctuations. The Fall 2013 forecast for the 2013–15 biennium is 472 families, 10.8 percent lower than the Spring 2013 forecast. The caseload is expected to average 474 families during the 2015–17 biennium about the same as the forecast for the current biennium.

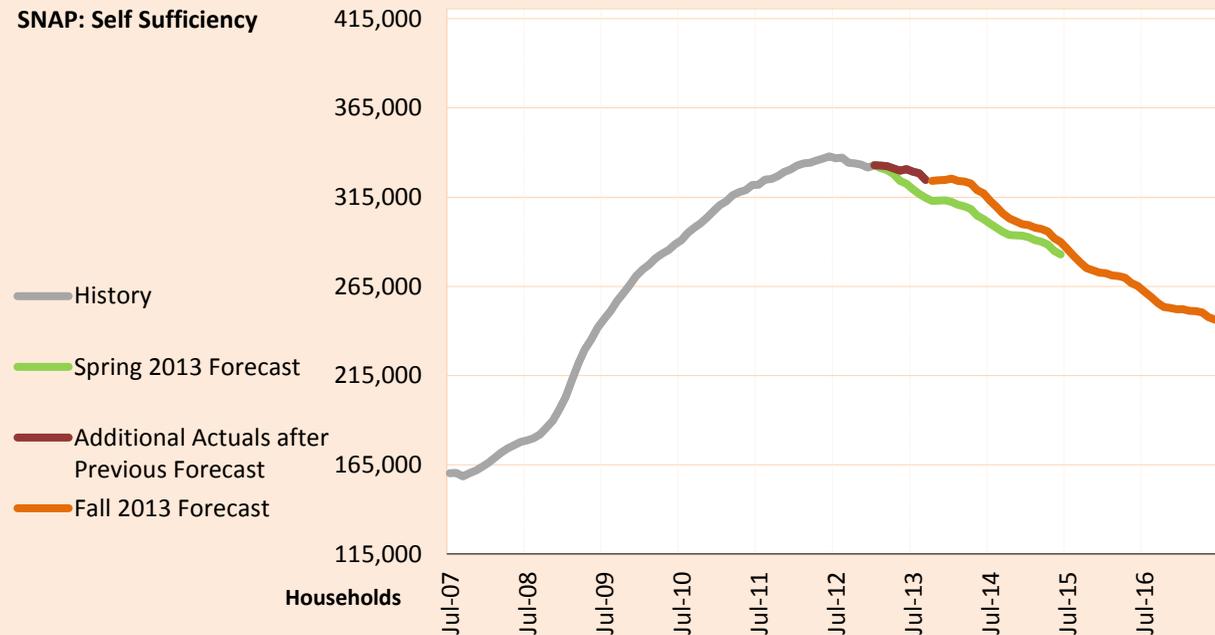
Total Supplemental Nutrition Assistance Programs

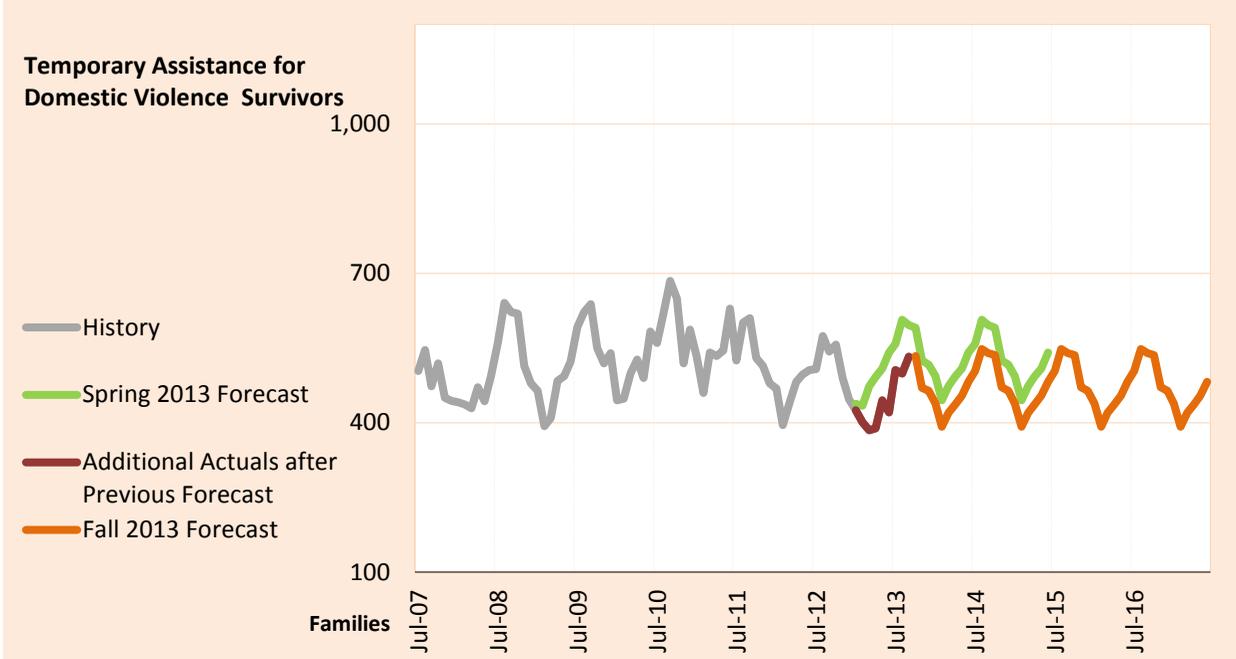
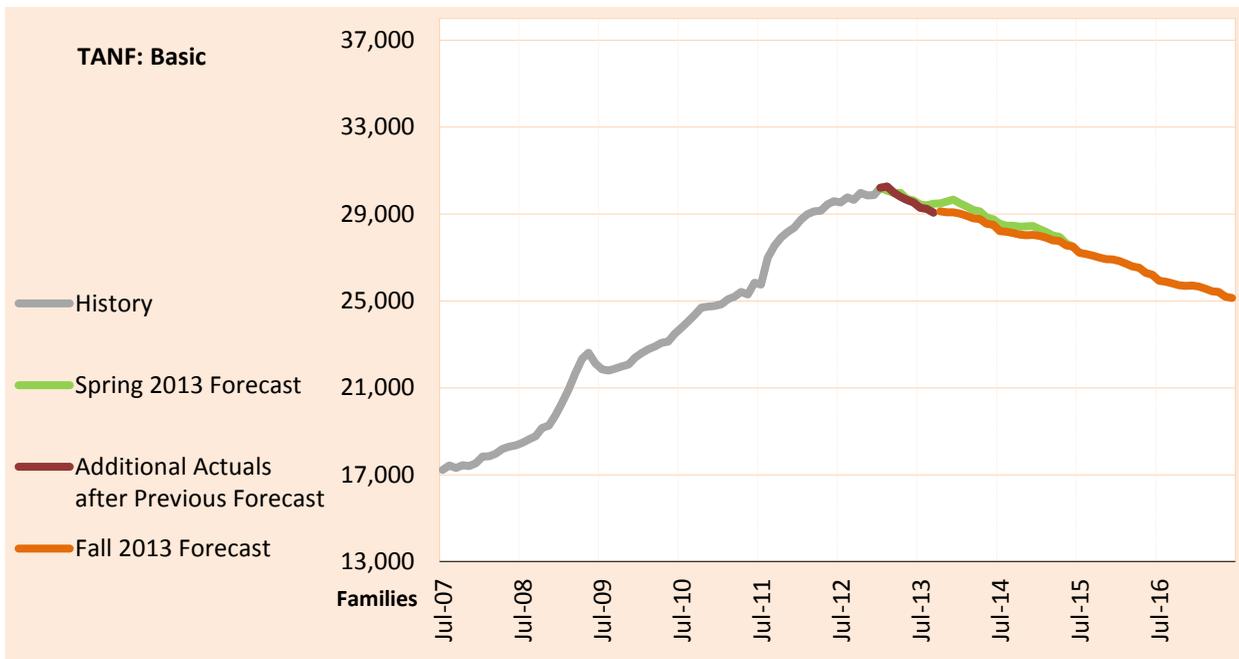
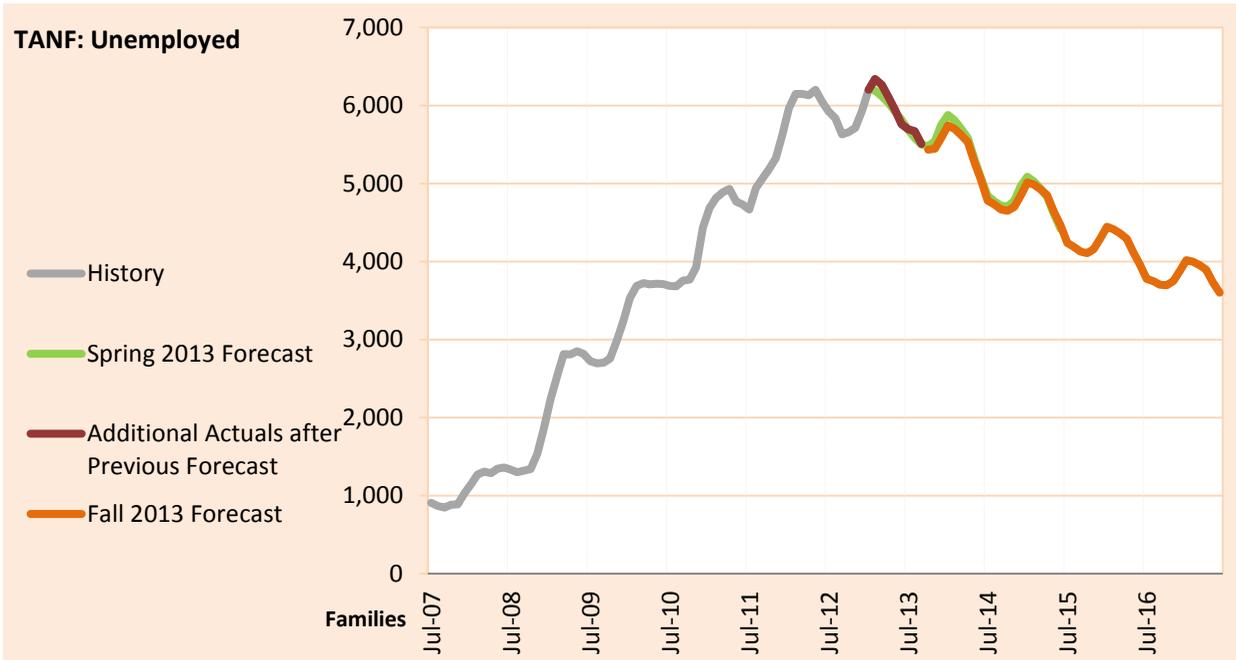
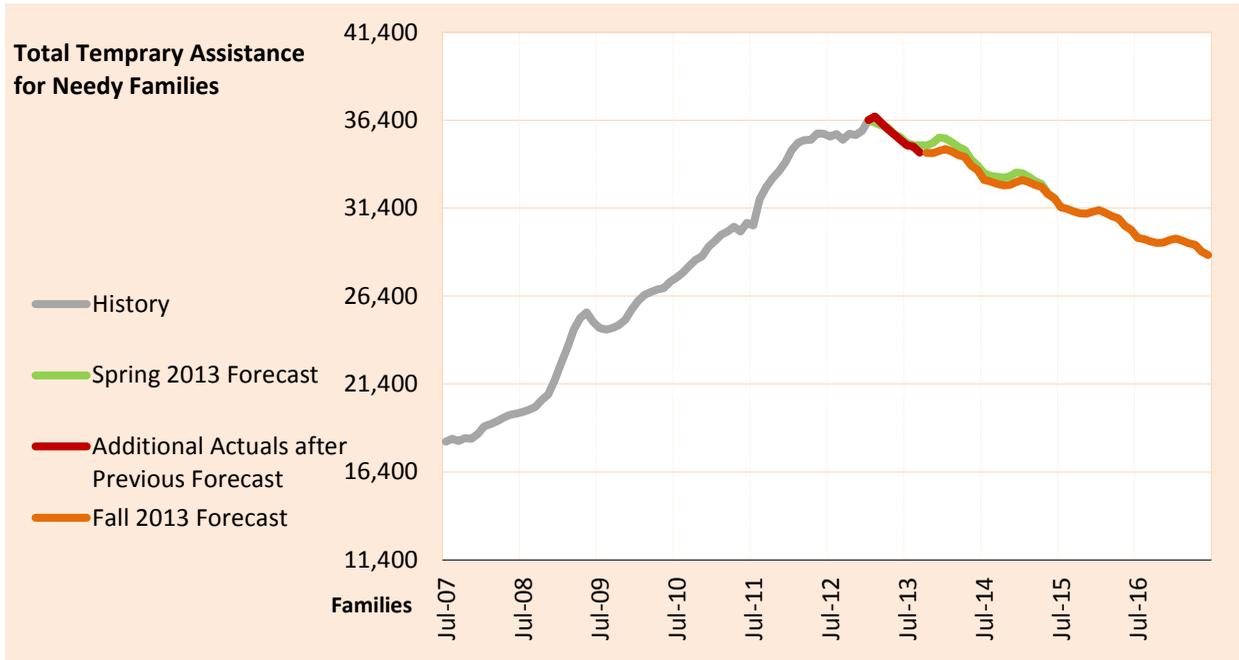


SNAP: Aging and People with Disabilities



SNAP: Self Sufficiency





Self Sufficiency Biennial Average Forecast comparison

	Spring 13 Forecast 2013-15	Fall 13 Forecast 2013-15	% diff. Spring 13 to Fall 13 2013-15	Fall 13 Forecast 2013-15	Fall 13 Forecast 2015-17	% diff. Fall 13 2013-15 to 2015-17
Supplemental Nutrition Assistance Program (households)						
Self Sufficiency	301,800	312,211	3.4%	312,211	263,328	-15.7%
Aging and People with Disabilities	119,874	120,110	0.2%	120,110	130,388	8.6%
SNAP total	421,674	432,321	2.5%	432,321	393,716	-8.9%
Temporary Assistance for Needy Families (families: cash/grants)						
Basic	28,754	28,443	-1.1%	28,443	26,193	-7.9%
UN	5,193	5,148	-0.9%	5,148	4,020	-21.9%
TANF total	33,947	33,591	-1.1%	33,591	30,212	-10.1%
Pre-SSI	493	498	1.0%	498	488	-2.0%
Temporary Assistance for Domestic Violence Survivors (families)	529	472	-10.8%	472	474	0.5%

Child Welfare

DHS implemented a new Child Welfare computer system (OR-KIDS) in August 2011. This explains the gaps in the forecast graphs, as several months of data were not collected during the transition process. The Fall 2013 forecast is the second edition based on OR-KIDS data.

Adoption Assistance – This caseload was on a steady growth trajectory for many years, increasing an average of 6 percent annually. In mid-2009 the caseload flattened and remained at an average of 10,760 children served per month for the next two years. The percentage of children transferring to adoption assistance from foster care declined, possibly as a result of a rate redesign. It is thought that adoptive families wanted to wait and see the details and effects of the new rate structure. OR-KIDS counts started in August 2011 and were slightly higher but still flat, averaging 10,900 until early 2012 when the caseload again started to grow at a modest pace. In October 2012 the caseload exceeded 11,000 for the first time. Caseload growth was slower than expected in the first half of 2013, and the Fall 2013 forecast continues this pattern of slow to moderate growth. The caseload is expected to average 11,243 for the 2013-15 biennium, 1.7 percent lower than the Spring 2013 forecast. The caseload is expected to average 11,524 over the 2015-17 biennium, 2.6 percent lower than the previous forecast and 2.5 percent higher than the current forecast for the 2013-15 biennium.

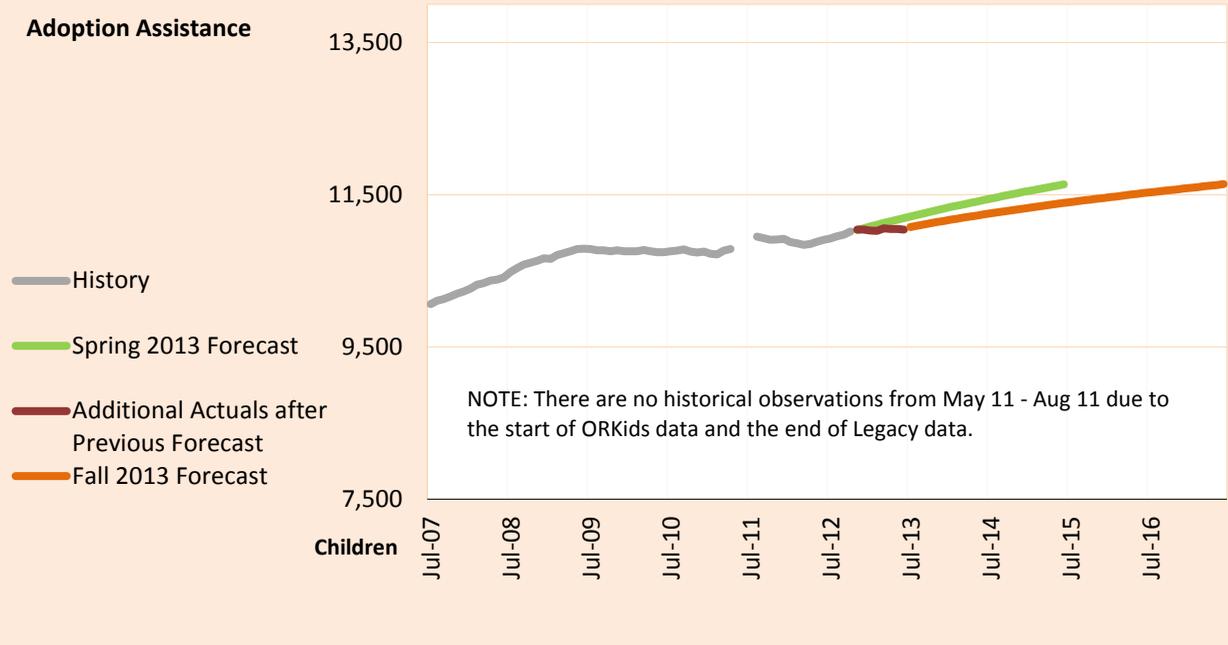
Guardianship Assistance – This caseload has exhibited steady and moderate to high growth for its entire history, increasing an average of 23 percent annually between 2001 and 2013. In November 2012 the caseload was 1,200, and it grew more quickly than expected in the first half of 2013. The Fall 2013 forecast continues growth pattern and is expected to average 1,385 for the 2013-15 biennium, 4.5 percent higher than the Spring 2013 forecast. The caseload is expected to average 1,557 over the 2015-17 biennium, 7.6 percent higher than the previous forecast and 12.4 percent higher than the current forecast for the 2013-15 biennium.

Foster Care — This caseload is comprised of paid foster care, non-paid foster care (including trial home visits), and residential care. Paid foster care is by far the largest portion of the group. Prior to the Fall 2013 forecast, the data system was modified, correcting the logic used to identify exits from foster care. As a result, the whole historical line shifted down, and there are approximately 500 fewer foster care clients as of June 2013 compared with the prior version. The total foster care caseload experienced a significant decrease in the four years between January 2006 and December 2009, declining from 10,300 to 8,000 children. During this period the number of children supervised in home also declined as well as the percentage of in-home children who transferred into foster care. Between May 2012 and June 2013, the caseload decreased 6.5 percent. The Fall 2013 forecast takes this decline into account, however it reflects a phase-in of 48 beds between January and June 2014, due to restored general funds. The caseload is expected to average 7,482 for the 2013-15 biennium, 5.2 percent lower than the Spring 2013 forecast. The caseload is expected to average 7,542 over the 2015-17 biennium, 5.1 percent lower than the previous forecast and 0.8 percent higher than the current forecast for the 2013-15 biennium.

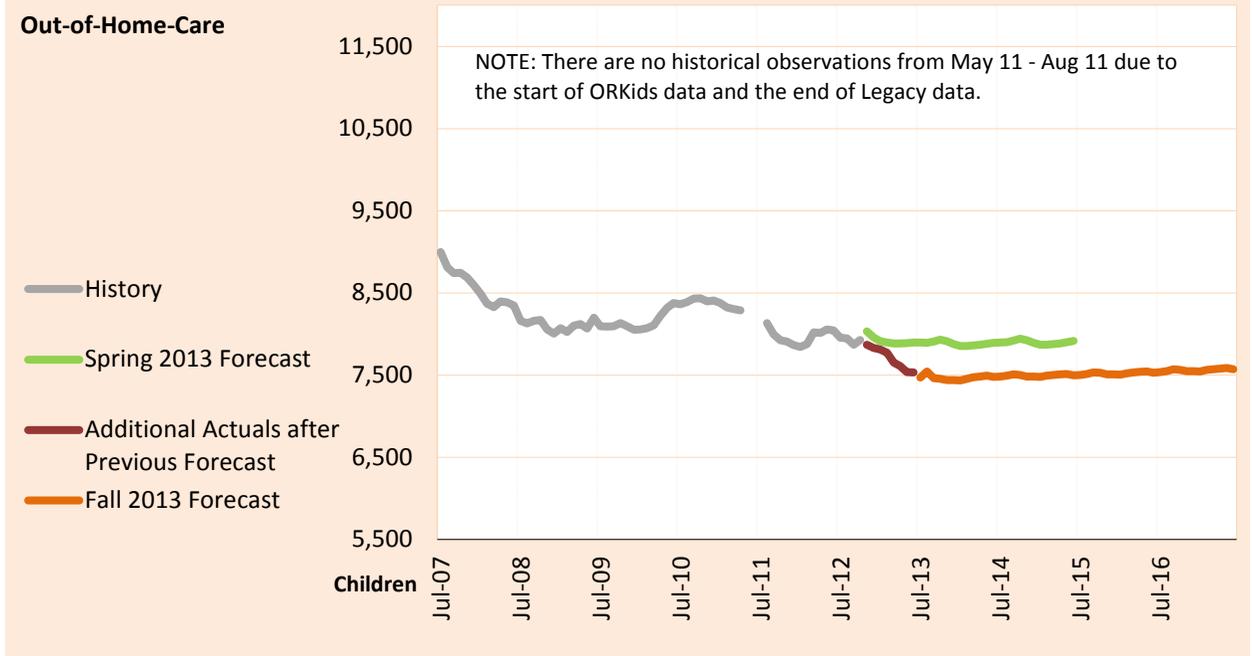
Child in Home — This caseload experienced a steady drop between 2004 and 2007 and has shown continued volatility since that time. The first half of 2013 has remained somewhat flat. The Fall 2013 forecast shows a slight decrease and then a relatively flat growth pattern that is expected to average 1,699 for the 2013-15 biennium, 2.7 percent lower than the Spring 2013 forecast. The caseload is expected to average 1,672 over the 2015-17 biennium, 5.4 percent lower than the previous forecast and 1.6 percent lower than the current forecast for the 2013-15 biennium.

Risks to this forecast include continued implementation of differential response, a program designed to reduce the use of foster care in favor of supervising children in their homes. Some counties will engage more families in prevention, and they may not end up with a case plan. Another risk is the influence of over-due or unclosed assessments. If they are not entered in the system, Child in Home numbers could be affected.

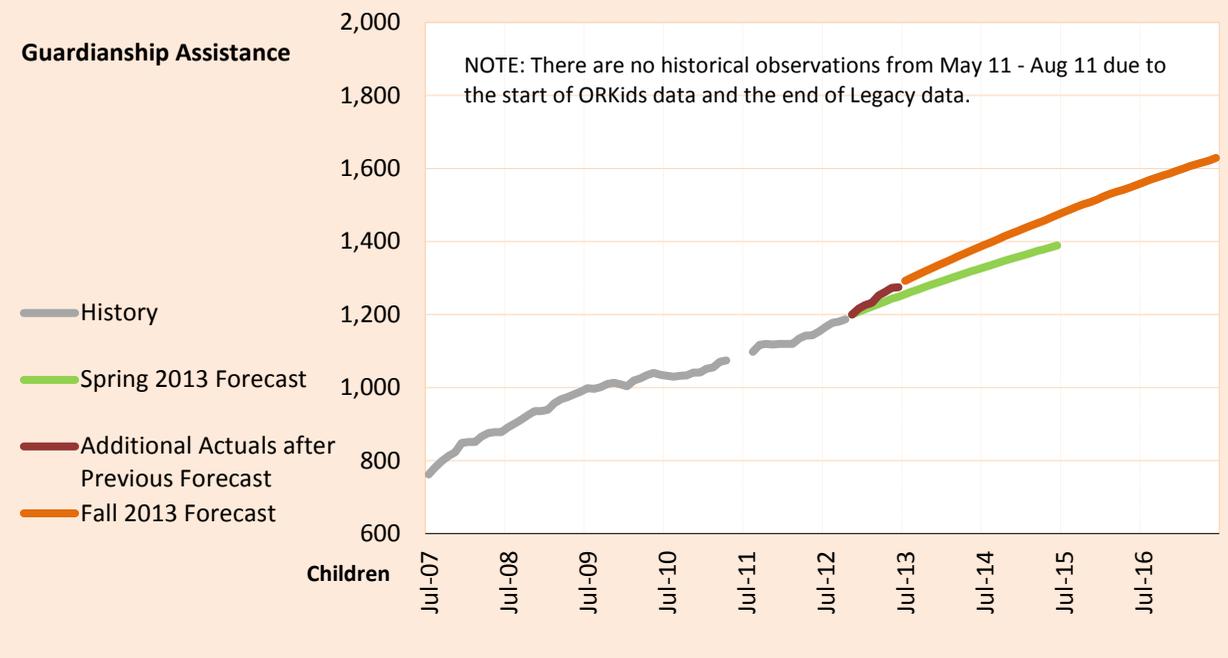
Adoption Assistance



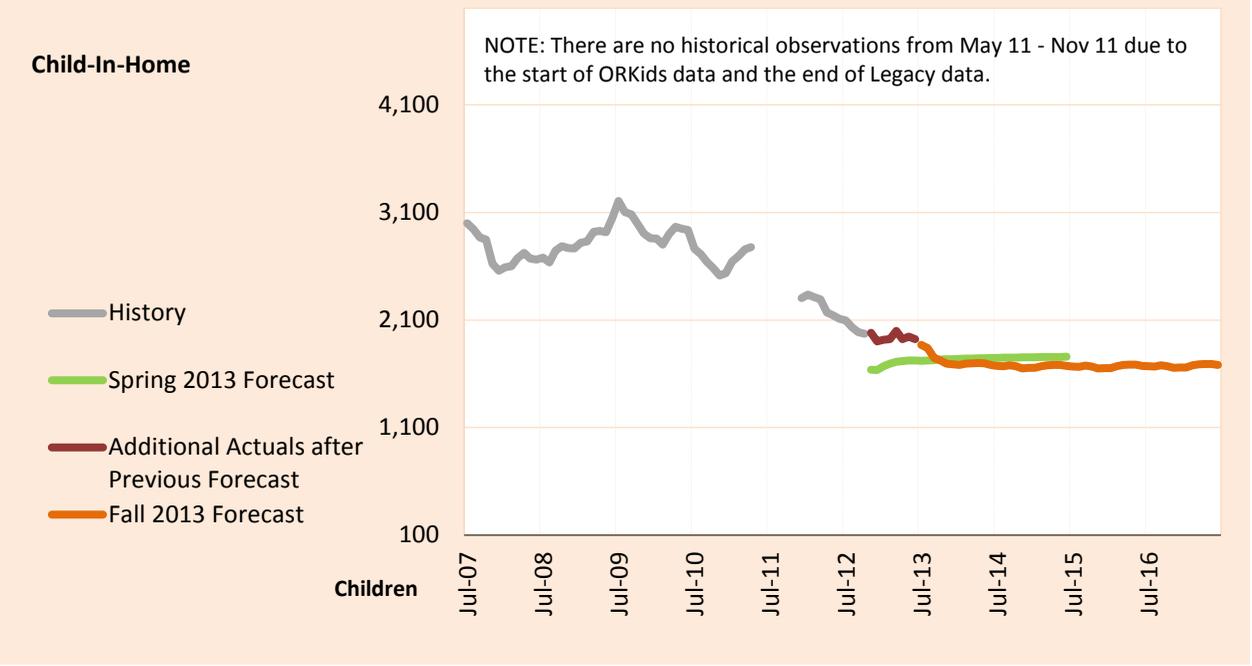
Out-of-Home-Care

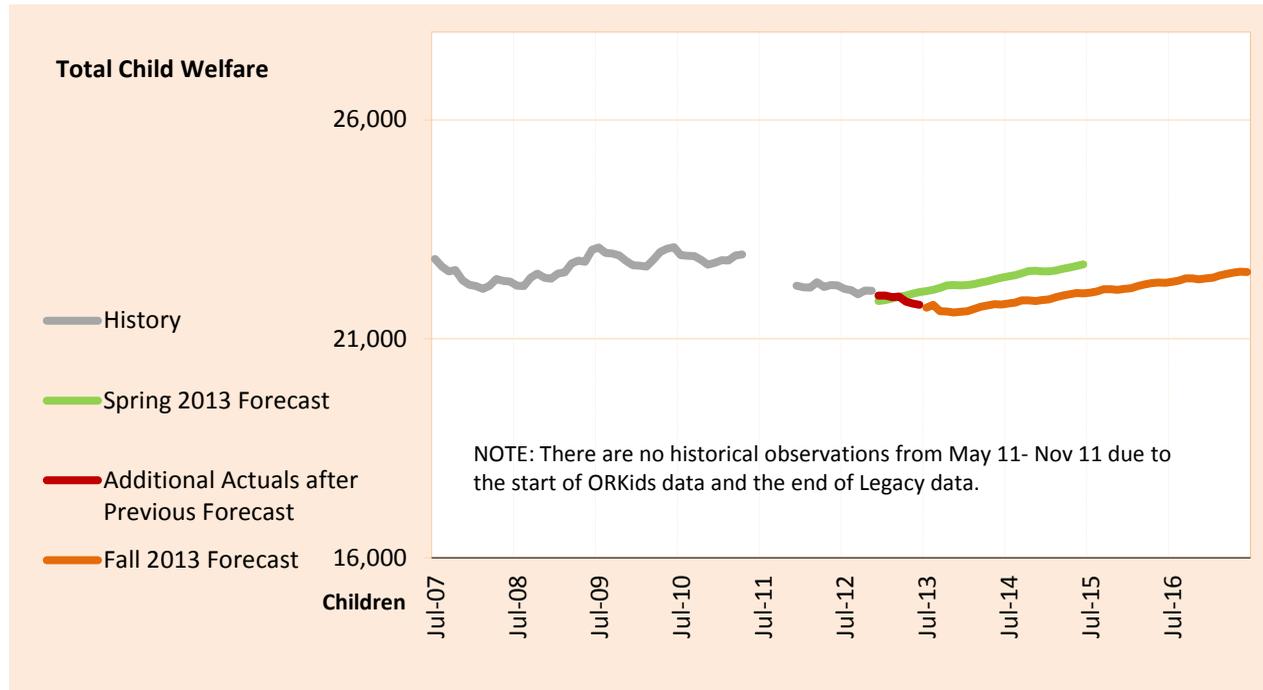


Guardianship Assistance



Child-In-Home



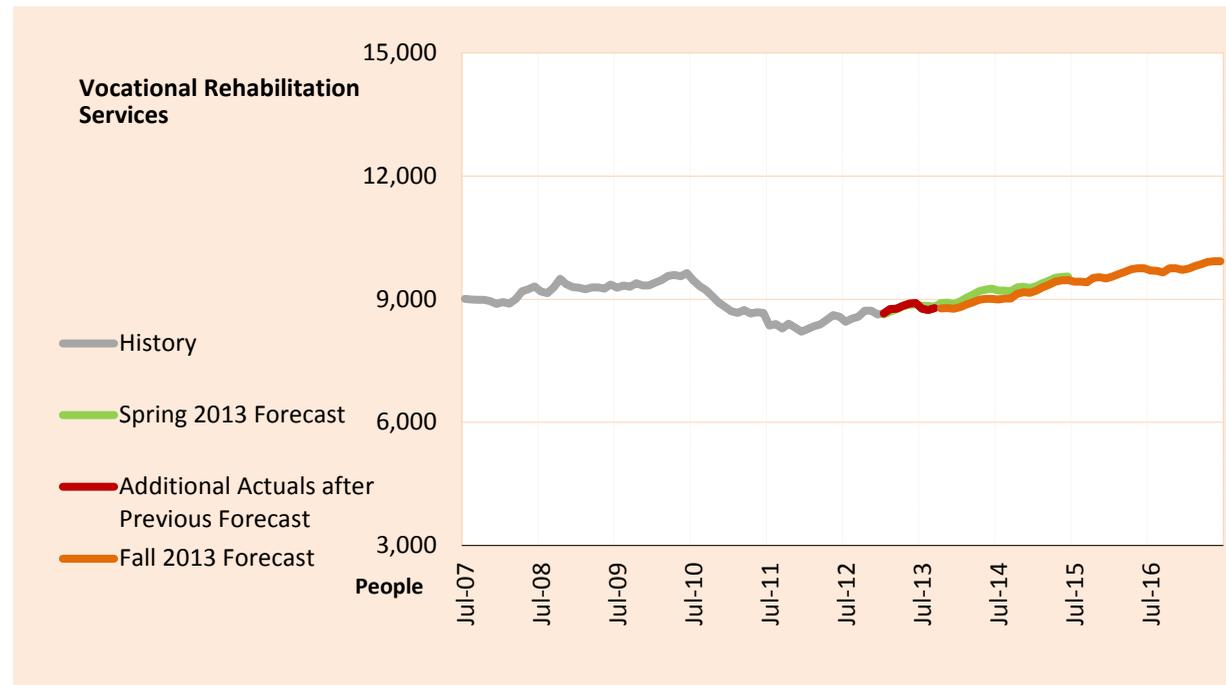


Child Welfare Biennial Average Forecast comparison

	Spring 13 Forecast 2013-15	Fall 13 Forecast 2013-15	% diff. Spring 13 to Fall 13 2013-15	Fall 13 Forecast 2013-15	Fall 13 Forecast 2015-17	% diff. Fall 13 2013-15 to 2015-17
Child Welfare (children)¹						
Adoption Assistance	11,435	11,243	-1.7%	11,243	11,524	2.5%
Guardianship Assistance	1,325	1,385	4.5%	1,385	1,557	12.4%
Out of Home Care	7,893	7,482	-5.2%	7,482	7,542	0.8%
Child In-Home	1,746	1,699	-2.7%	1,699	1,672	-1.6%
Total Child Welfare	22,399	21,810	-2.6%	21,810	22,295	2.2%

Vocational Rehabilitation

From 2006 through 2008 the OVRS caseload averaged 9,100 clients. In 2009 budget reductions caused the program to operate under an order of selection, a means of prioritizing clients when demand for services exceeds program capacity. As a result, the caseload averaged 6,000 clients during 2009. Since 2010 OVRS has avoided placing clients on the waiting list and the caseload has averaged 8,600 clients. The Fall 2013 forecast for the 2013–15 biennium is 9,038 clients, 1.5 percent lower than the Spring 2013 forecast. The caseload is expected to average 9,681 clients during the 2015–17 biennium, 7.1 percent higher than in 2013–15. Major risks include the eventual outcome of Lane v. Kitzhaber (a federal class-action lawsuit), and Executive Order 13-04 which requires OVRS to serve an additional 275 clients by FY 2017.



