

FALL 2014 DHS|OHA CASELOAD FORECAST

Budget Planning and Analysis

Office of Forecasting, Research and Analysis





FALL 2014 DHS OHA
CASELOAD FORECAST

OCTOBER 2014

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EXECUTIVE SUMMARY

The **Supplemental Nutrition Assistance Program (SNAP)** Biennial Average Forecast for 2013–15 is 437,386 households, 1.8 percent higher than the Spring 2014 forecast. The forecast average for the 2015–17 biennium is 421,679 households, 3.6 percent lower than the forecast average for 2013–15.

The **Temporary Assistance to Needy Families (TANF)** Biennial Average Forecast for 2013–15 is 32,953 families, 1.1 percent lower than the Spring 2014 forecast. The forecast average for the 2015–17 biennium is 29,048 families, 11.9 percent lower than the forecast average for 2013–15.

The **Child Welfare** Biennial Average Forecast for 2013–15 is 21,344 children, 1.9 percent lower than the Spring 2014 forecast. The forecast average for the 2015–17 biennium is 21,465 children, 0.6 percent higher than the forecast average for 2013–15.

The **Vocational Rehabilitation** Biennial Average Forecast for 2013–15 is 8,936 clients, 1.1 percent higher than the Spring 2014 forecast. The forecast average for the 2015–17 biennium is 9,963 clients, 11.5 percent higher than the forecast average for 2013–15.

The total **Aging and People with Disabilities Long-Term Care (LTC)** Biennial Average Forecast for 2013–15 is 30,183 clients, 1.2 percent higher than the Spring 2014 forecast. The forecast average for the 2015–17 biennium is 31,424 clients, 4.1 percent higher than the forecast average for 2013–15.

The **Intellectual and Developmental Disabilities Case Management** Biennial Average Forecast for 2013–15 is 22,303 clients, 0.7 percent higher than the Spring 2014 forecast. The forecast average for the 2015–17 biennium is 24,223 clients, 8.6 percent higher than the forecast average for 2013–15.

The total **Medical Assistance Programs** Biennial Average Forecast for 2013–15 is 935,819 clients, 7.1 percent higher than the Spring 2014 forecast. The forecast average for the 2015–17 biennium is 988,757 clients, 5.7 percent higher than the forecast average for 2013–15. The current caseloads are higher than expected due to deferred redeterminations. The Fall 2014 forecast predicts that by March 2015 caseloads should drop back to their natural growth curves following an intensive period of redeterminations scheduled to take place from October 2014 through February 2015.

The total **Adult Mental Health** Biennial Average Forecast for the 2013–15 biennium is 47,991 clients served. This includes clients who are currently committed (1,778 people), who were committed sometime in the past (2,787 people), and who have never been committed (43,416 people). The forecast average for the 2015–17 biennium is 53,881 clients, 12.3 percent higher than the Fall 2014 Forecast for 2013–15.

1. Not everyone who is eligible for means-tested public programs participates in them, and Medicaid is no exception. When public programs are expanded, new enrollment often occurs not only among the newly eligible, but also among the previously eligible populations. This is referred to as the "welcome mat effect" and was seen after CHIP was created in 1997 and more recently as several states expanded coverage for children.

Introduction

This document summarizes the Fall 2014 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 which compares forecast accuracy across programs and over time is also available.¹

1. Forecast accuracy reports can be found at <http://www.oregon.gov/dhs/ofra/Pages/index.aspx>. For current monthly reports go to the Home page, for the annual report go to About Us, for older reports go to Forecasts, Reports & Publications. For information on OFRA's forecast methodology, go to the Forecast Process page.

Forecast environment and risks

Oregon's economy is still recovering from the Great Recession of 2008-2009. 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.

Oregon's total employment has increased consistently over the past few years. Total nonfarm employment was 1,713,700 for July 2014 – 9,900 fewer jobs than in July 2008 but 109,000 more jobs than in July 2010. This growth, however, has not been evenly distributed among industry sectors. Compared to 2008, there are 18,600 fewer construction jobs, 15,700 fewer durable goods manufacturing jobs, 11,600 fewer jobs in finance, and 8,900 fewer government jobs. At the other end of the spectrum, there are 26,400 more jobs in health care and social assistance, 12,600 more jobs in professional and business services, and 9,800 more jobs in accommodation and food services. The U.S. Bureau of Labor Statistics reported that during 2013, 141,000 Oregonians worked part-time because they could not find full-time work (*economic reasons*). This is an increase from 2012 when there were 112,000 involuntary part-time workers and 2007 when there were just 47,000.

These trends have affected DHS clients. For example, employment among adults on the January 2014 SNAP caseload declined by 7 percent between 2008 and 2013, yet their real wages declined by 25 percent. Some employment shifted from manufacturing and construction to employment as care providers to the elderly and disabled, work in accommodation and food services, or work for temporary employment agencies. Work in these sectors tends to pay less and provide fewer hours when compared to manufacturing or construction employment. Such employment dynamics explain why Oregon's overall increase in employment has not translated into large decreases in Self Sufficiency and some Medicaid caseloads.

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 second quarter 2014 edition lists the major risks as federal fiscal policies, strength of the housing market recovery, European debt problems and potential financial instability, commodity price inflation, and uncertainty surrounding federal timber payments.²

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. For a complete discussion of risks to Oregon's economy, see OEA's most recent forecast: <http://www.oregon.gov/DAS/OEA/docs/economic/oregon.pdf>.

Department of Human Services

The background features a solid blue horizontal bar at the bottom. Above it is a decorative graphic consisting of several overlapping, wavy bands in shades of gold, tan, and light grey, creating a sense of movement and depth.

Total Department of Human Services Biennial Average Forecast Comparison

	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Self Sufficiency						
Supplemental Nutrition Assistance Program (households)	429,661	437,386	1.8%	437,386	421,679	-3.6%
Temporary Assistance for Needy Families - Basic and UN (families: cash assistance)	33,336	32,953	-1.1%	32,953	29,048	-11.9%
Child Welfare (children served)						
Adoption Assistance	11,190	11,101	-0.8%	11,101	11,182	0.7%
Guardianship Assistance	1,365	1,382	1.2%	1,382	1,557	12.7%
Out-of-Home Care	7,477	7,319	-2.1%	7,319	7,285	-0.5%
Child In-Home	1,717	1,543	-10.1%	1,543	1,441	-6.6%
Vocational Rehabilitation Services	8,836	8,936	1.1%	8,936	9,963	11.5%
Aging and People with Disabilities						
Long-Term Care: In-Home	13,863	14,438	4.1%	14,438	15,486	7.3%
Long-Term Care: Community-Based	11,656	11,526	-1.1%	11,526	11,915	3.4%
Long-Term Care: Nursing Facilities	4,320	4,219	-2.3%	4,219	4,023	-4.6%
Intellectual and Developmental Disabilities						
Total Case Management Enrollment	22,139	22,303	0.7%	22,303	24,223	8.6%
Total I/DD Services	16,251	16,067	-1.1%	16,067	17,868	11.2%

Self Sufficiency Programs

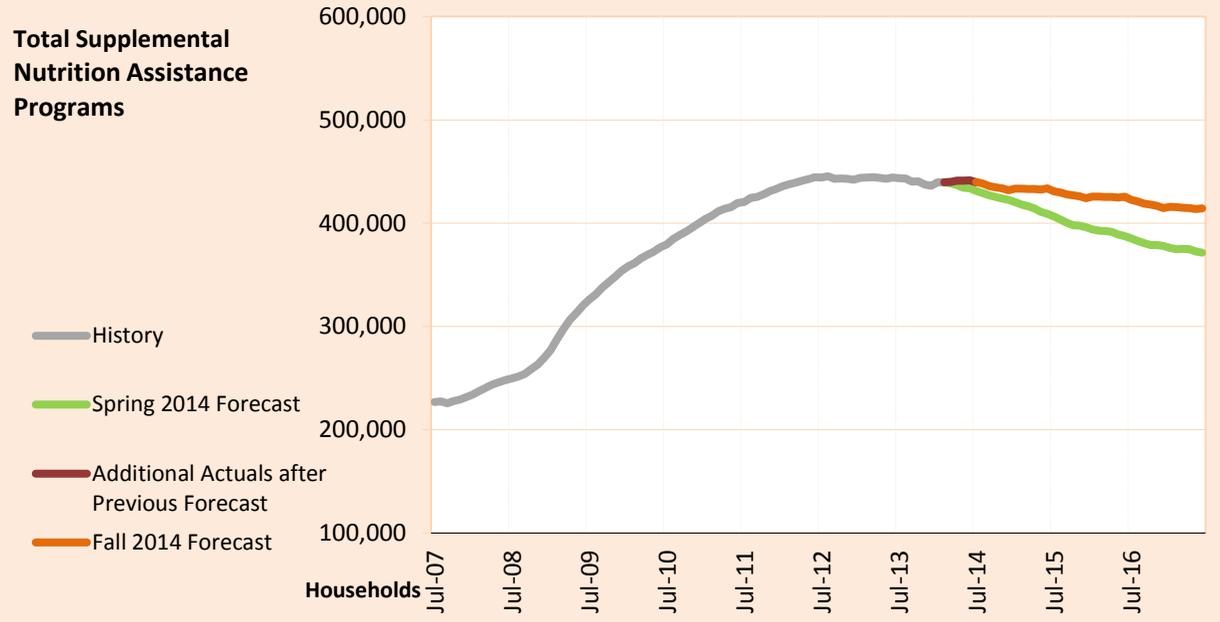
Supplemental Nutrition Assistance Program (SNAP) — There were 441,500 households (791,500 persons) receiving SNAP benefits in June 2014, approximately one-fifth of all Oregonians. The SSP portion of SNAP rose rapidly at the outset of 2009 and continued to grow at a steadily decreasing rate until leveling off in mid-2012. The caseload has declined by 17,400 households since June 2012. The smaller APD SNAP caseload has been increasing steadily for several years. The combined SNAP biennial average forecast for 2013-15 is 437,386 households, 1.8 percent higher than the Spring 2014 forecast. The Fall 2014 Forecast average for the 2015–17 biennium is 421,679 households, 3.6 percent lower than the biennial average forecast for 2013-15. APD SNAP is in the pilot phase of increasing from 12-month to 24-month redeterminations. When this policy is implemented statewide it may decrease the “churn” in the APD SNAP caseload. Churn occurs when clients do not complete the redetermination process in a timely manner and temporarily drop off the caseload. All other things being equal, implementation of this change could increase the total caseload. Finally, the SNAP caseload could be affected by the issues stated in the “Forecast environment and risks” section above.

Temporary Assistance for Needy Families (TANF) — There were 33,188 families receiving TANF benefits in June 2014. 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 and is currently 3,400 cases below its February 2013 peak. Over the current and next 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 32,953 families, 1.1 percent lower than the Spring 2014 forecast. The current forecast average for the 2015–17 biennium is 29,048 families, 11.9 percent lower than the forecast for 2013-15. The major risk to the TANF forecast is a potential program re-design that may be adopted in the upcoming legislative session. The TANF caseload also could be affected by the issues stated in the “Forecast environment and risks” section above.

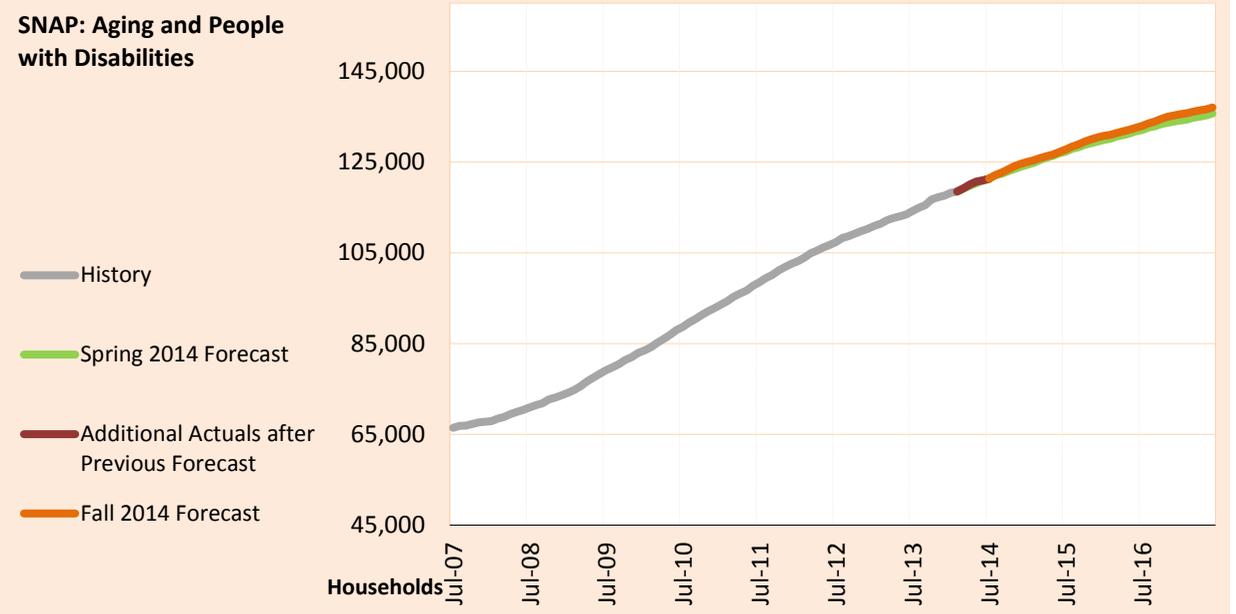
Pre-SSI - The Fall 2014 forecast for the 2013–15 biennium is 502 families, 3.6 percent lower than the Spring 2014 forecast. The caseload is expected to average 485 families during the 2015–17 biennium, 3.4 percent lower than the forecast for the current biennium.

Temporary Assistance for Domestic Violence Survivors (TA-DVS) — This is a relatively small caseload that experiences regular seasonal fluctuations. The Fall 2014 forecast for the 2013–15 biennium is 449 families, 1.3 percent lower than the Spring 2014 forecast. The caseload is expected to average 457 families during the 2015–17 biennium, 1.8 percent higher than the forecast for the current biennium.

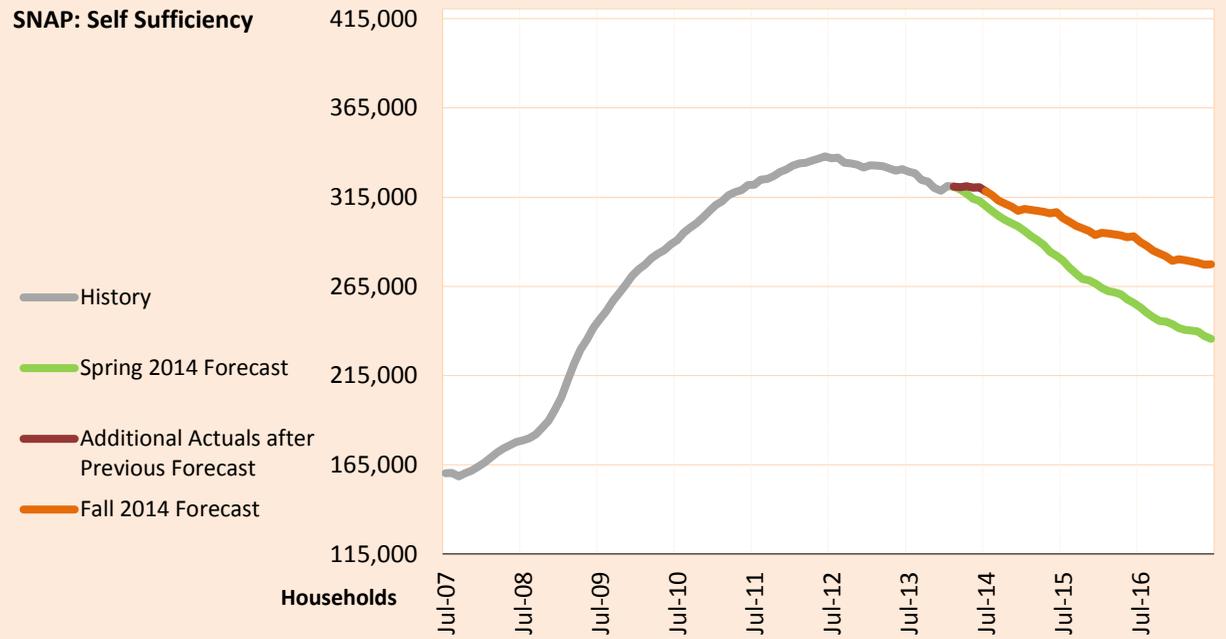
Total Supplemental Nutrition Assistance Programs



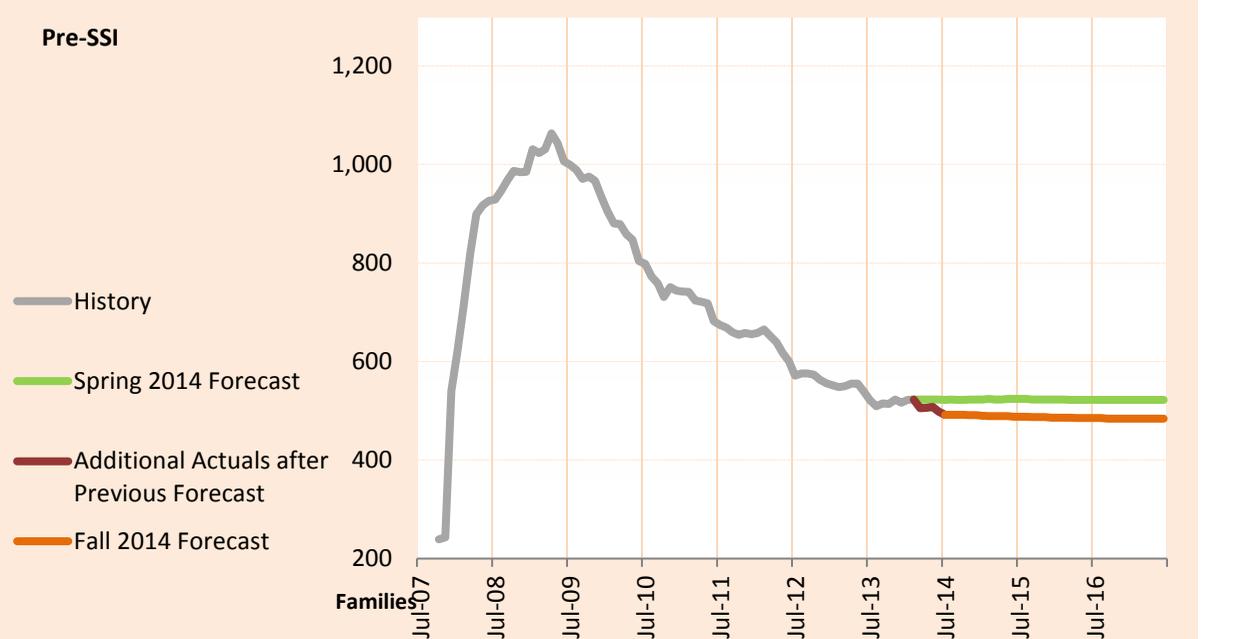
SNAP: Aging and People with Disabilities