Vocational Rehabilitation Services Biennial Average Forecast comparison

	Spring 13 Forecast 2013-15	Fall 13 Forecast 2013-15	% diff. Spring 13 to Fall 13 2013-15	Fall 13 Forecast 2013-15	Fall 13 Forecast 2015-17	% diff. Fall 13 2013-15 to 2015-17
Vocational Rehabilitation Services						
Total clients receiving service	9,177	9,038	-1.5%	9,038	9,681	7.1%

Aging and People with Disabilities

Following five years of steady decline, the Total Long-Term Care (LTC) caseload began to increase in 2008 due to the economic downturn as well as demographic and program changes. The caseload grew slowly for the next three years before leveling out for a year, and then declining slightly since mid-2012 despite the rising number of Oregon seniors.

Historically, Oregon's LTC services were provided under the authority of a Medicaid 1915 (c) Home and Community-Based Services (HCBS) Waiver. Starting in July 2013, Oregon can also provide services through the Community First Choice Option under 1915 (k) of the Social Security Act.

Total Long-Term Care — A total of 29,108 clients received services in June 2013. The biennial average Total LTC forecast for 2013-15 is 29,231, 2.9 percent lower than the Spring 2013 forecast. This is mainly due to closure of Relative Foster Care (about 10 percent of the total Community Based-Care caseload) in June 2013, as well as reductions in Nursing Facility caseloads. The LTC caseload forecast for 2015-17 is 29,975 clients, 2.5 percent higher than the forecast for 2013-15.

The LTC forecast is divided into three categories: In-Home, Community-Based Care, and Nursing Facilities.

In-Home Care — A total of 12,191 clients received In-Home Care services in June 2013. However, in July 2013 the In-Home Care caseload increased significantly due to clients transferred from the Relative Foster Care program (a type of community-based care) which was discontinued in June 2013. As a result, the biennial average forecast for 2013-15 is 13,394 clients, 8.1 percent higher than the Spring 2013 forecast. The caseload forecast for 2015-17 is 13,609 clients, 1.6 percent higher than 2013-15. In-Home Care caseload accounted for 46 percent of total Long-Term Care in July 2013, and is forecasted to be 45 percent of total LTC in June 2017.

The forecasted caseload for almost every subcategory of In-Home Care has been increased since the last forecast, particularly In-Home Hourly (both with and without State Plan Personal Care), In-Home Agency (both with and without State Plan Personal Care), and In-Home Live-In, which increased by 7.2 percent, 16.8 percent, and 9.0 percent respectively.

APD is currently implementing a variety of policy and program changes that may cause caseload to rise in ways not anticipated in the forecast. For example, under the old rules clients who met income limits and service need criteria, but whose income exceeded \$710 per month, were required to relinquish all of their income over \$710 to contribute to their own support. Under the new rules, clients will be allowed to keep up to \$1,210 per month. Since low income clients are sometimes reluctant to relinquish their limited income, even in exchange for needed supports, participation may now be somewhat more attractive than before. The fact that provisions exist which will allow family members, friends or neighbors (natural supports) under certain circumstances, to be paid for services provided to the client may entice more individuals to enroll for In-Home Care services. In addition, the growth previously anticipated for the discontinued CBC program (Relative Foster Care) may shift to In-Home categories instead.

Community-Based Care — A total of 12,745 clients received Community-Based Care (CBC) services in June 2013. However, starting July 2013, the Relative Foster Care program ended and most clients transferred to In-Home settings, with a small number transferring to other CBC services, and some choosing to leave state care altogether. As a result of closing the Relative Foster Care program, the total CBC biennial average forecast for 2013-15 is 11,793 clients, a 10.7 percent decrease from the Spring 2013 forecast. The caseload forecast for 2015-17 is 12,411 clients, a 5.2 percent increase from 2013-15. CBC caseload accounted for 39 percent of total Long-Term Care in July 2013, and is forecasted to be 42 percent of total LTC in June 2017.

Most of the rise in Total LTC caseload is occurring in Community-Based Care, particularly Residential Care Facilities. CBCs continue to be a popular placement choice due to the fact that they are easier to coordinate than In-Home services, and that hospitals prefer discharging patients to higher service settings in order to avoid repeat emergency visits or hospitalizations. While Medicaid reimbursement rates continue to lag behind private market rates, low housing prices and slow home sales have reduced the flow of private pay clients, thus making Medicaid clients relatively more attractive.

Based on recent trends in clients' actual utilization of CBC services, the Fall 2013 forecast for 2013-15 contains the following changes from Spring 2013: Contract Residential Care and Assisted Living have been revised upward by 1.0 percent and 1.4 percent respectively, and Commercial Foster Care, Regular Residential Care, and ElderPlace have been revised downward by 2.5 percent, 3.4 percent, and 0.7 percent respectively.

Nursing Facility Care (NFC) — A total of 4,172 clients received Total Nursing Facility Care in June 2013. The biennial average forecast for 2013-15 is 4,044, 10.0 percent lower than the Spring 2013 forecast. The forecast for 2015-17 is 3,955, 2.2 percent lower than the forecast for 2013-15. NFC caseload accounted for 14 percent of total Long-Term Care in July 2013, and is forecasted to be 13 percent of total LTC in June 2017.

NFC caseload has been declining since 2001, the entire period for which historical data is available. From November 2012 thru June 2013, the NFC caseload declined by an additional 315 clients, probably due to the Diversion and Transition Program which focuses on moving clients out of nursing homes and into their own homes or community settings whenever possible.

Additional Risks

The Patient Protection and Affordable Care Act of 2010 (ACA) established a new State Plan option to provide Home and Community-based attendant services and supports, known as Medicaid State Plan (K) option starting July 1, 2013. Some provisions of ACA and the new K Plan introduce significant risks to the LTC caseload forecast.

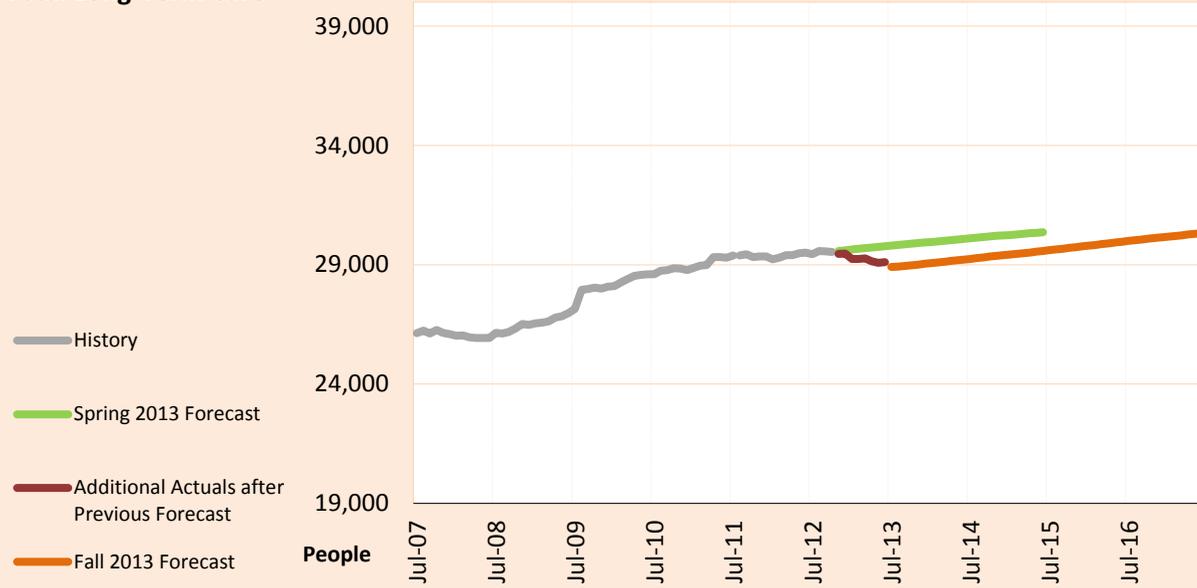
Beginning in July 2013, Oregon has the authority to provide LTC services under both the HCBS Waiver historically used by Oregon, and the new K Plan. The most significant risk arises from a change in eligibility rules between the Waiver and the K Plan. To qualify for LTC under the HCBS Waiver, requirements include income and asset limits, disability (or age) requirements, and a level of care assessment. To qualify for LTC under the K Plan, the only requirements are income limits and the level of care assessment. Program management does not expect removal of the asset test and the need to obtain an official disability determination to significantly lower the bar for eligibility. The change does, however, open the door for clients to qualify based on needs that are essentially short-term in nature. Consequently, a K Plan amendment is planned to limit service to clients who are expected to meet level of care needs for six months or longer.

It is important to note that if the assumption that K Plan will not lower the bar for eligibility turns out to be wrong, LTC caseload could grow dramatically. For instance, if the bar is significantly lower, then an unknown portion of the current Medicaid population might request, and qualify for, LTC services (including in-home services). And, if that were to happen, then the ACA expansion of Medicaid could seriously aggravate that problem. For more information about ACA's impact on Medicaid enrollment, see the "Medical Assistance Programs" section below.

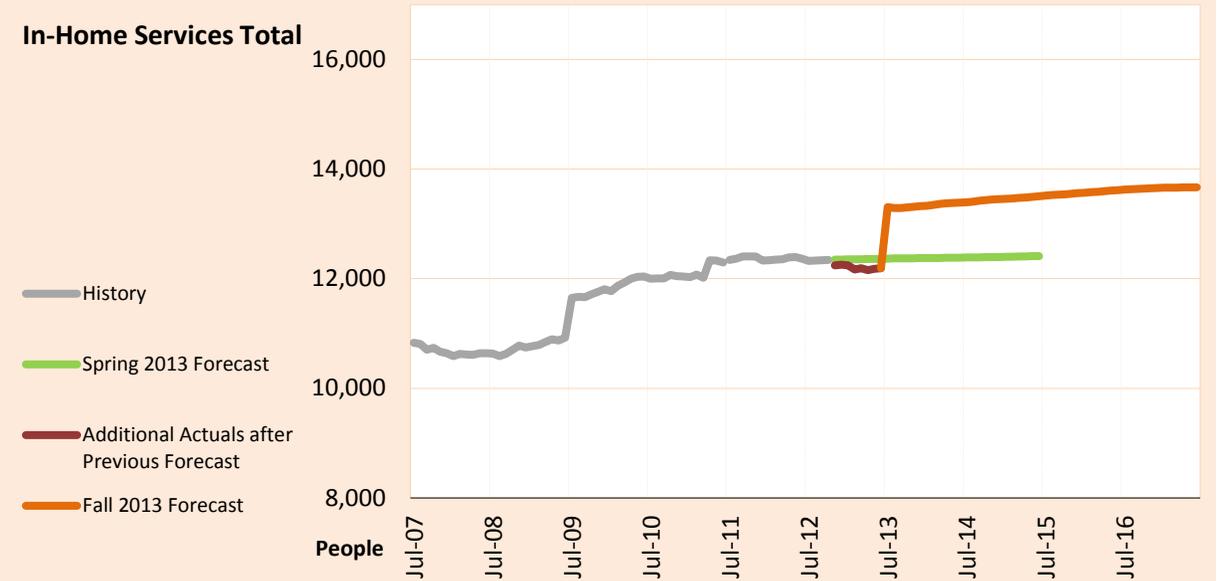
The vision for K Plan includes a wide variety of changes in how this population is served. Those changes introduce risks to the forecast in ways that might increase, decrease, or shift caseload over the forecast horizon.

On a smaller scale, one of the provisions of the Oregon House Bill 2216 is to reduce overall Long-Term Care bed capacity by 1,500 beds by Dec 31, 2015. This may also introduce some risk to the Long-Term Care forecast.

Total Long-Term Care

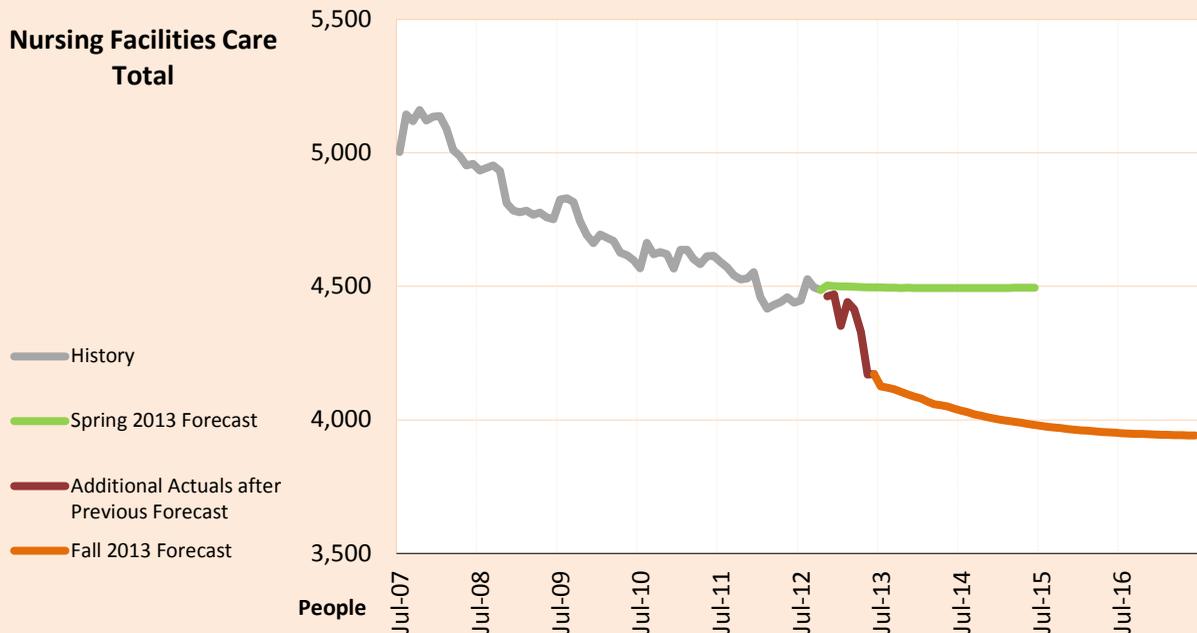


In-Home Services Total

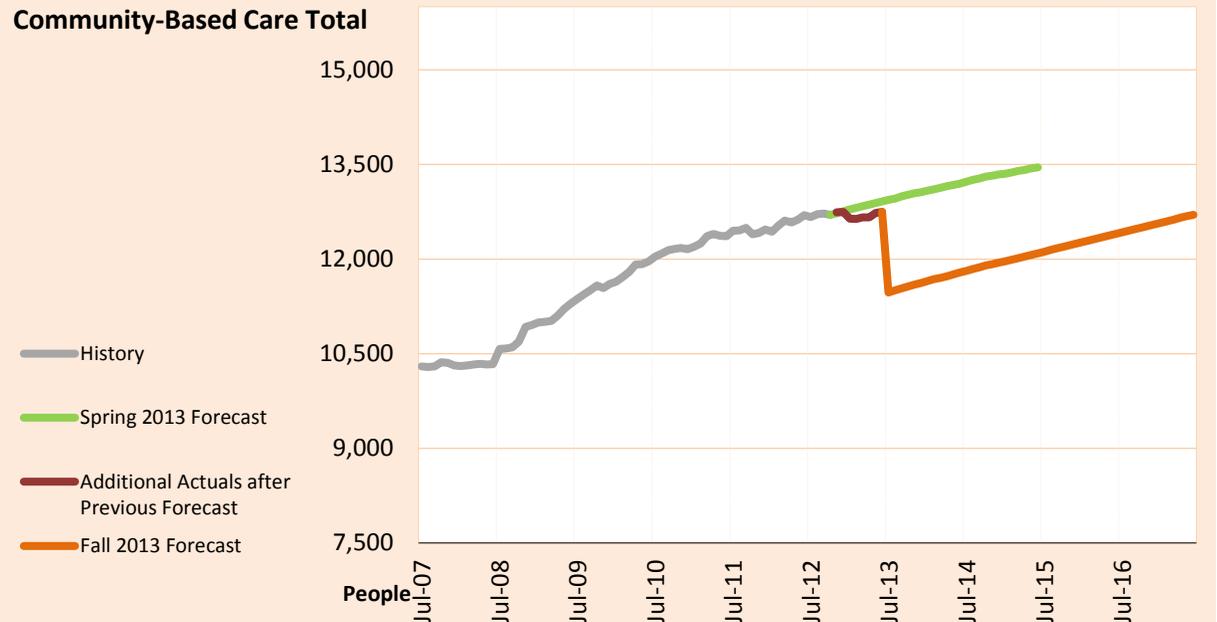


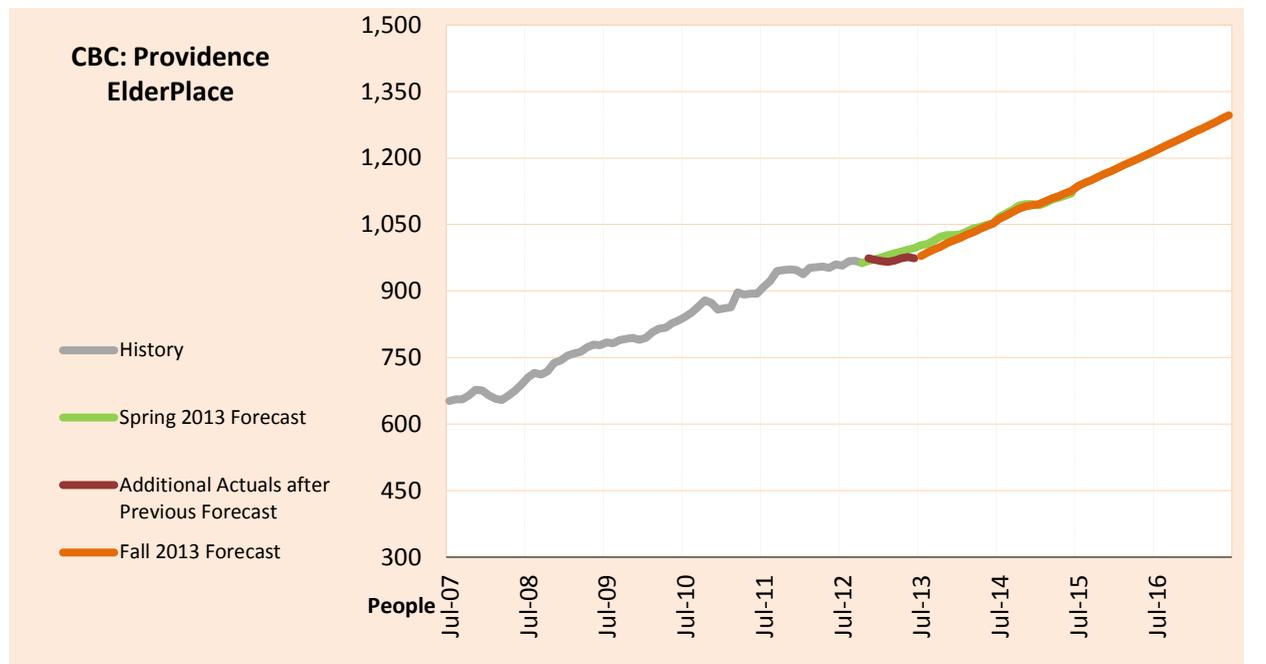
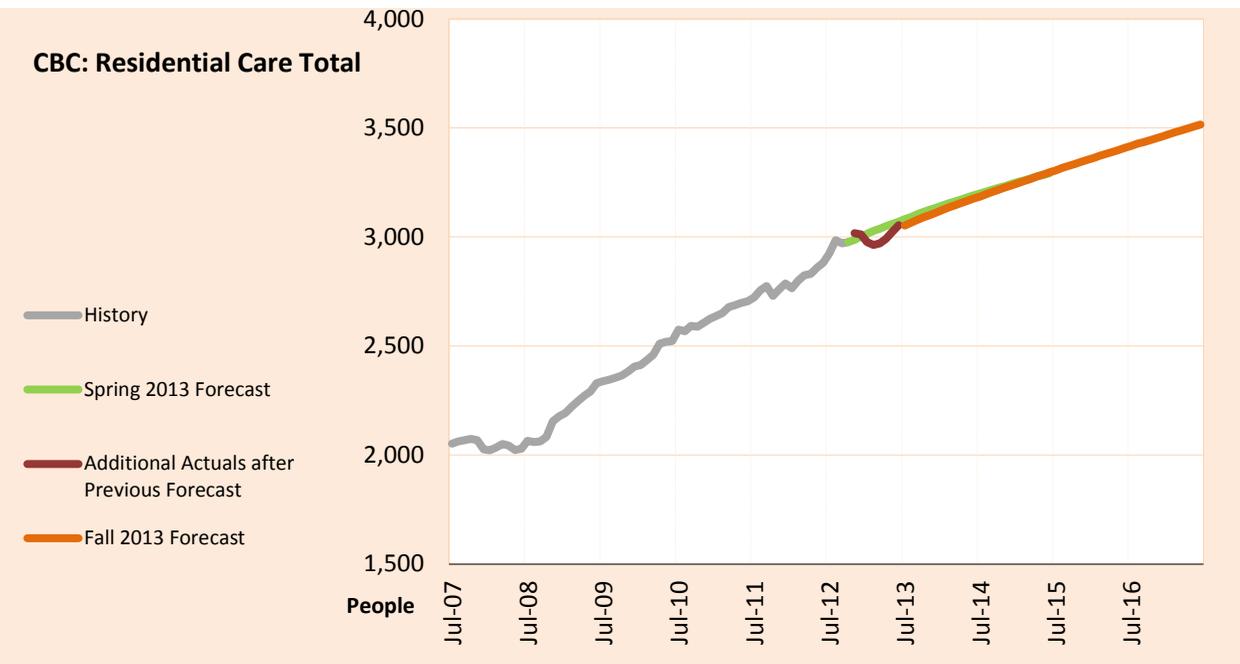
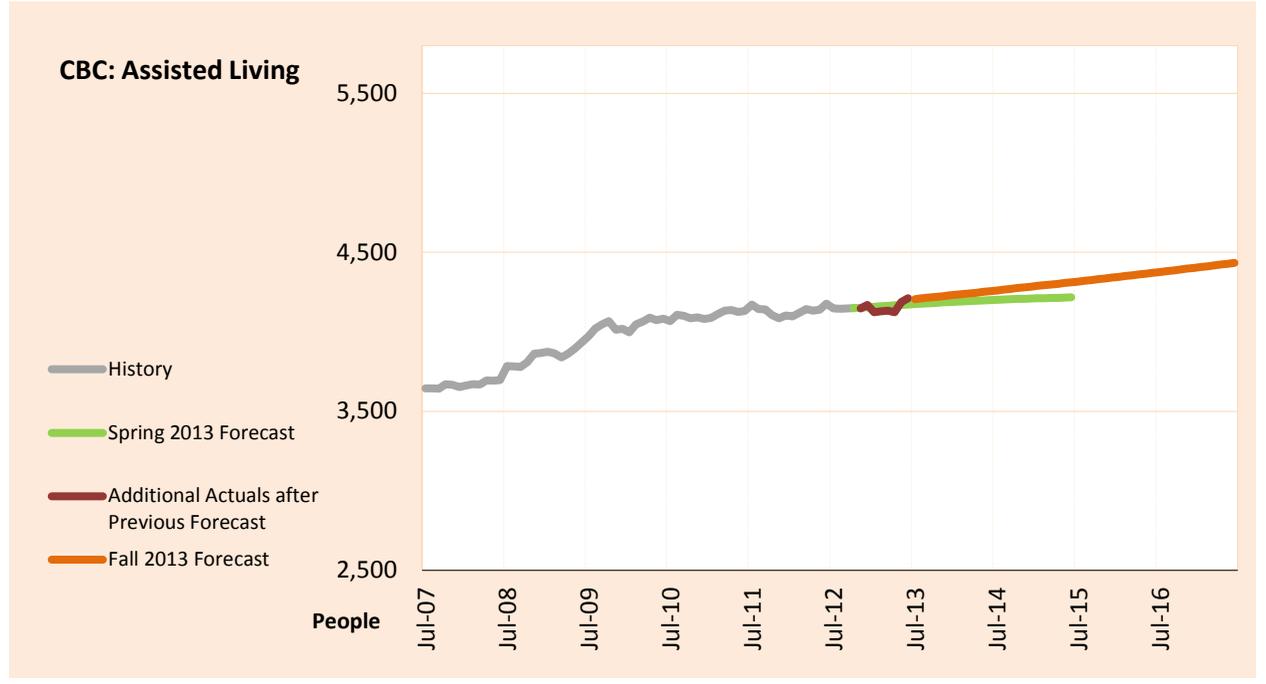
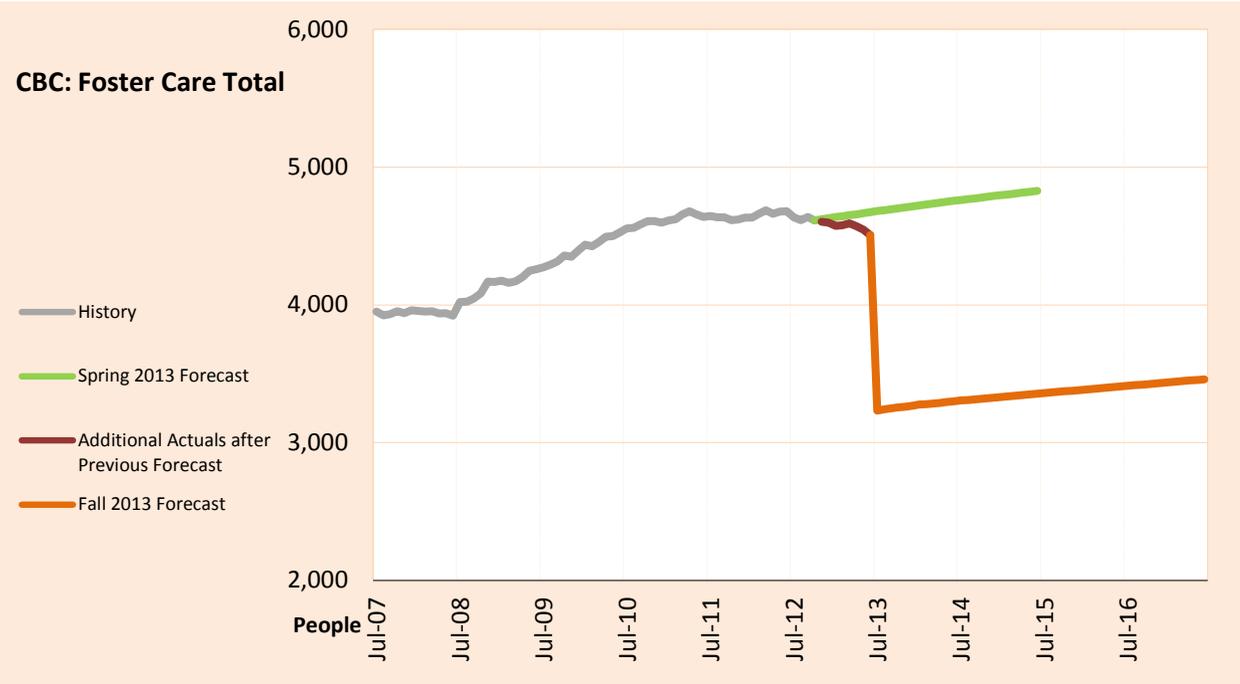
In Spring 2013 the In-Home caseload category was expanded to include three additional existing services. In-Home Agency and State Plan Personal Care Agency were added to the historical line starting July 2009, and Independent Choices was added starting July 2011.

Nursing Facilities Care Total



Community-Based Care Total





Aging and People with Disabilities Biennial Average Forecast comparison

	Spring 13 Forecast 2013-15	Fall 13 Forecast 2013-15	% diff. Spring 13 to Fall 13 2013-15	Fall 13 Forecast 2013-15	Fall 13 Forecast 2015-17	% diff. Fall 13 2013-15 to 2015-17
Aged and People with Disabilities						
In-Home Hourly without SPPC	8,455	9,009	6.6%	9,009	9,159	1.7%
In-Home Live-In	1,111	1,211	9.0%	1,211	1,231	1.7%
In-Home Spousal Pay	91	94	3.3%	94	96	2.1%
In-Home Agency without SPPC	1,046	1,212	15.9%	1,212	1,232	1.7%
Independent Choices	285	285	0.0%	285	285	0.0%
Specialized Living	160	165	3.1%	165	165	0.0%
In-Home Waivered Subtotal	11,148	11,976	7.4%	11,976	12,168	1.6%
In-Home Hourly with State Plan Personal Care (Non-Waivered Services)	1,029	1,163	13.0%	1,163	1,182	1.6%
In-Home Agency with State Plan Personal Care (Non-Waivered Services)	210	255	21.4%	255	259	1.6%
In-Home Non-waivered Subtotal	1,239	1,418	14.4%	1,418	1,441	1.6%
Total In-Home¹	12,387	13,394	8.1%	13,394	13,609	1.6%
Commercial Adult Foster Care	3,385	3,300	-2.5%	3,300	3,410	3.3%
Relative Adult Foster Care ¹	1,371	-	-	-	-	-
Regular Residential Care	1,046	1,010	-3.4%	1,010	1,039	2.9%
Contract Residential Care	2,147	2,169	1.0%	2,169	2,373	9.4%
Assisted Living	4,199	4,258	1.4%	4,258	4,374	2.7%
ElderPlace(PACE)	1,063	1,056	-0.7%	1,056	1,215	15.1%
Community-Based Care subtotal	13,211	11,793	-10.7%	11,793	12,411	5.2%
Basic Nursing Facility Care	3,768	3,404	-9.7%	3,404	3,327	-2.3%
Complex Medical Add-On	614	528	-14.0%	528	516	-2.3%
Enhanced Care	60	60	0.0%	60	60	0.0%
Pediatric Care	52	52	0.0%	52	52	0.0%
Nursing Facilities subtotal	4,494	4,044	-10.0%	4,044	3,955	-2.2%
Total Long-Term Care	30,092	29,231	-2.9%	29,231	29,975	2.5%

1. CBC: Relative Adult Foster Care was closed in June 2013, and the majority of the caseload transferred to In-Home Care.

Developmental Disabilities

Case Management Enrollment is an entry-level eligibility, evaluation and coordination service delivered to all individuals with intellectual and developmental disabilities. There were 21,192 clients enrolled in Case Management in June 2013, of which over three-quarters received additional developmental disability services. The biennial average forecast for 2013–15 is 22,045 clients, 2.0 percent higher than the Spring 2013 forecast. The forecast for the 2015–17 biennium is 23,684 clients, 7.4 percent higher than the forecast for 2013-15.

The remaining caseload categories are divided into three groups: adult services, children services, and other services.

Adult Services include:

Brokerage services — Caseload is forecast for rise to the current contractual limit of 7,805 clients by January 2014, and to remain at that level through the 2015-17 biennium. Consequently, the biennial average forecast for 2013-15 is 7,727 clients, 1.0 percent less than the Spring 2013 forecast, and the forecast for 2015-17 is 7,805 clients, 1.0 percent higher than 2013-15.

However, if the volume of Brokerage clients was not capped, this category would be expected to continue expanding by its historical rate of growth. Since implementation of the new K Plan requires that services be provided to all eligible applicants, clients who would have been served through brokerages will be diverted to county Community Developmental Disability Programs (CDDPs) – and served primarily in the category called Comprehensive In-Home Support Services (CIHS). To estimate the volume and timing of clients who will likely be diverted, an uncapped forecast was prepared for Brokerage Enrollment and the volume exceeding the current contractual limit for Brokerage Enrollment was added to the CIHS caseload instead.

24-Hour Residential Care — The biennial average forecast for 2013–15 is 2,714 clients, 0.7 percent higher than the Spring 2013 forecast. The forecast for the 2015–

17 biennium is 2,809 clients, 3.5 percent higher than the forecast for 2013-15.

Supported Living — The biennial average forecast is 705 clients for 2013–15, and 703 clients for the 2015-17 biennium.

Comprehensive In-Home Services (CIHS) — Caseload is forecast to grow dramatically in both 2013-15 and 2015-17 due to the new K Plan requirement to serve all eligible applicants, combined with the fact that Brokerage Enrollment have limited capacity. Once Brokerage Enrollment reach their current contractual limit, clients seeking support will be served primarily through this program. As a result, the biennial average forecast for 2013–15 is 463 clients, 51.3 percent higher than the Spring 2013 forecast. The forecast for the 2015–17 biennium is 990 clients, 113.8 percent higher than the forecast for 2013-15.

Supported Living and State Operated Community Program — Caseload is expected to remain at the current level of 108 through 2015-17.

Foster Care — This category serves both adults and children, with children representing slightly less than 20 percent. Closure of the Children Proctor Care program in January 2014 is expected to increase this caseload by 40 clients. Consequently, the biennial average forecast for 2013–15 is 3,068 clients, 0.9 percent higher than the Spring 2013 forecast. The forecast for the 2015–17 biennium is 3,212 clients, 4.7 percent higher than the forecast for 2013-15.

Children Services include:

Children Intensive In-Home Services — is a category which includes the Medically Fragile Children, Intensive Behavior Program, and Medically Involved Programs. The biennial average forecast is 404 children for 2013–15, slightly lower than the Spring 2013 forecast, and 417 for 2015-17.

Children's Residential Care — Caseload is expected to grow slightly to a biennial average of 154 in 2013-15 and 160 in 2015-17 due to the addition of 16 new beds in December 2013, March 2014, and June 2014.

Children's Proctor Care — This service category will be closed in January 2014. The majority of the existing Proctor Care caseload will be placed in the Non-Relative Foster Care, with a smaller number going to Children Residential Care, In-Home Support and Children Intensive In-Home Services.

In-Home Support for Children (also known as Long-Term Support) — 187 children were served in June 2013. Under the new Medicaid State Plan (K) option, additional children may qualify for developmental disability services, and this caseload category is expected to grow. The Fall 2013 biennial average forecast for 2013–15 is 198 clients, 10.0 percent higher than the Spring 2013 forecast, and the forecast for 2015-17 is 240 clients, 21.2 percent higher than 2013-15. These increases do not reflect the potential growth as a result of the K Plan.

Other DD Services include:

Crisis Services — Caseload significantly declined in 2009–11 due to management action and is expected to remain stable at or below the current forecast level of 55 through the 2015–17 forecast.

Employment and Community Inclusion — The biennial average forecast for 2013–15 is 4,267 clients, slightly lower than the Spring 2013 forecast. The forecast for the 2015–17 biennium is 4,397 clients, 3.0 percent higher than the forecast for 2013-15. As part of the Employment First initiative, this program is undergoing significant changes including an increased focus on early job preparation programs for qualifying High-School students. As a result, these students will graduate from high school with their employment training and employment in place. Under the new strategy, this program will unbundle the employment and community inclusion program into discrete services starting July 2014 (possible categories include sheltered workshop, pre-vocational, alternative to employment and supported employment services). The Employment First program may lead to increased enrollment in this program.

Transportation — The biennial average forecast for 2013–15 is 2,205 clients, 0.2 percent lower than the Spring 2013 forecast. The forecast for the 2015–17 biennium is 2,272 clients, 3.0 percent higher than the forecast for 2013-15.

Additional Risks

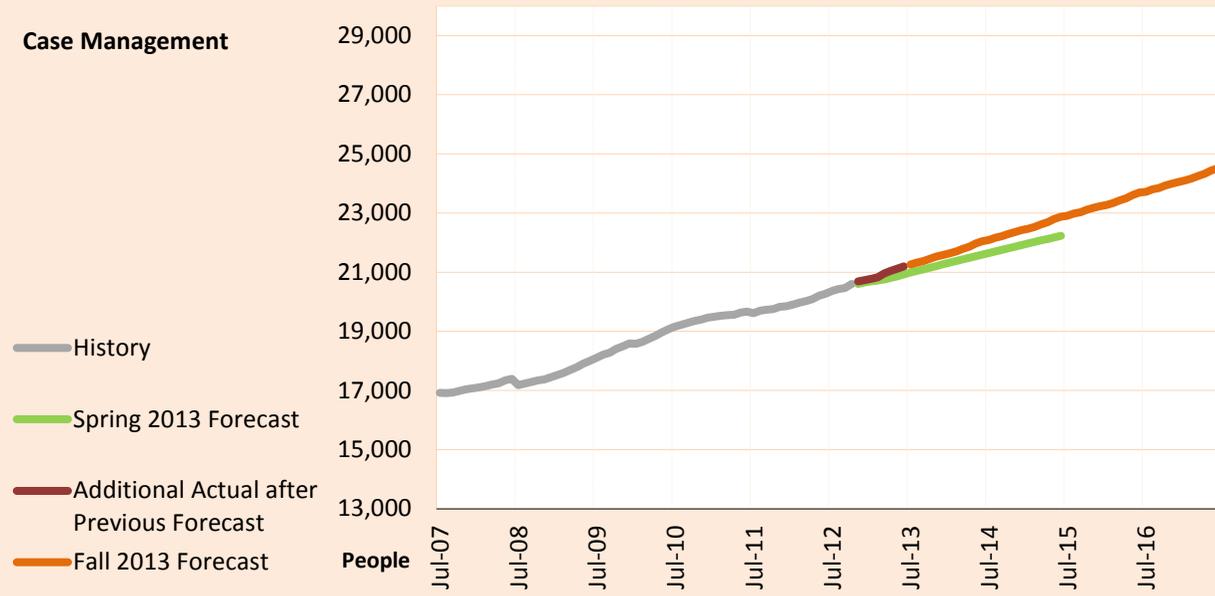
The biggest risks to the developmental disabilities caseload forecast are changes resulting from implementation of the new Medicaid State Plan (K) option which began on July 1, 2013.

The most significant change is “opening” the Brokerage waitlist, which is expected to cause Brokerage enrollment to climb relatively rapidly to the current contractual and budgetary limit of 7,805 clients by January 2014. Since the new K Plan requires Oregon to provide services to all eligible applicants and the brokerages will be at capacity, the caseload growth that would otherwise have been forecast for Brokerage Enrollment will instead be served through county Community Developmental Disability Programs (CDDP) - primarily in the category called Comprehensive In-Home Support Services (CIHS). The CIHS caseload will be funded through K plan rather than through waiver services and does not require having a service cost of greater than \$21,833 per year. Thus, it can serve additional clients diverted from Brokerage to CDDP. Since CIHS is a small program, the increase from clients diverted due to Brokerage capacity limitations is expected to swell the CIHS caseload to several times its current size by the end of 2015-17. Conversely, if Brokerage capacity is increased, CIHS growth, or some portion of it, could be reversed.

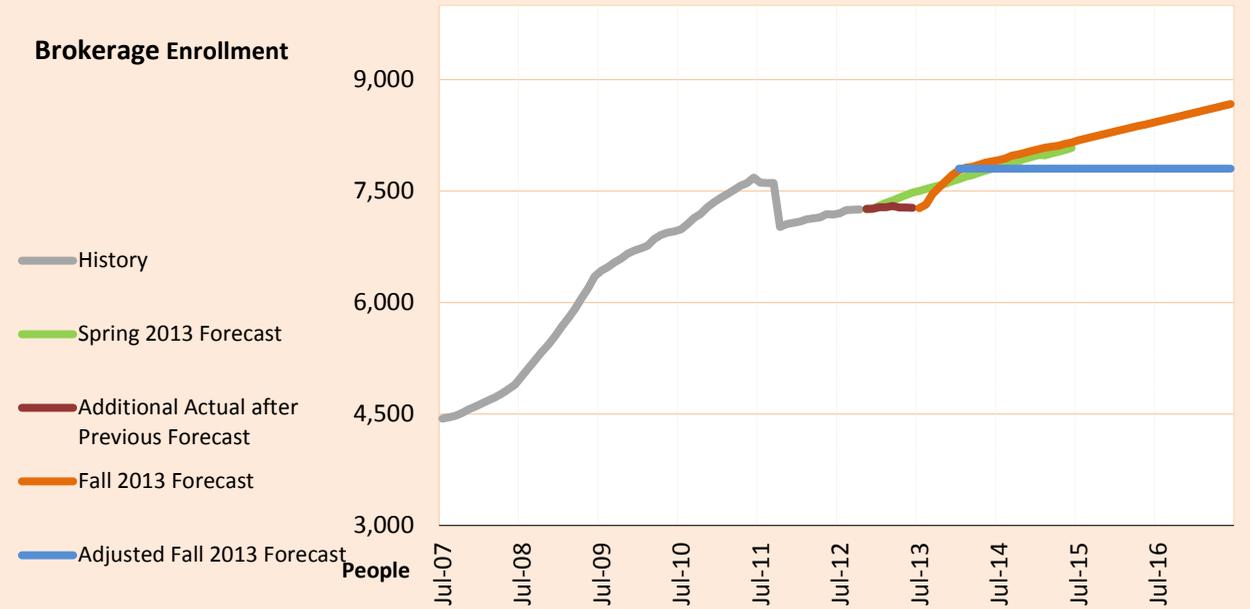
With the K Plan implementation, this opens developmental disability services to more children as parental income will no longer be considered in determining financial eligibility. This policy change has not been factored into the forecast and hence, presents a risk that the forecast for In-Home Support for Children may be significantly too low, and perhaps that the forecast for Non-Relative Foster Care may be too high.

In addition, the adoption of K Plan may also increase risk to other caseloads such as the 24 Hour Residential Care. Under K Plan, crisis services should not be necessary and clients will be able to choose among all available services. As a result, the demand for the 24 Hour Residential Care services may increase since there is substantial pent up demand for this service.

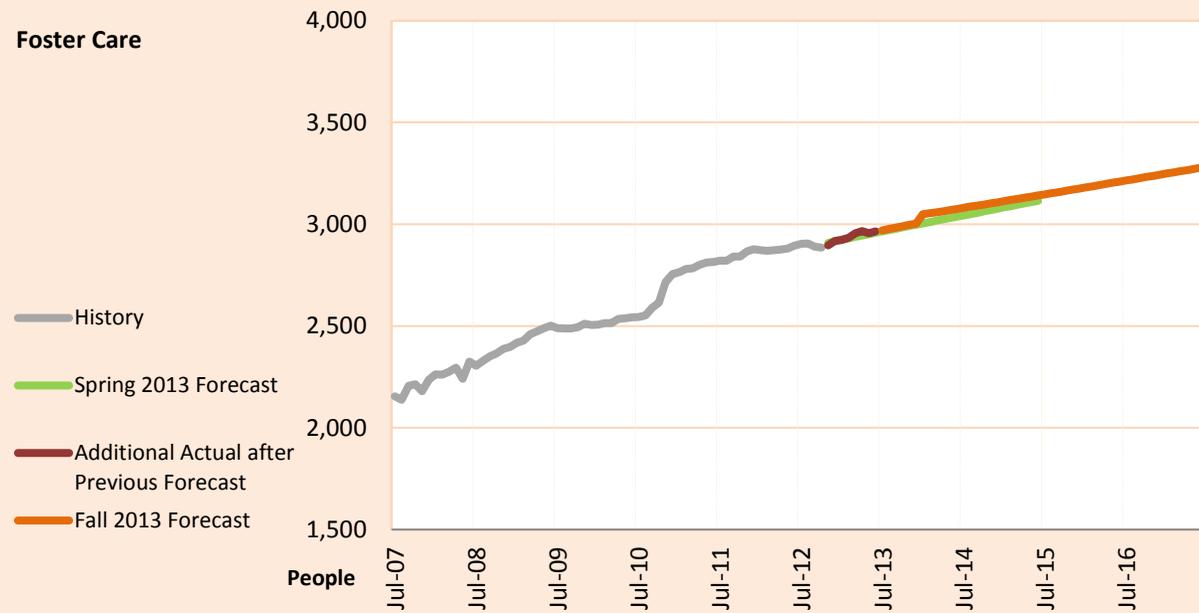
Case Management



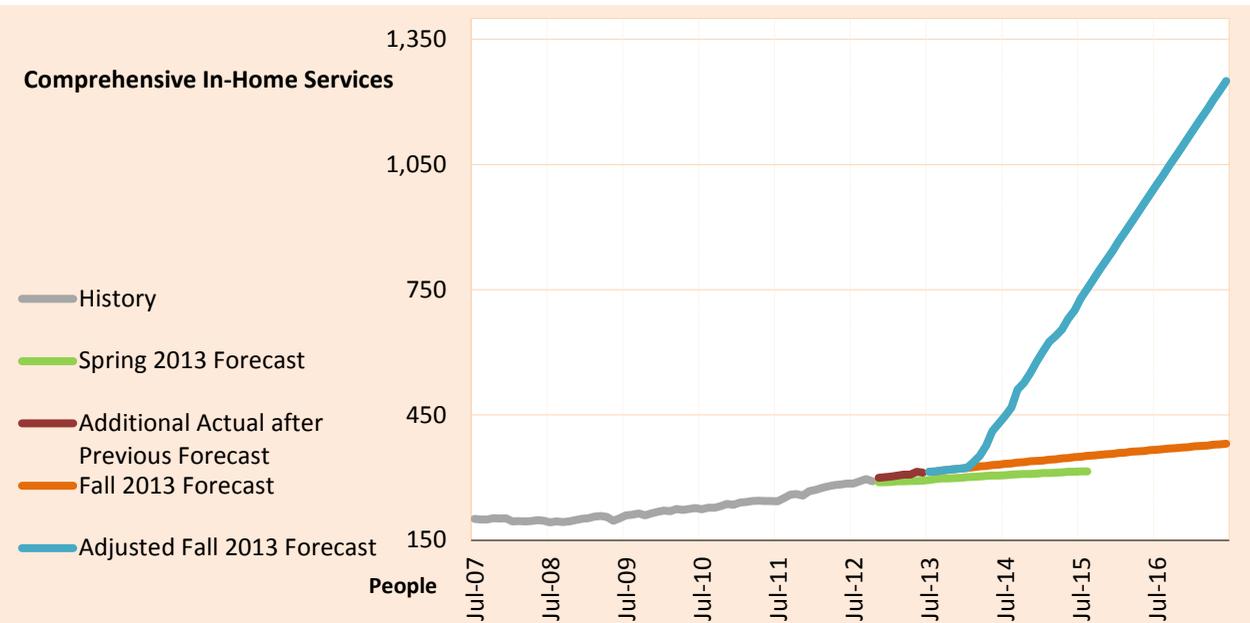
Brokerage Enrollment

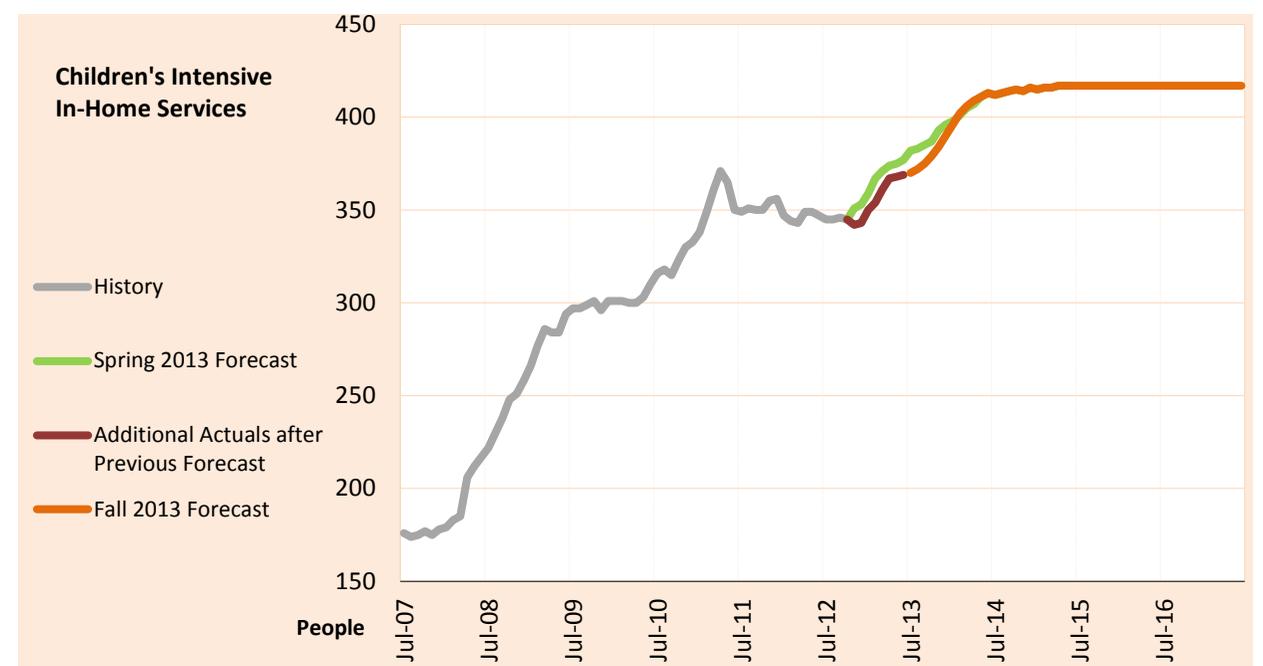
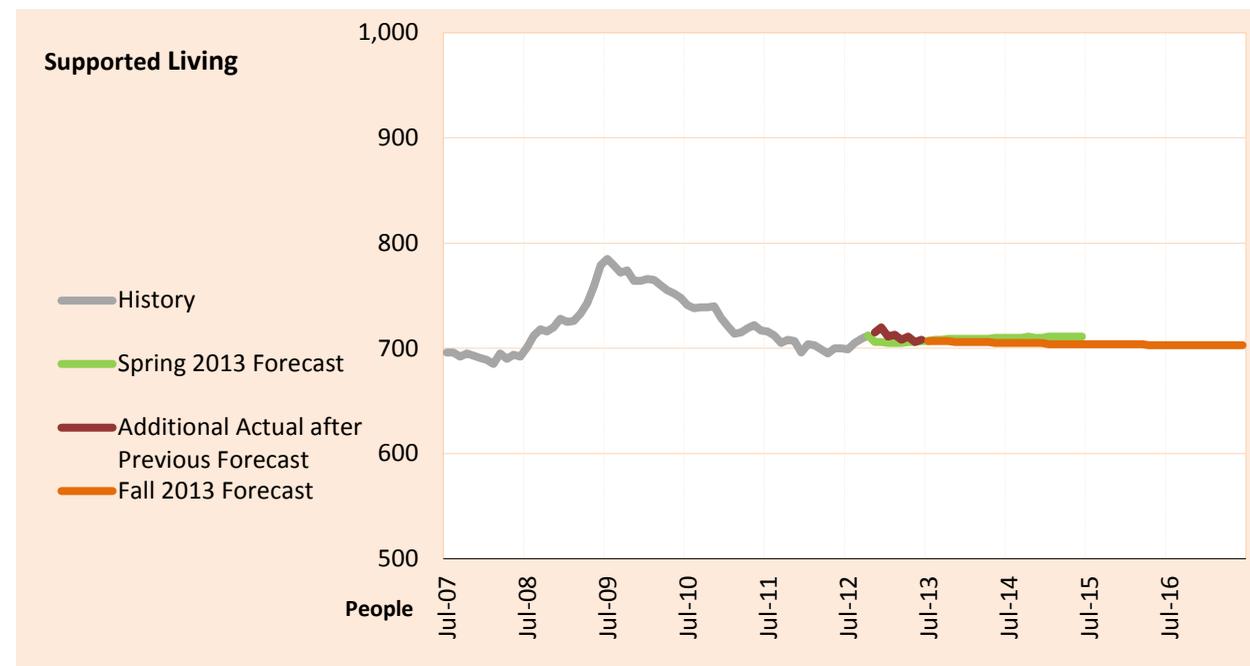
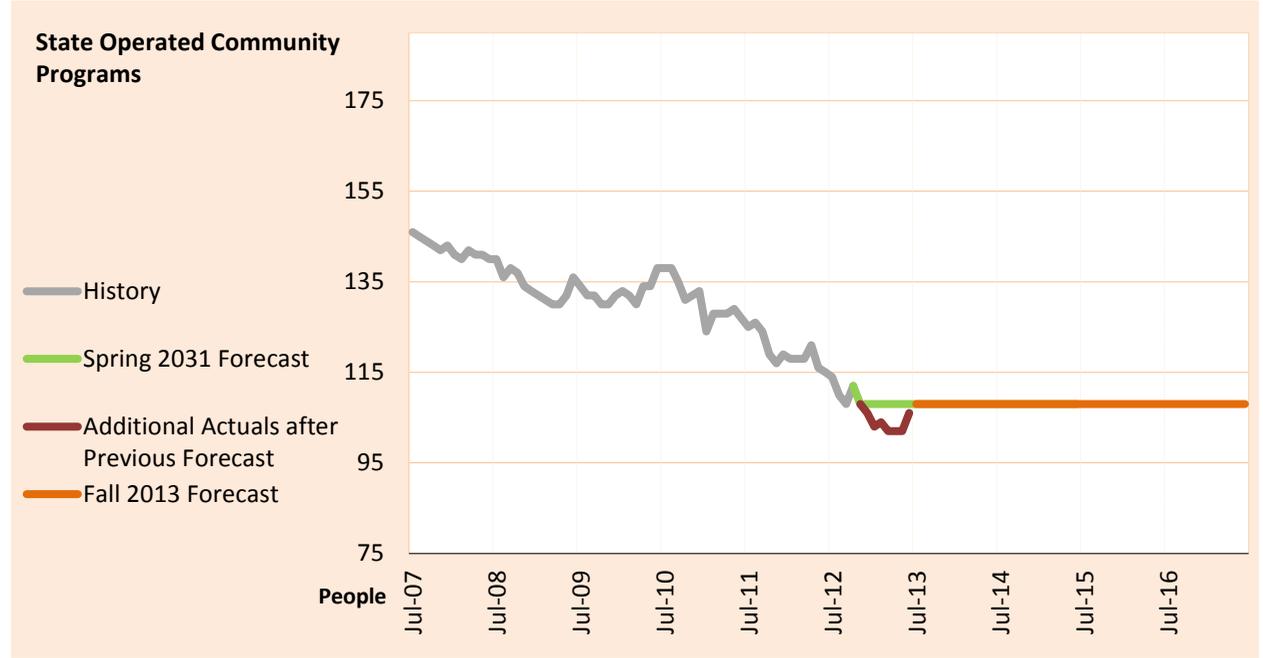
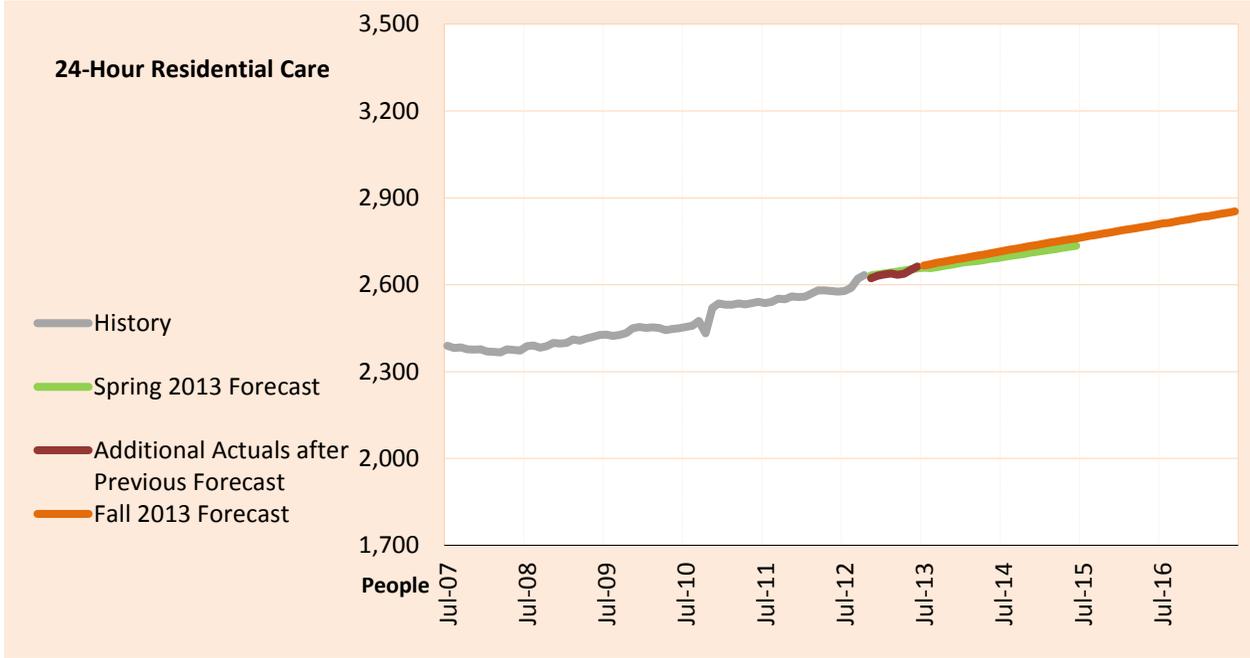


Foster Care

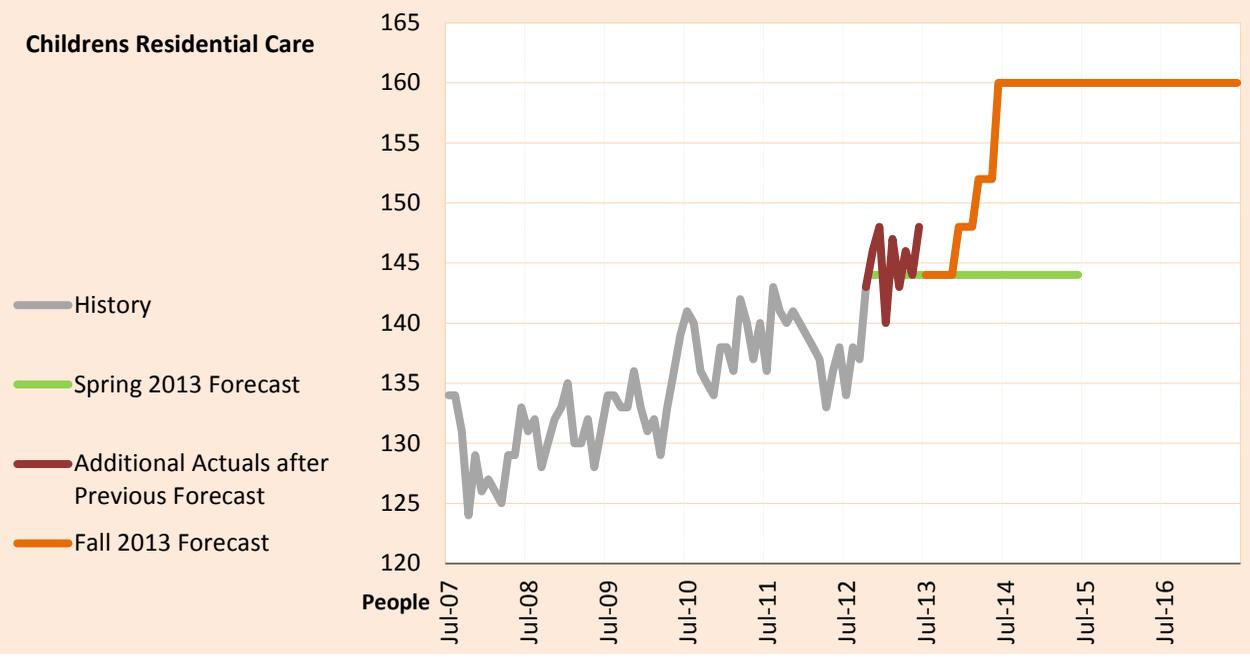


Comprehensive In-Home Services





Childrens Residential Care



Developmental Disabilities Biennial Average Forecast comparison

	Spring 13 Forecast 2013-15	Fall 13 Forecast 2013-15	% diff. Spring 13 to Fall 13 2013-15	Fall 13 Forecast 2013-15	Fall 13 Forecast 2015-17	% diff. Fall 13 2013-15 to 2015-17
Total Case Management Enrollment ¹	21,617	22,045	2.0%	22,045	23,684	7.4%
Adult						
Brokerage Enrollment	7,805	7,727	-1.0%	7,727	7,805	1.0%
24-Hour Residential	2,695	2,714	0.7%	2,714	2,809	3.5%
Supported Living	710	705	-0.7%	705	703	-0.3%
Comprehensive In-Home Services	306	463	51.3%	463	990	113.8%
State-Operated Community Programs	108	108	0.0%	108	108	0.0%
Foster Care	3,040	3,068	0.9%	3,068	3,212	4.7%
Children						
Children Intensive In-Home Services	406	404	-0.5%	404	417	3.2%
Children Residential Care	144	154	6.9%	154	160	3.9%
Children Proctor Care ²	62	16	-74.2%	16	-	-
In-Home Support (Long-Term Support)	180	198	10.0%	198	240	21.2%
Total DD Services	15,456	15,557	0.7%	15,557	16,444	5.7%
Other DD Services						
Crisis Services	55	55	0.0%	55	55	0.0%
Transportation	2,210	2,205	-0.2%	2,205	2,272	3.0%
Employment and Community Inclusion	4,271	4,267	-0.1%	4,267	4,397	3.0%

1. Total DD Services and Other DD Services do not add up to Total Case Management Enrollment.

2. Children Proctor Care will be closed in January 2014; caseload is expected to shift primarily to Non-Relative Foster Care, Children Residential Care, In-Home Support and Children Intensive In-Home Support.