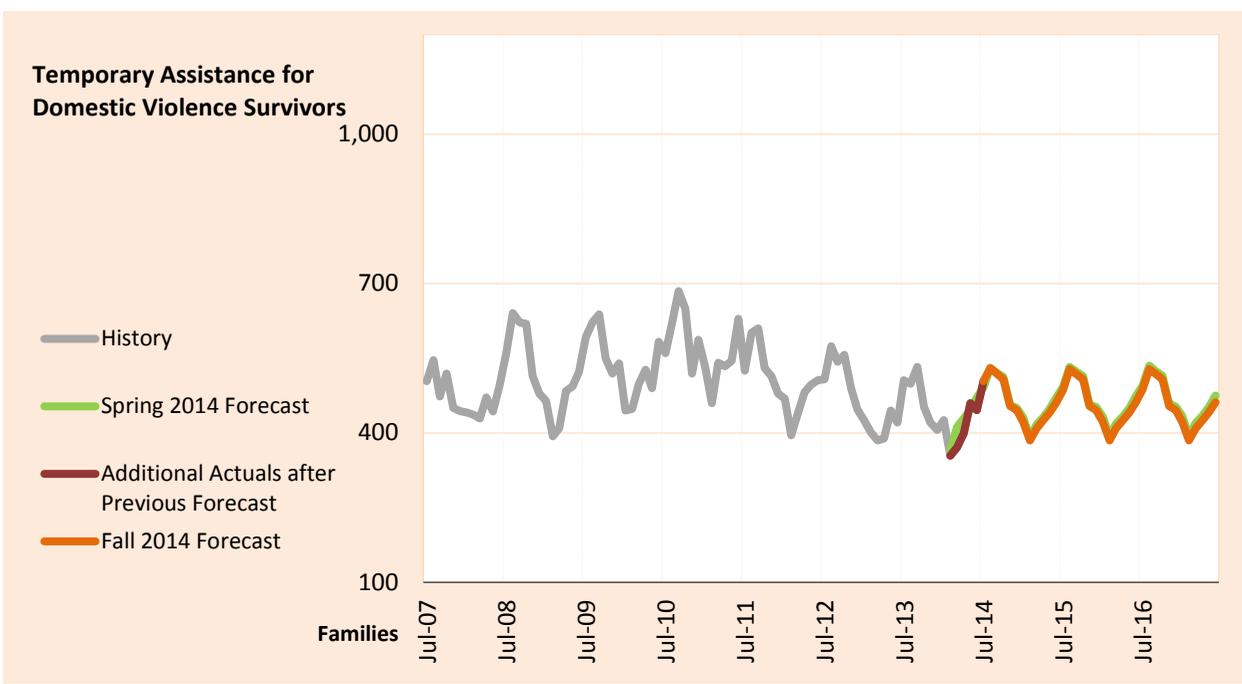
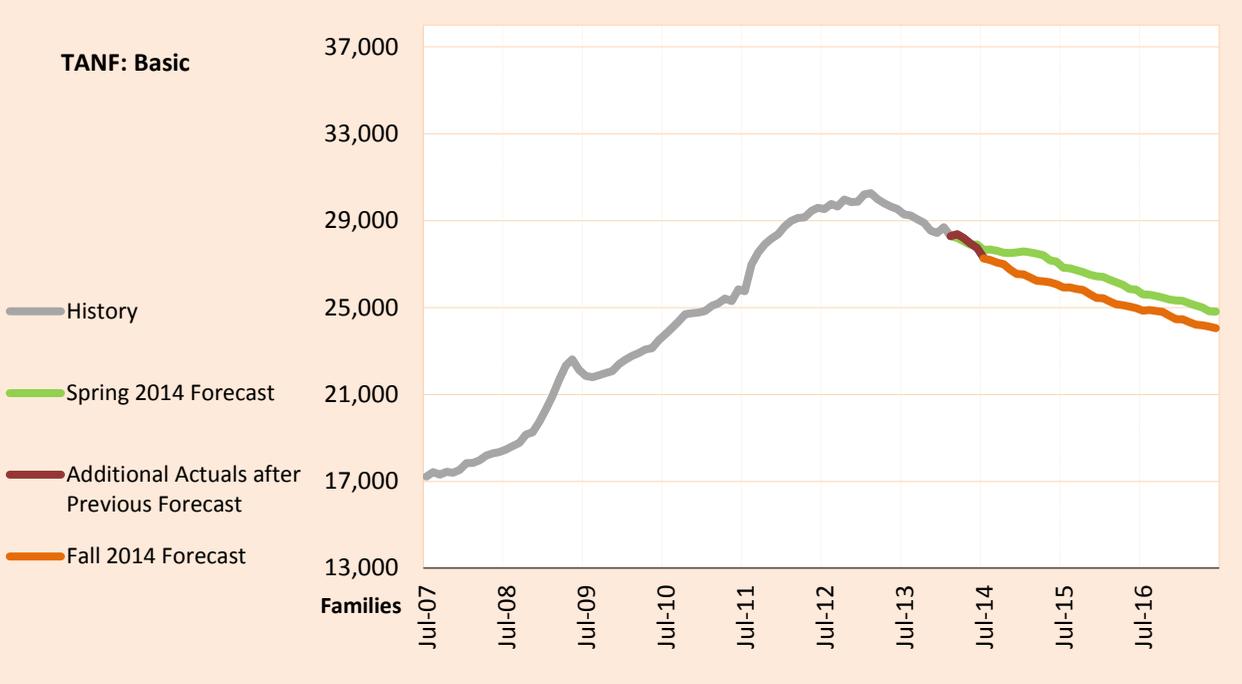
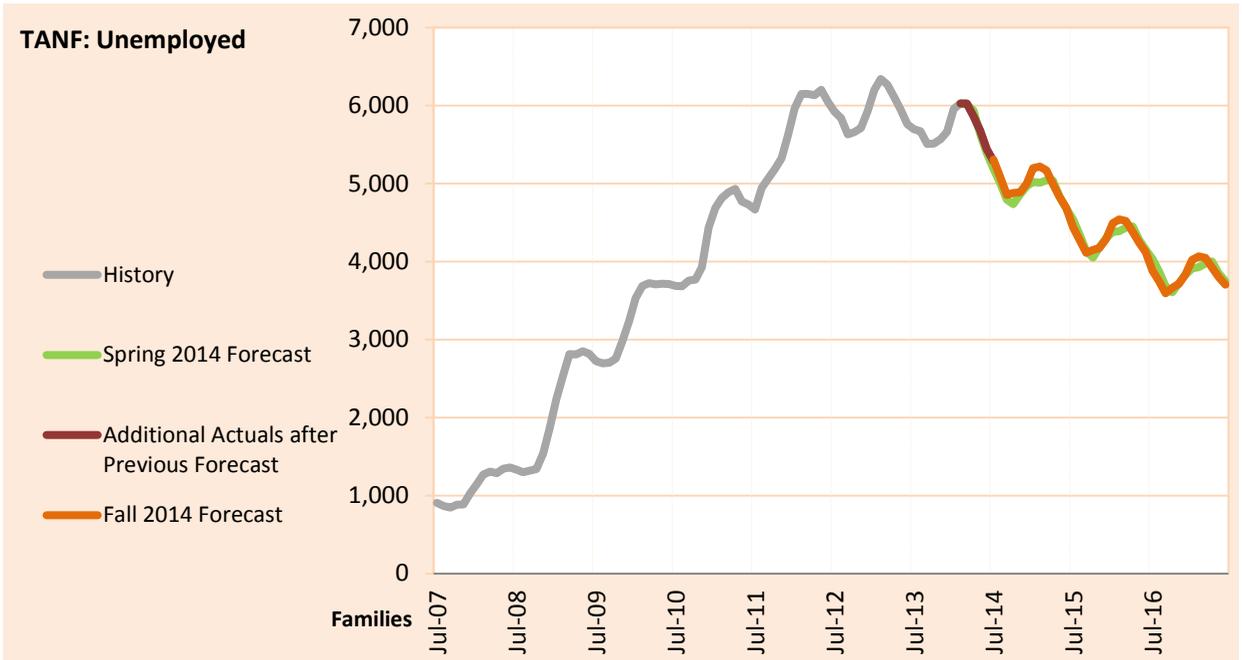
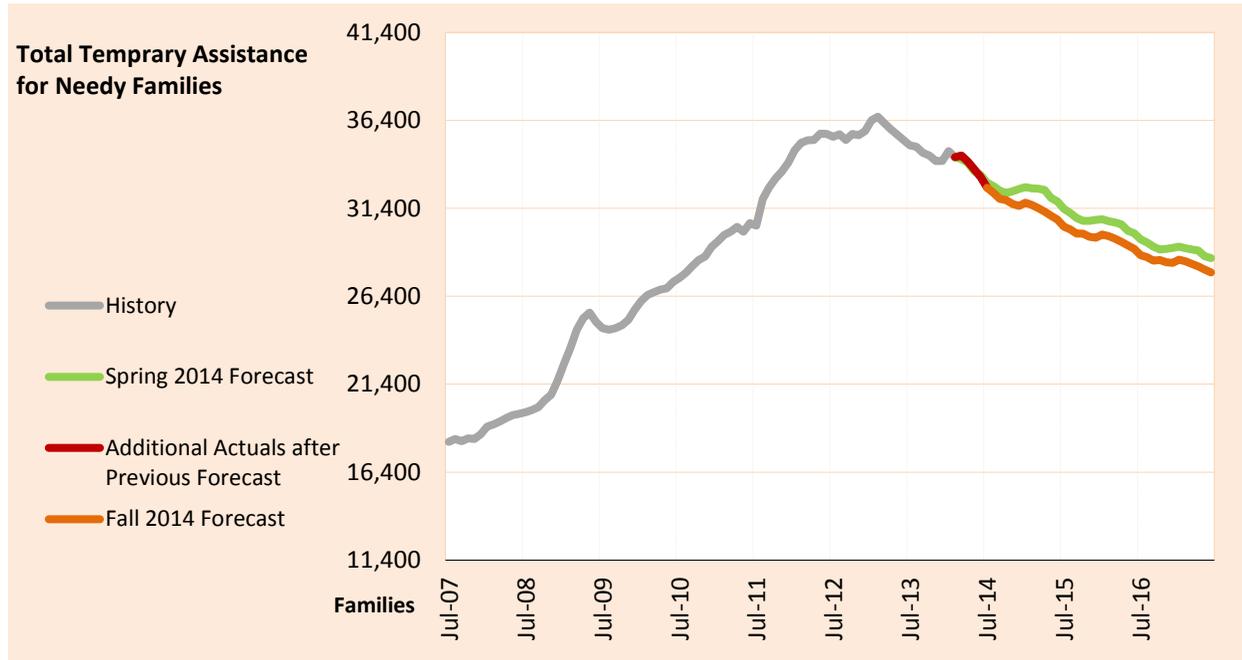


SNAP: Self Sufficiency



Pre-SSI





Self Sufficiency Biennial Average Forecast comparison

	Current Biennium		% Change Between Forecasts	Fall 2014 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Supplemental Nutrition Assistance Program (households)						
Self Sufficiency	308,682	316,190	2.4%	316,190	288,875	-8.6%
Aging and People with Disabilities	120,979	121,197	0.2%	121,197	132,804	9.6%
Total SNAP	429,661	437,386	1.8%	437,386	421,679	-3.6%
Temporary Assistance for Needy Families (families: cash/grants)						
Basic	28,012	27,589	-1.5%	27,589	24,975	-9.5%
UN	5,324	5,364	0.8%	5,364	4,073	-24.1%
Total TANF	33,336	32,953	-1.1%	32,953	29,048	-11.9%
Pre-SSI (families)	521	502	-3.6%	502	485	-3.4%
Temporary Assistance for Domestic Violence Survivors (families)	455	449	-1.3%	449	457	1.8%

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 2014 forecast is the fourth 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 has been relatively flat from July 2013 to the present, averaging 11,080 children served per month. The caseload is expected to average 11,101 for the 2013-15 biennium, 0.8 percent lower than the Spring 2014 forecast. The caseload is expected to average 11,182 over the 2015-17 biennium, 0.7 percent higher than the biennial average forecast for 2013-15.

Guardianship Assistance – This caseload has exhibited steady, fairly rapid growth for its entire history. It increased an average of 23 percent annually between 2001 and 2013, although growth slowed in 2013. This spring the caseload appears to be picking up its rate of growth, increasing 2 percent between March and April 2014. Current policies are in place to shorten the length of time to permanency, so we expect continued increases to this caseload as children move out of foster care. The Fall 2014 forecast reflects this expected growth. The caseload is expected to average 1,382 for the 2013-15 biennium, 1.2 percent higher than the Spring 2014 forecast. The caseload is expected to average 1,557 over the 2015-17 biennium, 12.7 percent higher than the biennial average forecast for 2013-15.

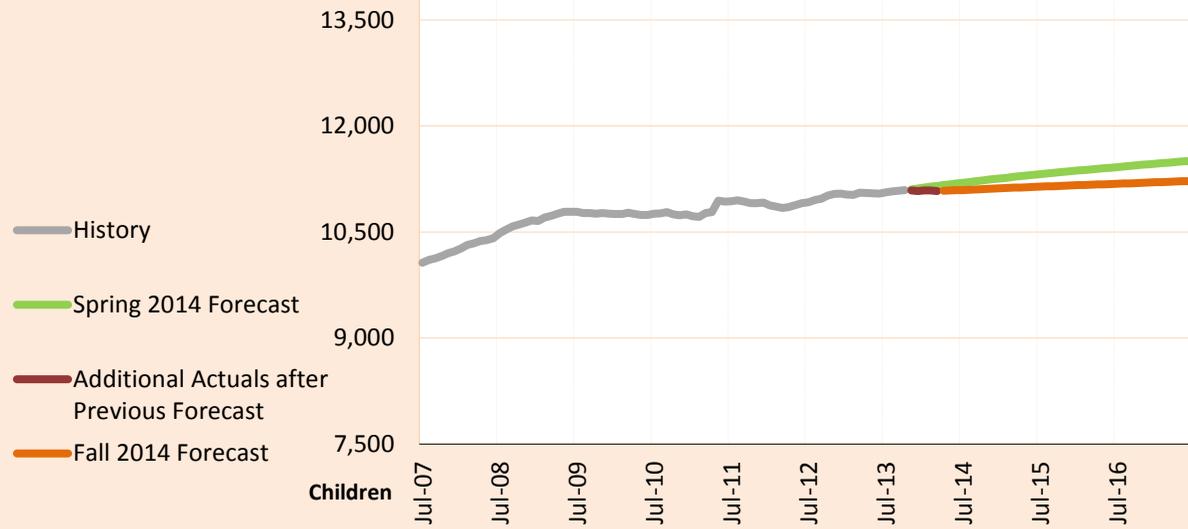
Out-of-Home Care — This caseload is comprised of paid foster care, non-paid foster care (including trial home visits), and residential care. Paid foster care is by far the largest portion of the group. The total foster care caseload experienced a significant decrease in the four years between January 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 March 2014, the caseload decreased 10 percent. There are many initiatives in place that are designed to decrease the foster care caseload even though the child population in Oregon continues to grow. In recent months the caseload decline has slowed somewhat. The Fall 2014 forecast also reflects a phase-in of 48 beds between April and September 2014, due to restored general funds. The caseload is expected to average 7,319 for the 2013-15 biennium, 2.1 percent lower than the Spring 2014 forecast. The caseload is expected to average 7,285 over the 2015-17 biennium, 0.5 percent lower than the biennial average forecast for 2013-15.

Child-In-Home — This caseload experienced steady decline from 2004 to 2007, followed by a period of rising and falling caseloads through 2011, then shifted to a period of slow decline that ended in late 2013. Since that time, caseload has fluctuated within a narrow band of 1,500 to 1,600. The Fall 2014 forecast reflects this history, with a very slow growth pattern that is expected to average 1,543 for the 2013-15 biennium, 10.2 percent lower than the Spring 2014 forecast. The caseload is expected to average 1,441 over the 2015-17 biennium, 6.6 percent lower than the biennial average forecast for 2013-15.

Risk and Assumptions

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 engage more families in prevention, so those children may not end up with a case plan, and as such, will not get counted in the caseload. In addition, there is a group working to re-define the Child-In-Home caseload. New definitions for Child-In-Home could affect which children are counted as part of the caseload. Another risk is the influence of overdue or unclosed assessments; if not entered in the system, Child-In-Home numbers could be affected.