Oregon Health Authority



Total Oregon Health Authority Biennial Average Forecast comparison

	Spring 13 Forecast 2013-15	Fall 13 Forecast 2013-15	% diff. Spring 13 to Fall 13 2013-15	Fall 13 Forecast 2013-15	Fall 13 Forecast 2015-17	% diff. Fall 13 2013-15 to 2015-17
Medical Assistance Programs						
OHP Plus: Temporary Assistance to Needy Families (Medical)	196,484	190,170	-3.2%	190,170	192,457	1.2%
OHP Plus: Total ACA Adults ^{1, 2}	123,168	191,295	55.3%	191,295	293,301	53.3%
OHP Plus: Poverty Level Medical - Women	13,417	13,726	2.3%	13,726	14,183	3.3%
OHP Plus: Poverty Level Medical - Children ³	150,990	172,607	14.3%	172,607	181,888	5.4%
OHP Plus: Aid to the Blind & Disabled	85,577	85,578	0.0%	85,578	88,189	3.1%
OHP Plus: Old Age Assistance	37,826	37,826	0.0%	37,826	41,361	9.3%
OHP Plus: Substitute Care & Adoption Services	19,208	18,852	-1.9%	18,852	18,810	-0.2%
OHP Plus: Children's Health Insurance Program ^{3, 4}	77,824	70,546	-9.4%	70,546	73,262	3.8%
Total OHP Plus	704,494	780,600	10.8%	780,600	903,451	15.7%
Other Medical Assistance Programs						
	50,312	49,793	-1.0%	49,793	53,357	7.2%
OHP Standard²						
	15,525	15,714	1.2%	15,714	-	-
Total Medical Assistance Programs	770,331	846,107	9.8%	846,107	956,808	13.1%
KidsConnect⁴						
	9,347	1,738	-81.4%	1,738	-	-
Addictions and Mental Health⁵						
Total Criminal Commitment	867	872	0.6%	872	872	0.0%
Total Civil Commitment ⁶	4,729	4,412	-6.7%	4,412	4,626	4.9%

1. The ACA uptake assumption has changed for the Fall 2013 forecast compared to Spring 2013 forecast. Due to the Fast Track enrollment option a higher percentage of qualified individuals are expected to enroll than the original SHADAC estimates.

2. OHP Standard closes on Dec 31, 2013. All current enrollees will transfer to ACA Adults.

3. Children aged 6-18 with family incomes of 100-138% FPL have been moved from CHIP to PLMC.

4. Kids Connect program closes on Dec 31, 2013. All current enrollees will transfer to CHIP.

5. All groups and subgroups are forecast independently using unduplicated client counts. Since one individual can be counted in more than one group due to overlapping service episodes, totals may be less than the sum of the lower level categories.

6. Following the Spring 2013 Forecast, ICS implemented rules to close overlapping CPMS records to count only one record when the provider changed. The reduction between Spring and Fall 2013 forecasts reflects elimination of duplicates in the database.

Medical Assistance Programs

The primary drivers of caseload growth for MAP since 2008 were the most recent recession (December 2007 through an official ending date of June 2009), and implementation of the Oregon Healthy Kids Initiative in July 2009. Taken together these two factors drove the total MAP caseloads from about 408,000 clients prior to the recession to about 634,000 clients by February 2011, when most of the Healthy Kids impact was realized, for the net increase of 226,000 clients (55 percent). From December 2007 thru February 2011, the caseloads grew at an average 1.2 percent monthly growth rate (14.4 percent annual growth rate). Since February 2011 the growth in caseloads slowed down to 0.2 percent monthly growth rate (2.4 percent annual growth rate), reaching 679,000 level as of May 2013.

In the beginning of 2014 we are entering a new era for MAP; with implementation of the Patient Protection and Affordable Care Act of 2010 (ACA) we are forecasting the largest net increase in clients for the entire history of MAP. The direct impact of ACA is the expansion of Medicaid coverage to Oregon adults (aged 18-64) with incomes up to 138 percent Federal Poverty Level (FPL). Despite the growing economy with its downwards pressure on MAP caseloads, implementation of ACA is expected to add approximately 260,000 new clients (newly eligible clients, plus individuals who were eligible under the old rules but were not enrolled, the so called “welcome mat” effect) to the caseload over the next few years, bringing the total to 967,155 clients in June 2017.

There are three major risks to the current caseload forecast: the economy, implementation of ACA, and changes to the eligibility re-determination rules.

The first major risk relates to the economic recovery, availability of jobs, and timing of the recovery for MAP clients. Theoretically, economic recovery should lead to an eventual reduction in MAP caseloads since eligibility is tied to client income. However, the timing and magnitude of that reduction is difficult to predict. The Oregon unemployment rate remains high at 8.1 percent (August 2013) despite the official ‘end’ of the recession in June of 2009. Historical experience shows that when a

recession ends, caseloads typically continue growing for months, if not years, before demonstrating a slow-down in growth, much less an actual decline in caseload levels. Oregonians falling into poverty often find it difficult to recover from that condition, resulting in high caseloads extending into the future. Even when the economy grows and new jobs are added, the jobs added may require different skills, or pay so poorly that clients remain on caseload. For additional information about economic risks see the “Forecast environment and risks” section at the beginning of this document.

The second major risk is associated with the extension of Medicaid to more individuals as a result of the Patient Protection and Affordable Care Act of 2010 (ACA). Despite confidence in the estimated number of newly eligible clients (approximately 241,500 by June 2017, based on State Health Access Data Assistance Center, SHA-DAC, estimates), the timing of that increase has a significant impact on the biennial average for the ramp up period. Given the Fast Track⁵ enrollment option implemented in Oregon, the Fall 2013 forecast assumes that 89 percent of the incremental clients will be enrolled by December 2014. Implementation of ACA is expected to impact a variety of caseload categories including: TANF, PLMW, ABAD, CAWEM, and BCCP. See below for more specific information about the anticipated impact.

The third major risk arises from changes being made to current eligibility re-determination practices. Starting in October 2013 all client re-determinations are being deferred until April 2014. Once resumed, re-determinations will be performed electronically every 12 months instead of every 6 months as in the past. This may lengthen the average duration on caseload, thereby causing an increase in caseload count. If an increase does occur, it could be due to clients staying longer on caseload due to less frequent re-determinations, or because of reductions in “churn” created when clients temporarily lose coverage due to incomplete renewal paperwork.

TANF Related Medical (TANF-RM) and TANF Extended (TANF-EX) are often combined since they are programmatically tied. These two groups represented 27.9 percent of the total OHP caseload in May 2013. The signs of a growing economy are now evident, as TANF Related Medical has been declining steadily since February 2013. TANF

5. Fast Track allows current SNAP clients and parents of kids who are enrolled in one of the kids programs, with income at or under 138 percent FPL, to enroll in a medical assistance program without having to go thru an application process. They are presumed eligible based on their known income level and residency status. All they need to do is provide their consent to be enrolled into a medical assistance program.

Extended Medical has been increasing, which is expected as some of those who leave TANF Related Medical transition to TANF Extended Medical. Without ACA expansion these groups combined are expected to decline very slowly through the forecast horizon. The ACA expansion is expected to add approximately 15,000 clients by June 2017 (SHADAC's estimates of the "welcome mat" impact) to the otherwise slowly declining caseloads. Addition of the "welcome mat" effect created by ACA increases the forecast risk for this category.

Poverty Level Medical Children (PLMC) represents the second largest MAP caseload at 22.3 percent. This group is expected to grow at a very slow rate based on the belief that relatively few eligible, uninsured children remain available to be added to the group. However, there will be a level shift in January 2014 as about 24,000 children aged 6-18 with family income of 100-133 percent FPL are moved from CHIP into this program. The reclassification of these clients increases the forecast risk as our current data system does not capture FPL data in a way that allows us to accurately count the children in this sub-group.

Aid to the Blind and Disabled (ABAD) represented 12.2 percent of the May 2013 caseload. This group has grown consistently over several years and is expected to continue this growth pattern into the future as the proportion of elderly in the overall population continues to grow. Slight adjustments were made to the normal growth pattern to compensate for an expected reduction in the eligibility determination backlog. There is an additional risk associated with ACA expansion which, although not currently quantifiable, represents a real possibility. General consensus is that the number of clients entering this caseload may decline somewhat when low income adults become eligible for medical coverage without having to first be determined to be disabled. The impact will be closely monitored as ACA implementation takes place.

Children's Health Insurance Program (CHIP) represented 11.2 percent of the May 2013 caseload. This caseload has grown recently primarily due to improving economic conditions that cause children to move from TANF and PLMC into CHIP. Continued slow growth is expected due to economic conditions. However, there are two additional changes that will impact this caseload: 1) expansion of CHIP to cover children with family income levels of 200-300 percent of FPL and 2) reclassification of children of ages 6-18 with family income levels of 100-138 percent of FPL from CHIP to PLMC. The

first change will add about 16,000 children to this group by June 2017, including integration of about 8,000 children from the KidsConnect program. The second change will decrease current CHIP caseloads by about 24,000.

Old Age Assistance (OAA) caseloads represented 5.2 percent of the May 2013 caseload. The group has grown at a fairly rapid rate since January of 2009 and has only recently shown any indication that the growth rate might slow. The current forecast is for this caseload to continue growing into the foreseeable future. This group is driven by population dynamics as well as economic conditions.

Citizen-Alien Waived Emergency Medical (CAWEM) represented 3.7 percent of the May 2013 caseload. This caseload has two components: 1) the regular program, which covers only emergency medical services, and 2) the prenatal program, which also covers prenatal services. CAWEM eligibility uses the same rules as Medicaid except for the citizenship/residency requirement. Consequently, when Medicaid expands due to ACA, this category will expand as well (both for adults up to 138 percent of FPL and children with family incomes of 200-300 percent of FPL). CAWEM caseload is notoriously difficult to forecast because it is heavily influenced by the ever changing population of non-citizens in Oregon. However, caseloads for this category have been declining in the recent months and were expected to decline if not for the ACA implementation. Thus, the current forecast is for this caseload to remain relatively stable at approximately 25,500 through the forecast horizon. The prenatal program was previously available only in participating counties, but as of October 2013 it is now a state-wide program. Expansion of CAWEM Prenatal to a statewide program will cause some caseload to shift from CAMEM Regular to CAWEM Prenatal.

Qualified Medicare Beneficiary (QMB) represented 3.1 percent of the May 2013 caseload. This caseload has grown at a consistent rate since January of 2009 and is expected to continue in this growth pattern through the forecast horizon.

Foster / Substitute Care represented 2.8 percent of the May 2013 caseload. Current estimates are for this caseload to remain relatively stable at approximately 18,800 through the forecast horizon.

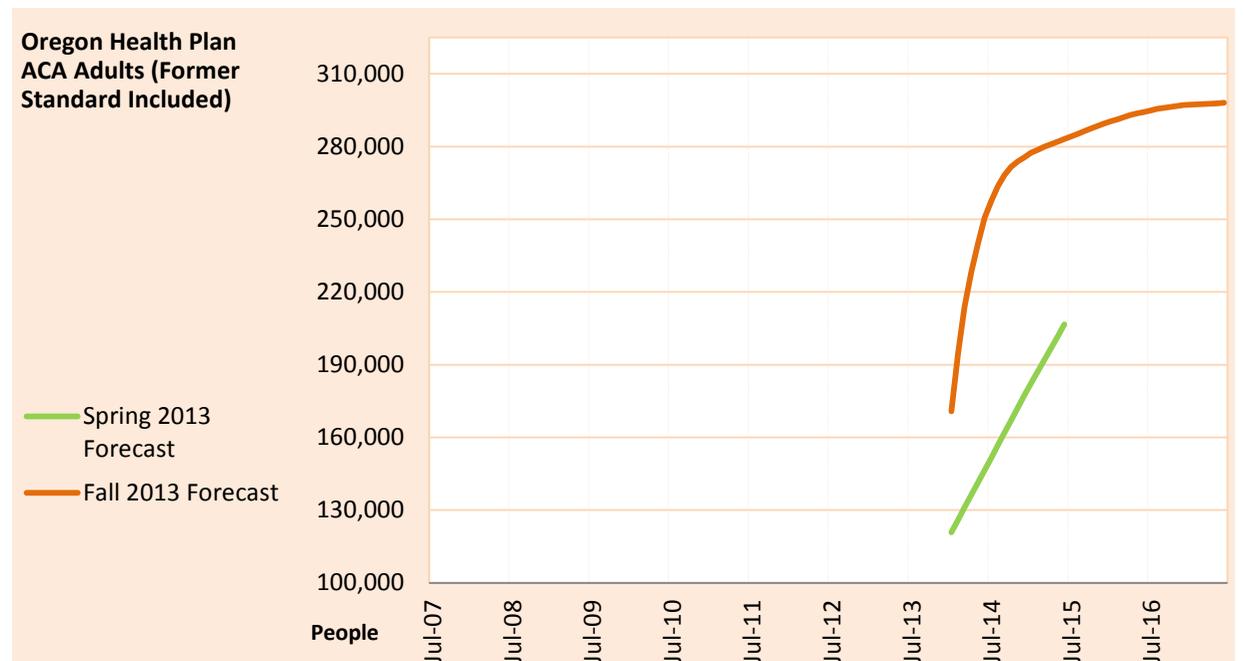
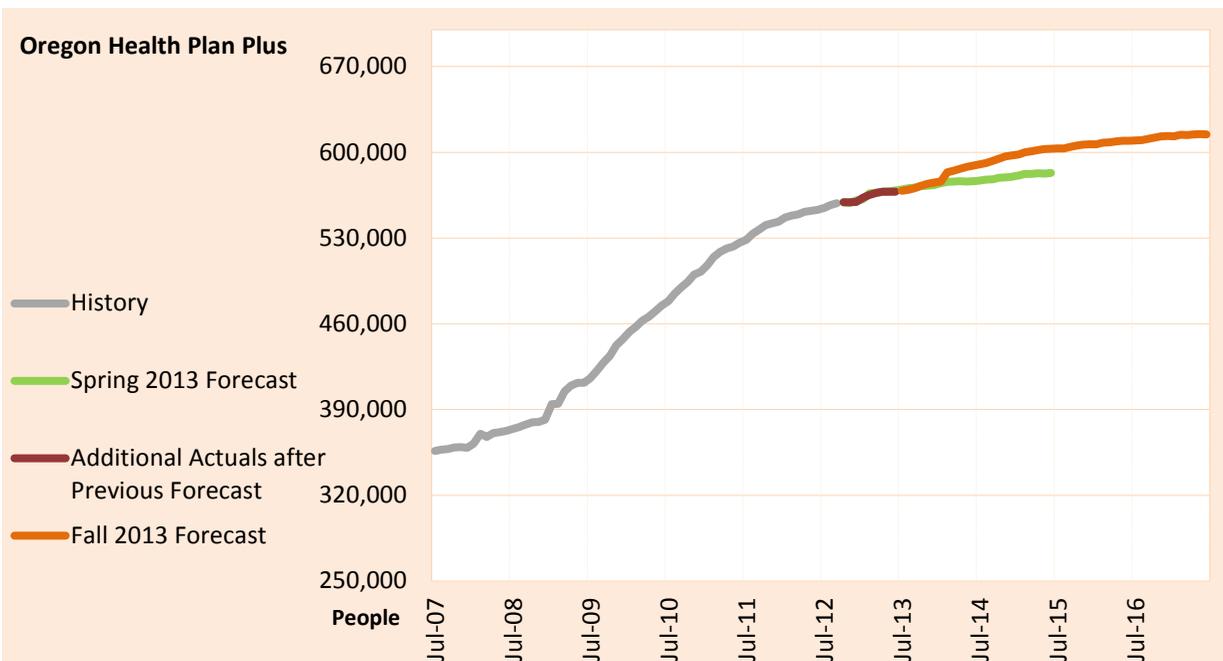
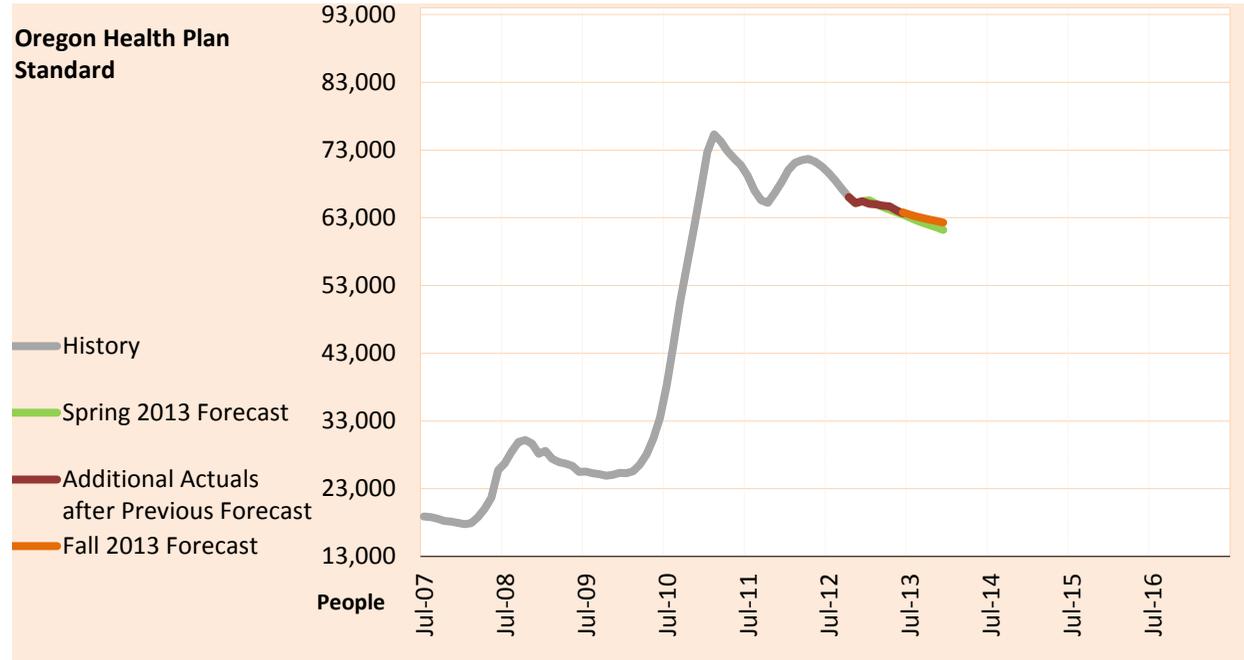
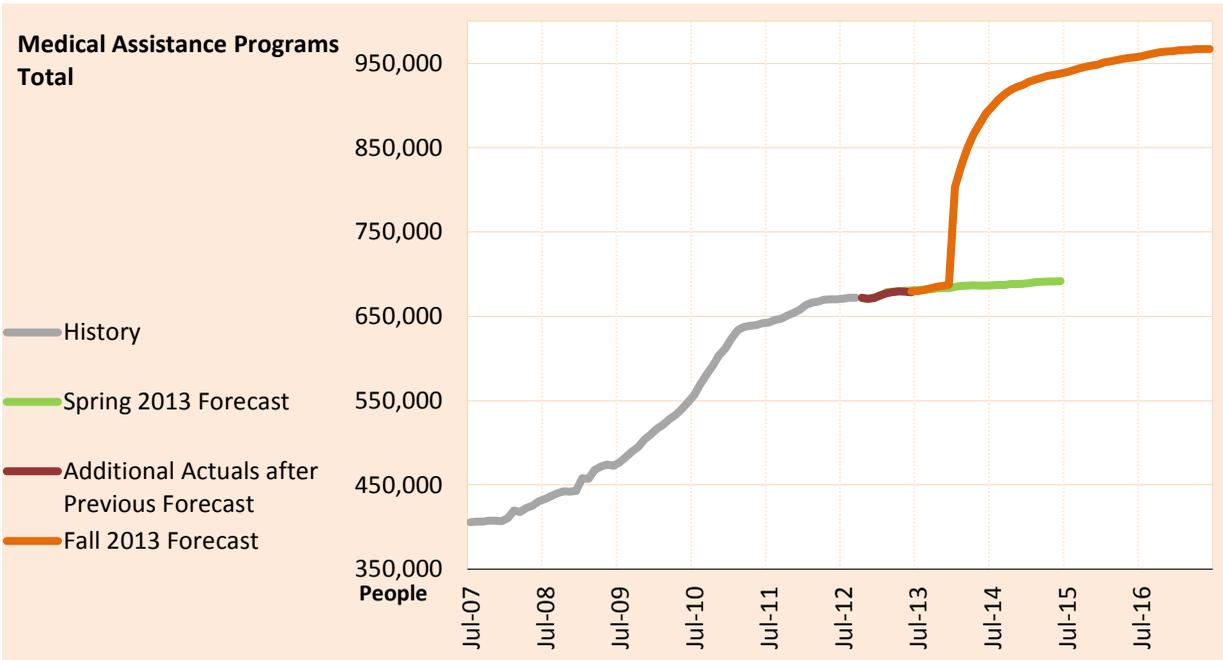
Poverty Level Medical Women (PLMW) represented approximately 2.0 percent of the May 2013 caseload. The forecast for this group is to continue the historical pattern of

slow, steady increases with strong seasonal variability. ACA implementation poses a risk to this forecast since some women who previously did not have medical coverage may choose to have a child now that their medical costs would be covered. In addition, caseload may increase due to the “welcome mat” effect.

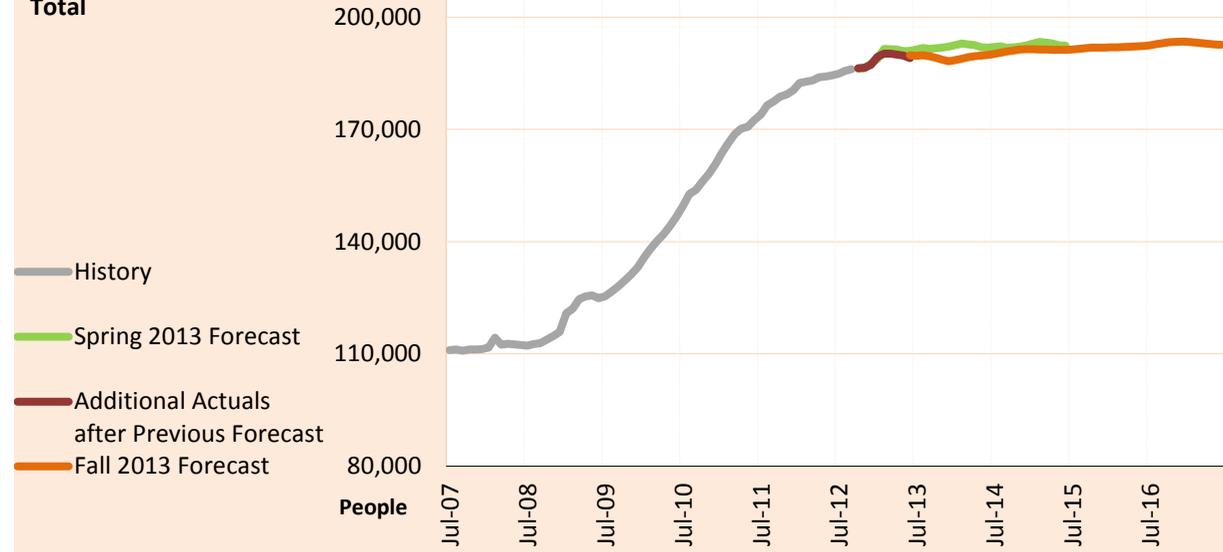
Breast and Cervical Cancer Program (BCCP) represented one-tenth of one percent of the total caseload in May of 2013. The history of this program presents something of a moving target since participation is directly tied to the number of ‘screenings’ completed via Oregon Public Health, which itself varies based on funding. The number of screenings conducted has varied over time with the most recent ‘increase’ in screenings implemented in 2012. A downward adjustment to the normal forecast for this group was made due to an expectation that ACA would lead more women to have regular medical coverage, resulting in fewer who would need screenings through Public Health.

OHP STANDARD — represented 9.4 percent of total caseload in May of 2013 and is comprised of two eligibility groups: Families, and Adults & Couples. This program is currently funded through specialized taxing structures and is capped at an attained biennial average of 60,000 clients. This group has stopped accepting new clients and the program will end on December 31, 2013. All clients enrolled in OHP Standard when the program ends will be converted to the new ACA Adults group which is divided into two parallel eligibility groups: ACA Adults with Children, and ACA Adults without Children.

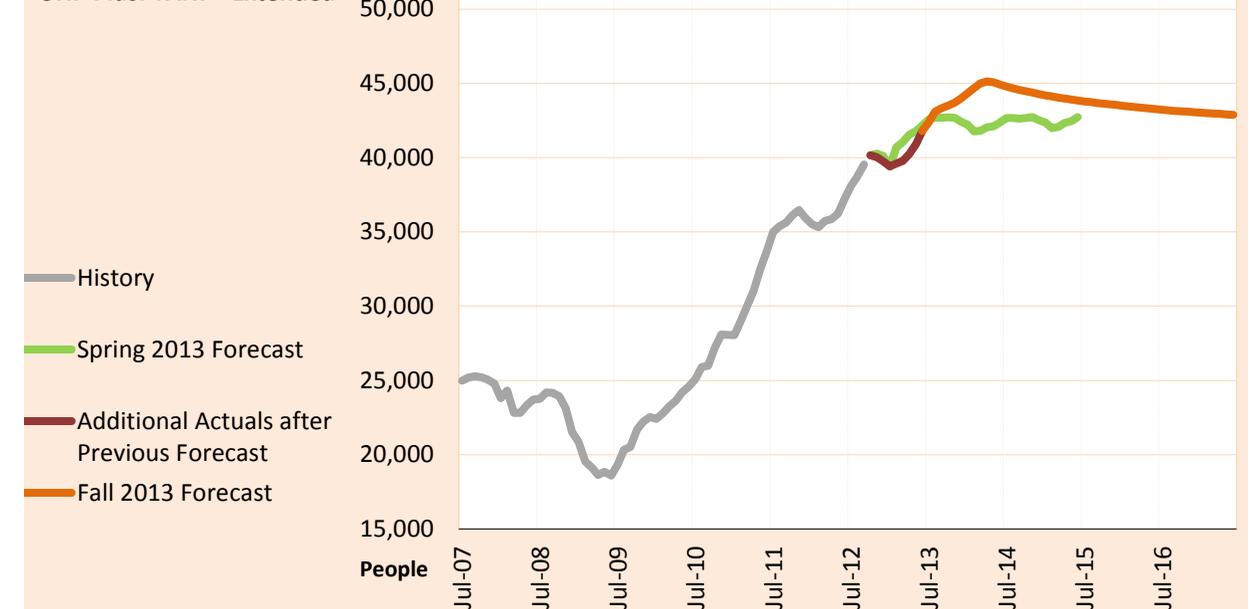
KIDSCONNECT — is a non-Medicaid eligibility group limited to children under the age of 19 with family income levels of 200-300 percent of FPL. This program currently has special funding and requires a sliding scale co-pay for participation. The potential pool for this caseload is capped at approximately 16,000 clients as this represents the most recent demographic estimates from the American Community Survey (U.S. Census Bureau) in combination with the most recent Oregon Health Survey. This program will end on December 31, 2013. All clients enrolled in KidsConnect when the program ends will be converted to the CHIP program.



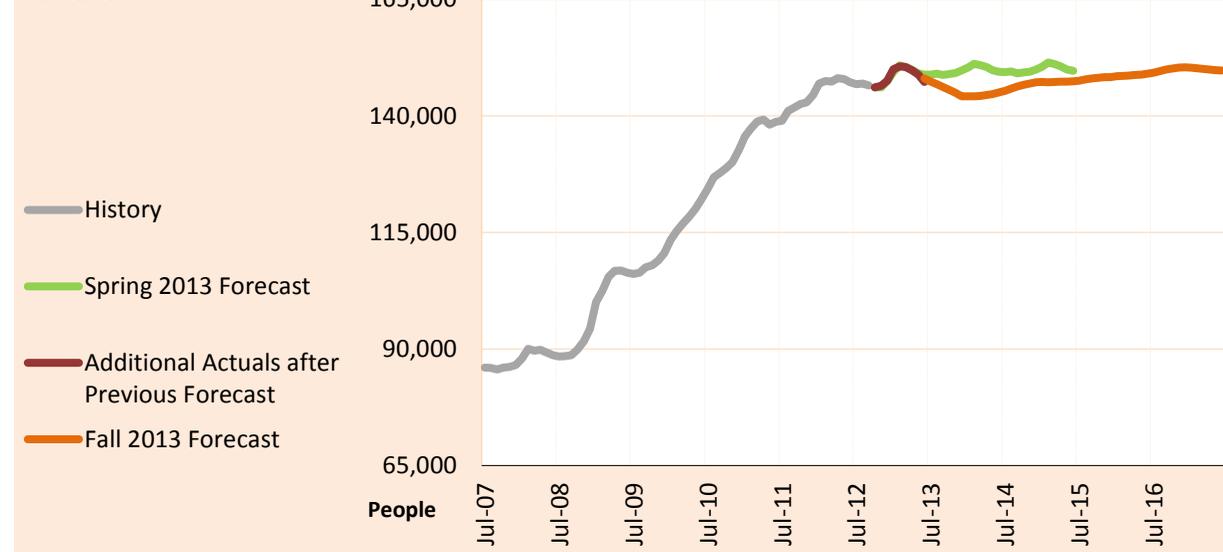
OHP Plus: Temporary Assistance for Needy Families - Total



OHP Plus: TANF - Extended



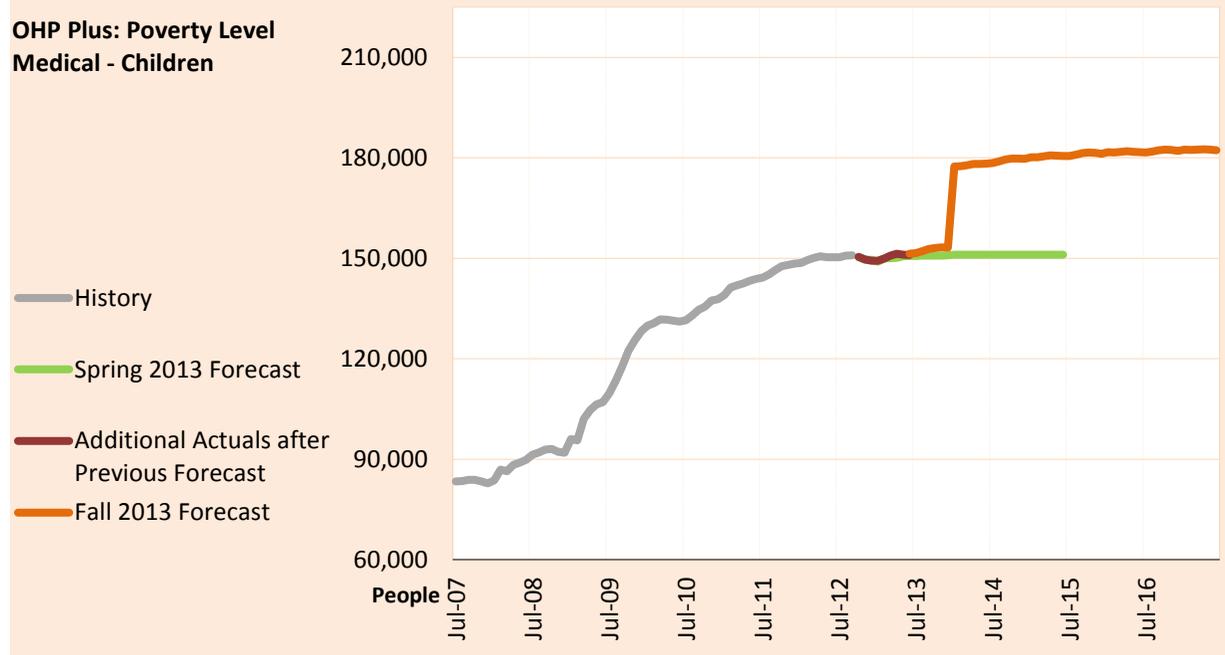
OHP Plus: TANF - Related Medical



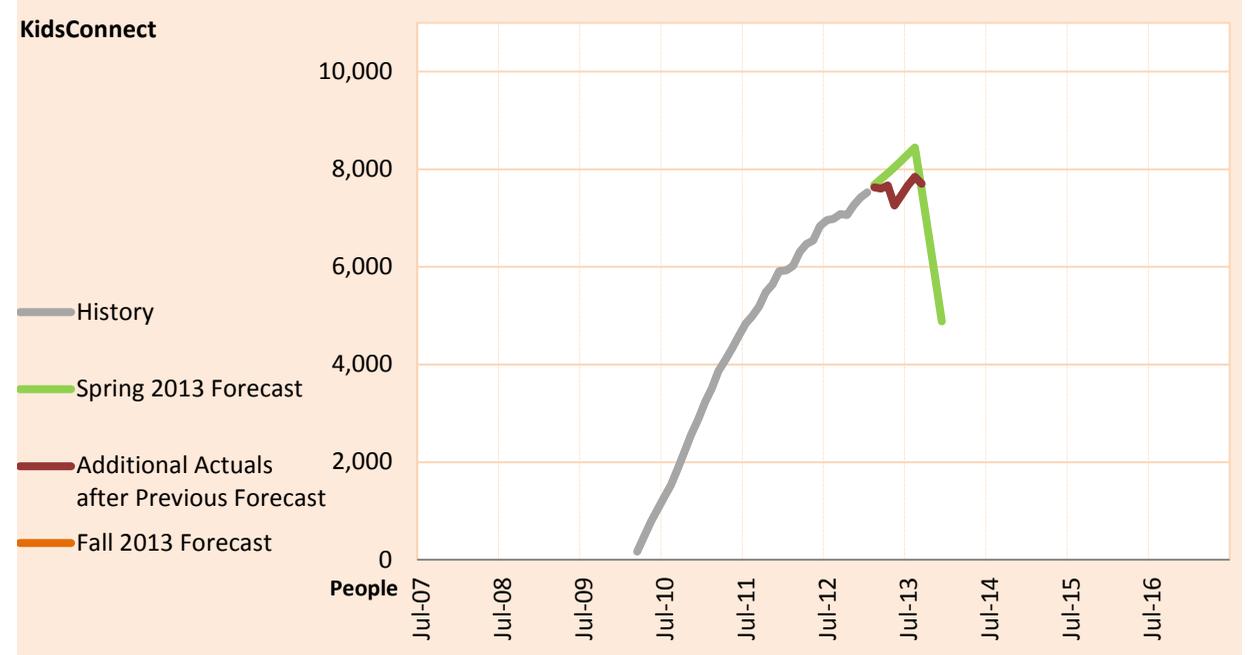
OHP Plus: Poverty Level Medical - Women



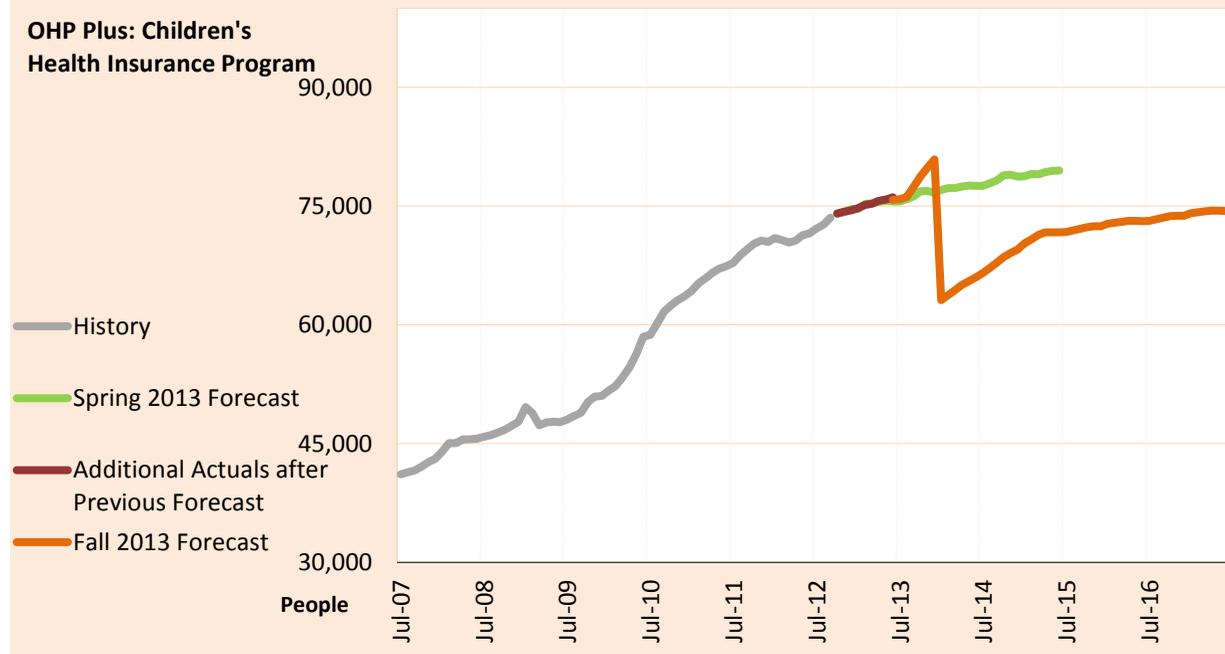
OHP Plus: Poverty Level Medical - Children



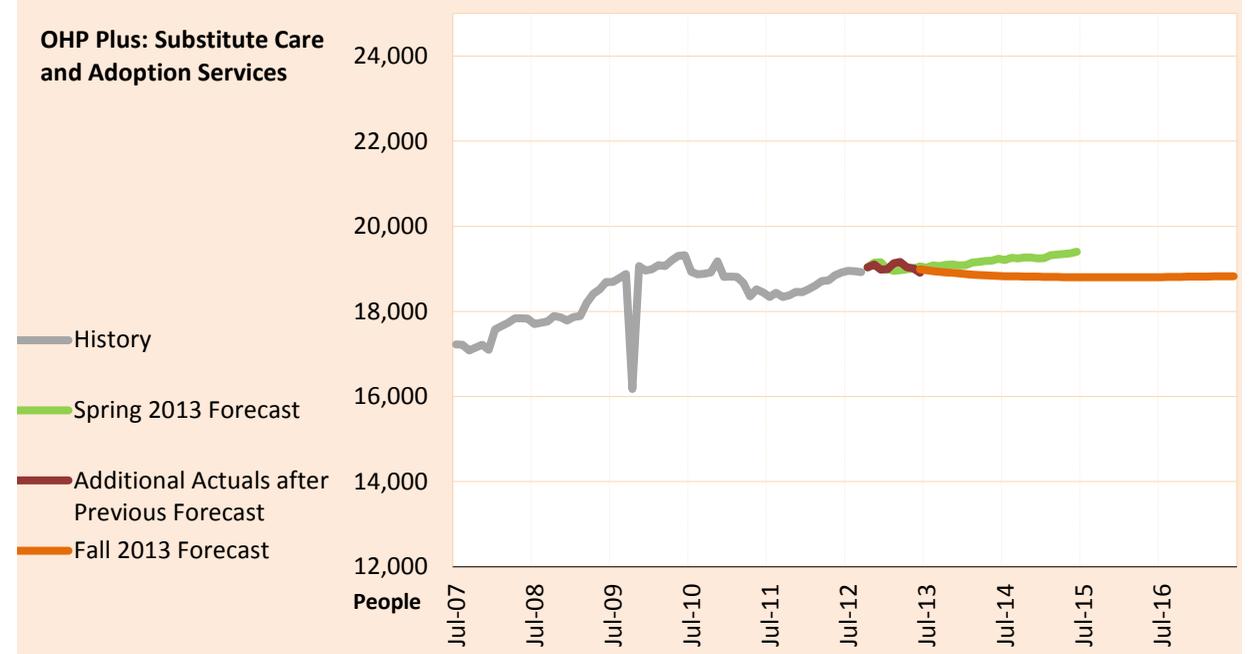
KidsConnect

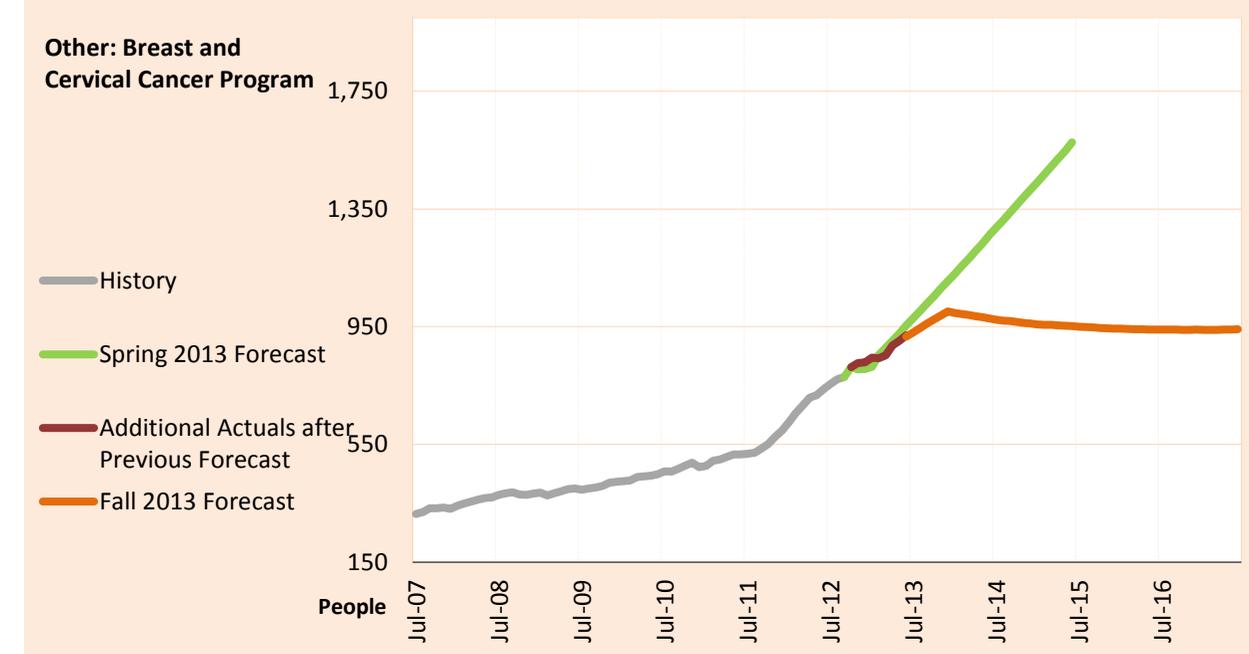
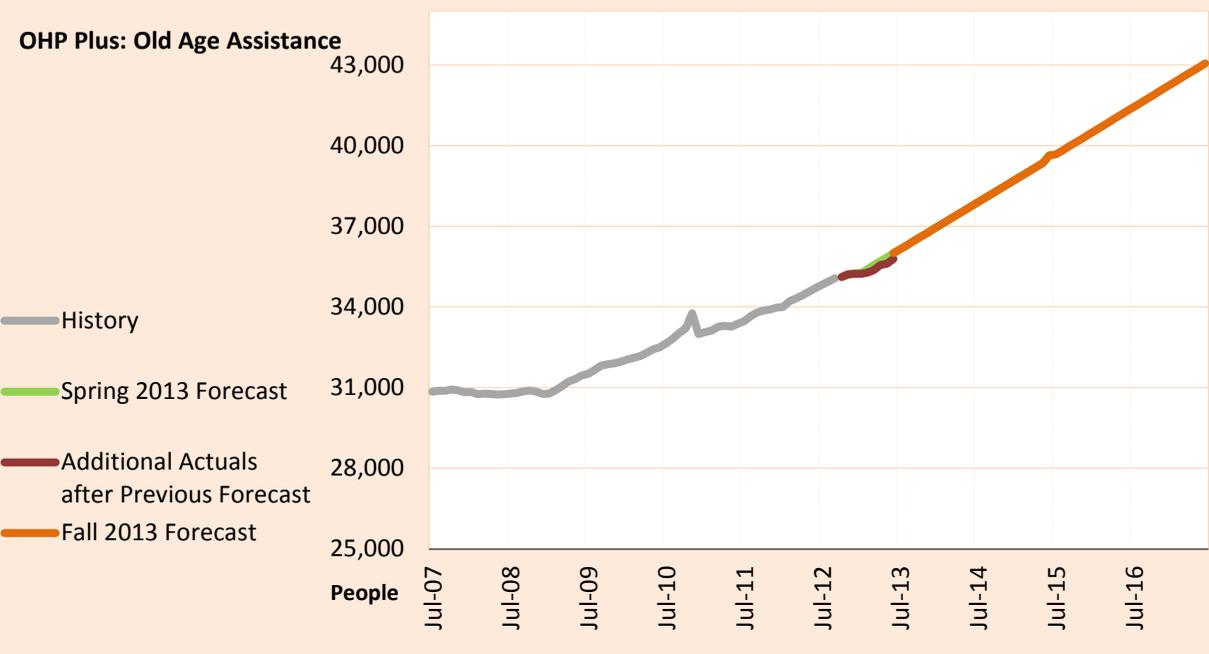
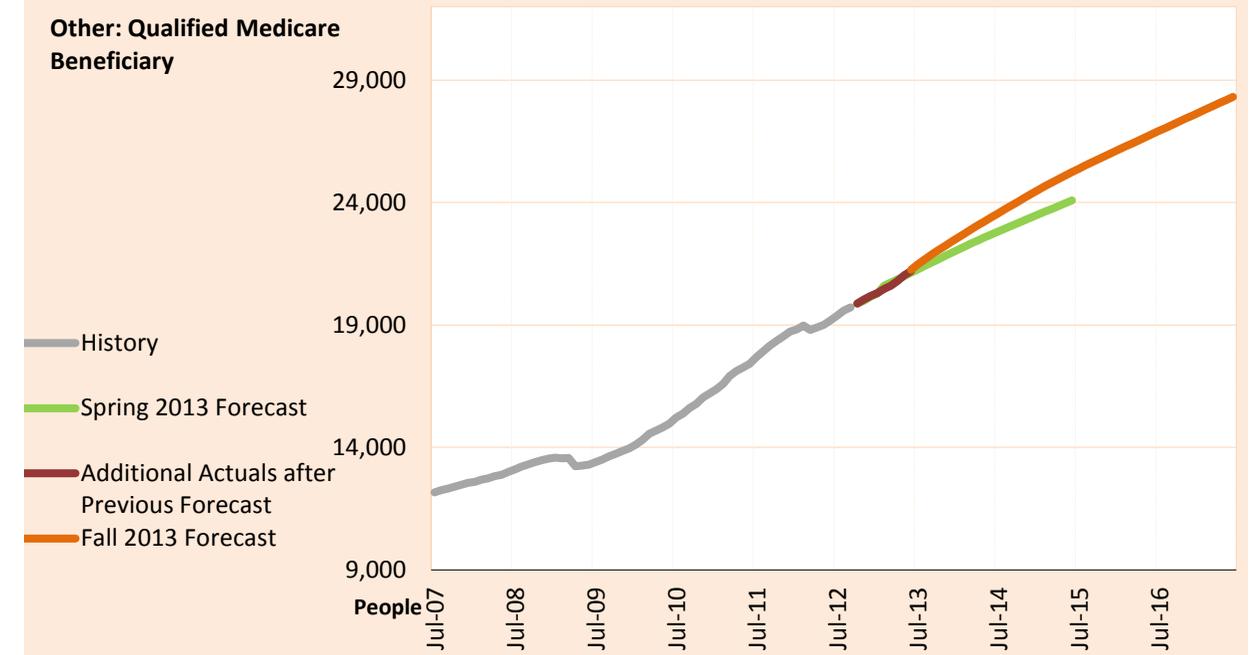
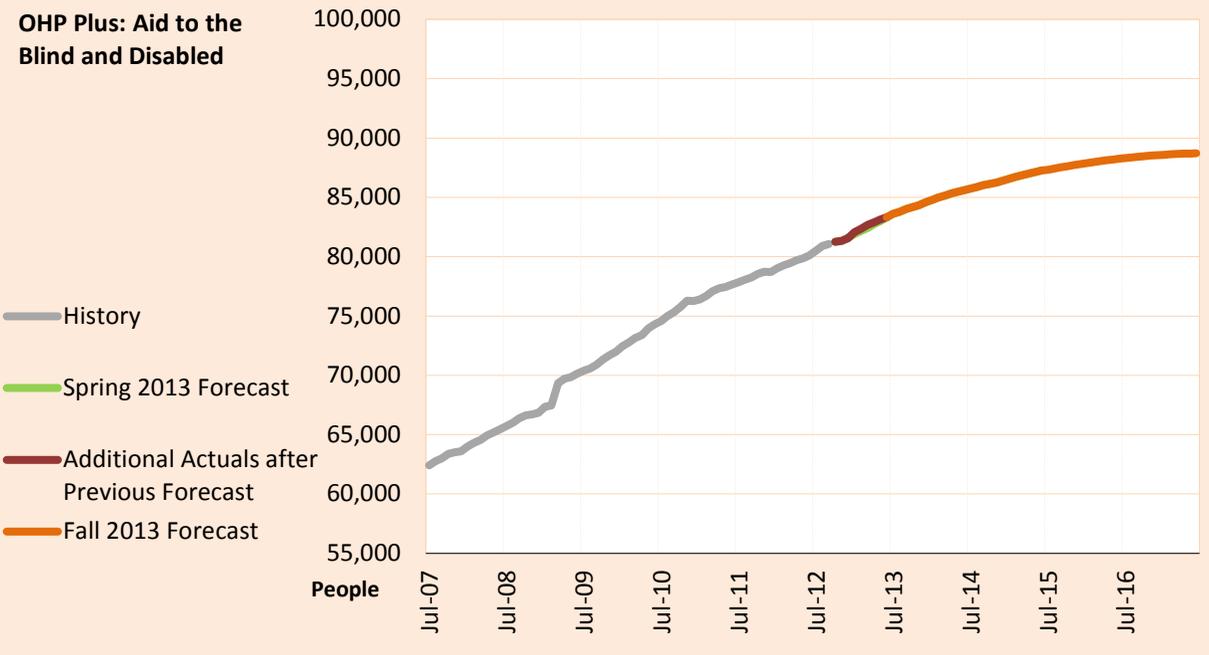


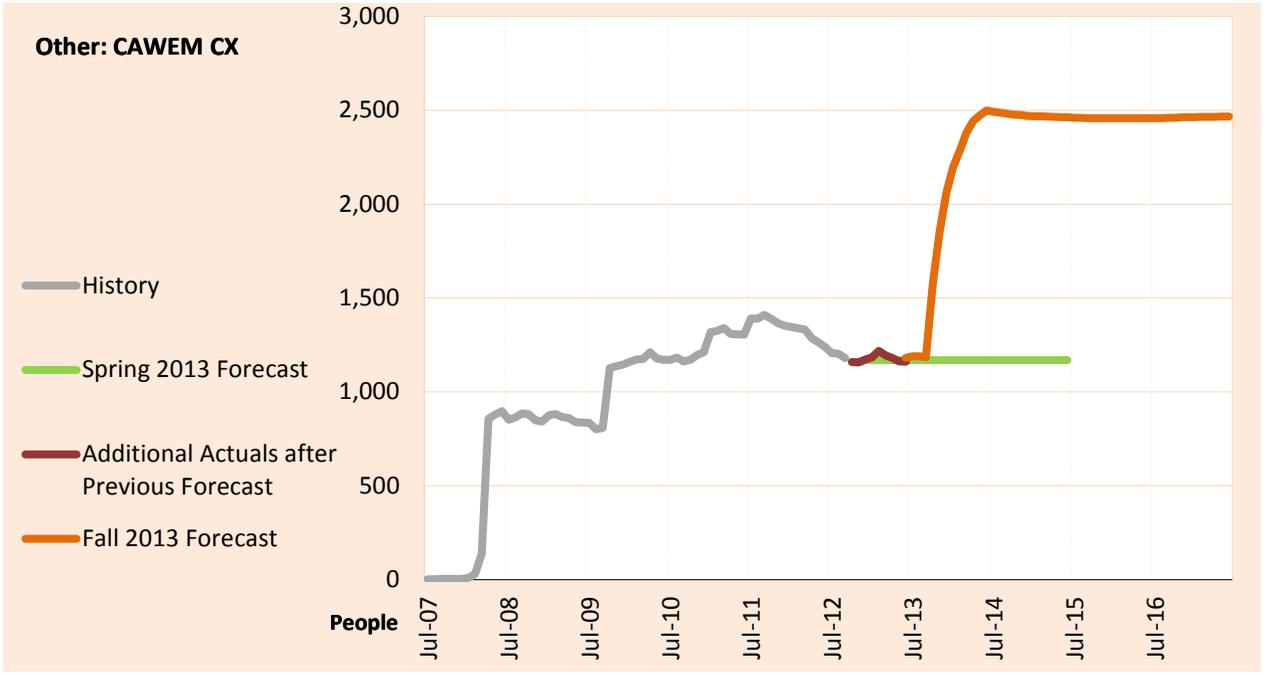
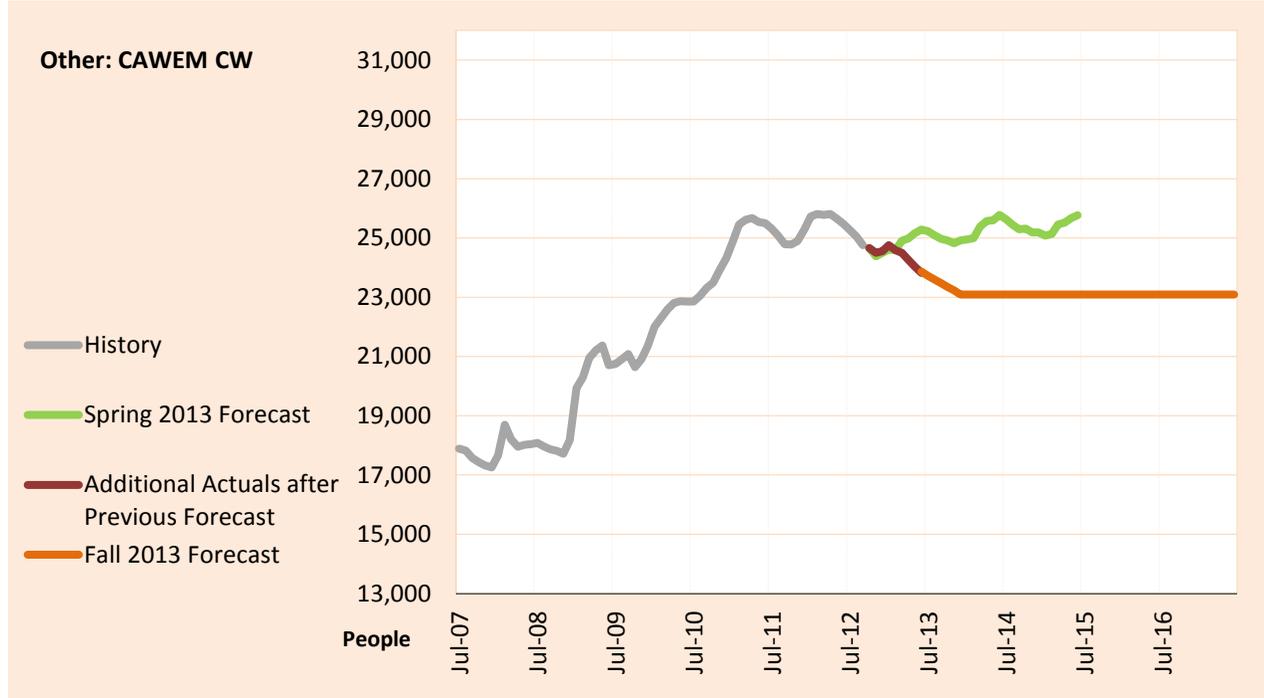
OHP Plus: Children's Health Insurance Program



OHP Plus: Substitute Care and Adoption Services







Medical Assistance and KidsConnect Biennial Average Forecast comparison

	Spring 13 Forecast 2013-15	Fall 13 Forecast 2013-15	% diff. Spring 13 to Fall 13 2013-15	Fall 13 Forecast 2013-15	Fall 13 Forecast 2015-17	% diff. Fall 13 2013-15 to 2015-17
OHP Plus						
TANF-Related Medical	154,068	145,984	-5.2%	145,984	149,173	2.2%
TANF-Extended	42,416	44,186	4.2%	44,186	43,284	-2.0%
TANF Medical subtotal	196,484	190,170	-3.2%	190,170	192,457	1.2%
ACA Adults with children	44,352	64,328	45.0%	64,328	98,321	52.8%
ACA Adults without children	78,816	126,967	61.1%	126,967	194,980	53.6%
Total ACA Adults ^{1,2}	123,168	191,295	55.3%	191,295	293,301	53.3%
Poverty Level Medical - Women	13,417	13,726	2.3%	13,726	14,183	3.3%
Poverty Level Medical - Children ³	150,990	172,607	14.3%	172,607	181,888	5.4%
Aid to the Blind and Disabled	85,577	85,578	0.0%	85,578	88,189	3.1%
Old Age Assistance	37,826	37,826	0.0%	37,826	41,361	9.3%
Substitute Care and Adoption Services	19,208	18,852	-1.9%	18,852	18,810	-0.2%
Children's Health Insurance Program ^{3,4}	77,824	70,546	-9.4%	70,546	73,262	3.8%
OHP Plus subtotal	704,494	780,600	10.8%	780,600	903,451	15.7%
Other Medical Assistance Programs						
Citizen/Alien Waived Emergency Medical - Regular	25,286	23,171	-8.4%	23,171	23,091	-0.3%
Citizen/Alien Waived Emergency Medical - Prenatal	1,169	2,209	89.0%	2,209	2,461	11.4%
Qualified Medicare Beneficiary	22,726	23,444	3.2%	23,444	26,863	14.6%
Breast and Cervical Cancer Program	1,131	969	-14.3%	969	942	-2.8%
Other Medical Assistance subtotal	50,312	49,793	-1.0%	49,793	53,357	7.2%
OHP Standard ²	59,203	48,809	-17.6%	48,809	-	-
Total Medical Assistance Programs	814,009	846,107	3.9%	846,107	956,807	13.1%
KidsConnect ⁴	9,347	1,738	-81.4%	1,738	-	-

1. The ACA uptake assumption has changed for the Fall 2013 forecast compared to Spring 2013 forecast. Due to the Fast Track enrollment option a higher percentage of qualified individuals are expected to enroll than the original SHADAC estimates.

2. OHP Standard closes on Dec 31, 2013. All current enrollees will transfer to ACA Adults.

3. Children aged 6-18 with family incomes of 100-138% FPL have been moved from CHIP to PLMC.

4. KidsConnect program closes on Dec 31, 2013. All current enrollees will transfer to CHIP.

Addictions and Mental Health

This forecast covers clients receiving mental health services from the Oregon Health Authority. For budgeting purposes, the Mental Health caseload is divided between Mandated and Non-Mandated populations. Oregon law requires Mandated populations, including criminally and civilly committed patients, to receive mental health services. Only Mandated caseloads are forecast.

Mandated services are provided through community programs, including residential care, and the Oregon State Hospital system. Non-Mandated services are primarily provided in community outpatient settings. Community programs provide outpatient services including intervention, therapy, case management, child and adolescent day treatment, crisis, and pre-commitment services. The state hospitals provide 24-hour supervised care to people with the most severe mental health disorders, including people who have been found guilty except for insanity.

The DHS|OHA Integrated Client Services (ICS) Data Warehouse continues to be upgraded, resulting in a revision of AMH caseload history. Following the Spring 2013 Forecast, ICS implemented rules to close overlapping records where the provider changed to count only the most recent record. The reduction in community counts between the Spring and Fall 2013 forecasts reflects elimination of duplicates in the database.

Total Mandated Mental Health Services — The mandated caseload is expected to increase to 5,305 clients by June 2015. The biennial average forecast for 2013-15 is 5,237 clients, 2.7 percent lower than the Spring 2013 forecast. The 2015-17 biennial average is 5,372 clients, 2.6 percent higher than the 2013-15 biennial average.

Total Criminal Commitments — The Total Forensic (or Criminal Commitment) caseload is an unduplicated count of State Hospital Aid and Assist clients and clients under the jurisdiction of the Psychiatric Security Review Board and State Hospital Review Panel. The biennial average forecast for 2013-15 is 872 clients, 0.6 percent higher than the Spring 2013 forecast. The Total Forensic caseload is expected to remain steady through 2015-17.

The **Aid and Assist** caseload climbed steadily throughout the first half of 2013. The Fall 2013 biennial average forecast for 2013-15 is 163 clients, 11.8 percent higher than the Spring 2013 forecast. As AMH moves toward mobile forensic evaluation teams, Aid and Assist in the State Hospital will likely decrease. The 2015-17 biennial average is expected to be the same as the 2013-15 biennial average.

Psychiatric Security Review Board (PSRB) — Nationally, violent crimes are down despite population growth. For the past several years the Total PSRB caseload in Oregon has steadily declined. Between January 2012 and mid-2013, the caseload decreased approximately 5.7 percent. The Fall 2013 biennial average forecast for 2013-15 is 709, 1.3 percent lower than the Spring 2013 forecast. The 2015-17 biennial average is expected to be the same as the 2013-15 biennial average.

Total Civil Commitments — This caseload has grown steadily for many years. The decrease in the 2013-15 biennial averages between the Fall 2013 forecast and the Spring 2013 forecast is due to a change in how client data is tracked, not a decline in clients receiving service. The Fall 2013 forecast anticipates that the average caseload for the 2015-17 biennium will be 4,626 clients, an increase of 4.9 percent over the 2013-15 biennium.

Additional Risks

These forecasts were developed using common statistical methods based on month-to-month changes in caseload history. External factors such as population growth or program policies did not influence the forecast except to the degree they influence historical trends. Therefore, the base forecast assumption is that current trends will continue unchanged through the forecast horizon of June 2017.

Implementation of the United States Federal Patient Protection and Affordable Care Act of 2010 (ACA) will significantly impact delivery of mental health services in Oregon. Starting in January 2014, Medicaid enrollment will be extended to adults 18-64 with incomes up to 138 percent of FPL. This change alone is expected to provide medical coverage (including mental health services) to over 240,000 currently uninsured adults. With better access to both physical and mental health services, the need for mandated mental health services may be reduced, possibly even within the time horizon of this forecast. In addition, integration of mental health services under the new Coordinated Care Organizations is expected to improve the overall effectiveness of medical care, including mental health services.