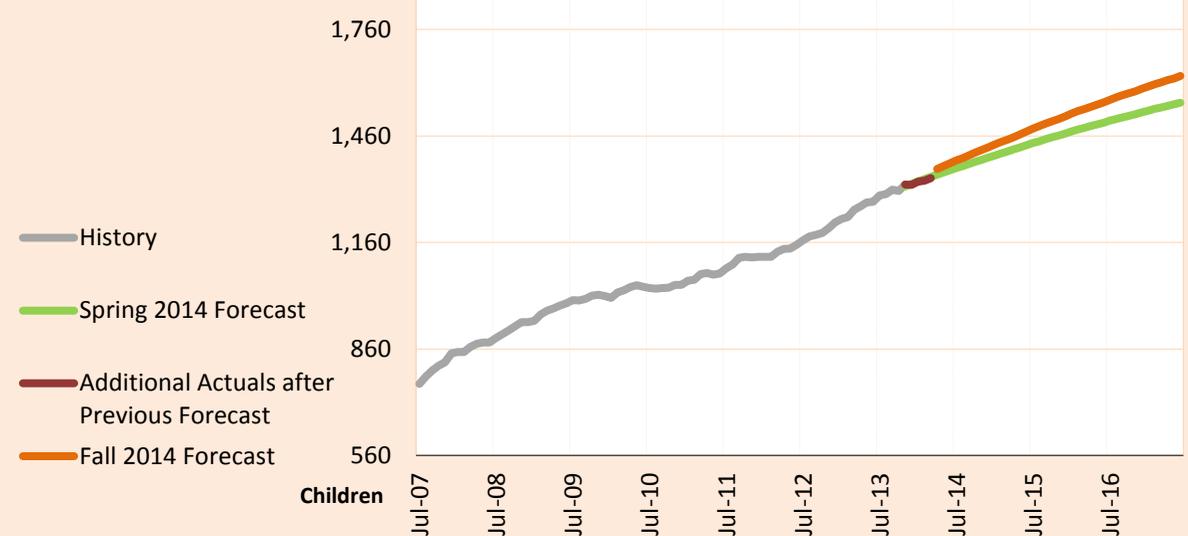
Adoption Assistance



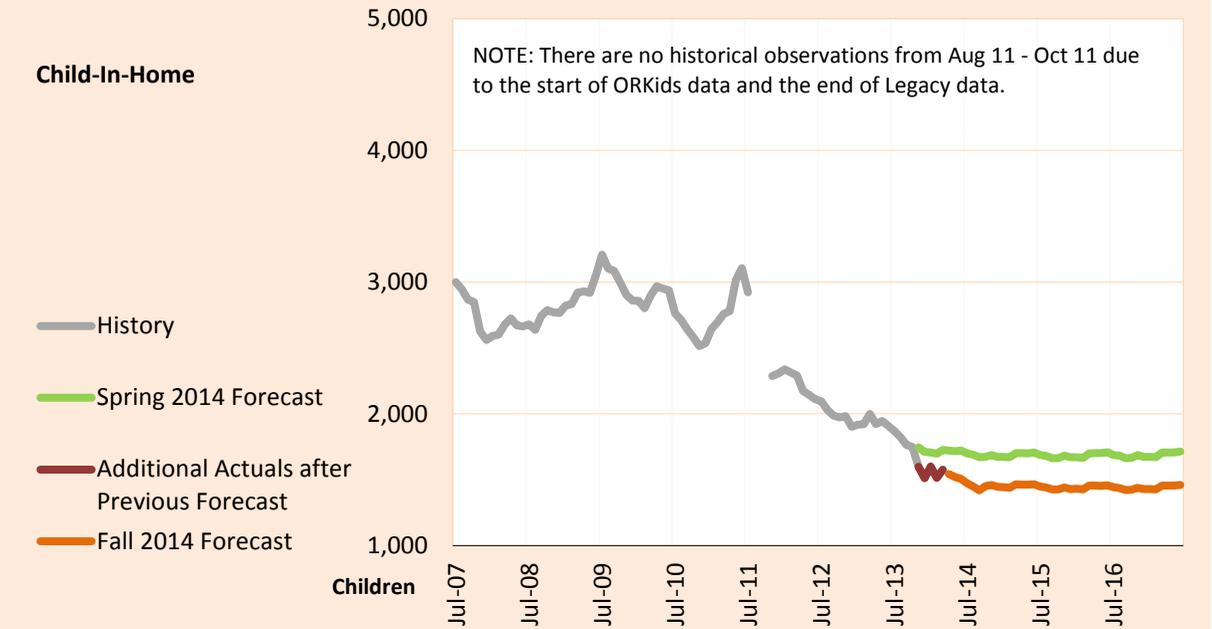
Out of Home Care

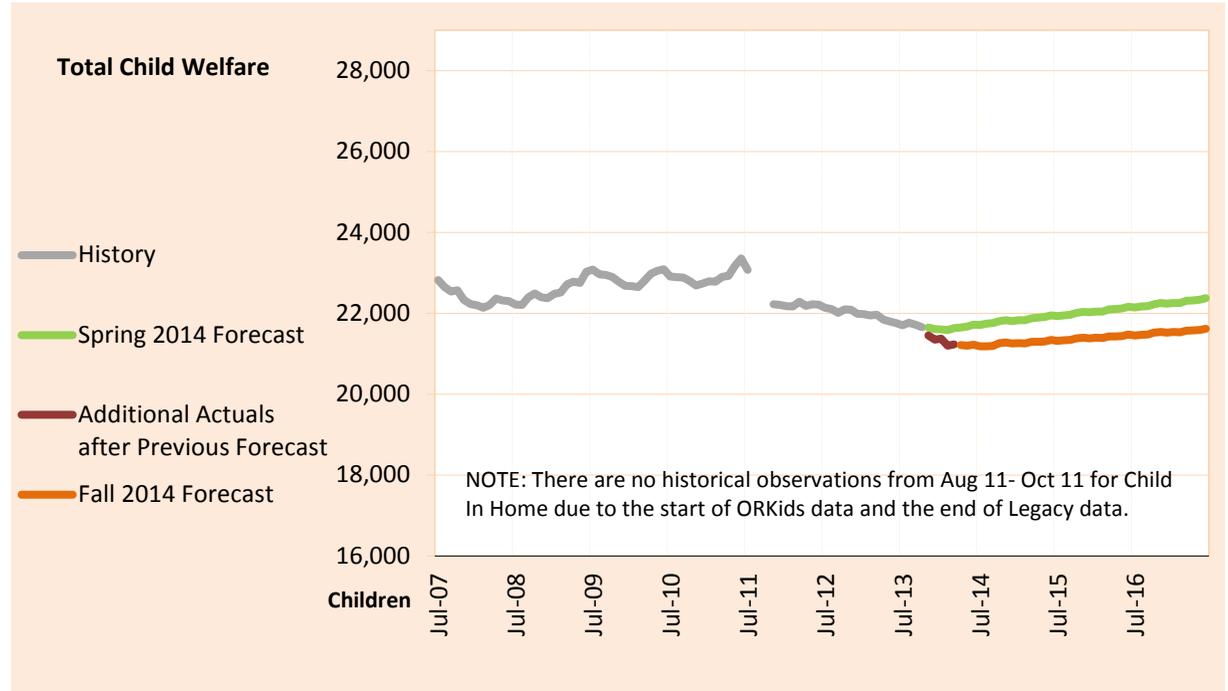


Guardianship Assistance



Child-In-Home



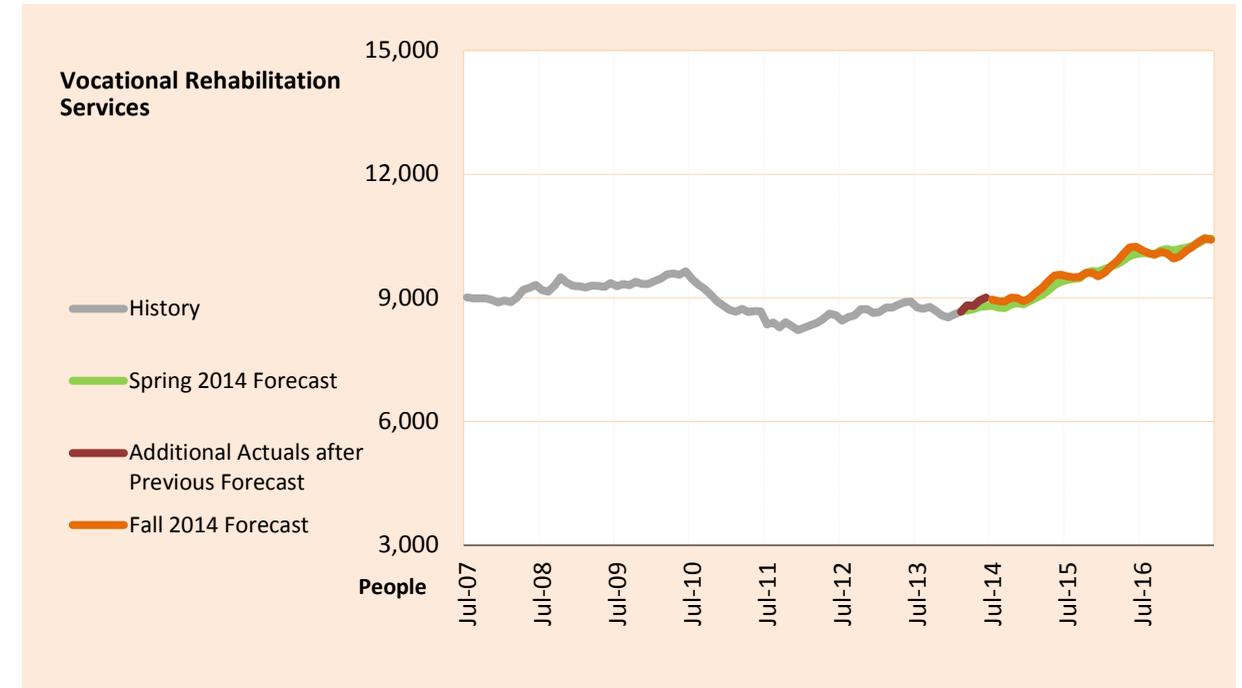


Child Welfare Biennial Average Forecast comparison

	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Adoption Assistance	11,190	11,101	-0.8%	11,101	11,182	0.7%
Guardianship Assistance	1,365	1,382	1.2%	1,382	1,557	12.7%
Out-of-Home Care	7,477	7,319	-2.1%	7,319	7,285	-0.5%
Child In-Home	1,717	1,543	-10.1%	1,543	1,441	-6.6%
Total Child Welfare	21,749	21,344	-1.9%	21,344	21,465	0.6%

Vocational Rehabilitation

From 2006 through 2008 the Vocational Rehabilitation 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 then, Vocational Rehabilitation has avoided placing clients on the waiting list and the caseload has averaged 8,600 clients over the past three years. The Fall 2014 forecast for the 2013–15 biennium is 8,936 clients, 1.1 percent higher than the Spring 2014 forecast. The caseload is expected to average 9,963 clients during the 2015–17 biennium, 11.5 percent higher than in 2013–15. Executive Order 13-04 requires the Vocational Rehabilitation program to serve an additional 275 clients by FY 2017, and the increase in caseload is expected as a result of hiring additional counselors. Risks include the eventual outcome of Lane v. Kitzhaber (a federal class-action lawsuit) and the reauthorization of the Rehabilitation Act as part of the Workforce Innovation and Opportunity Act (PL 113-128). This federal act was signed into law in July and is scheduled to take effect July 1, 2015. During the coming year the effect of this law on Oregon's Vocational Rehabilitation services should become clearer.



Vocational Rehabilitation Services Biennial Average Forecast comparison

	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Total receiving service	8,836	8,936	1.1%	8,936	9,963	11.5%

Aging and People with Disabilities

Following five years of steady decline, the Total Long-Term Care (LTC) caseload began to increase in the second half of 2008. In 2009 the caseload grew by roughly 6 percent, most likely due to the economic downturn. Since then caseload growth has been slow despite significant increases in the number of Oregon seniors. Caseload growth slowed to roughly 2 percent in 2010, 2 percent in 2011, and then remained essentially flat with some fluctuations until mid-2013 when the caseload resumed a pattern of slow growth.

Historically, Oregon's LTC services were provided under the authority of a Medicaid 1915 (c) Home and Community-Based Services (HCBS) Waiver. Beginning in July 2013, Oregon also began offering services through the Community First Choice Option under 1915 (k) of the Social Security Act (referred to as the K Plan).

Total Long-Term Care — A total of 30,241 clients received long-term care services in April 2014. The biennial average forecast for 2013-15 is 30,183, 1.2 percent higher than the Spring 2014 forecast. The biennial average forecast for 2015-17 is 31,424 clients, a 4.1 percent increase from 2013-15.

The LTC forecast is divided into three major categories: In-Home, Community-Based Care (CBC), and Nursing Facilities. Most of the forecasted increase in total LTC is expected to occur in In-Home Care, particularly In-Home Hourly. In-Home Care continues to be a popular placement choice, especially since APD implemented a variety of policy and program changes designed to make In-Home services more attractive to clients. Community-Based Care is still forecasted to grow, although the rate of growth has been lowered slightly due to the corresponding growth in In-Home Care services. Community-Based Care will continue to be a stable placement choice for many LTC clients because they are easier to set up and coordinate than In-Home Care services, and because hospitals prefer discharging patients to higher service settings in order to prevent repeat emergency visits or hospitalizations. Although Medicaid reimbursement rates continue to lag behind private market rates, low housing prices and slow home sales continue to impact the flow of private pay clients, thus making Medicaid clients more attractive than they might otherwise be to CBC providers.

In-Home Care — In April 2014, 14,504 clients received In-Home Care, which accounted for 48 percent of total LTC at that time. The biennial average forecast for 2013-15 is 14,438 clients, 4.1 percent higher than the Spring 2014 forecast. The biennial average forecast for 2015-17 is 15,486 clients, a 7.3 percent increase from 2013-15. In-Home Care is forecasted to be 49 percent of the total LTC in June 2017.

Recent growth in the In-Home Care caseload may be due to implementation of a variety of policy and program changes intended to promote the use of In-Home Care rather than more expensive forms of service. For example, under the new rules, clients who want long-term care services are required to contribute to their own support by relinquishing to the State all income over \$1,210 per month; previously, the limit for how much a client could keep was \$710 per month. Clients who may have been reluctant to forgo some of their limited income, even in exchange for needed supports, might now find the program more attractive. In addition, the fact that options exist which allow family members, friends, or neighbors (natural supports) to be paid (under certain circumstances) for providing services may also entice more individuals to request In-Home Care services.

Community-Based Care — In April 2014, 11,466 clients received Community-Based Care, which accounted for 38 percent of total LTC at that time. The biennial average forecast for 2013-15 is 11,526 clients, 1.1 percent lower than the Spring 2014 forecast. The biennial average forecast for 2015-17 is 11,915 clients, a 3.4 percent increase from 2013-15. Community-Based Care is forecasted to be 38 percent of the total LTC in June 2017.

Community-Based Care includes several different types of services. The forecasted caseload for each type has been revised to more accurately reflect clients' recent, actual utilization of services. Consequently, Assisted Living has become a larger portion of the CBC forecast, while Adult Foster Care (AFC) became smaller. Several factors may be contributing to the recent decline in AFC caseload: recent policy changes have improved the attractiveness of In-Home Care, potentially reducing demand for foster care; providers consider the current reimbursement rate inadequate and are requesting exception rates – but the exception approval process is cumbersome; unionization of workforce has made the relationship between workers and providers more adversarial; and capacity may be declining as individual providers retire without a replacement.

Nursing Facility Care (NFC) — In April 2014, 4,271 clients received Nursing Facility Care, which accounted for 14 percent of total LTC at that time. The biennial average forecast for 2013-15 is 4,219, 2.3 percent lower than the Spring 2014 forecast. The biennial average forecast for 2015-17 is 4,023, a 4.6 percent decrease from 2013-15. Nursing Facility Care is forecasted to be 14 percent of the total LTC in June 2017.

Risk and Assumptions

The Patient Protection and Affordable Care Act of 2010 (ACA) created a new option for providing Home and Community-Based attendant services and supports, known as Medicaid State Plan (K) option. Starting July 1, 2013, Oregon has been authorized to provide LTC services under either the HCBS Waiver or the new K Plan. The K Plan includes a wide variety of changes in how the long-term care population is served. Those changes introduce new risks to the LTC forecast.

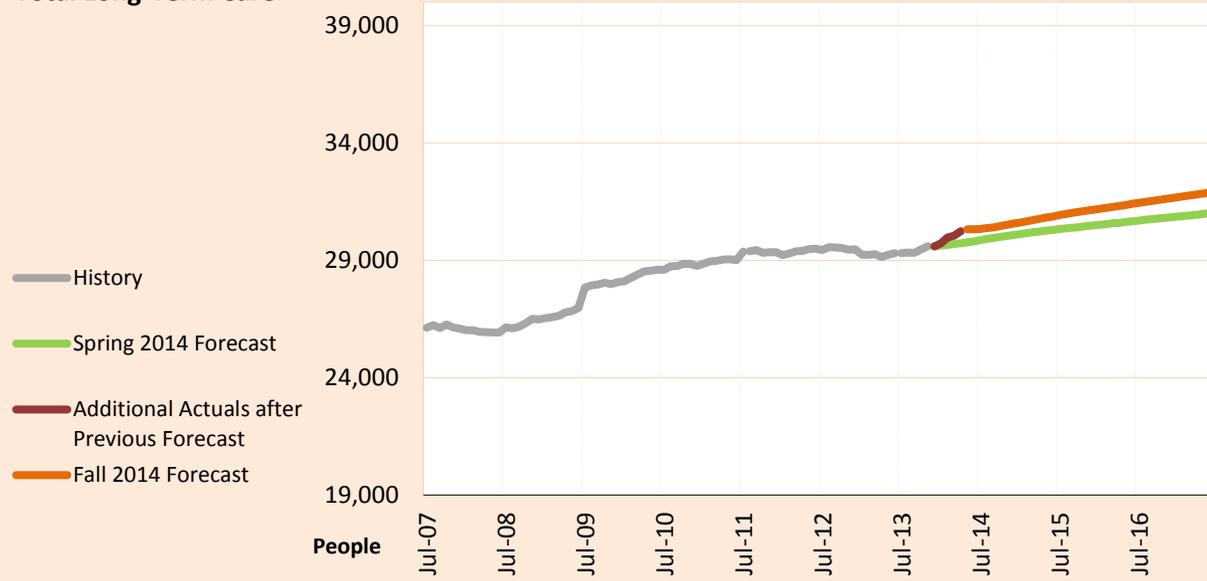
One of the most significant new risks comes from a change in eligibility rules between the Waiver and the K Plan. To qualify for LTC under the HCBS Waiver, requirements include income and asset limits, disability (or age) requirements, and a level of care assessment. To qualify for LTC under K Plan, there are fewer requirements: income limits (but no asset limits) and a level of care assessment (but no need to be determined “disabled”). Program management does not think these changes lower the bar for eligibility, so they do not expect it to increase the caseload. If, however, that assumption is wrong, then the LTC caseload might grow significantly and ACA’s expansion of Medicaid to low income adults under age 65 might aggravate that problem. For more information about ACA’s impact on Medicaid enrollment, see the “Medical Assistance Programs” section of this report.

Another significant risk has been created by the implementation of policy and program changes in 2013 which were designed to delay or prevent individuals from needing assistance, and to increase the attractiveness of In-Home Care relative to other more expensive forms of care. Successful prevention measures might eventually lower the caseload; and changes that make In-Home Care more attractive might lead clients to choose In-Home Care over Community-Based Care, or it might lead people who were struggling on their own to enroll for assistance. For another example of one of the new policies see the In-Home Care section above.

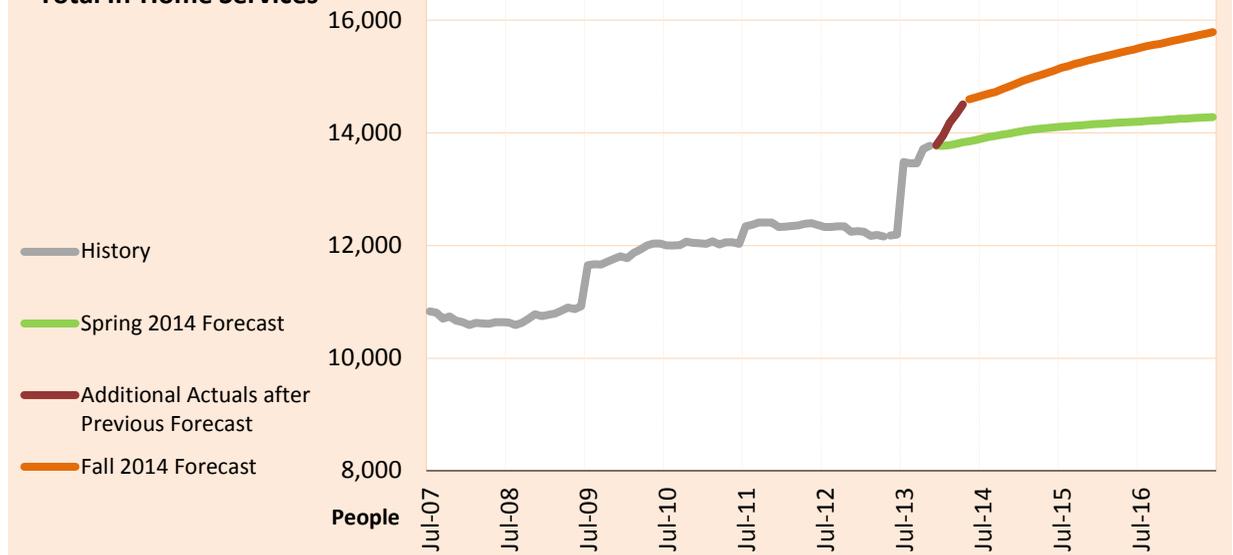
On a smaller scale, K Plan’s reduced requirements also open the door for clients to qualify based on needs that are essentially short-term in nature. Consequently, a K Plan amendment may be submitted to limit service to clients who are expected to meet level of care needs for six months or longer.

Another factor that might impact caseload is the passage of Oregon House Bill 2216 in 2013 which calls for a reduction in the overall Long-Term Care bed capacity by 1,500 by December 31, 2015.

Total Long-Term Care



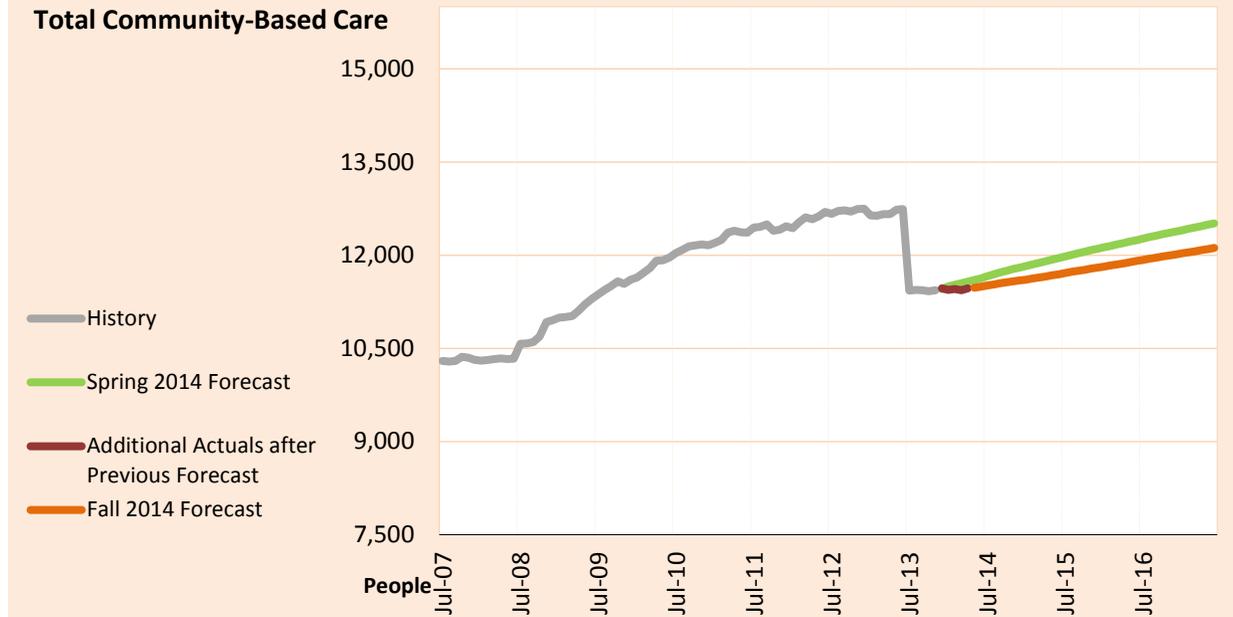
Total In-Home Services

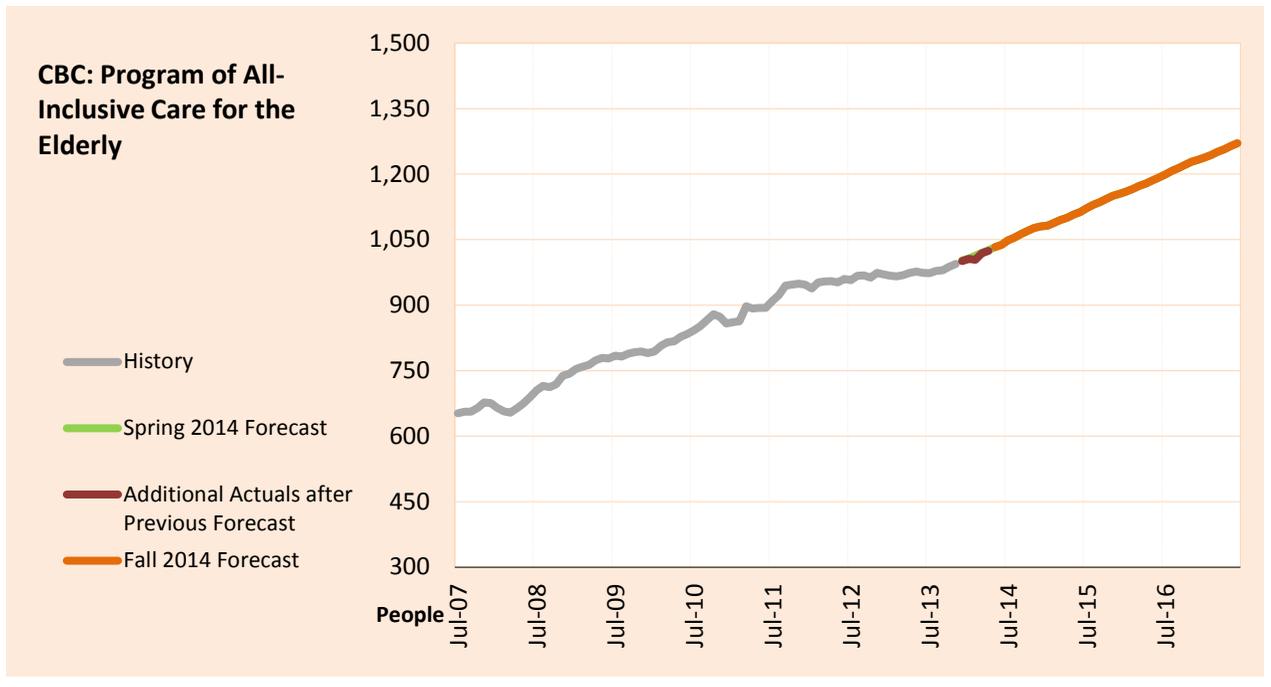
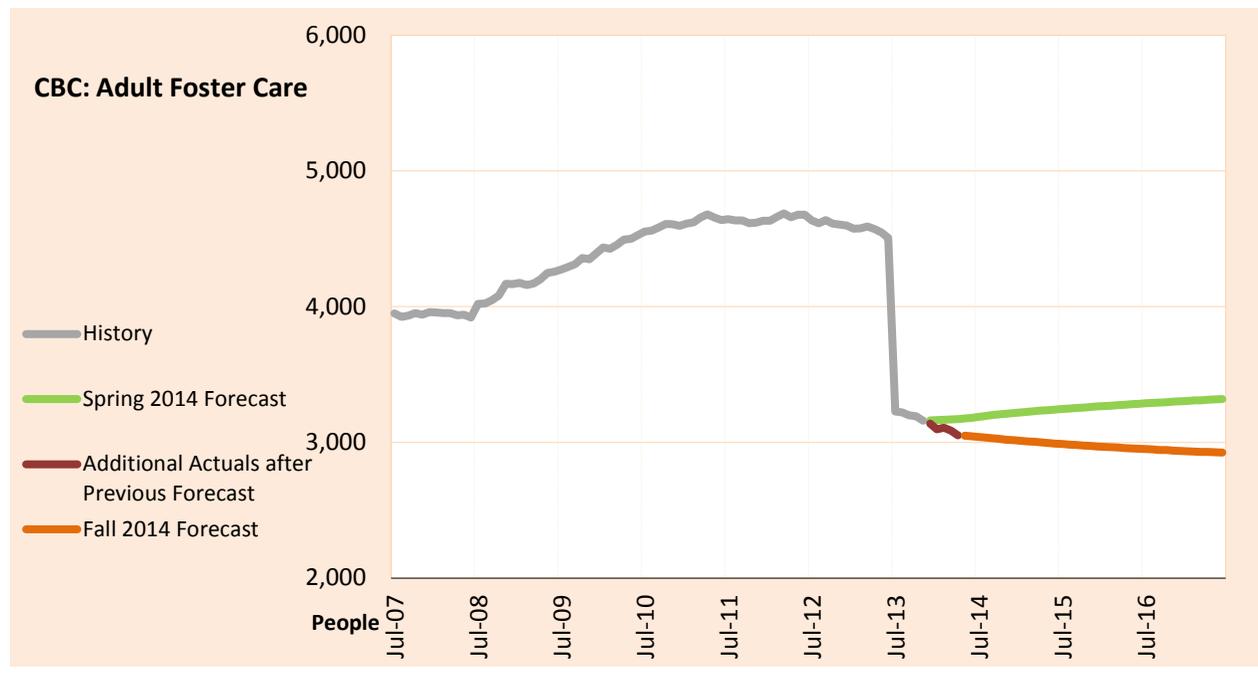
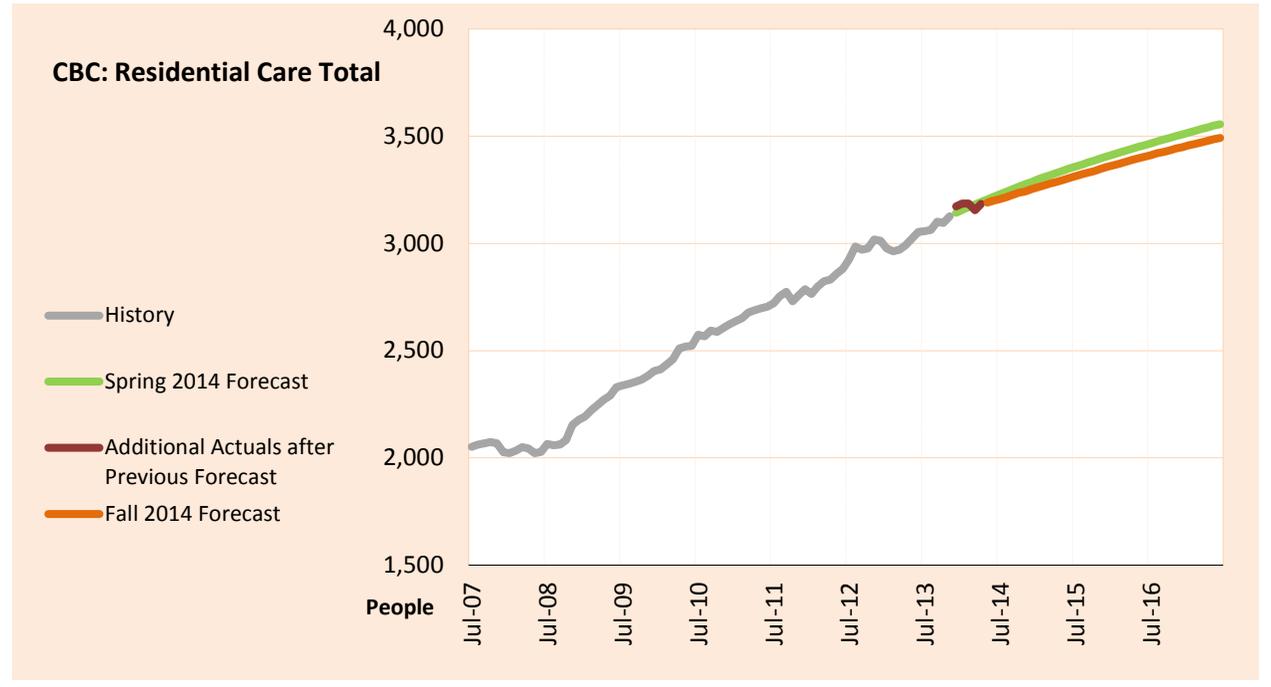
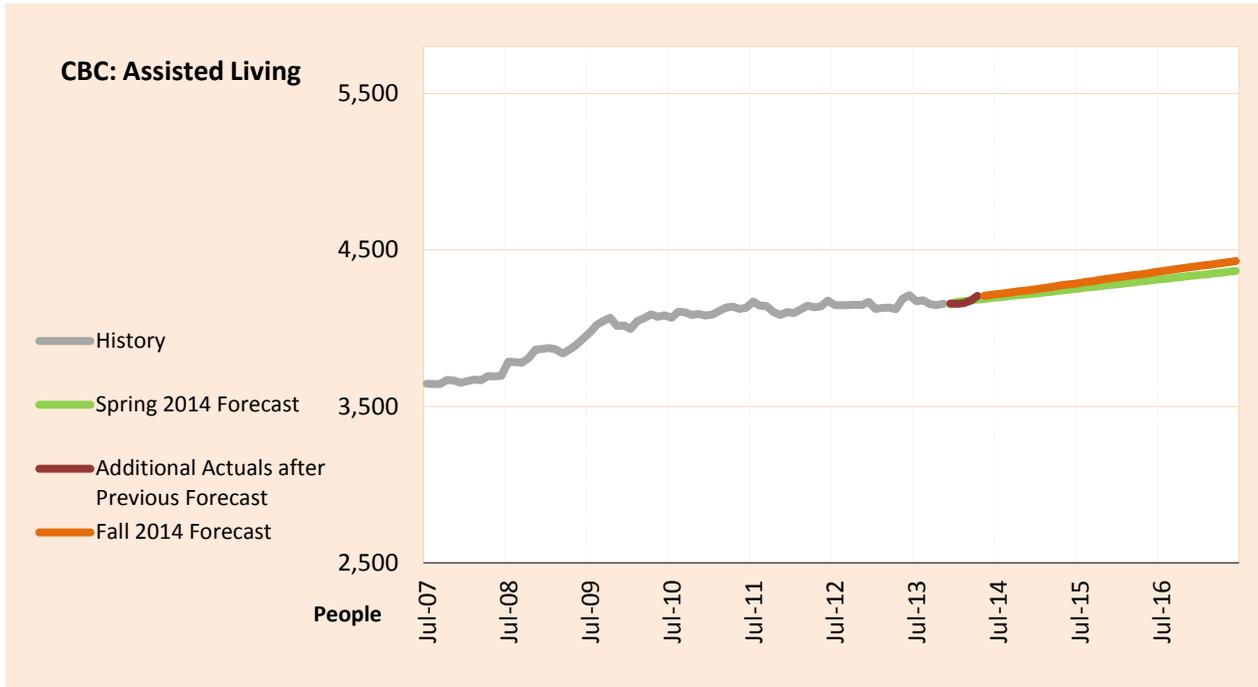


Total Nursing Facilities Care



Total Community-Based Care





Aging and People with Disabilities Biennial Average Forecast comparison

	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
In-Home Hourly without SPPC	8,846	9,136	3.3%	9,136	9,791	7.2%
In-Home Agency without SPPC	1,270	1,387	9.2%	1,387	1,508	8.7%
In-Home Live-In	1,815	1,892	4.2%	1,892	2,033	7.5%
In-Home Spousal Pay	91	92	1.1%	92	98	6.5%
Independent Choices	294	294	0.0%	294	295	0.3%
Specialized Living	180	180	0.0%	180	187	3.9%
In-Home K Plan Subtotal	12,496	12,981	3.9%	12,981	13,912	7.2%
In-Home Hourly with State Plan Personal Care	1,077	1,149	6.7%	1,149	1,242	8.1%
In-Home Agency with State Plan Personal Care	290	308	6.2%	308	332	7.8%
In-Home Non-K Plan Subtotal	1,367	1,457	6.6%	1,457	1,574	8.0%
Total In-Home	13,863	14,438	4.1%	14,438	15,486	7.3%
Assisted Living	4,196	4,211	0.4%	4,211	4,359	3.5%
Adult Foster Care	3,200	3,073	-4.0%	3,073	2,953	-3.9%
Contract Residential Care	2,189	2,158	-1.4%	2,158	2,321	7.6%
Regular Residential Care	1,028	1,042	1.4%	1,042	1,085	4.1%
Program of All-Inclusive Care for the Elderly (PACE)	1,043	1,042	-0.1%	1,042	1,197	14.9%
Community-Based Care Subtotal	11,656	11,526	-1.1%	11,526	11,915	3.4%
Basic Nursing Facility Care	3,641	3,615	-0.7%	3,615	3,456	-4.4%
Complex Medical Add-On	569	505	-11.2%	505	467	-7.5%
Enhanced Care	59	55	-6.8%	55	55	0.0%
Pediatric Care	51	44	-13.7%	44	45	2.3%
Nursing Facilities Subtotal	4,320	4,219	-2.3%	4,219	4,023	-4.6%
Total Long-Term Care	29,839	30,183	1.2%	30,183	31,424	4.1%

Intellectual and Developmental Disabilities

Historically, Oregon's LTC services were provided under the authority of a Medicaid 1915 (c) Home and Community-Based Services (HCBS) Waiver. Beginning in July 2013, Oregon also began offering services through the Community First Choice Option under 1915 (k) of the Social Security Act (referred to simply as the K Plan).

Case Management Enrollment is an entry-level eligibility, evaluation, and coordination service delivered to all individuals with intellectual and developmental disabilities. There were 22,127 clients enrolled in Case Management in April 2014, of which over 80 percent received additional I/DD services. The biennial average forecast for 2013–15 is 22,303 clients, 0.7 percent higher than the Spring 2014 forecast. The forecast for the 2015–17 biennium is 24,223 clients, a 8.6 percent increase from 2013-15.

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

Adult Services include:

Brokerage Enrollment — In general, if the volume of Brokerage clients was not capped, caseload would be expected to expand by its historical rate of growth. Because enrollment growth has slowed recently, caseload is now forecast to reach the current contractual limit of 7,805 clients by May 2015, and to remain at that level through 2015-17. Consequently, the biennial average forecast for 2013-15 is 7,650 clients, 0.7 percent less than the Spring 2014 forecast. And the biennial average forecast for 2015-17 is 7,805 clients, a 2.0 percent increase from 2013-15.