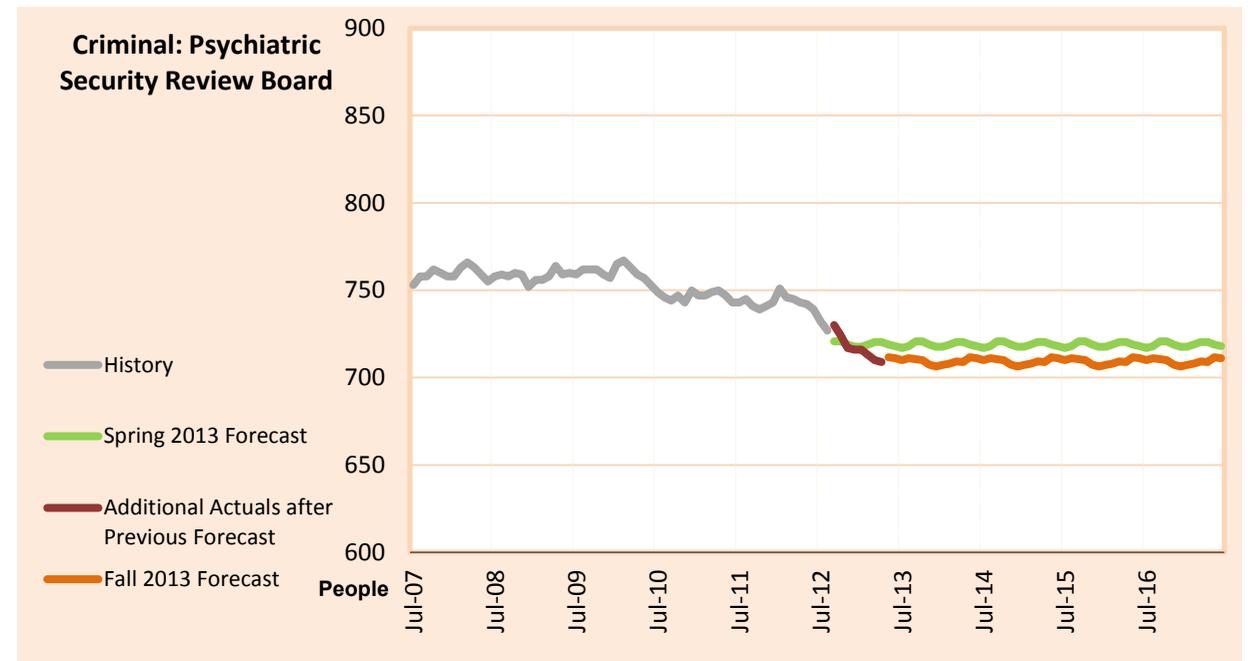
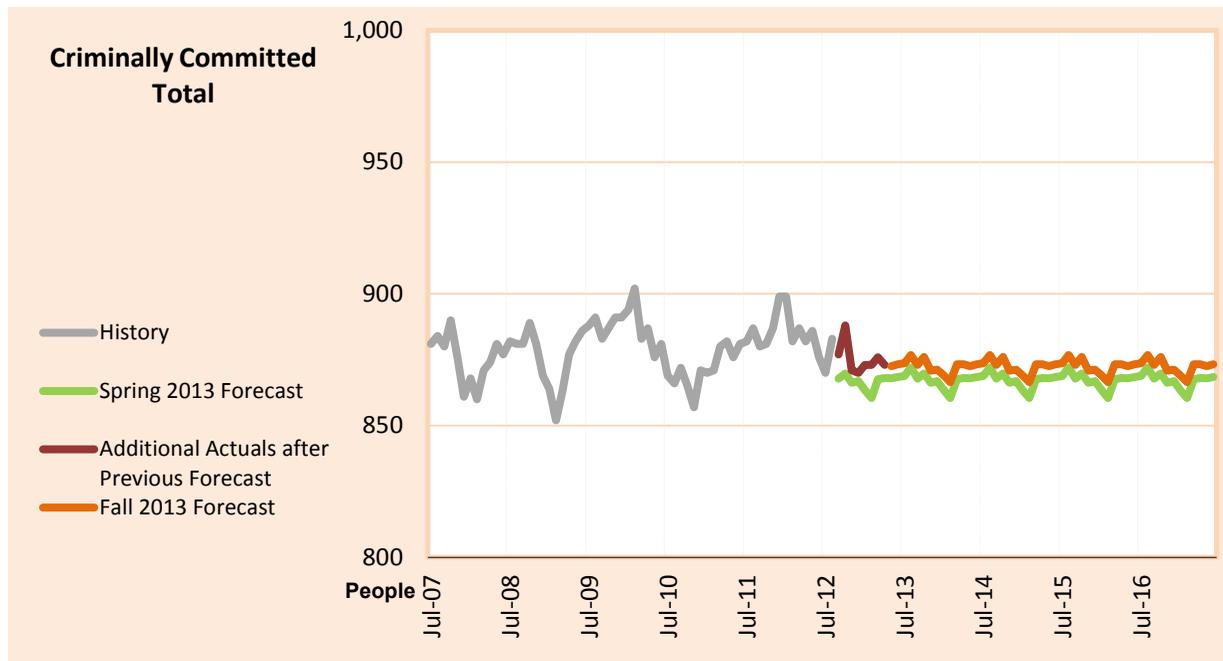
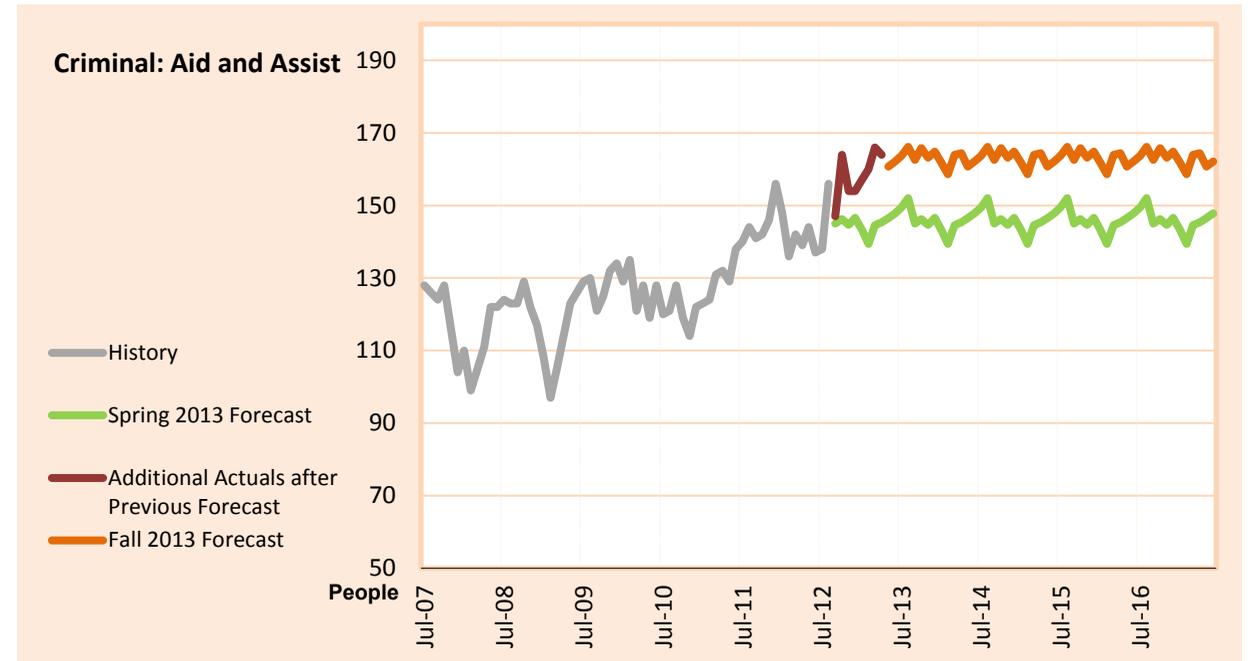
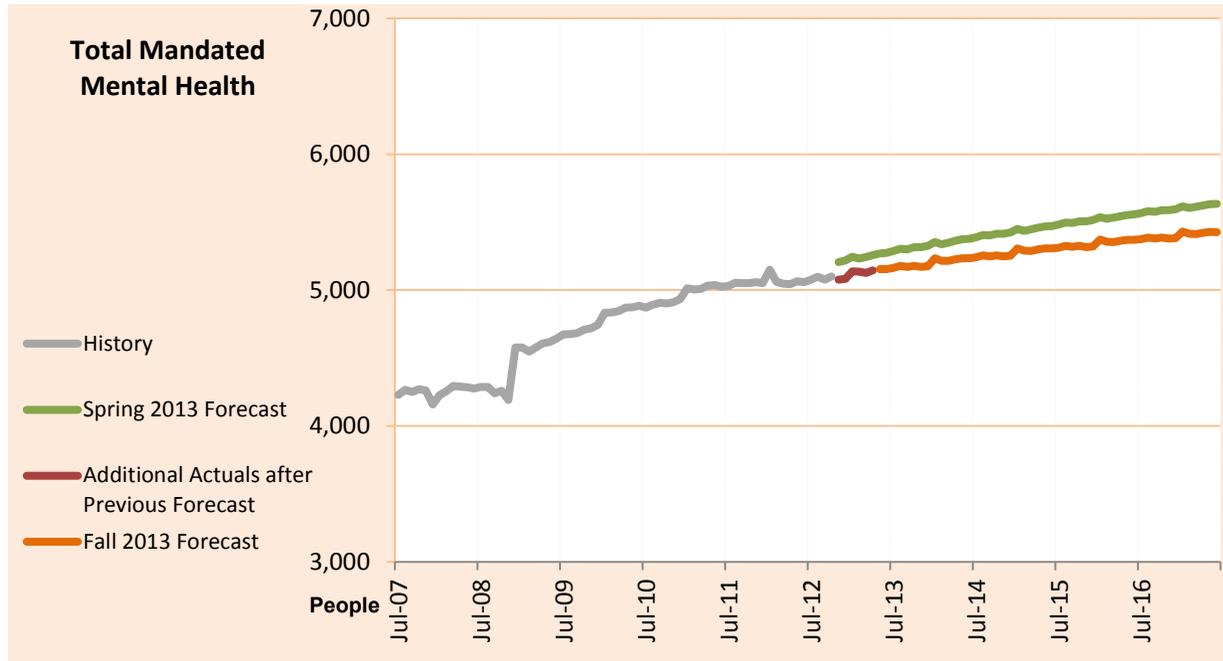
Capacity issues, such as the availability of beds in hospitals and community settings, can influence Court decisions concerning civil commitment. The availability of beds in various mental health settings can also influence client placement and the resulting caseloads. Two small campuses of the Oregon State Hospital are both slated for closure (Pendleton with 60 beds and Portland with 90 beds) and construction on a new 174-bed facility in Junction City has begun. At the main Oregon State Hospital campus in Salem additional units have been, and will continue to be, opened during the 2013-2015 biennium. These could reduce pressure on the civil commit waiting list and acute care settings. Additionally, three residential treatment homes are scheduled to open in Pendleton by January 1, 2014.

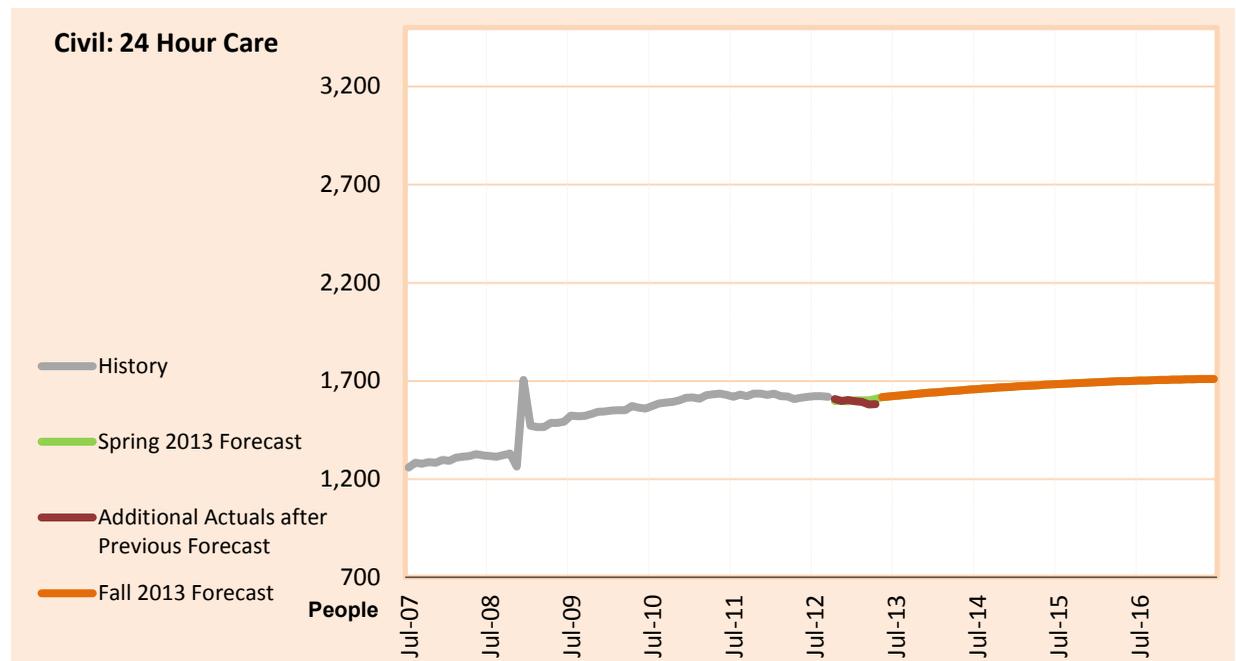
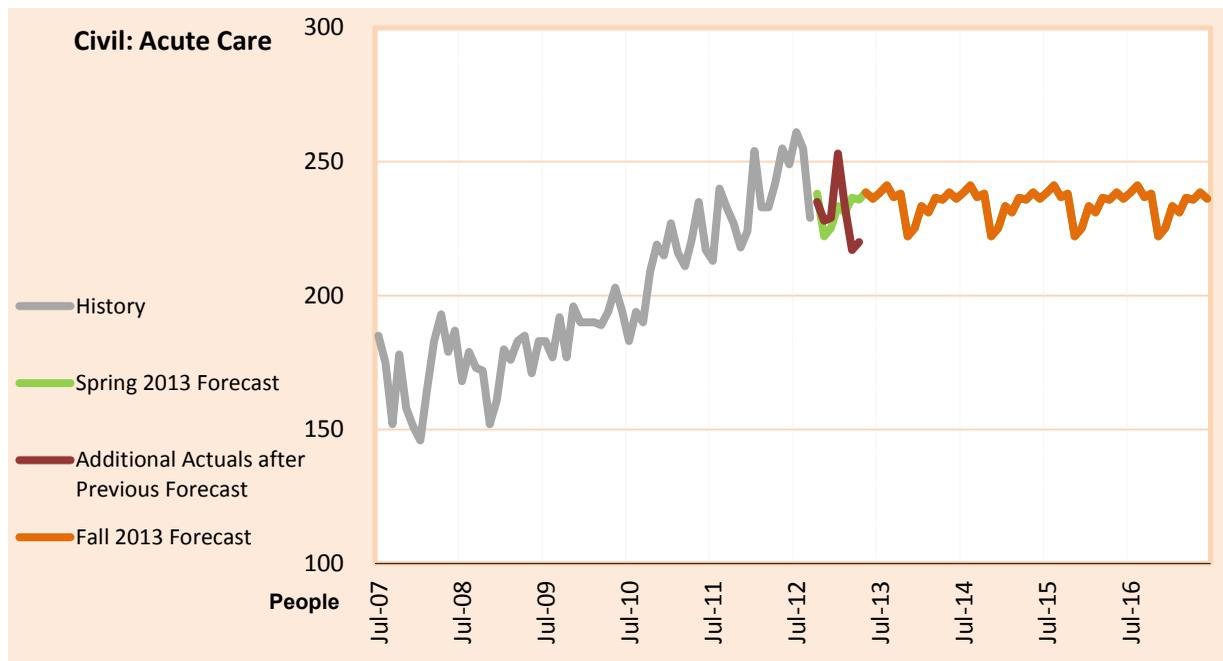
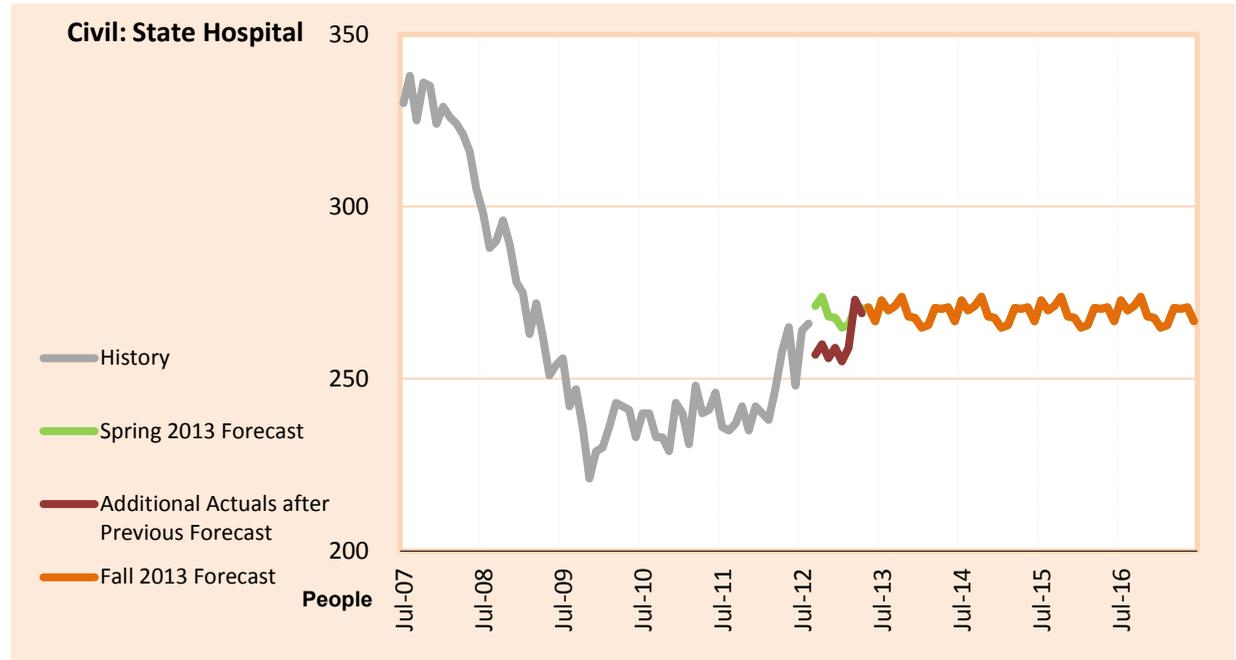
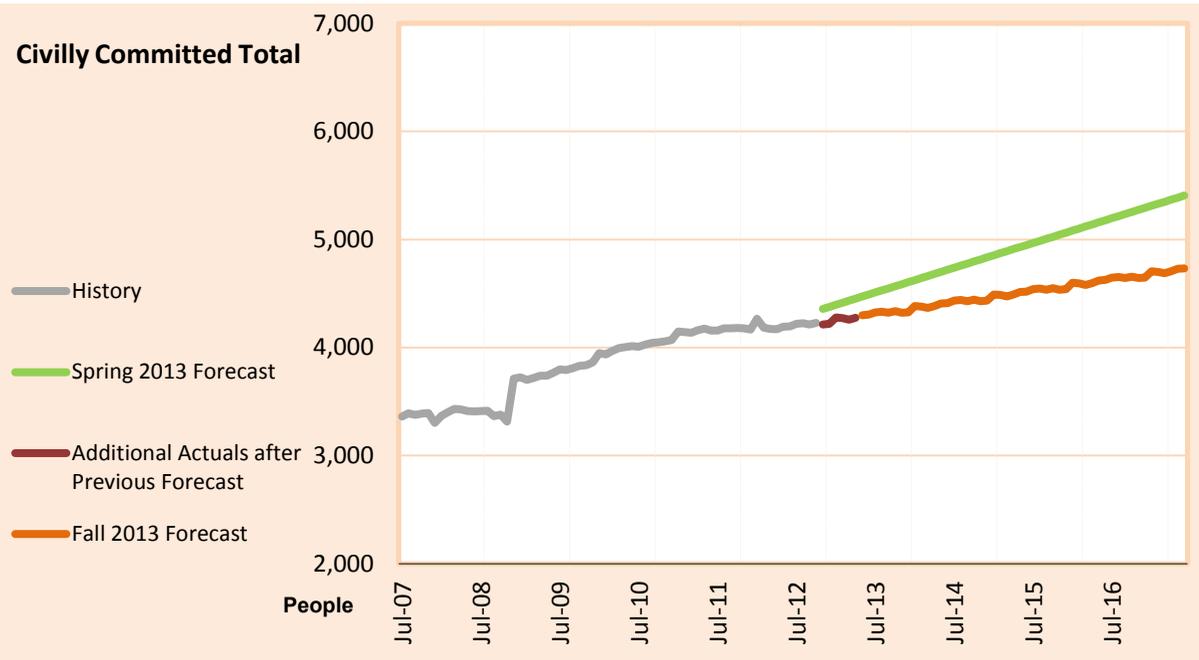
Budget reductions can also affect mental health caseloads as cuts are made to community housing programs. With reductions in community capacity, there are corresponding limitations to prevention homes, which are built with the intention of keeping clients out of the Oregon State Hospital civil commitment units.

Finally, the economic environment can also influence mental health caseloads. When the economy is doing poorly, individuals experience more stress than during good periods, and this may impact demand for mental health services.

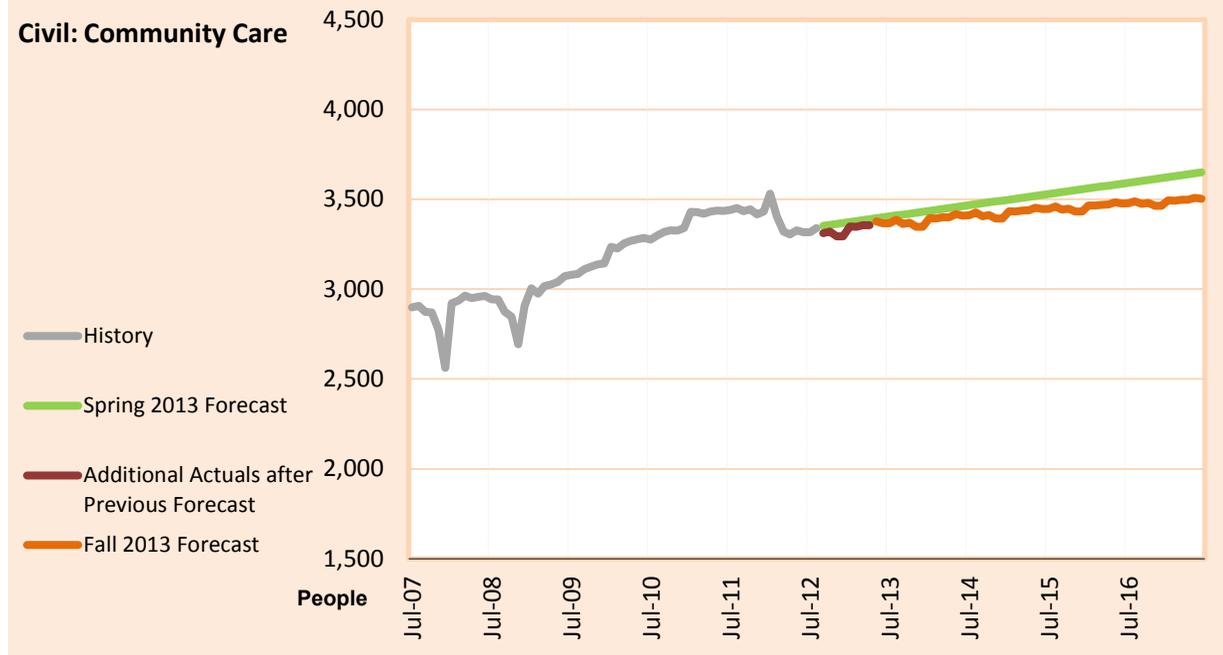
AMH Forecast Methodology Workgroup

The 2013 Oregon Legislative Session identified the need to establish a better system for forecasting AMH caseloads, due to the fact that “to a large extent, caseload forecasts are based on current utilization of services which have been held at reduced levels due to budget reduction decisions, thus holding caseload forecasts at the same reduced levels”. Work is currently underway to review caseload forecast methods, processes, and data and to potentially create new caseload categories.





Civil: Community Care



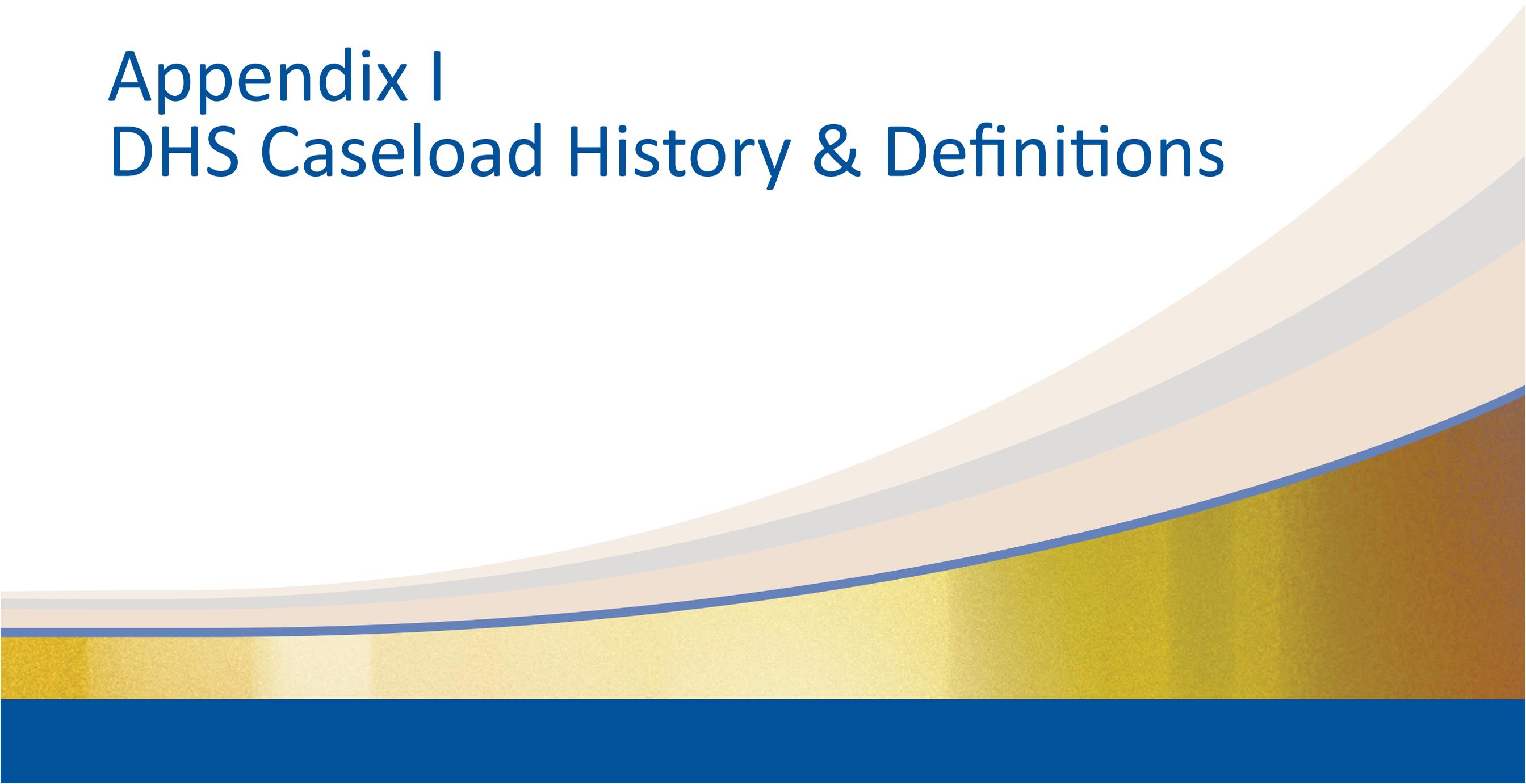
Addictions and Mental Health Biennial Average Forecast comparison¹

	Spring 13 Forecast 2013-15	Fall 13 Forecast 2013-15	% diff. Spring 13 to Fall 13 2013-15	Fall 13 Forecast 2013-15	Fall 13 Forecast 2015-17	% diff. Fall 13 2013-15 to 2015-17
Criminal Commitment						
Aid and Assist	146	163	11.6%	163	163	0.0%
Psychiatric Security Review Board ²	719	709	-1.4%	709	709	0.0%
Total Criminal Commitment	867	872	0.6%	872	872	0.0%
Civil Commitment						
Acute Care	234	234	0.0%	234	234	0.0%
State Hospital	269	269	0.0%	269	269	0.0%
24-Hour Care	1,656	1,656	0.0%	1,656	1,700	2.7%
Non-Residential Community Care	3,464	3,403	-1.8%	3,403	3,472	2.0%
Total Civil Commitment ³	4,729	4,412	-6.7%	4,412	4,626	4.9%
Total Mandated Care ³	5,383	5,237	-2.7%	5,237	5,372	2.6%

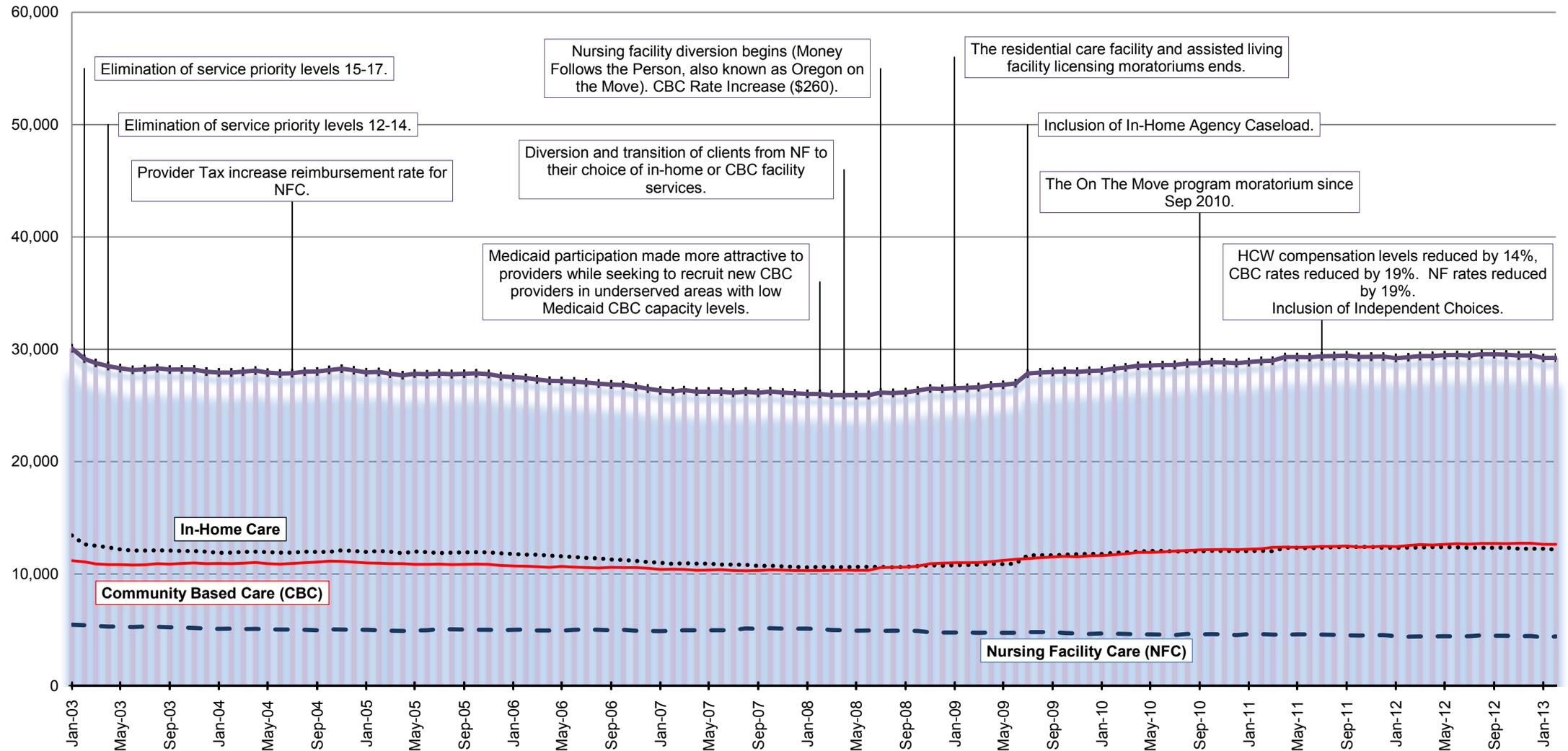
1. All groups and subgroups are forecast independently using unduplicated client counts. Since one individual can be counted in more than one group due to overlapping service episodes, totals may be less than the sum of the lower level categories.
2. In the past several years there have been fewer new admissions and an increase in discharges from the PSRB, resulting in a caseload that has been decreasing steadily since September 2012.
3. Following the Spring 2013 Forecast, ICS implemented rules to close overlapping CPMS records to count only one record when the provider changed. The reduction between Spring and Fall 2013 forecasts reflects elimination of duplicates in the database.