Since implementation of K Plan requires that services be provided to all eligible applicants, clients who would have used a brokerage if there was sufficient volume will be diverted to county Community Developmental Disability Programs (CDDPs) and served primarily through Comprehensive In-Home Support Services (CIHS). To estimate the volume and timing of clients likely be diverted from Brokerage services to CIHS, an uncapped forecast was prepared for Brokerage Enrollment and volume which exceeded the contractual limit for Brokerage Enrollment were added to the CIHS caseload instead. For additional information, see Comprehensive In-Home Services or the "Risks and Assumptions" section below.

24-Hour Residential Care — The biennial average forecast for 2013–15 is 2,698 clients, no change from the Spring 2014 forecast. The biennial average forecast for the 2015–17 biennium is 2,784 clients, a 3.2 percent increase from 2013-15.

Supported Living - The biennial average forecast is 706 clients for 2013-15, and 705 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 has limited capacity. Once Brokerage Enrollment reaches its current contractual limit, clients seeking support will be served by CDDPs, primarily through the CIHS program. Recent data shows Brokerage Enrollment growth continues to be slower than anticipated in the previous forecasts (Fall 2013 and Spring 2014). Consequently, the timing for when Brokerage requests will overflow into CIHS has been delayed and the biennial average forecast for 2013-15 has been reduced to 369, a 10.2 percent reduction from the Spring 2014 forecast level. The forecasted increase for 2015-17 will also be smaller – 615 clients instead of 904, which is a 66.7 percent increase from 2013-15. For additional information, see Brokerage Enrollment or the "Risks and Assumptions" section below.

I/DD Foster Care — This category serves both adults and children, with children representing approximately 18 percent. Closure of the Children Proctor Care program at the end of 2013 increased this caseload by 40 clients. Consequently, the biennial average forecast for 2013–15 is 3,079 clients, 0.3 percent higher than the Spring 2014 forecast. The biennial average forecast for 2015–17 is 3,233 clients, a 5.0 percent increase from 2013-15.

Stabilization and Crisis Unit — This category also serves both adults and children, with children representing approximately 11 percent. Caseload is expected to remain at the current level of 106 to 108 through 2015-17.

Children's Services:

In-Home Support for Children (also called Long-Term Support) — This caseload started growing rapidly following implementation of K Plan in late 2013, and is forecast to continue increasing throughout the forecast horizon. For instance, in November 2013, only 187 children were served, but by April 2014 the caseload had risen to 587 children. Even so, the actual growth began slightly later than anticipated in the Spring 2014 forecast, so the Fall 2014 forecast has been adjusted to account for that delay. As a result, the biennial average forecast for 2013-15 is 896 clients, 8.8 percent lower than the Spring 2014 forecast; and the biennial average forecast for 2015-17 is 2,041 clients, a 127.8 percent increase from 2013-15.

Growth in this caseload is due to the fact that K Plan changed the eligibility rules for children with intellectual and developmental disabilities. The new rules make almost all I/DD children eligible for service despite their family circumstances. Not known, however, is the total number of children who will now be eligible for service, or the portion of families that will want (and apply for) the newly available services. For this and other reasons, this caseload was especially difficult to forecast and the risk of error is high. For additional information, see the “Risks and Assumptions” section below.

Children Intensive In-Home Services is a category which includes Medically Fragile Children Services, Intensive Behavior Programs, and Medically Involved Program. The biennial average forecast for 2013-15 is unchanged at 400 children; and the biennial average for 2015-17 is 417 children.

Children Residential Care — Caseload is expected to grow slightly to a biennial average of 151 in 2013-15, and 160 in 2015-17 due to the addition of 16 new beds (total) in March, June, and September of 2014.

Other Services:

Employment and Day Support Activities — The biennial average forecast for 2013–15 is 4,258 clients, essentially unchanged from the Spring 2014 forecast. The biennial average forecast for 2015–17 is 4,416 clients, a 3.7 percent increase from 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. It is anticipated that these students will graduate from high school with their employment training and/or employment already in place. Consequently, the Employment First initiative may cause caseload to exceed the current forecast.

Transportation — This caseload is based on payment data that does not include services funded by local match. Since the Spring 2014 forecast, more clients have been covered by local match reduced the caseload by about 150 clients between November 2013 and April 2014. The biennial average forecast for 2013–15 is 1,879 clients, 6.5 percent lower than the Spring 2014 forecast. The biennial average forecast for 2015–17 biennium is 1,913 clients, a 1.8 percent increase from 2013-15.

Crisis Services — This caseload declined dramatically in 2009–11 due to management action. It is expected to remain at or below the current forecast level of 25 through the 2015–17 forecast.

Risks and Assumptions

The biggest risks to the intellectual and 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 affecting I/DD adults is “opening” of the Brokerage wait list, which is expected to cause **Brokerage Enrollment** to climb to the current contractual and budgetary limit of 7,805 clients by June 2015. Since K Plan requires that services be provided to all eligible applicants and brokerages will be at capacity, Brokerage Enrollment growth that cannot be served due to capacity limitations will instead be served through county Community Developmental Disability Programs (CDDPs), primarily in the category called **Comprehensive In-Home Services**.

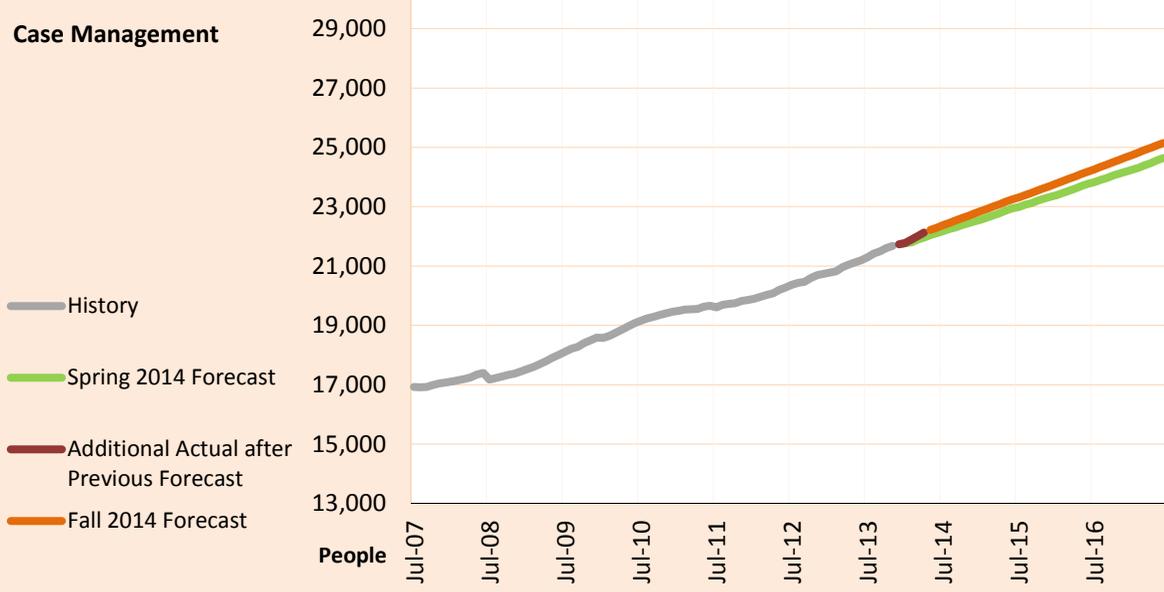
This caseload will be funded through K Plan rather than through Waiver services and does not require having a service cost of greater than \$21,833 per year. Thus, it can serve additional clients diverted from Brokerage to CDDP. Since Comprehensive In-Home Services is a small program, clients diverted due to Brokerage capacity limitations are expected to swell the caseload to several times its current size by the end of 2015-17. Conversely, if Brokerage capacity is increased, Comprehensive In-Home Services growth, or some portion of it, could be reversed.

The most significant change affecting I/DD children is that with K Plan many more children will qualify for **In-Home Support for Children** since eligibility is based on the income of the child, not their family. The In-Home Support caseload averaged fewer than 200 prior to K Plan, but is now expected to grow to more than 2,000 by the end of 2015-17 biennium. Accurately estimating the increase is difficult for a variety of reasons. Processing of applications for In-Home Support under K Plan began slowly in November 2013, but escalated rapidly in early 2014. Since the change began so recently, data is not yet available to show the new volume, rate of growth, or patterns of service. To further complicate matters, Client Process Monitoring System processing backlogs have increased the lag time needed before caseload counts can be considered complete.

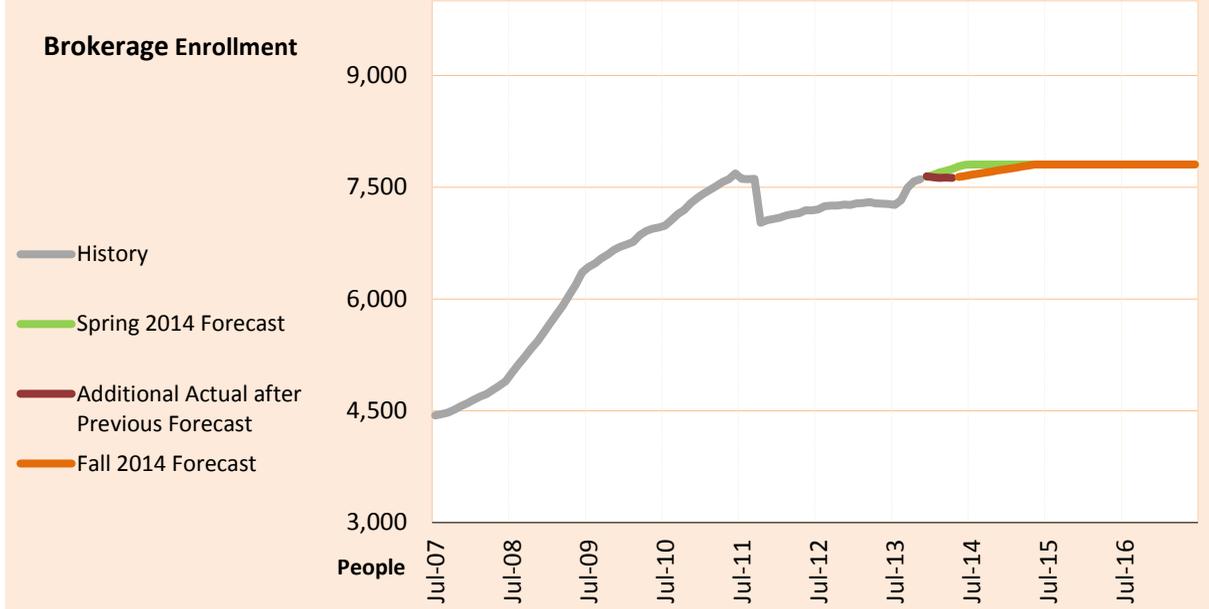
To forecast the likely volume of In-Home Support for Children clients for the Spring 2014 forecast, the 6 largest CDDPs were surveyed about their current and anticipated service volume. The counties surveyed (Clackamas, Deschutes, Lane, Marion, Multnomah and Washington) represent approximately two-thirds of all I/DD clients. The resulting forecast was developed based on 1) the pool of “potential” applicants (currently defined as children enrolled in Case Management but using no other services), 2) results of the CDDP survey prorated to reflect the full state, 3) extensive discussion with the I/DD Caseload Forecast Advisory Committee, and 4) forecaster's judgment. For the Fall 2014 forecast, the Spring 2014 forecast was adjusted slightly to reflect additional months of data which support the anticipated pattern, but with a delayed start date. It should also be noted that there may be families with I/DD children who have not yet enrolled in Case Management, in which case the pool of potential clients for may be larger than what was used to generate these forecasts. Program staff believe this number is small.

In addition to creating forecasting and budgeting challenges, K Plan also created capacity challenges for the CDDPs and their provider networks. To receive services, enrollees’ Medicaid eligibility must be established and an individual Plan of Care created within 60 days of the initial application for services. In addition to the new administrative requirements, initial implementation of K Plan was delayed by five months creating a compressed enrollment period and making the CDDPs workload backlog even larger. CDDP staff workload capacity, and provider service capacity, may impact the entry of new clients into services, particularly the services growing most quickly: Comprehensive In-Home Services and In-Home Support for Children. Going forward, an electronic I/DD Plan of Care that is compatible with K Plan eligibility requirements is expected to improve efficiency and be operational in fall 2014.

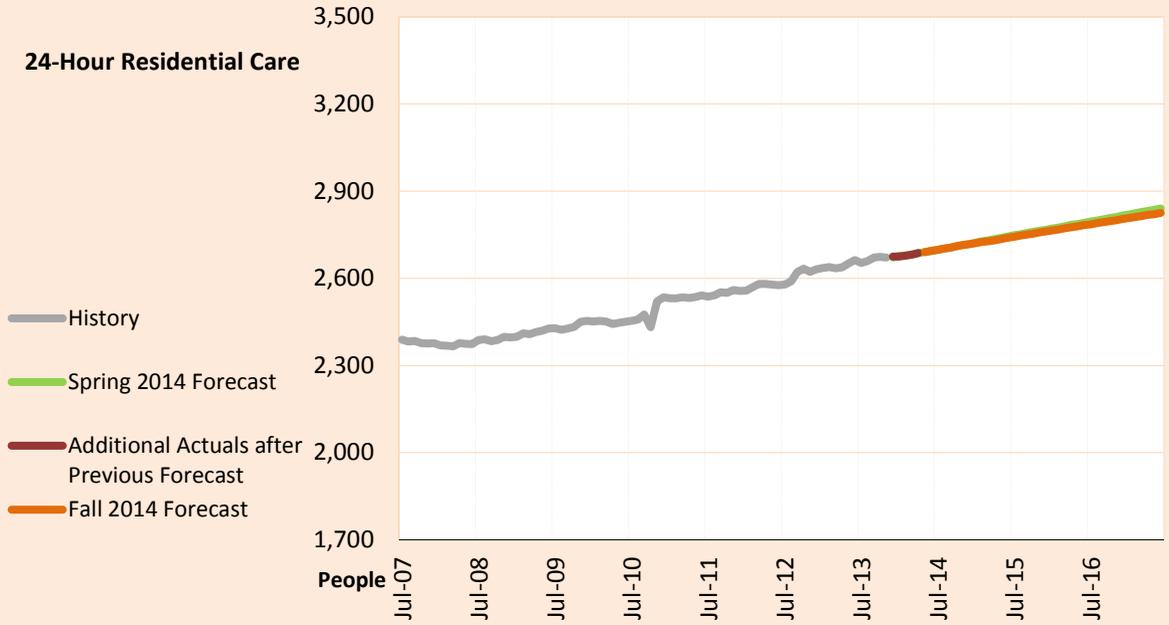
Case Management



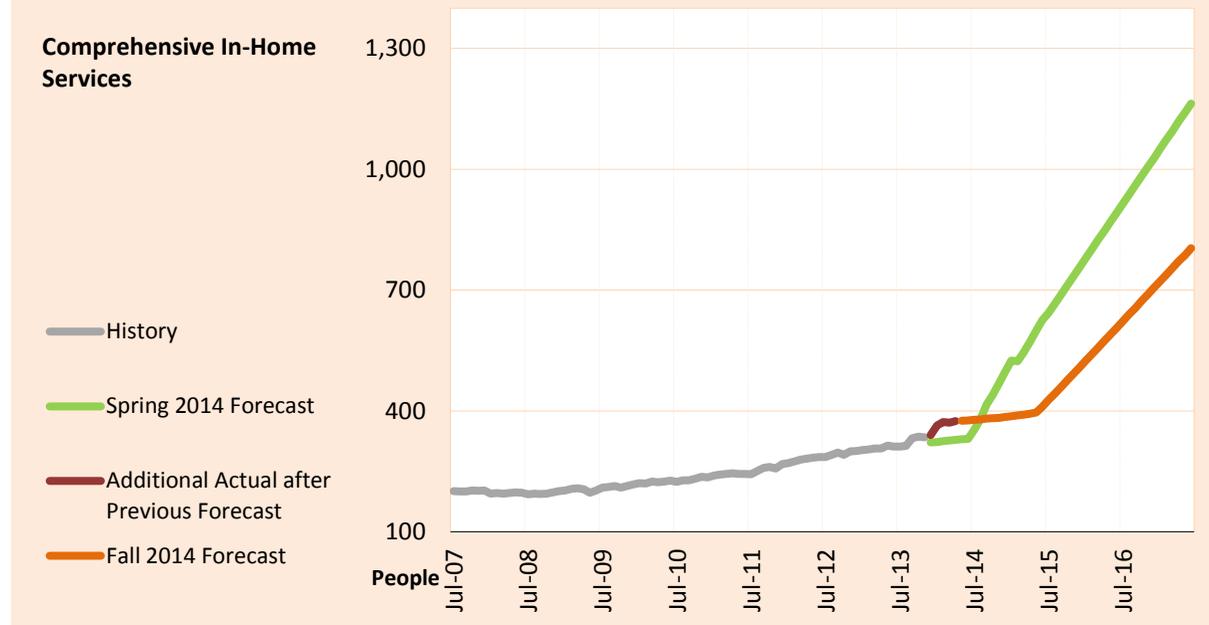
Brokerage Enrollment



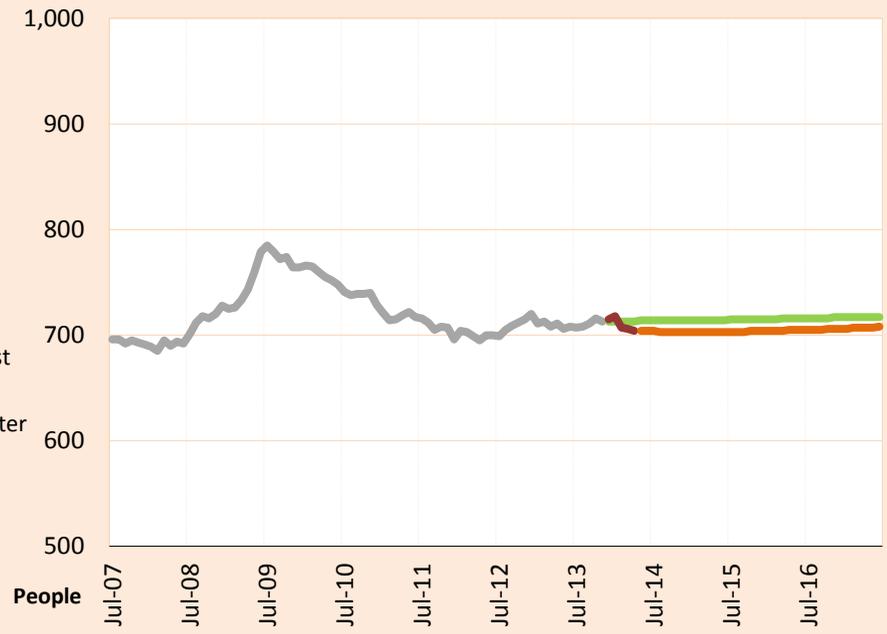
24-Hour Residential Care



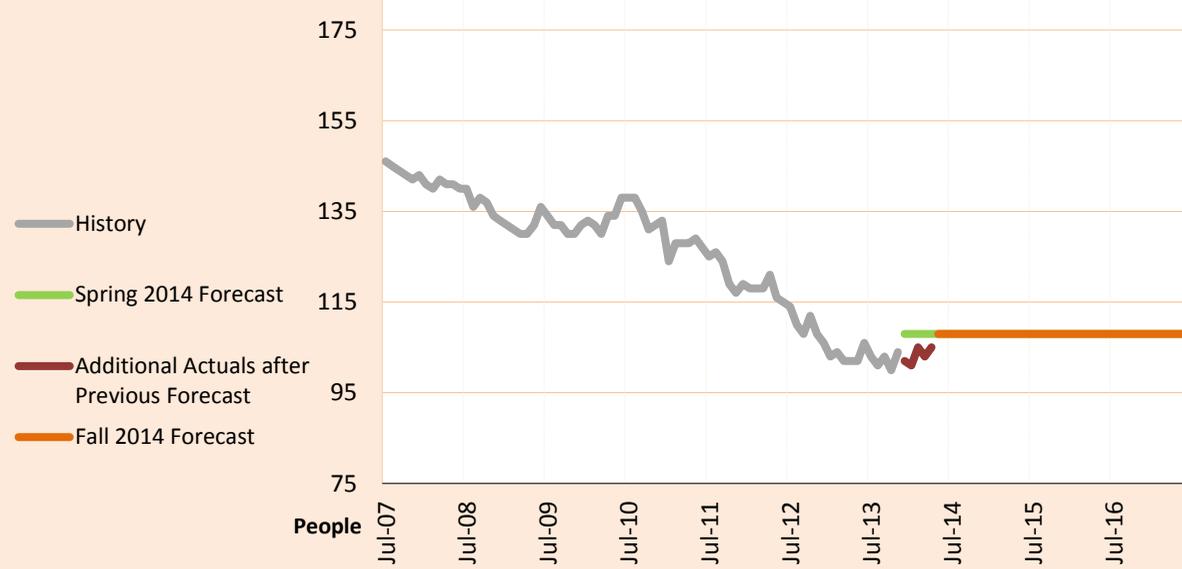
Comprehensive In-Home Services



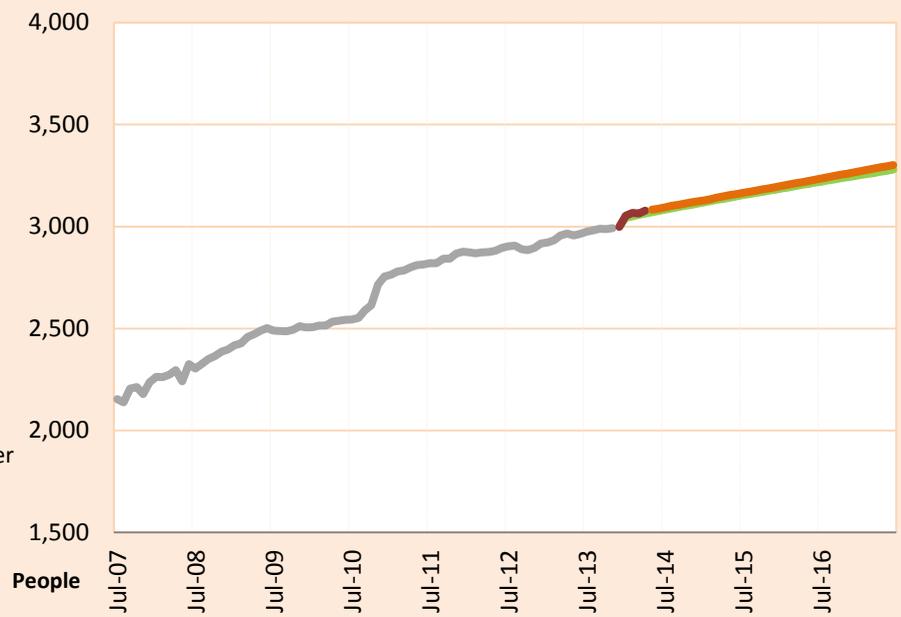
Supported Living



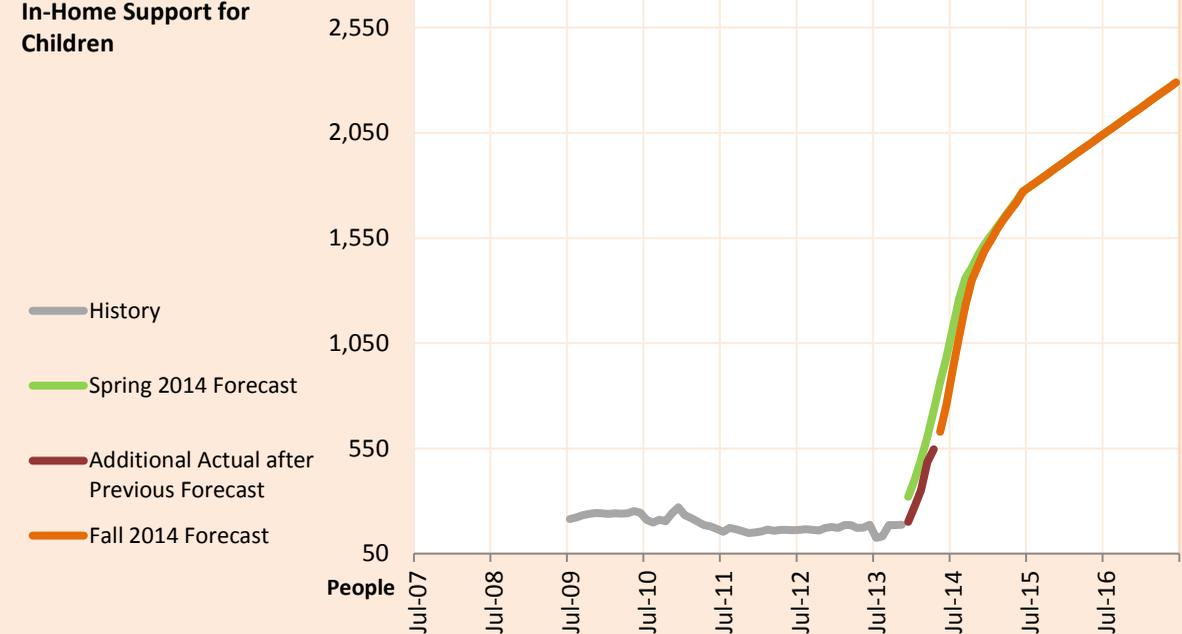
Stabilization and Crisis Unit



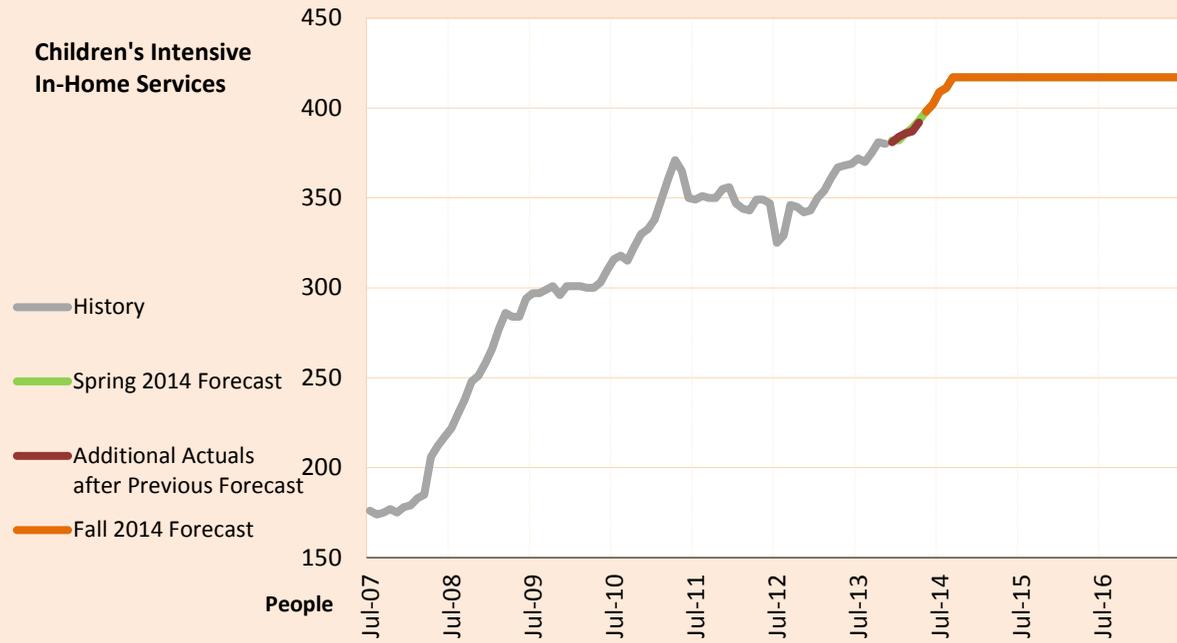
I/DD Foster Care



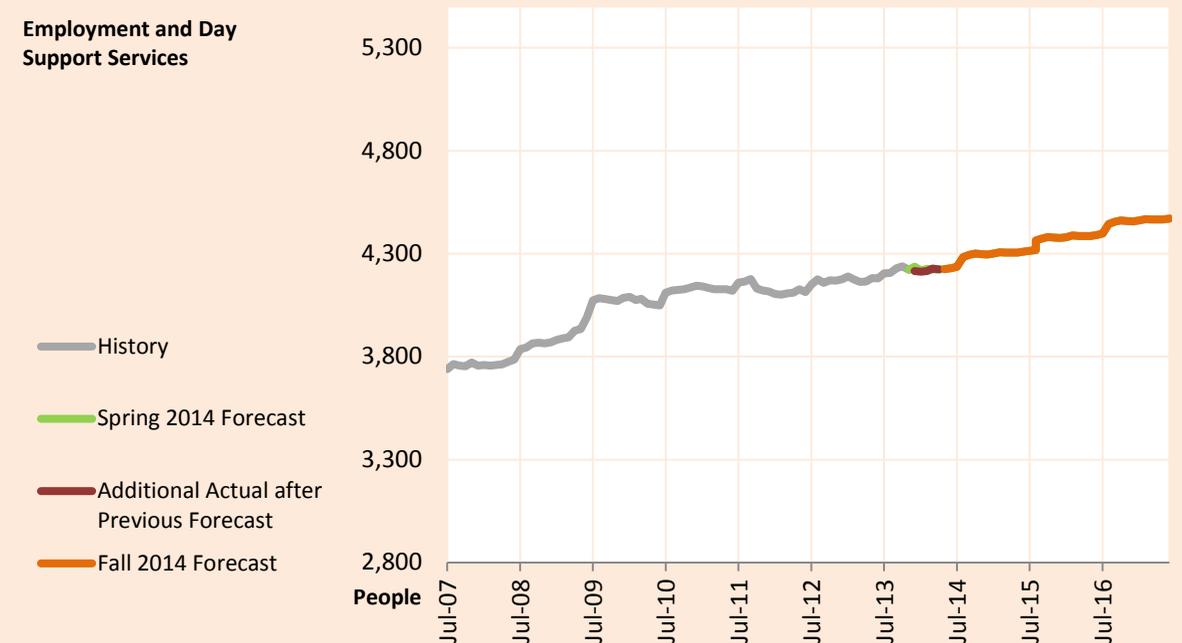
In-Home Support for Children



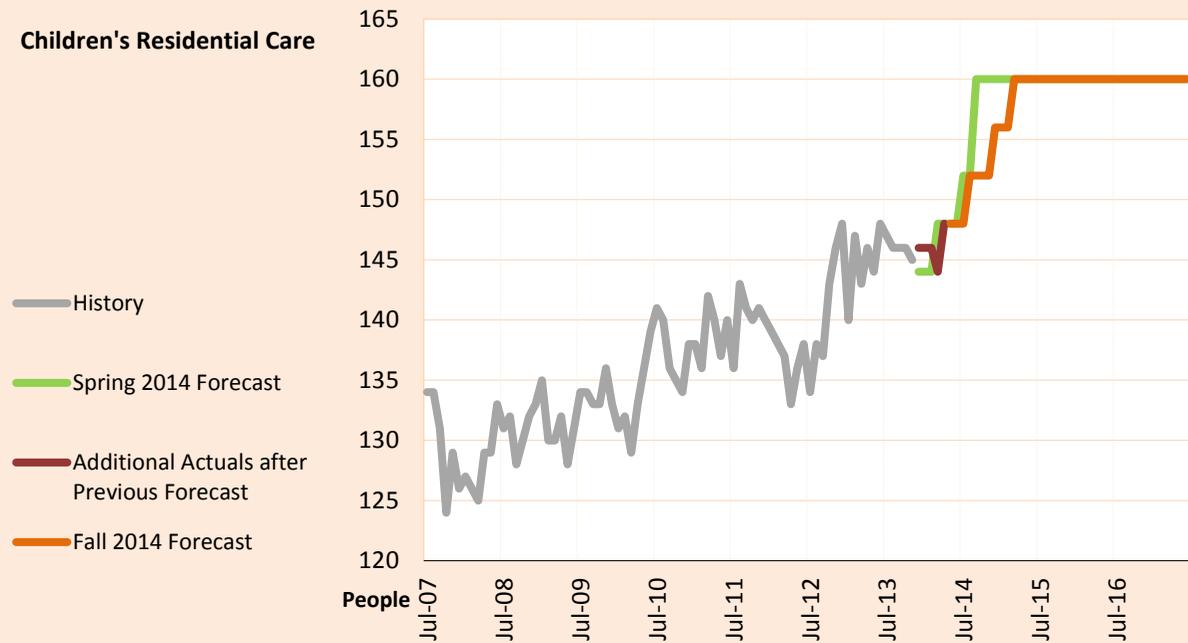
Children's Intensive In-Home Services



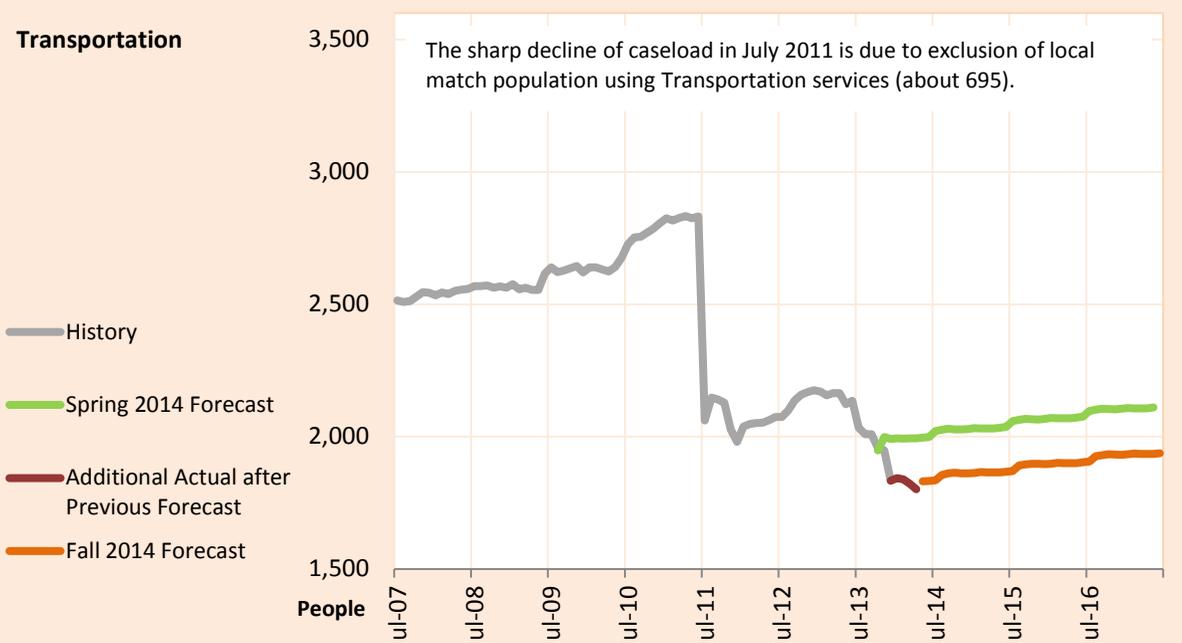
Employment and Day Support Services



Children's Residential Care



Transportation



Intellectual and Developmental Disabilities Biennial Average Forecast comparison

	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Total Case Management Enrollment¹	22,139	22,303	0.7%	22,303	24,223	8.6%
Adult						
Brokerage Enrollment	7,707	7,650	-0.7%	7,650	7,805	2.0%
24-Hour Residential Care	2,698	2,698	0.0%	2,698	2,784	3.2%
Supported Living	713	706	-1.0%	706	705	-0.1%
Comprehensive In-Home Services ²	409	369	-9.8%	369	615	66.7%
I/DD Foster Care ³	3,070	3,079	0.3%	3,079	3,233	5.0%
Stabilization and Crisis Unit ³	107	106	-0.9%	106	108	1.9%
Children						
In-Home Support for Children ⁴	982	896	-8.8%	896	2,041	127.8%
Children Intensive In-Home Support	400	400	0.0%	400	417	4.3%
Children Residential Care	152	151	-0.7%	151	160	6.0%
Children Proctor Care ⁵	13	12	-7.7%	12	0	NA
Total I/DD Services	16,251	16,067	-1.1%	16,067	17,868	11.2%
Other DD Services						
Employment & Day Support Activities	4,260	4,258	0.0%	4,258	4,416	3.7%
Transportation	2,010	1,879	-6.5%	1,879	1,913	1.8%
Crisis Services	54	31	-42.6%	31	25	-19.4%

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

2. The Comprehensive In-Home Services biennial average for 2015-17 is expected to be significantly higher than 2013-15 due to clients entering this category instead of Brokerages due contractual limitations on the number of Brokerage clients.

3. Foster Care and the Stabilization and Crisis Unit serve both adults and children: (I/DD FC - 82% / 18%; SACU - 89% / 11% respectively).

4. In-Home Support caseload is expected to increase significantly in 2015-17 due to K Plan implementation, but at a slower rate than anticipated in the Spring 2014 forecast.

5. Children Proctor Care was closed in December 2013; caseload transferred primarily to I/DD Foster Care and other I/DD Children services including In-Home Support.