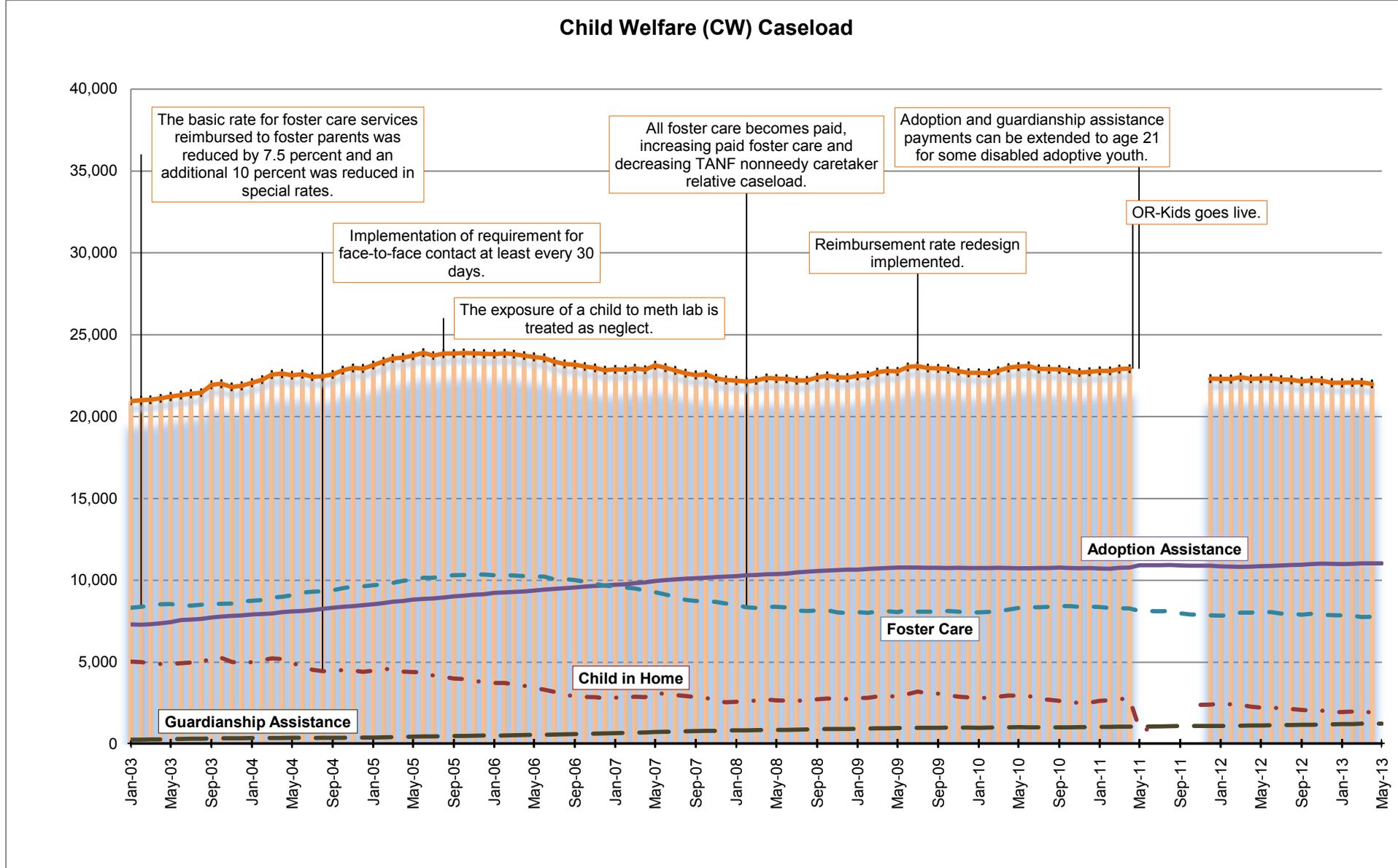
Appendix I

DHS Caseload History & Definitions



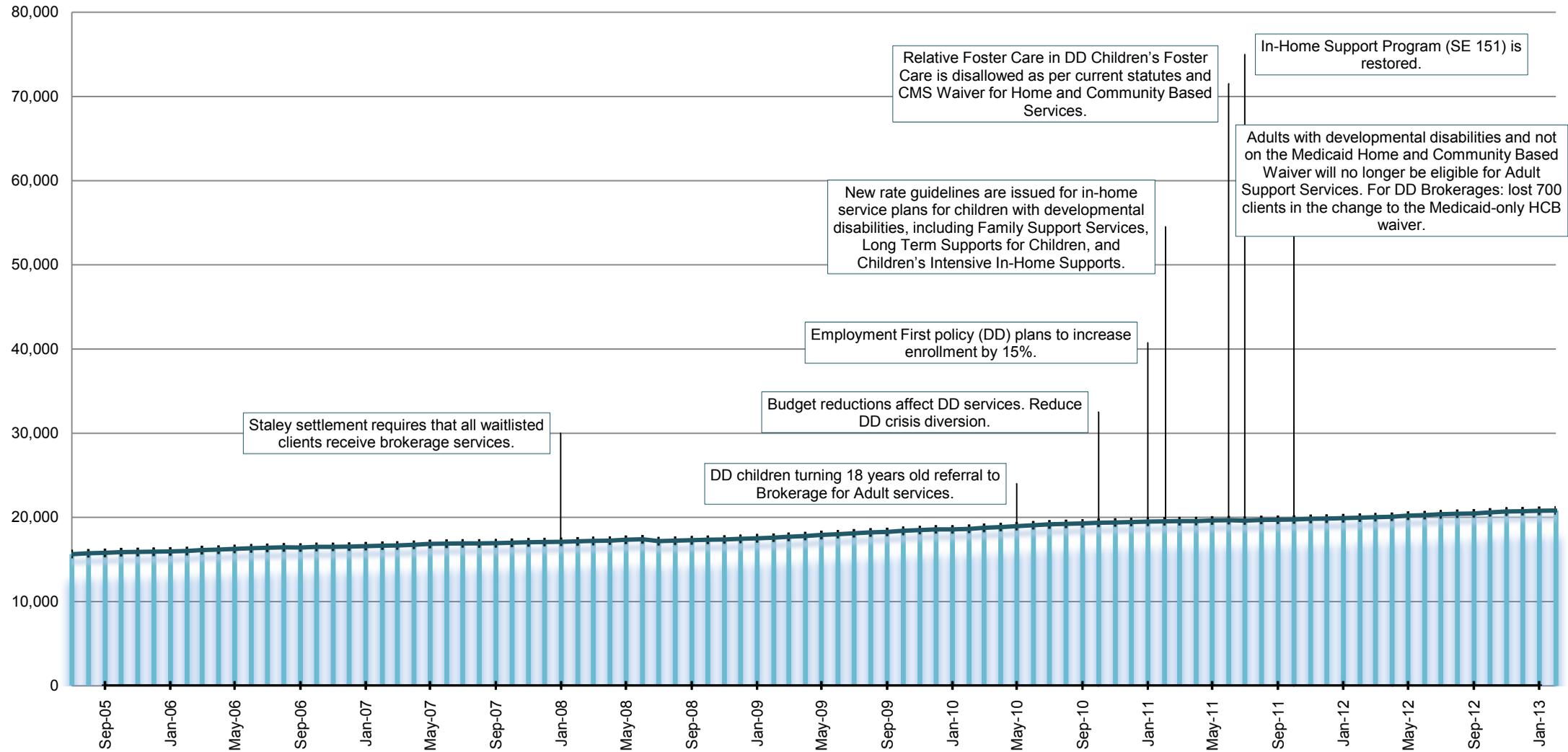
Aging and People with Disabilities (APD): Long Term Care Caseload



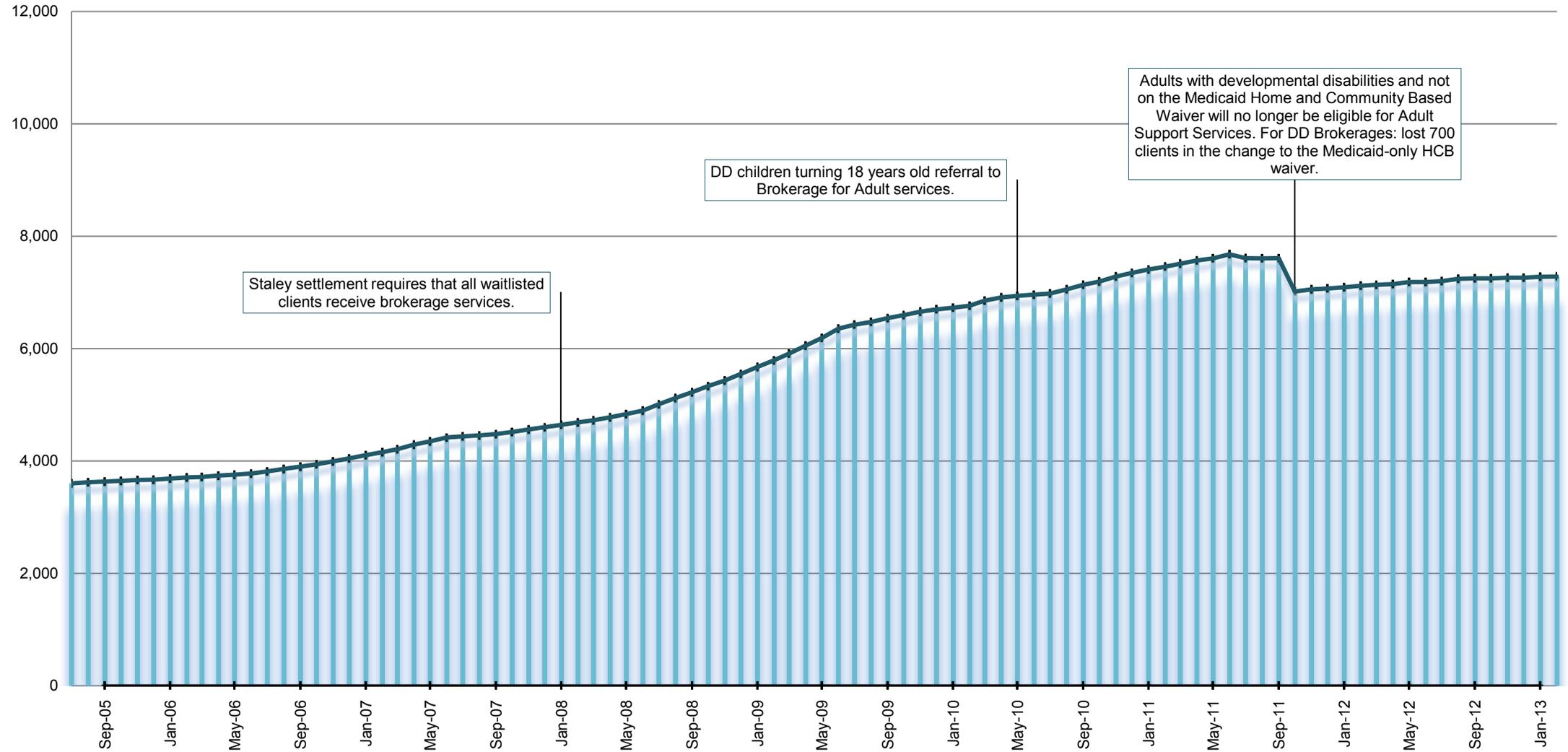


NOTE: There is no historical observations from May - Nov 11 due to the start of ORKids data and the end of Legacy data.

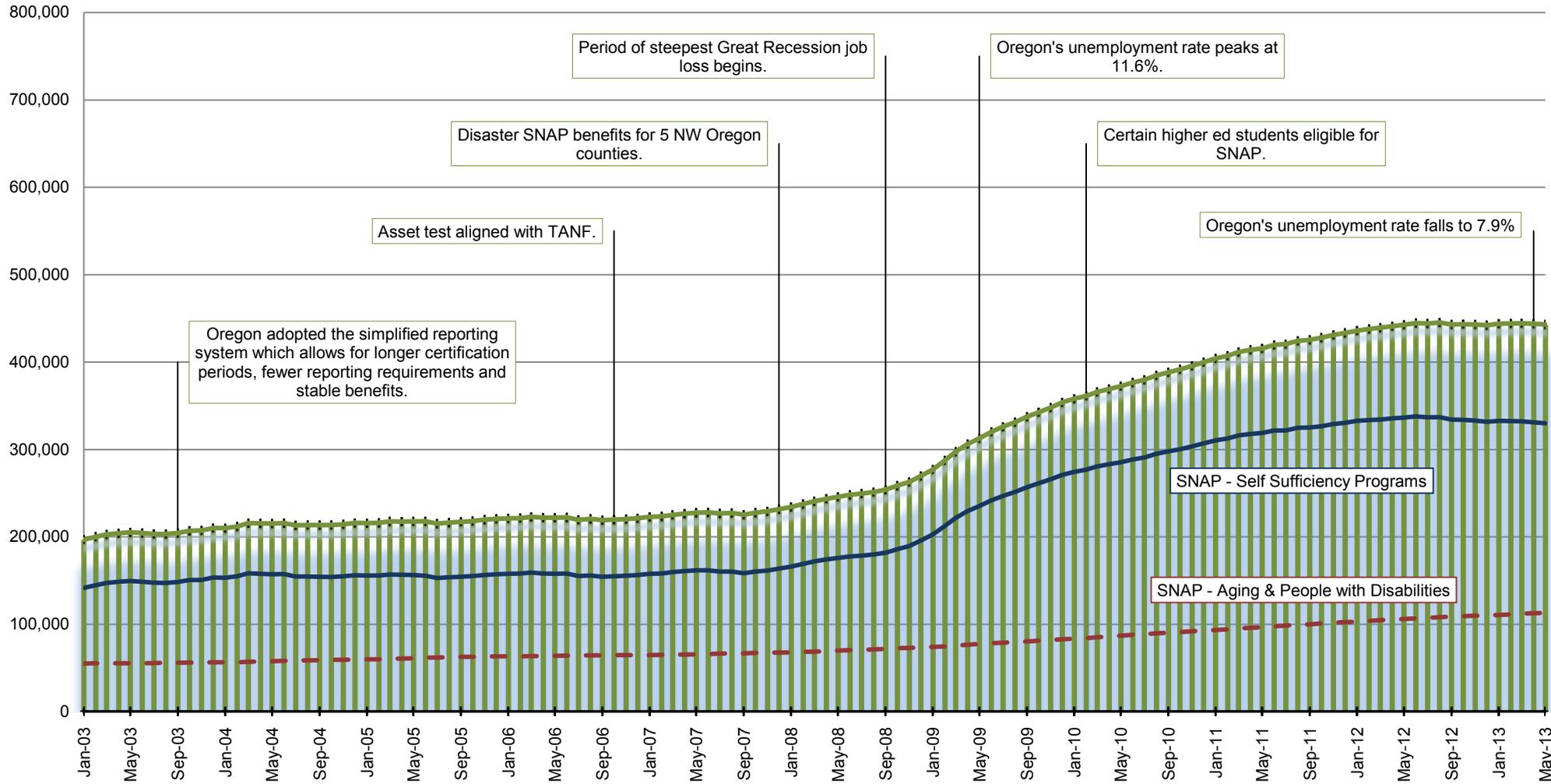
Developmental Disabilities: Case Management Caseload



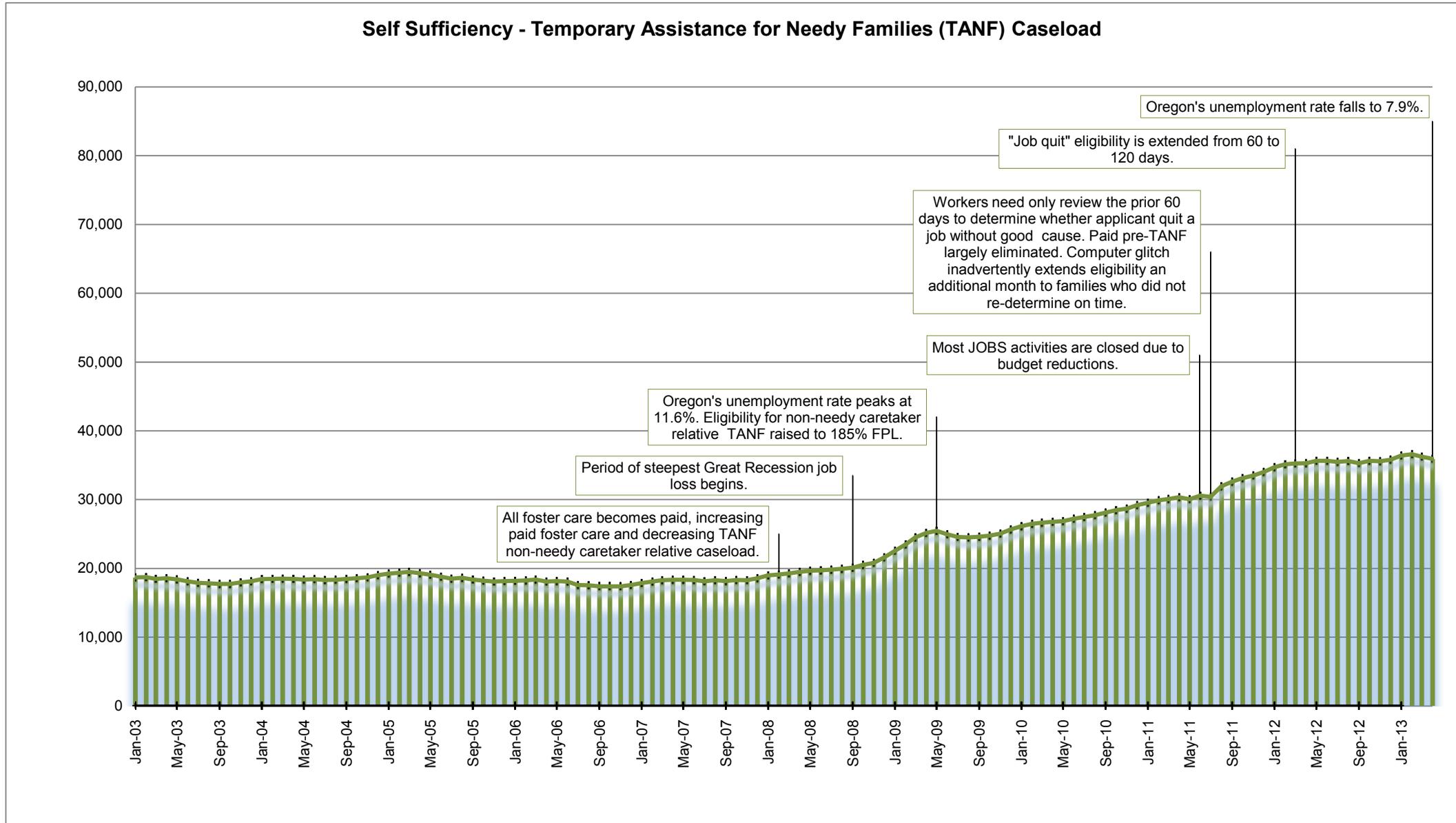
Developmental Disabilities: Brokerage Enrollment Caseload (Adult)



Self Sufficiency - Supplemental Nutrition Assistance Program (SNAP) Caseload



Self Sufficiency - Temporary Assistance for Needy Families (TANF) Caseload



Federal Poverty Level (FPL)

“The set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. Public assistance programs, such as Medicaid in the U.S., define eligibility income limits as some percentage of FPL.”ⁱ

i. Source: www.investopedia.com. November 13, 2013.

AGING AND PEOPLE WITH DISABILITIES (APD)

Aging and People with Disabilities programs provide Long-Term Care (LTC) services to qualifying people who, due to their age or disabilities, need help with their activities of daily living (ADL), including eating, dressing/ grooming, bathing/ personal hygiene, mobility, bowel and bladder management, and cognition.

Area Agencies on Aging (AAA) and DHS staff help clients find the appropriate care settings to meet their needs and determine financial eligibility.

To qualify for LTC clients must meet financial and non-financial requirements which vary depending on whether the individual will be covered under the Medicaid Waiver or the new K State Plan. For coverage under the waiver, clients must meet income and asset requirements, as well as disability (or age) requirements, and have a service priority level (SPL) assessment consistent with the amount and skill of care needed. For coverage under the K Plan, clients must meet income requirements and have a service priority level (SPL) assessment consistent with the amount and skill of care needed.

Medicaid 1915 (c) Home and Community–Based Services Waiver — The Home and Community-Based Services (HCBS) for Long-Term Care are granted to the State under the Medicaid 1915 (c) waiver as part of the 1981 Omnibus Budget Reconciliation Act. The HCBS waiver allows the State to provide home and community-based care alternatives to institutional care such as nursing facilities.

The K Plan — The Patient Protection and Affordable Care Act of 2010 enacted the Community First Choice Option under 1915 (k) of the Social Security Act. This authorizes a new State Plan option which provides home and community-based attendant services and supports with a higher federal matching rate.

The LTC forecast is divided into three categories: In-Home, Community-Based Care, and Nursing Facilities (NF).

IN-HOME PROGRAMS

In-Home programs provide personal assistance services that help people stay in their homes when they need assistance with Activities of Daily Living (ADL).

In-Home Hourly

In-Home Hourly caseload includes clients who hire hourly workers to assist them in meeting their ADL needs and other common household tasks.

Live-In Provider

Live-In Provider caseload includes clients who hire a live-in home care worker to provide 24-hour care.

Spousal Pay

Spousal Pay caseload includes those clients who choose to have their care provided by their spouse. Spouses are paid for services that they provide.

Specialized Living

Specialized Living provides care in a home-like environment for clients with specialized needs (such as quadriplegics or clients with acquired brain injuries). These clients are eligible for a live-in attendant, but because of their special needs, cannot live independently or be served in other Community-Based Care facilities.

In-Home Agency

In-Home Agency is an alternative way to purchase in-home care (including personal grooming, mobility assistance, nutrition/hydration assistance and others). Under this program, clients contract with an agency for the services they need, and those services are delivered in the client's own home by an employee of the agency. Screening and scheduling are often simpler when working with an agency.

Independent Choices

Independent Choices allows clients more control in the way they receive their in-home services. Under this program, clients decide for themselves which services they will purchase, but are also required to keep financial records of services they've purchased.

State Plan Personal Care (Non-Waivered Medicaid Services)

State Plan Personal Care services are available to people who are eligible for Medicaid, but not eligible for waived services. Services supplement an individual's own personal abilities and resources, and are limited to assistance with Activities of Daily Living and Instrumental Activities of Daily Living.

COMMUNITY-BASED CARE (CBC)

Community-Based Care caseload includes clients receiving services in licensed Community-Based Care settings. Services include assistance with ADL, medication oversight, and social activities; services can also include nursing and behavioral supports to meet complex needs.

Adult Foster Care (AFC)

Adult Foster Care provides long-term care in home-like settings licensed for five or fewer unrelated people.

Relative AFC clients receive services at their relative care taker's home [this service was discontinued June 2013].

Commercial AFC is open to clients who are not related to the care provider.

Residential Care Facilities (RCF)

Residential Care Facilities are licensed 24-hour care settings serving six or more residents. Facilities range in size from six beds to over 100.

Regular RCF

Contract RCF are licensed to provide specialized Alzheimer care.

Assisted Living Facilities (ALF)

Assisted Living Facilities are licensed 24-hour care settings for six or more residents that includes private apartments and focuses on resident independence and choice.

Elder Place (PACE)

Elder Place is a capitated Medicare/Medicaid Program of All-Inclusive Care for the Elderly (PACE). Seniors served in this program live in a variety of care settings. PACE is responsible for coordinating their clients' acute health and long-term care needs.

NURSING FACILITIES (NF)

Nursing Facilities provide institutional services for seniors and people with disabilities in nursing facilities licensed and regulated by DHS. Nursing facilities provide individuals with skilled nursing services, housing, related services and ongoing assistance with activities of daily living.

Basic Care

Basic Care clients need 24-hour comprehensive care in nursing facilities for assistance with activities of daily living and ongoing nursing care due to either age or physical disability.

Complex Medical Add-On

Complex Medical Add-On clients have medical conditions that require additional nursing services and staff assistance beyond Basic Care.

Enhanced Care

Enhanced Care clients have difficult to manage behavioral issues such as self-endangering behaviors, physical aggression, intrusiveness, intractable psychiatric symptoms, or problematic medication needs that requires special care in Nursing Facilities. Some of these clients are also served in community-based care facilities.

Pediatric Care

Pediatric Care clients are children under 21 who receive nursing care in pediatric nursing facility units.

CHILD WELFARE

Child Welfare programs oversee the safety of children who have been abused or neglected. The Child Protective Services (CPS) program investigates reports of child abuse or neglect. If abuse or neglect is founded, caseworkers prepare an action plan and provide case management to ensure safety for the child using the strengths of the family.

The Child Welfare caseload is an unduplicated count of children served in the various programs listed below. A child can be counted only once during a month, and if there is participation in more than one of the programs listed below, they are counted in only one group. The groups are listed below in order of this counting priority.

Adoption Assistance

Adoption Assistance coordinates and supervises adoption for children in foster care who cannot return safely to the care of their biological parents. Adoption Assistance services can include financial and/or medical help with the costs associated with the adoptive child's needs.

Guardianship Assistance

Guardianship Assistance helps remove financial barriers for individuals who provide a permanent home for children who would otherwise be in Foster Care. Guardianship allows an alternative plan to adoption. Guardianship Assistance services can include financial support for costs associated with the needs of the child (similar to a Foster Care payment).

Out of Home Care

Out of Home Care programs provide a safe, temporary home for abused or neglected children who cannot remain safely in their homes. Children in the program are placed

with relatives, foster families, or in residential treatment care settings. The program aims to reunite children with their parents. Out of Home Care services can include financial support and/or medical help for costs associated with the child's needs.

Child In-Home

In-Home Services provide support and safety monitoring services to prevent placement of children in Foster Care and to support reunification with the parents after Foster Care. Caseworkers oversee services and monitor in-home safety plans for children. In-Home Services can include financial support for costs associated with the safety, permanence and well-being of children, and outside resources to help meet those needs.

DEVELOPMENTAL DISABILITIES SERVICES

Developmental Disabilities programs provide support to qualified adults and children with developmental disabilities through a combination of case management and services. Developmental disabilities include intellectual disabilities, cerebral palsy, Down's syndrome, autism and other impairments of the brain that occur during childhood. Some people with developmental disabilities also have significant medical or mental health needs.

Adults with developmental disabilities may be eligible for services ranging from supports to help individuals live in their own homes to 24-hour comprehensive services. Twenty-four-hour services are provided in a variety of settings including group homes and foster homes. Children with developmental disabilities may be eligible for services ranging from family support to out-of-home placements. Placements include foster homes or residential group home settings.

The forecasted Developmental Disabilities programs are counts of individual clients receiving a program's services within the month. Clients can receive services from more than one program in the same month (for example, from both a residential and a support program).

Case Management

Case Management provides entry-level eligibility, evaluation and coordination services to individuals with developmental disabilities.

All other developmental disability caseload categories are grouped into three distinct areas: adult services, children services, and other services.

Adult services include:

Brokerage Enrollment

Brokerage Enrollment provide planning and coordination of services to individual adults with developmental disabilities and allows them to live in their own homes or in their family homes.

24-Hour Residential Care

24-Hour Residential Care provides 24-hour supervised care, training and support services delivered in neighborhood homes to individuals with developmental disabilities.

Supported Living

Supported Living provides individualized support services to clients with developmental disabilities in their home based on their Individual Support Plan.

Comprehensive In-Home Support Services (CIHS)

Comprehensive In-Home Support Services help individuals aged 18 years or older with developmental disabilities to continue to live in their homes.

State Operated Community Programs

State Operated Community Programs offer 24-hour care and supervision to individuals with developmental disabilities who represent the most risk to the public.

Foster Care

Foster Care provides 24-hour foster home care, supervision, provision of room and board, and assistance with activities of daily living. Non-Residential Foster Care serves both adults and children, with approximately 18 percent of clients under the age of 18.

Children's services include:

Children Intensive In-Home Services

Children Intensive In-Home Services cares for children with intensive medical or behavioral needs in their homes. This caseload is composed of three distinct groups: Medically Fragile Children Services, Intensive Behavior Program and Medically Involved Programs.

Children Residential Care

Children Residential Care provides 24-hour care, supervision, training and support services to individuals under the age of 18 years in neighborhood homes other than the family home or foster care.

Children Proctor Care [this service will be discontinued January 2014]

Children Proctor Care provides individualized services to children through contracted proctor care agencies. A proctor care provider manages, directs and supports services for individuals who reside in homes that meet the state's requirements for child foster homes.

In-Home Support for Children

In-Home Support for Children (also known as Long-Term Support) provides services to individuals under the age of 18 years with developmental disabilities in the family home.

Other DD services include:

Crisis Services

Crisis Services offer temporary out-of-home placement services to adults and

children.

Employment and Community Inclusion

Employment and Community Inclusion services are out-of-home employment or community training services and related supports, delivered to individuals aged 18 or older with developmental disabilities, to improve the individuals' productivity, independence and integration in the community.

Transportation

Transportation services are state-paid public or private transportation provided to individuals with developmental disabilities.

SELF SUFFICIENCY PROGRAMS (SSP)

Self Sufficiency programs provide assistance for low-income families to help them become healthy, safe, and economically independent. With the exception of SNAP, self-sufficiency program caseloads count the number of families receiving program benefits within the month. In the SNAP program, caseloads count the number of households receiving the benefit within the month.

Supplemental Nutrition Assistance Program (SNAP)

As of October 1, 2008, the new name for the federal Food Stamp Program is the Supplemental Nutrition Assistance Program (SNAP). Oregon began using the new name on January 1, 2010.

SNAP benefits improve the health and well-being of low-income individuals by providing them a means to meet their nutritional needs. Recipients use SNAP benefits to buy food.

To be eligible for SNAP benefits, applicants provide proof of household composition (living in same dwelling, purchase food and prepare meals together) and have assets and income within program limits. The maximum income limit is 185 percent of Federal Poverty Level (FPL) (\$43,567 for a household of four); most recipients qualify below 130 percent of FPL.

The SNAP forecast includes two caseloads – APD and SSP. Households entering the program through the Self Sufficiency Programs (SSP) are classified as SSP households, while those entering the program through Aging and People with Disabilities (APD) are classified as APD households. The two caseloads share eligibility guidelines and benefits amounts.

Temporary Assistance to Needy Families (TANF)

The Temporary Assistance for Needy Families (TANF) program provides case management and cash assistance to very poor families with minor children. The goal of

the program is to reduce the number of families living in poverty through employment services and community resources.

Recipients must meet basic TANF asset requirements (including a \$2,500 - \$10,000 resource limit and income less than 40 percent of FPL) to be eligible for the program. They must also meet non-financial eligibility requirements including dependent children in the case, Oregon residence, citizenship status, parental school attendance, pursuing assets, deprivation (death, absence, incapacity, or unemployment of a parent) and pursuing treatment for drug abuse or mental health as needed.

The TANF Basic program includes one-parent families and two-parent families where at least one parent is unable to care for children, or families headed by an adult relative who is not considered financially needy.

The TANF UN program includes families where both parents are able to care for their children, but both are unemployed or underemployed.

Pre-SSI

The State Family Pre-SSI/SSDI (SFPSS) program provides cash assistance, case management, and professional level support to TANF-eligible adults and their family in pursuing Supplemental Security Income (SSI) and Supplemental Security Disability Income (SSDI). To be eligible for Pre-SSI, the adult must be found eligible for a TANF grant and must have severe physical or mental impairment(s) that has been assessed and determined to meet the program impairment criteria by the program's disability analyst.

Temporary Assistance to Domestic Violence Survivors (TA-DVS)

The TA-DVS program supports domestic violence survivors by providing temporary financial assistance to flee domestic violence. TA-DVS payments can be issued to

meet the family's needs for shelter, food, medical care, relocation, stabilization, or to promote safety or independence from the abuser.

To be eligible for TA-DVS, a survivor must have a current or future risk of domestic violence; be a pregnant woman or a parent or relative caring for a minor child; and must have income not exceeding TANF limits (40 percent of FPL; TA-DVS only considers income on hand that is available to meet emergency needs).