Oregon Health Authority



Total Oregon Health Authority Biennial Average Forecast Comparison

	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Medical Assistance Programs						
OHP Plus						
ACA Adults	212,496	246,675	16.1%	246,675	315,000	27.7%
Parents/Caretaker Relative ¹	NA	74,859	NA	74,859	69,512	-7.1%
Old Age Assistance	37,280	37,442	0.4%	37,442	39,944	6.7%
Pregnant Woman Program ²	14,098	16,611	17.8%	16,611	14,780	-11.0%
Aid to the Blind & Disabled	84,657	83,797	-1.0%	83,797	85,456	2.0%
Children's Medicaid Program ³	NA	308,052	NA	308,052	307,000	-0.3%
Children's Health Insurance Program	72,382	77,127	6.6%	77,127	75,245	-2.4%
Foster, Substitute & Adoption Care	18,683	18,753	0.4%	18,753	18,753	0.0%
Previously used caseloads						
TANF Medical ^{1, 3}	188,538	NA	NA	NA	NA	NA
Poverty Level Medical - Children ³	179,103	NA	NA	NA	NA	NA
Total OHP Plus	807,237	863,316	6.9%	863,316	925,690	7.2%
Total Other Medical Assistance Programs	50,978	57,059	11.9%	57,059	63,067	10.5%
OHP Standard ⁴	15,444	15,444	0.0%	15,444	NA	NA
Total Medical Assistance Programs	873,659	935,819	7.1%	935,819	988,757	5.7%
Addictions and Mental Health						
Aid & Assist ⁵	178	158	NA	158	168	6.3%
Guilty Except for Insanity (GEI) ⁶	673	610	NA	610	595	-2.5%
Civil Commitment ^{6, 7}	3,389	1,020	NA	1,020	990	-2.9%
Total Mandated Care	5,115	1,788	NA	1,788	1,753	-2.0%

1. Parent/Caretaker Relative is a new caseload group for adults under 42% FPL. This caseload used to be part of the TANF Medical caseload.

2. Pregnant Woman Program is a new name for Poverty Level Medical - Women.

3. Children's Medicaid Program is a new group for children previously in TANF Medical, Poverty Level Medical - Children, and CHIP under 133% FPL.

4. OHP Standard program closed on Dec 31, 2013.

Starting with the Fall 2014 forecast cycle, the Mental Health caseload categories have been redefined.

5. In prior forecasts some clients were counted more than once. With the new definitions, each client is counted only once for any given month.

6. The old Civil Commitment caseload included everyone receiving service who had been civilly committed at some point in time. The new definition counts only clients who are currently under commitment (although a proxy rule is being used to estimate the end date for clients' mandated service).

7. Prior forecasts did not include these two caseload categories.

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), implementation of the Oregon Healthy Kids Initiative in July 2009, and implementation of the Patient Protection and Affordable Care Act of 2010 (ACA) in January 2014. Taken together, these three factors drove the total MAP caseloads from about 408,000 clients prior to the recession to about 1,000,000 clients by January 2014, for a net increase of 592,000 clients (145 percent). The impact of ACA reform was by far the largest ever experienced.

The most significant 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 added more than 315,000 adults to the OHP Plus caseload (including 60,000 who were transferred from the discontinued program called OHP Standard) and about 12,000 adults to the CAWEM group. Other impacts of ACA reform include:

1. “Welcome Mat” effect – Not everyone who is eligible for public programs, participates in them. When public programs are expanded, new enrollment often occurs not only among the newly eligible, but also among the previously eligible populations. Parent/Caretaker Relative, Pregnant Woman, CHIP, and Children’s Medicaid Program caseloads all experienced a welcome mat effect due to ACA reform. However, the exact magnitude is hard to estimate due to other impacts of the reform, such as deferred redetermination and new coverage alternatives (see below).
2. Deferred redeterminations – ACA reform created workload management challenges. To prepare for the influx of new applications and enrollments due to expansion, OHA asked CMS for approval to defer scheduled redeterminations for a six month period. As a result of these deferred redeterminations, fewer people exited than normal, resulting in higher total caseloads. Almost all caseloads were impacted to some degree by the deferred redeterminations. The caseloads most impacted include: Parent/Caretaker Relative, Pregnant Woman Program, Children’s Medicaid Program, CHIP, and CAWEM.
3. Availability of alternative coverage – Some caseloads declined due to the avail-

ability of regular OHP coverage for more low income adults than in the past. This effect was observed in BCCP and ABAD.

Risks and Assumptions

There are still a lot of uncertainties surrounding ACA reform, the biggest known risks to the accuracy of the current forecast are: 1) deferred redeterminations, 2) October 2014 open enrollment and the Federal Exchange operation, and 3) data quality.

The first major risk arises from temporary changes made to eligibility redetermination timelines. Typically, a client is enrolled for a 12-month period, and prior to the end of that coverage, the case is scheduled for a review. At that time, a new determination is made whether the person is 1) still eligible for coverage in the same group, 2) eligible for coverage in a different group, or 3) no longer eligible for coverage. Redeterminations scheduled for October 2013 – March 2014 were initially deferred for six months, and then deferred again. Consequently, there will be an intensive period of redeterminations occurring from roughly November 2014 through February 2015, after which the normal schedule for redeterminations should resume. To the extent possible, the Fall 2014 forecast incorporates the impact of these deferred redeterminations. However, operational details continue to change, data is limited, and there is no precedent to use for how this will impact caseload during the deferment period or when redeterminations resume.

The second major risk is associated with the upcoming open enrollment period starting November 2014 and ending March 2015, and operation of the Federal Exchange. While it is expected that enrollment will increase, there are no estimates of how many additional people might enroll. In addition, there are uncertainties around how smoothly the process will go and how agency workload will be impacted.

The third major risk is associated with the quality of data available. Implementation of ACA created an array of changes that impacted the quality of data and disrupted the time series critical for forecasting. In general, the forecast is built using three main components: exits, transfers, and new clients. For each given month, the caseload is calculated as the previous month caseload, plus new clients, plus transfers in from other caseloads, minus exits, and minus transfers out.

ACA severely impacted all three of these components:

1. Exits declined due to deferred redeterminations.
2. Transfer patterns between caseloads changed due to reorganization of some existing caseloads and addition of the new ACA Adults caseload. In addition, transfers declined because most transfers occur at redetermination.
3. New client patterns have changed for some of the caseload groups due to the availability of alternative coverage, such as ACA Adults. In addition, deferred redeterminations reduced administrative “churn”, causing fewer people to temporarily drop off caseload due to incomplete paperwork and then return as new clients.

ACA Adults, the new OHP Plus caseload group, is expected to reach 315,000 by March 2015 and will account for 34 percent of OHP Plus total caseload. Former OHP Standard enrollees transferred into this group (about 60,000) as of January 2014. Similar to OHP Standard, this group is split into two sub-groups: ACA Adults with Children (similar to Standard – Families) and ACA Adults without Children (similar to Standard – Adults & Couples). ACA Adults with Children and without Children are expected to be 26 percent and 74 percent respectively. Starting with the Spring 2015 forecast, the ACA Adult subgroups will be changed from family composition to age cohorts.

Parent/Caretaker Relative Program, previously known as TANF Medical adults, is expected to be 73,200 by March 2015 and will account for 7.9 percent of the OHP Plus caseload. The signs of a growing economy were evident, as Parent/Caretaker Relative caseload was declining steadily prior to ACA reform. Without ACA expansion, Parent/Caretaker Relative caseload was expected to continue to decline. However, due to the welcome mat effect of ACA reform and deferred redeterminations, the Parent/Caretaker Relative caseload is expected to reach 81,000 by October 2014 when is expected to start declining.

Pregnant Woman Program, previously known as Poverty Level Medical – Women (PLMW), is expected to be 14,400 by March 2015, accounting for 1.6 percent of the OHP Plus caseload. Without ACA expansion, this group was expected to continue the historical pattern of slow, steady increases with some seasonal variability. As with the Parent/Caretaker Relative caseload, this group is also impacted by the welcome mat

effect and deferred redeterminations. This caseload will continue growing, reaching 23,000 by Oct 2014, after which it is expected to drop rapidly.

Children’s Medicaid Program, was previously known as Poverty Level Medical – Children (PLMC). This caseload now contains children who would previously have been included in the TANF Medical caseload and children 6-18 years of age with family incomes under 133 percent FPL who would previously have been included in the CHIP caseload. This caseload is expected to reach 307,000 by March 2015, accounting for 33.1 percent of OHP Plus caseload.

Children’s Health Insurance Program (CHIP) is expected to be 75,200 by March 2015 and will account for 8.1 percent of OHP Plus caseload.

Foster, Substitute, and Adoption Care is expected to be 18,700 by March 2015 and will account for two percent of OHP Plus caseload. Current estimates are for this caseload to remain relatively stable and grow at a very slow pace through the forecast horizon.

Aid to the Blind and Disabled (ABAD) is expected to be 84,500 by March 2015 and will account for 9.1 percent of OHP Plus caseload. This group has grown consistently over several years and is expected to continue growing at a slightly slower pace than in the past. Program staff anticipate that the number of clients entering this caseload may decline somewhat (slowing the overall rate of growth) when low income adults become eligible for medical coverage without having to first be officially determined to be disabled.

Old Age Assistance (OAA) is expected to be 38,600 by March 2015 and will account for 4.2 percent of OHP Plus 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.

Other Medical Assistance Programs

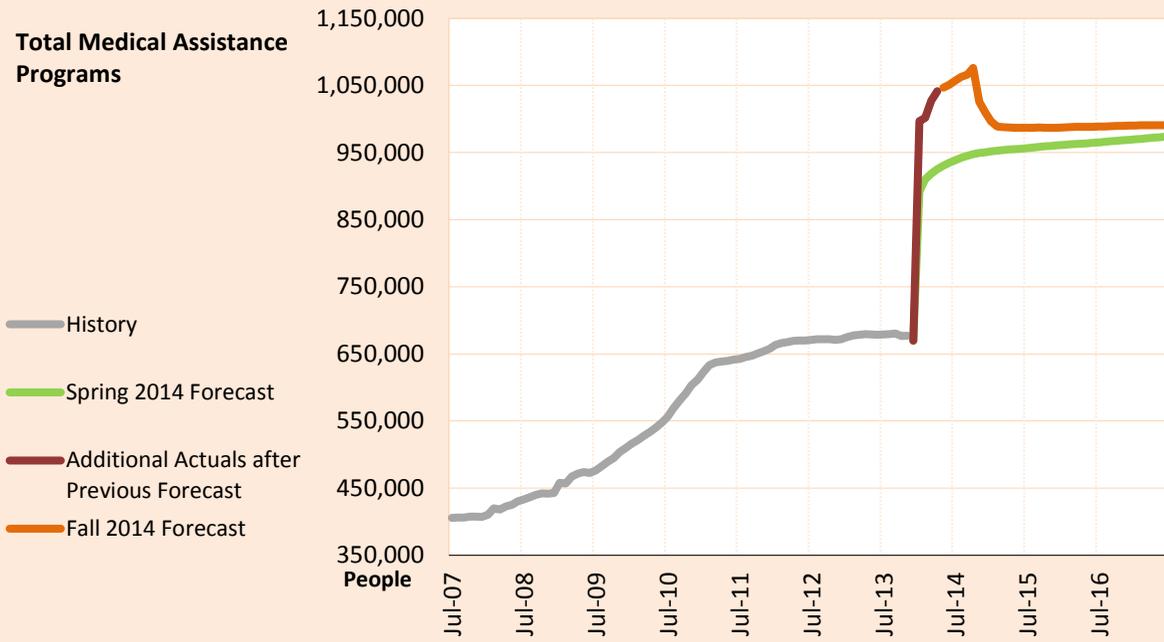
Citizen-Alien Waived Emergent Medical (CAWEM) is expected to be 36,100 by March 2015 and will account for 59 percent of the Other MAP caseload. This caseload has two subcomponents: 1) the regular program, which covers only emergency medical services, and 2) the prenatal program, which also covers prenatal services. CAWEM eligibility

uses the same rules as Medicaid except for the citizenship/residency requirement. Consequently, when Medicaid expanded due to ACA, this category expanded as well – both for adults up to 138 percent of FPL and children with family incomes of 200-300 percent of FPL.

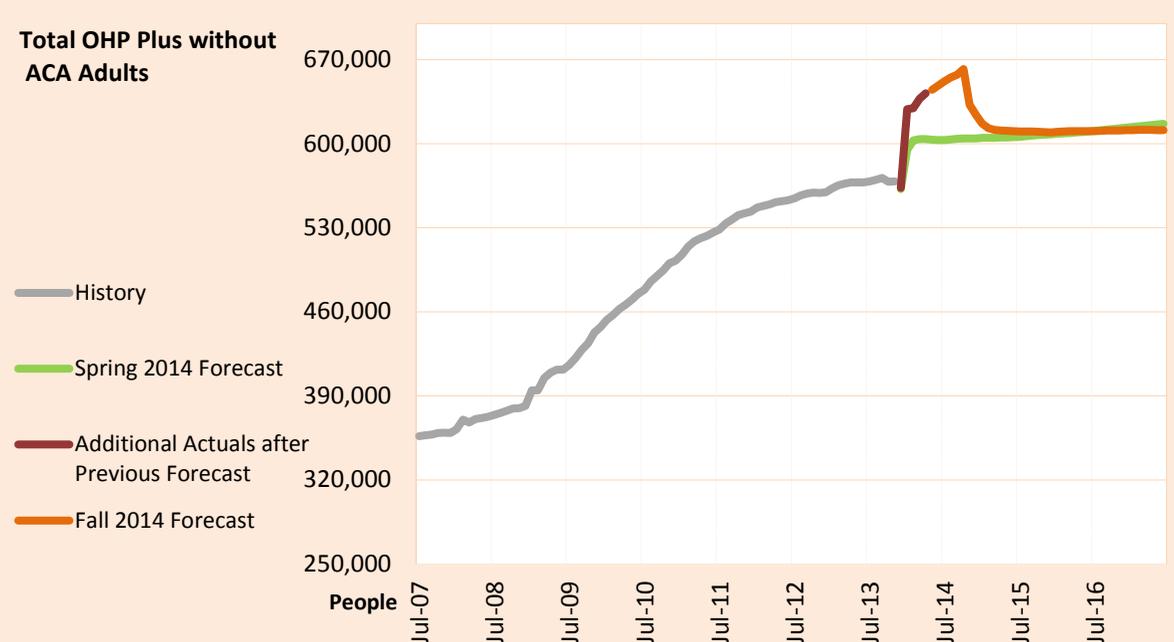
Qualified Medicare Beneficiary (QMB) is expected to be 24,000 by March 2015 and will account for 39.9 percent of Other MAP caseload. This caseload has grown at a consistent rate since January of 2009 and is expected to continue this growth pattern through the forecast horizon.

Breast and Cervical Cancer Program (BCCP) is expected to be 712 by March 2015 and will account for 1.1 percent of the Other MAP caseload. Forecasting this caseload is something of a moving target because the caseload is directly tied to the number of ‘screenings’ completed via Oregon Public Health, which itself varies based on funding and is only offered to women who are uninsured. The number of screenings conducted has varied over time with the most recent ‘increase’ implemented in 2012. Due to ACA reform, this caseload is expected to decline significantly as the number of uninsured women declines, resulting in fewer who need screenings through Public Health.