VOCATIONAL REHABILITATION

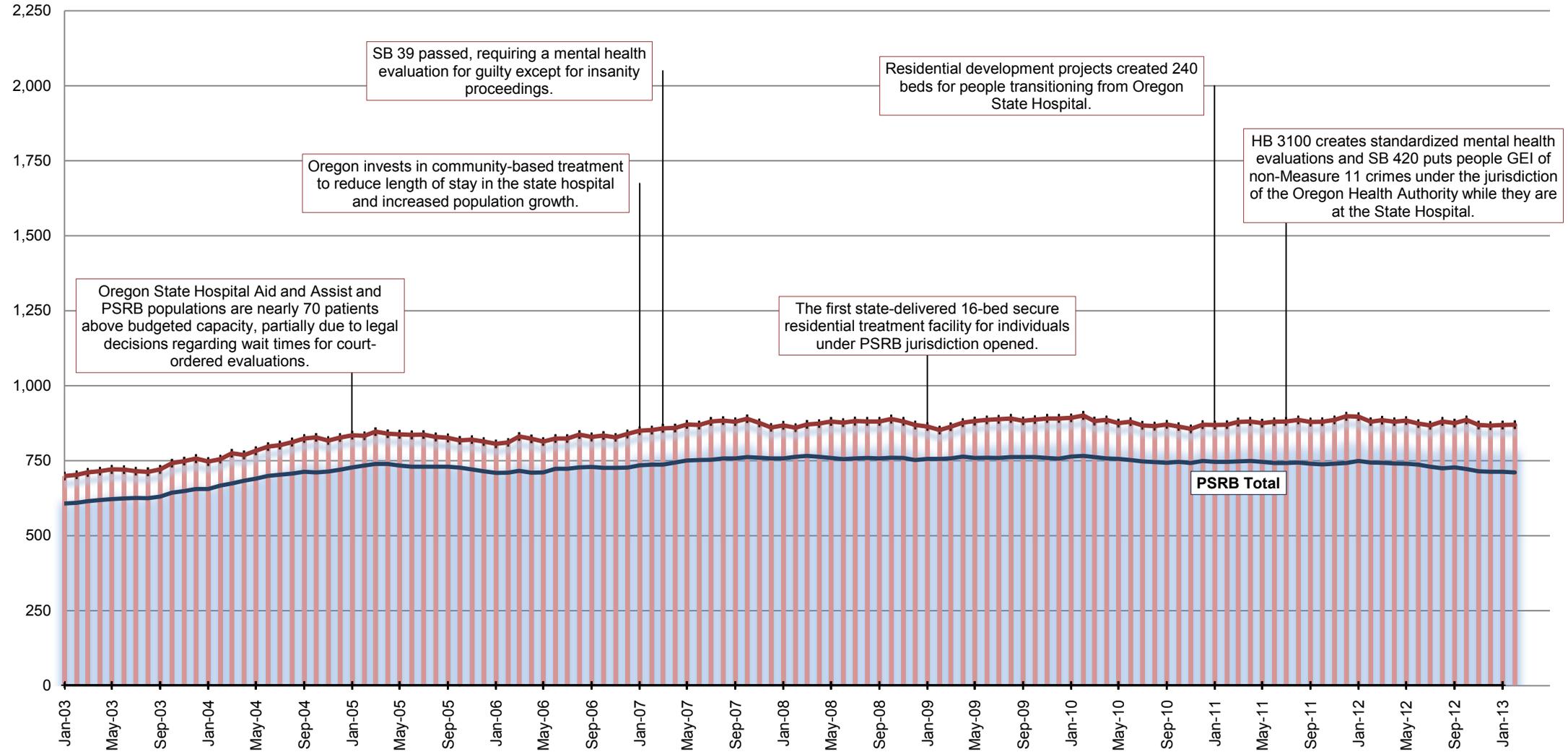
The Office of Vocational Rehabilitation Services (OVR) assesses plans and coordinates vocational rehabilitation services for people who have physical or mental disabilities and need assistance to get and retain employment that matches their skills, potential, and interest. Services are provided through local OVR offices across the state. The program provides counseling, training, job placement, assistive technology, and extended services and supports.

Appendix II

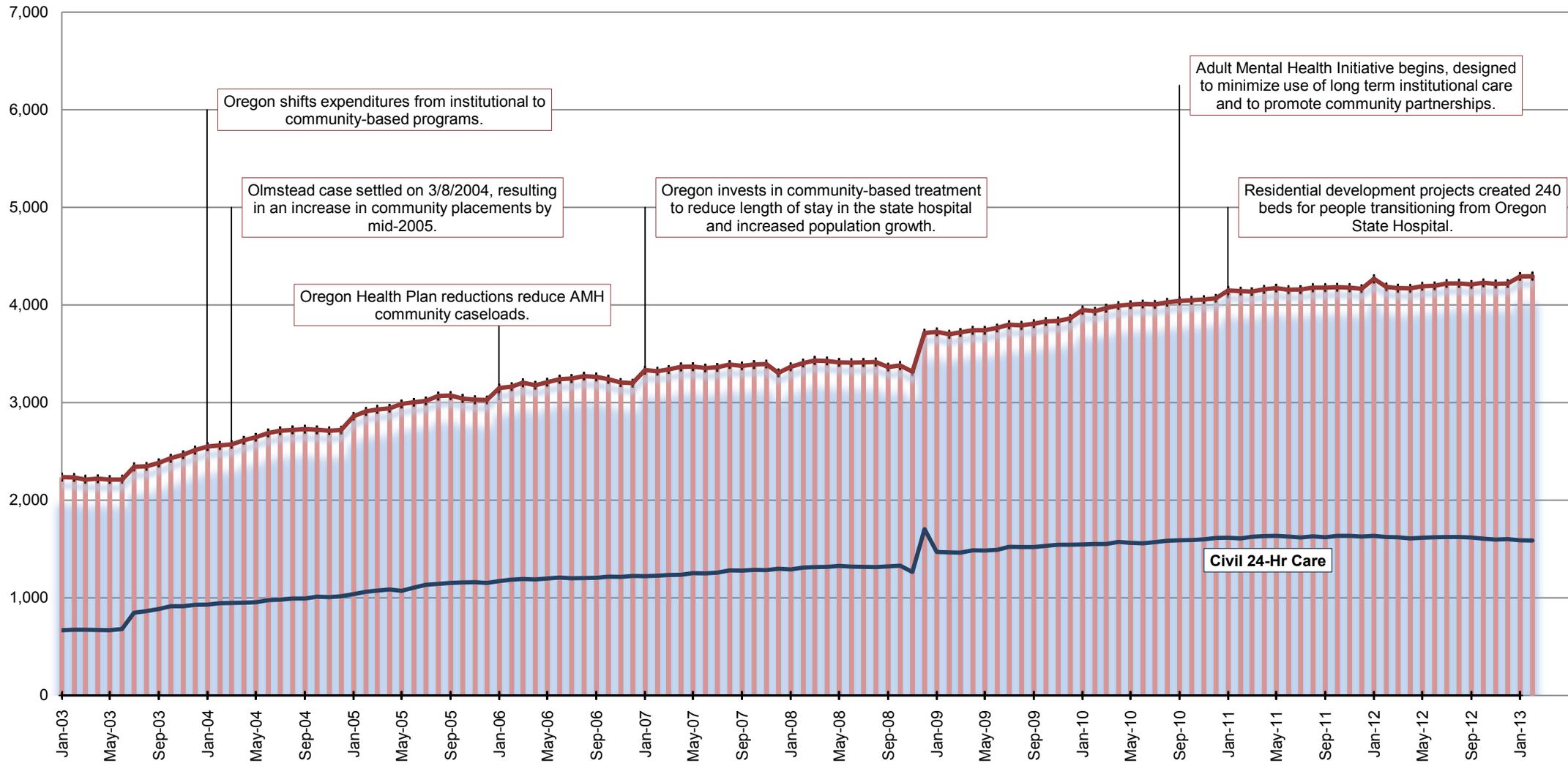
OHA Caseload History & Definitions



Addictions and Mental Health (AMH): Total Criminal Commitment Caseload



Addictions and Mental Health (AMH): Total Civil Commitment Caseload



Oregon shifts expenditures from institutional to community-based programs.

Olmstead case settled on 3/8/2004, resulting in an increase in community placements by mid-2005.

Oregon Health Plan reductions reduce AMH community caseloads.

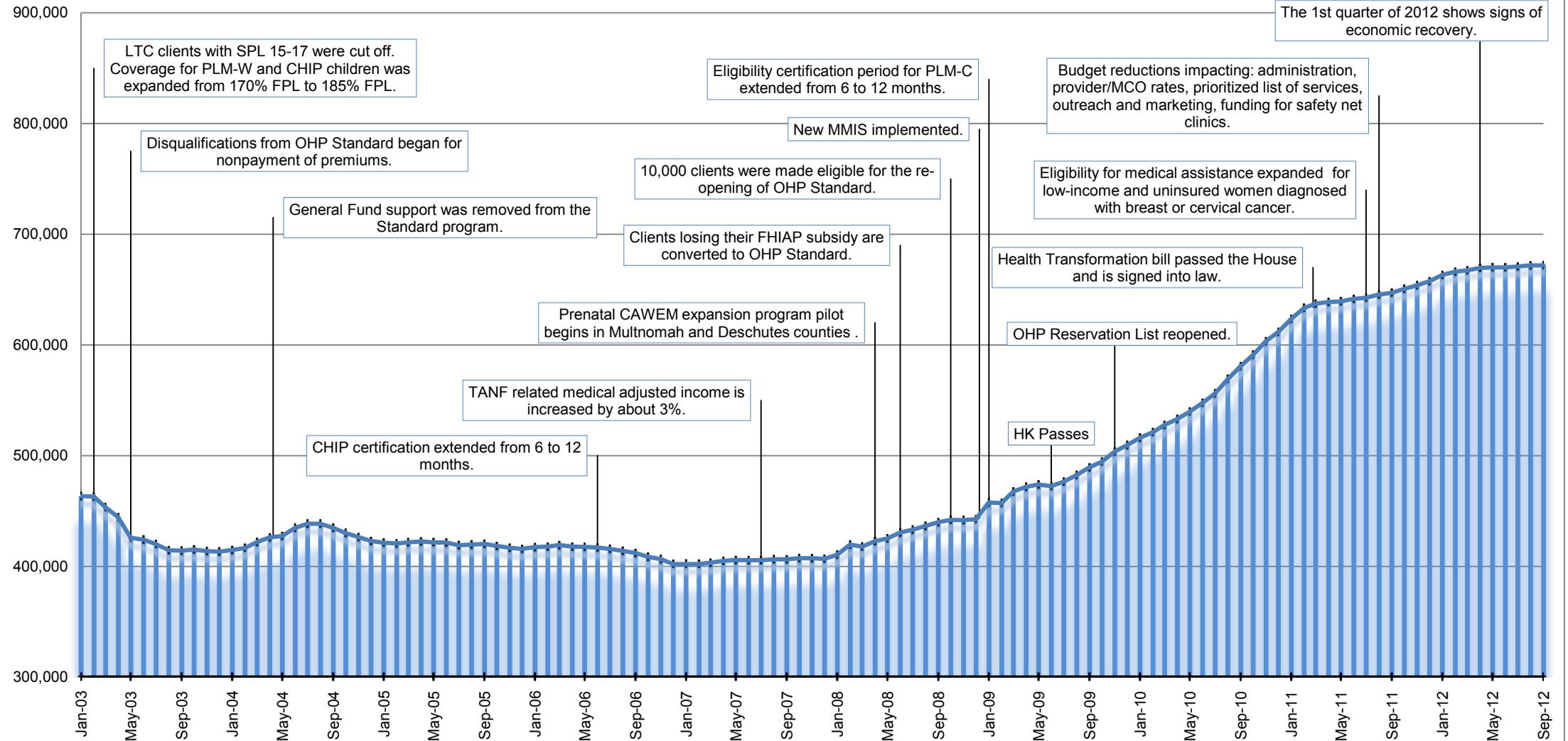
Oregon invests in community-based treatment to reduce length of stay in the state hospital and increased population growth.

Adult Mental Health Initiative begins, designed to minimize use of long term institutional care and to promote community partnerships.

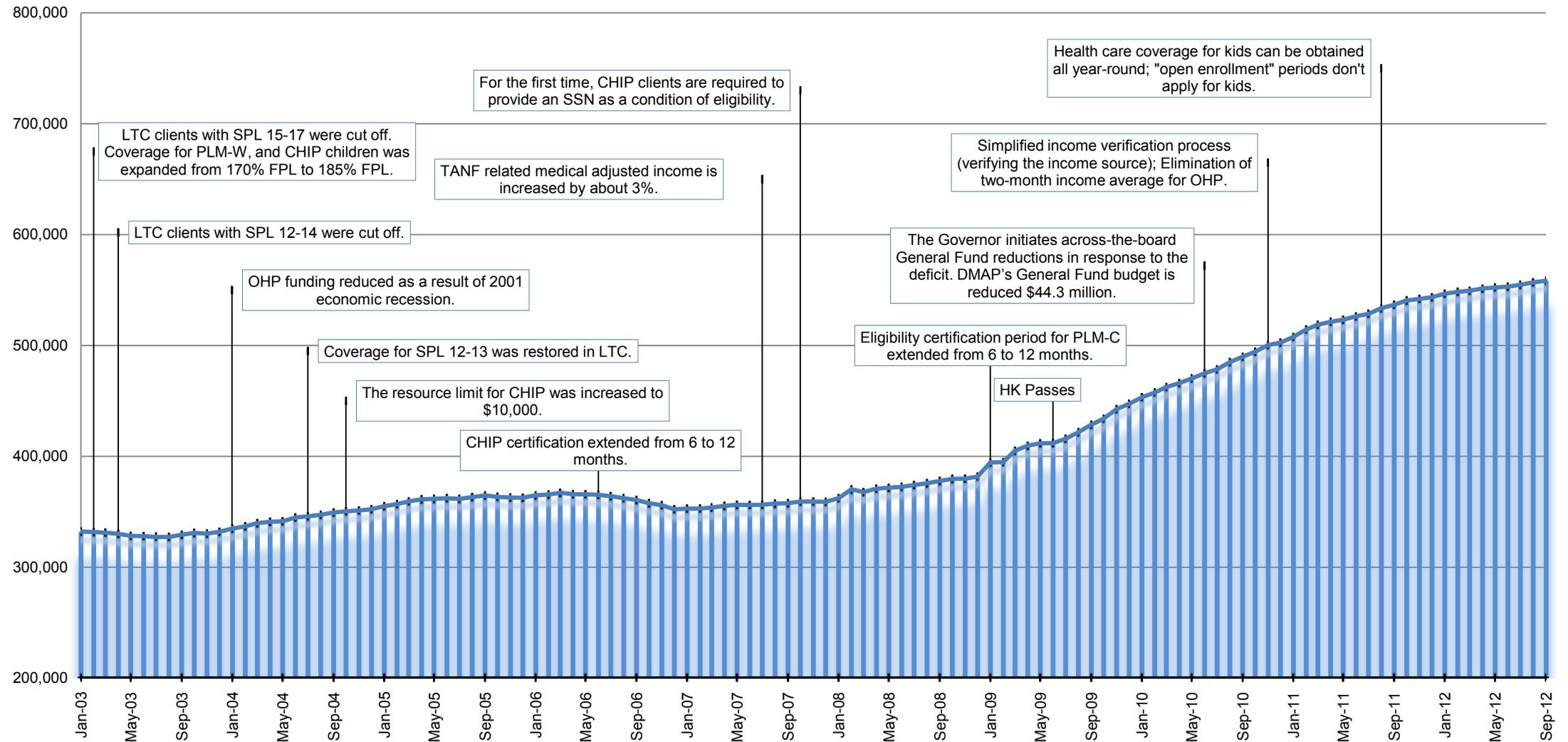
Residential development projects created 240 beds for people transitioning from Oregon State Hospital.

Civil 24-Hr Care

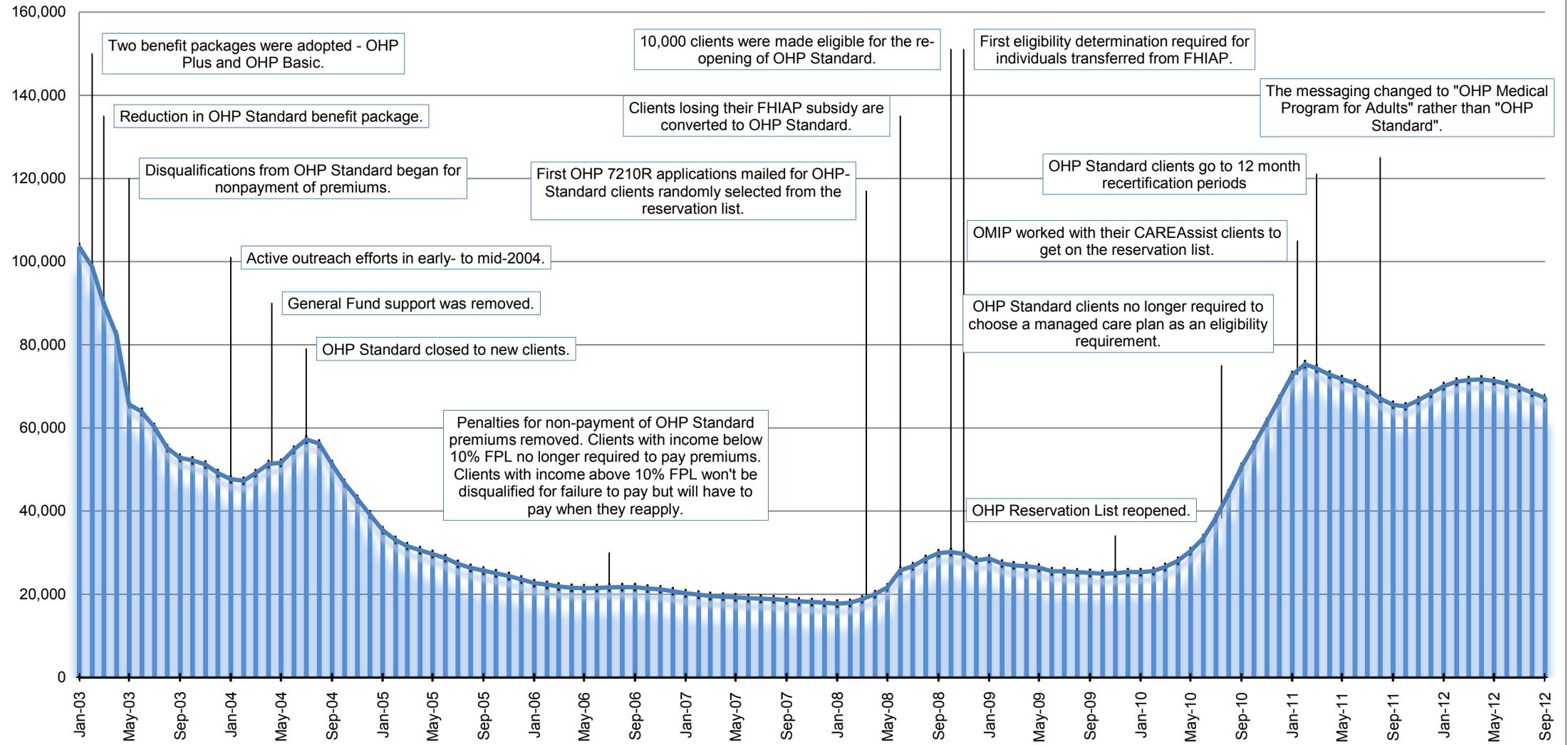
Total Oregon Health Plan Caseload



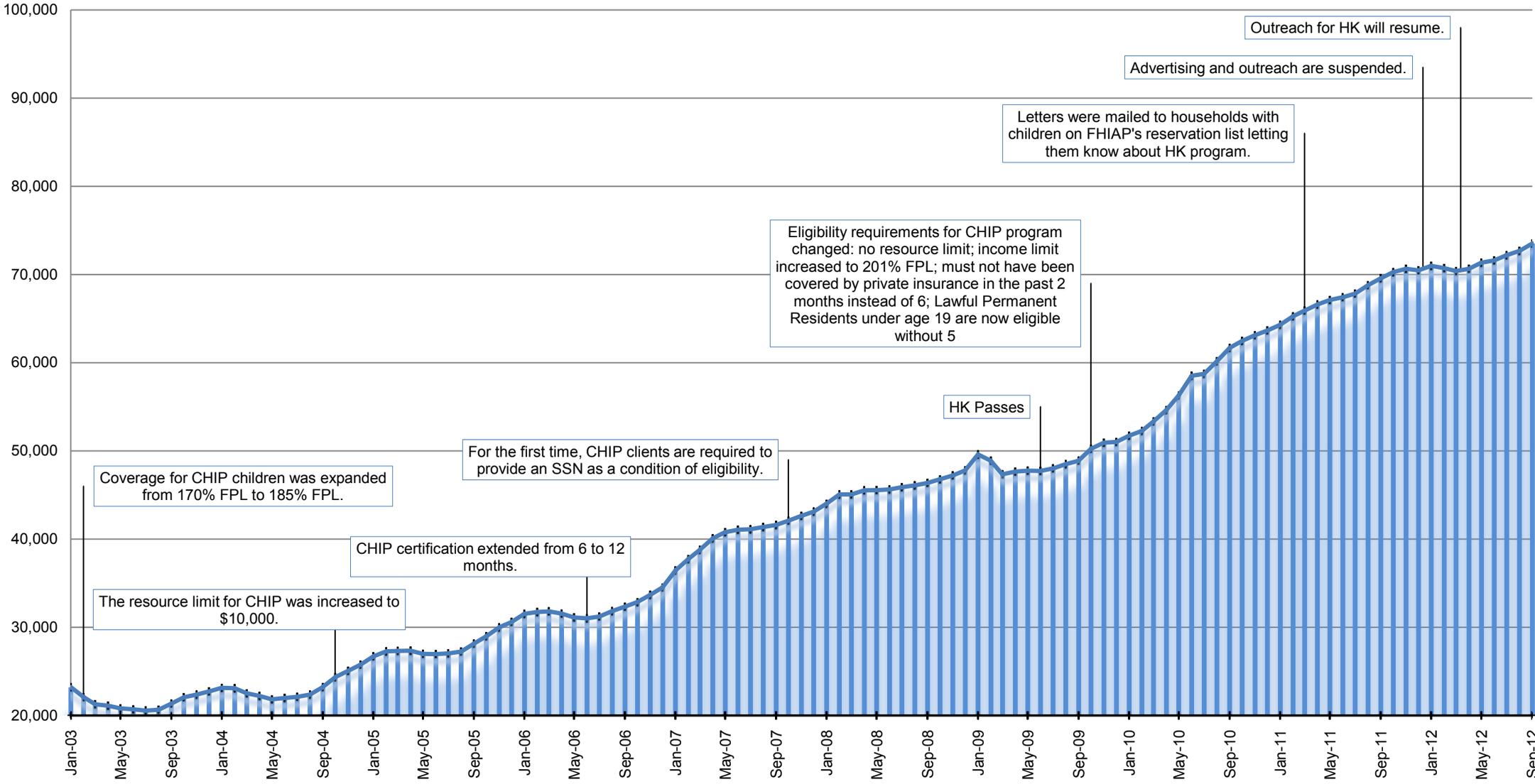
Oregon Health Plan Plus Caseload



Oregon Health Plan Standard Caseload



Oregon Health Plan CHIP Caseload



Federal Poverty Level (FPL)

“The set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. Public assistance programs, such as Medicaid in the U.S., define eligibility income limits as some percentage of FPL.”ⁱ

i. Source: www.investopedia.com. November 13, 2013.

ADDICTIONS AND MENTAL HEALTH (AMH)

The Addictions and Mental Health program provides prevention and treatment options for clients with addictions and/or mental illnesses. However, caseload forecasts are only provided for mandated mental health services.

Total Mandated Population

AMH provides both Mandated and Non-Mandated mental health services. Only mandated caseloads are forecast, including both criminal commitment and civil commitment caseloads. Mandated populations are required to receive mental health services by Oregon law through community settings and State Hospitals.

The State Hospitals provide 24-hour supervised care to people with the most severe mental health disorders, many of whom have been committed because they are a danger to themselves or others, including people who have been found guilty except for insanity.

The AMH mandated caseload forecast is the total number of individual clients receiving a mental health service or residing in a facility per month. There may be overlaps between some services, specifically between Residential and Community services. The forecast is calculated using two methods: a monthly count of individuals and average daily population (ADP). ADP is calculated by summing the total days of service used for a particular program and then dividing by the number of days in a month.

Total Criminal Commitment

Total Criminal Commitment (Forensic) caseload is composed of two categories: Aid and Assist and Psychiatric Security Review Board (PSRB). Each category is forecast separately. The total Criminal Commitment caseload forecast adjusts for overlaps.

Aid and Assist — State Hospital

Criminal Aid and Assist (or "Fitness to Proceed") caseload serves clients who have been charged with a crime and are placed in the Oregon State Hospital until they are fit to stand trial. "Fitness to Proceed" means that the client is able to understand and assist the attorney. Clients in the Aid and Assist caseload receive psychiatric assessment and treatment until they are able to assist their attorney and stand trial.

Psychiatric Security Review Board (PSRB)

The PSRB caseload includes clients who are under the jurisdiction of the Psychiatric Security Review Board. In the current forecast, the PSRB caseload also includes clients at the State Hospital who are under the jurisdiction of the State Hospital Review Panel. Clients in PSRB caseloads have been found "guilty except for insanity" of a crime by a court. AMH is required by Oregon law to provide treatment and supervision for these individuals, either in the community or in a State Hospital. Clients in this caseload receive a full range of counseling, medication, skills training and supports to assist their progress toward recovery.

Total Civil Commitment

The Civilly Committed caseload includes people who are found through a civil court process to be dangerous to themselves and/or others or are unable to care for themselves as a result of mental illness, with the court mandating treatment for the individual. The total Civil Commitment caseload is forecast after adjusting for overlaps in the following four categories:

Acute Care

Civil Acute Care includes clients who, having previously been civilly committed, undergo a "crisis" and are briefly placed into a hospital with beds specified

for mental health clients.

24-Hour Care

Civil 24-Hour Care includes clients who, having been civilly committed, are placed into a residential 24-hour setting.

State Hospital

Civil State Hospital Care includes clients who, having been civilly committed, are placed into one of the Oregon State Hospitals.

Community Non-Residential

Civil Community Non-Residential Care includes clients who, after having been civilly committed, receive services in a community setting.

MEDICAL ASSISTANCE PROGRAMS (MAP)

The Medical Assistance Programs division coordinates the Medicaid portion of the Oregon Health Plan (OHP) and directly administers OHP physical, dental, and mental health coverage.

MAP programs are divided into three major categories based on benefit packages:

Oregon Health Plan Plus (OHP Plus) – a basic benefit package.

Oregon Health Plan Standard (OHP Standard) – a reduced set of benefits with additional premiums and co-payments for coverage.ⁱⁱ

Other Medical Assistance Programs – programs that provide medical benefits but are not considered part of OHP.

Each program is represented by an unduplicated count of individuals on caseload as of the last day of the month.

OHP Plus Benefit Package

The OHP Plus package offers comprehensive health care services to children and adults who are eligible under traditional, federal Medicaid rules or the CHIP program.

TANF Related Medical (TANF-RM)

TANF Related Medical offers OHP Plus medical coverage to families with children who have incomes not exceeding 42 percent of federal poverty level (FPL).

TANF Extended (TANF-EX)

TANF Extended is made up of clients who have left the TANF-RM group due to a change in income resulting in a loss of eligibility. Maximum duration of continuing Medicaid coverage is 12 months.

ACA Adults

The United States Federal Patient Protection and Affordable Care Act of 2010 (ACA) is designed to reduce the number of uninsured Americans as well as the overall costs of health care to the general population. A variety of mechanisms are incorporated in the Act to achieve these goals. The most significant portion of the Act (as it relates to Medicaid caseloads) is the expansion of Medicaid eligibility to citizens 18 to 64 years old with incomes up to 138 percent of the FPL. For Oregon, this translates to an additional 241,000 clients over and above expected caseloads by the end of calendar 2016. ACA Adults will be split between two subcategories: ACA Adults with Children, and ACA Adults without Children.

Poverty Level Medical Women (PLMW)

Poverty Level Medical Women provides medical insurance coverage to pregnant women with income levels up to 185 percent of the FPL. Coverage is extended for 60 days after childbirth.

Poverty Level Medical Children (PLMC)

Poverty Level Medical Children provides medical insurance coverage for children ages 0 through 5 in households with incomes up to 133 percent of the FPL.

Aid to the Blind and Disabled Program (AB/AD)

Aid to the Blind and Disabled provides medical coverage through Medicaid to individuals who are blind or disabled and eligible for federal Supplemental Security Income (SSI). Aged, blind and disabled populations meeting long-term care criteria are eligible up to 300 percent of the SSI level (which is equivalent to approximately 225 percent of the FPL); otherwise, these populations are eligible up to 100 percent of the SSI level.

ii. OHP Standard closes on Dec 31, 2013. All current enrollees will transfer to ACA Adults with or without Children.

Old Age Assistance (OAA)

Old Age Assistance provides medical insurance coverage through Medicaid for individuals who are age 65 or over and eligible for federal SSI.

Foster/Substitute Care and Adoption Services

Foster/Substitute Care and Adoption Services provides medical insurance coverage through Medicaid for children in foster care and children whose adoptive families are receiving adoption assistance services. These clients are served up to age 21 with potential to age 26 depending on client eligibility.

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program covers uninsured children from birth through age 18 living in households with income up to 200 percent of the federal poverty level.

OHP Standard Benefit Package

Clients in OHP Standard are not eligible for traditional Medicaid programs under existing Federal rules and represent an expansion under the Oregon Health Plan. The OHP Standard program ends December 31, 2013. Participants at that time will be rolled into the ACA Adults category and will receive the OHP Plus benefit package. Until then, OHP Standard provides a reduced package of covered medical services compared to the OHP Plus program. OHP Standard also requires that participants share some of the costs of their medical coverage through premiums and co-payments. OHP Standard clients are split between two subcategories: Families, and Adults & Couples.

Other Medical Assistance Programs (Non-OHP Benefit Packages)

Citizen/Alien Waived Emergency Medical (CAWEM)

Citizen/Alien Waived Emergency Medical is a program that covers emergency medical care for non-citizens who would otherwise qualify for Medicaid services.

The program has two subcategories:

Regular (CAWEM CW) which provides only emergency medical care.

Prenatal (CAWEM CX) which also covers all pre-natal medical services (plus up to 2 months post-partum).

Qualified Medicare Beneficiary (QMB)

Qualified Medicare Beneficiary clients meet the criteria for both Medicare and Medicaid participation. The clients included in this caseload have incomes below 100 percent FPL, but above 100 percent of SSI, which is approximately 67 percent FPL. In addition, they do not meet the criteria for medical covered long-term care services. DHS pays for any Medicare Part A and Part B premiums as well as any applicable Medicare coinsurance and/or deductible not exceeding the department's fee schedule.

Breast and Cervical Cancer Program (BCCP)

The Breast and Cervical Cancer provides medical benefits for women diagnosed with breast or cervical cancer through the Breast and Cervical Cancer Early Detection program administered by Public Health through county health departments and tribal health clinics. After determining eligibility, the client receives OHP Plus benefits including mental and dental health services. A client is eligible until reaching the age of 65, obtaining coverage or ending treatment.

KidsConnect

Healthy KidsConnect (HKC) is the private market insurance component of Healthy Kids, Oregon's new health care program for children. Administered by the Office of Private Health Partnerships, HKC is for families that earn too much to qualify for the Oregon Health Plan, but can't afford private health insurance. The office also administers the Employer Sponsored Insurance (ESI)/group component. Those with access to ESI up to 300 percent of the FPL can receive premium assistance in the form of a reimbursement, as long as the employer plan meets federal guidelines.ⁱⁱⁱ

iii. The KidsConnect program closes on Dec 31, 2013. All current enrollees will transfer to the CHIP program as part of a waived expansion to 300 percent of FPL.



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