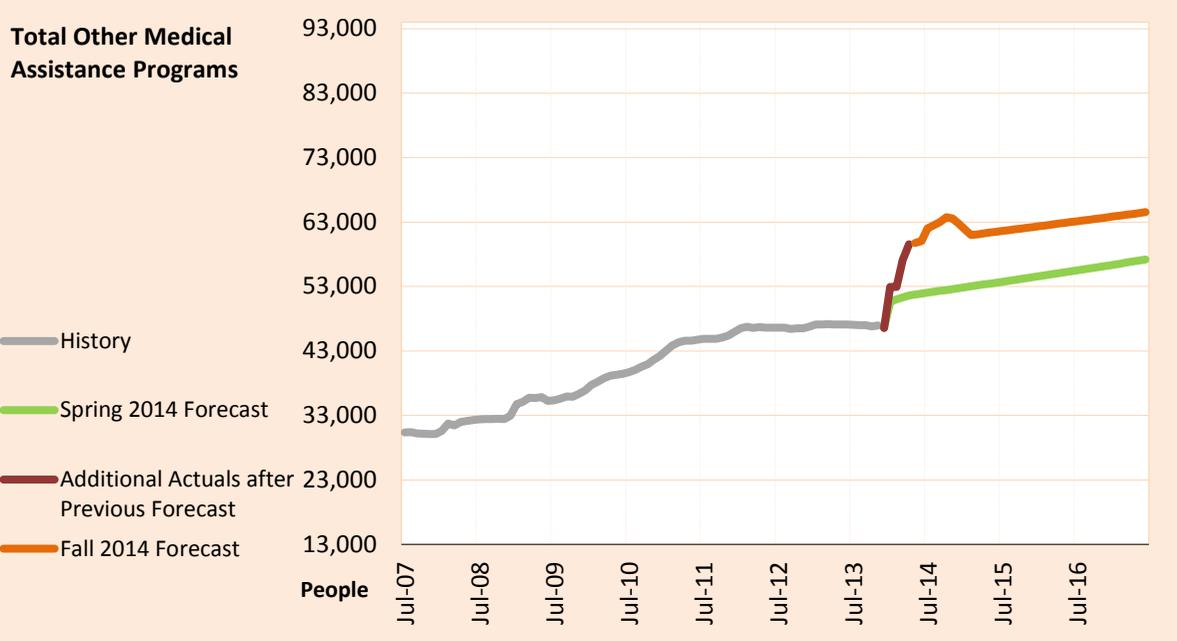
Total Medical Assistance Programs



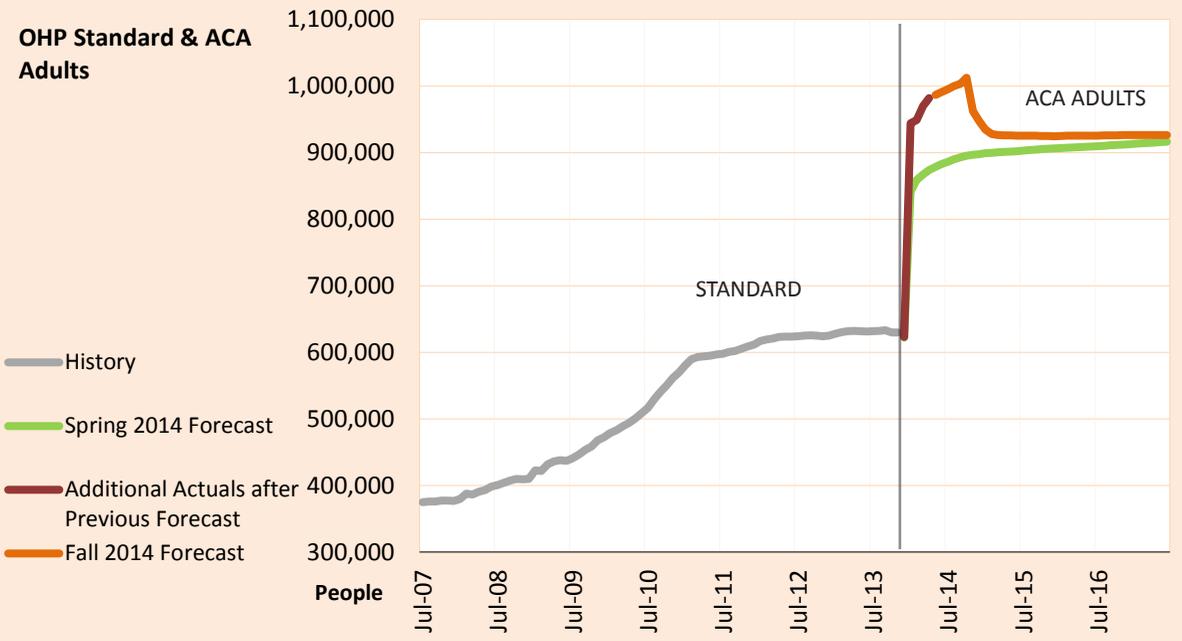
Total OHP Plus without ACA Adults



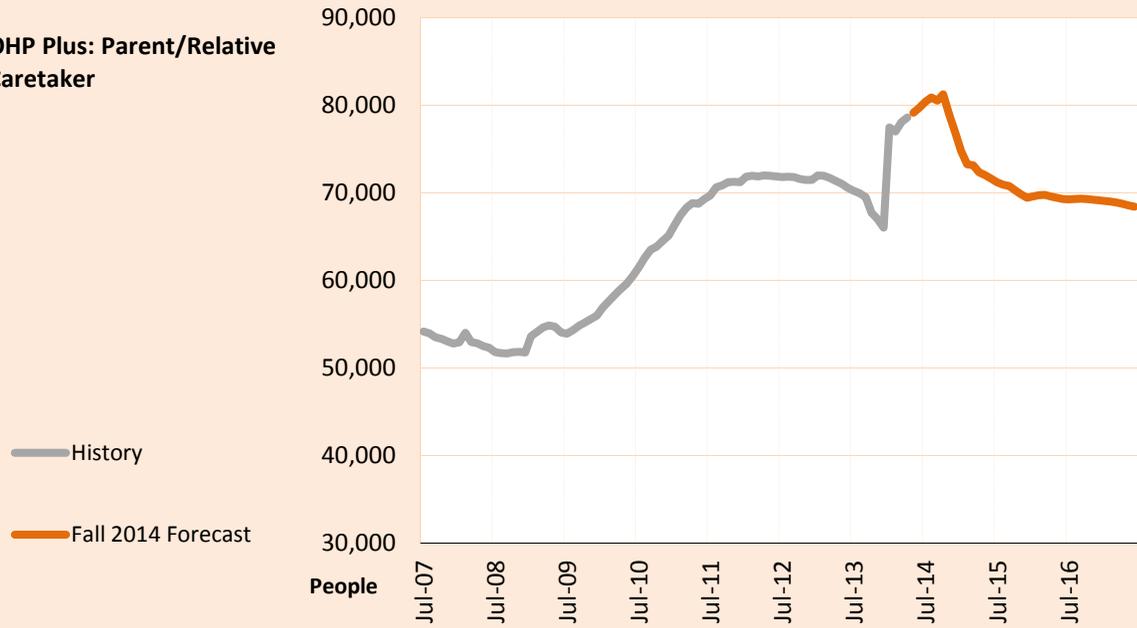
Total Other Medical Assistance Programs



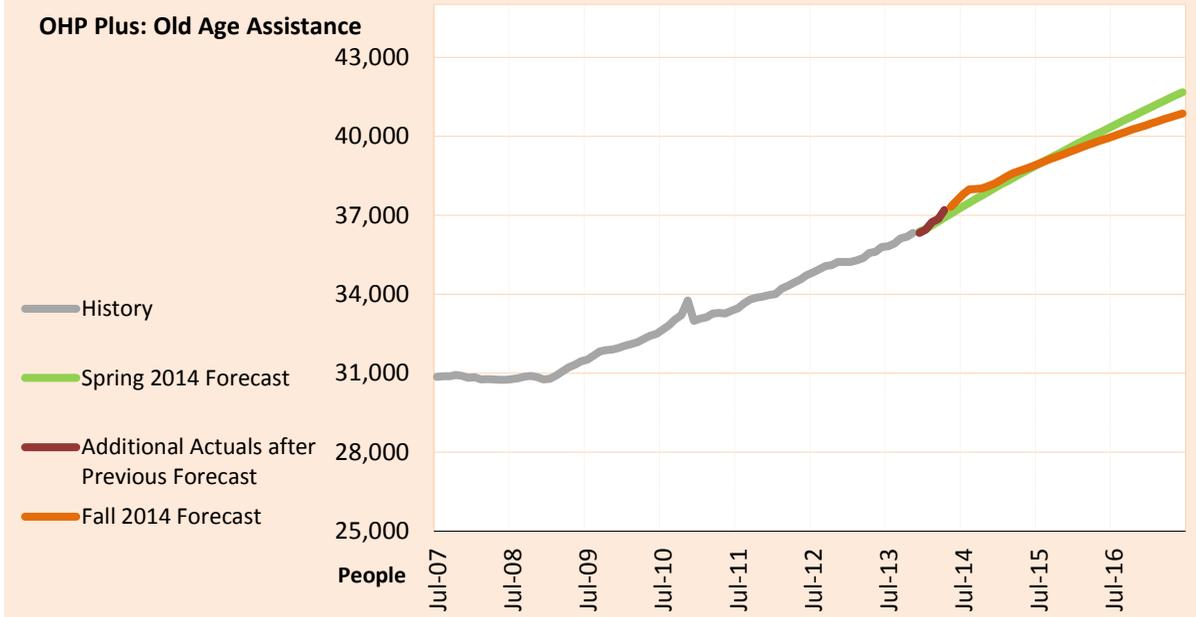
OHP Standard & ACA Adults



OHP Plus: Parent/Relative Caretaker



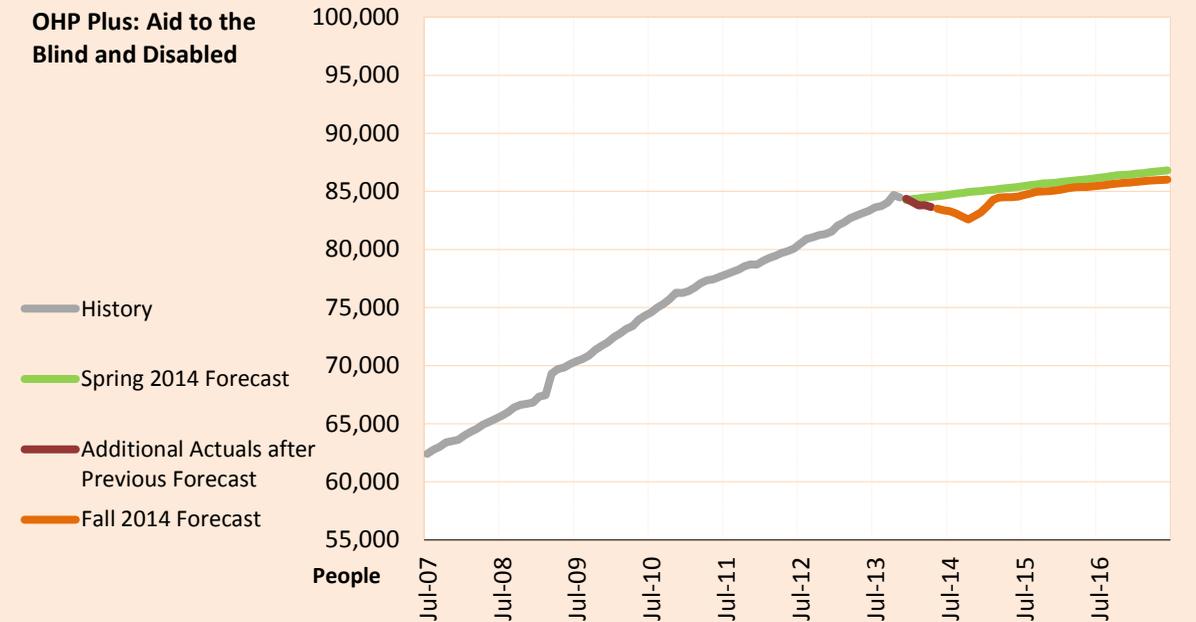
OHP Plus: Old Age Assistance



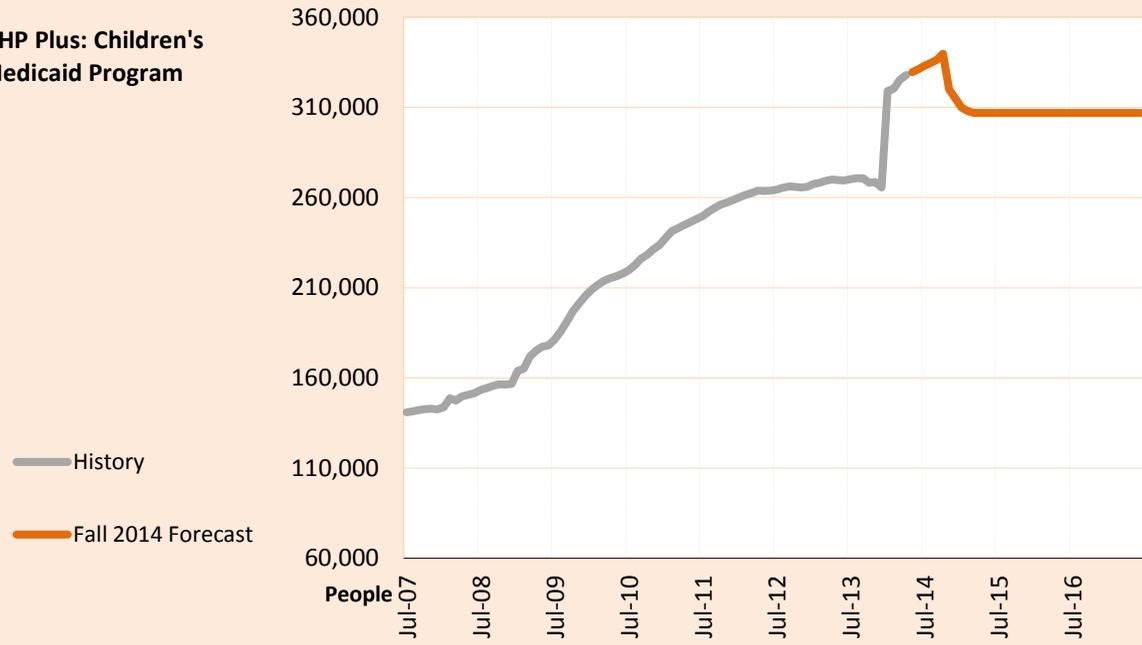
OHP Plus: Pregnant Woman Program



OHP Plus: Aid to the Blind and Disabled



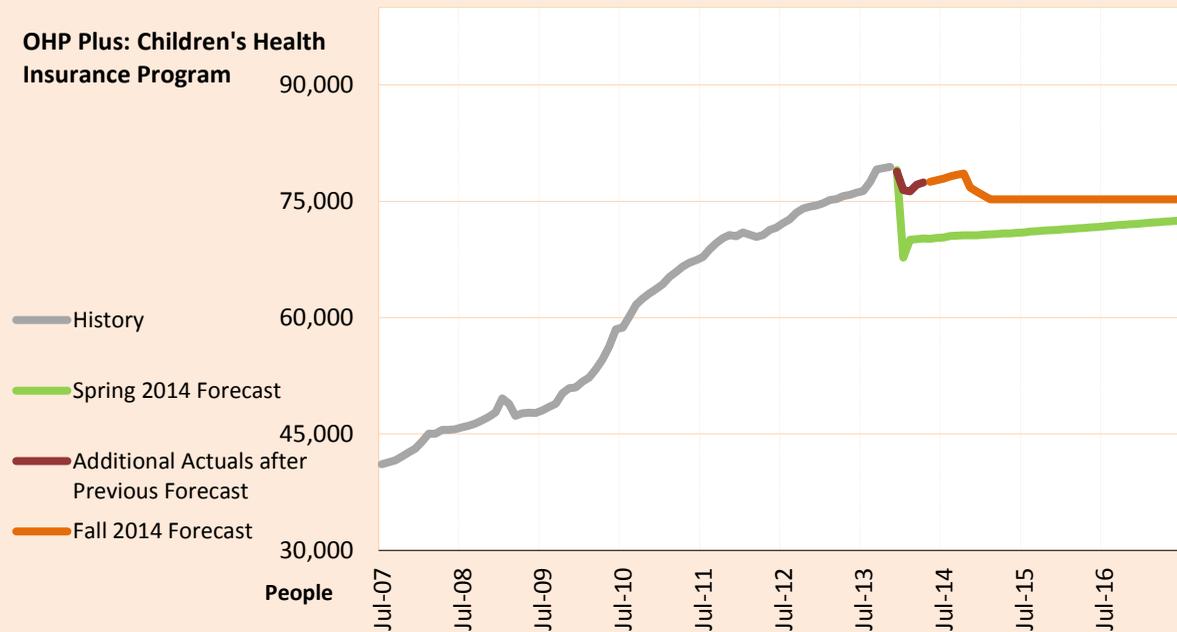
OHP Plus: Children's Medicaid Program

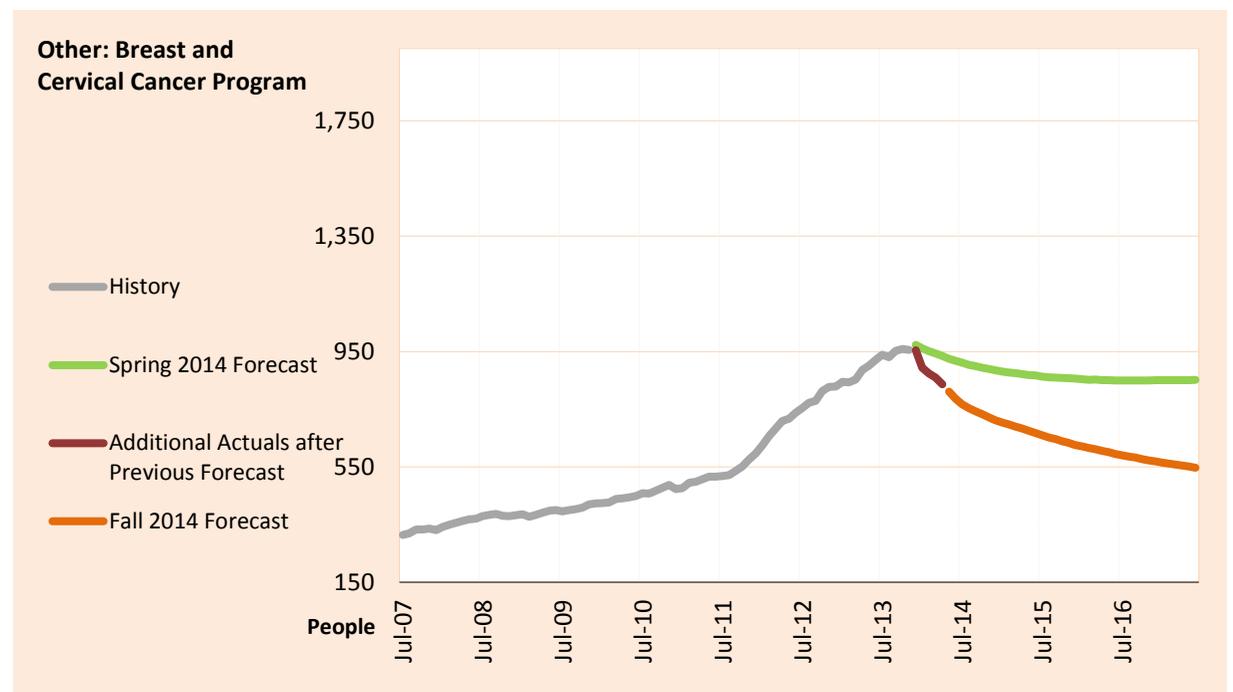
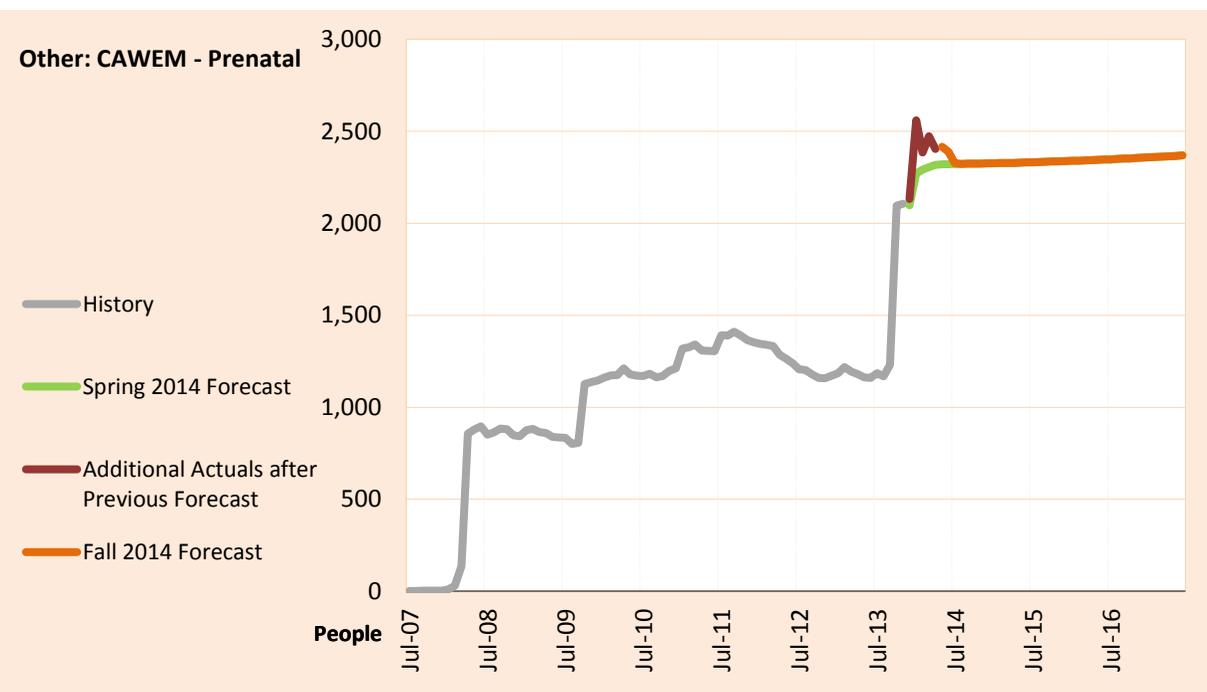
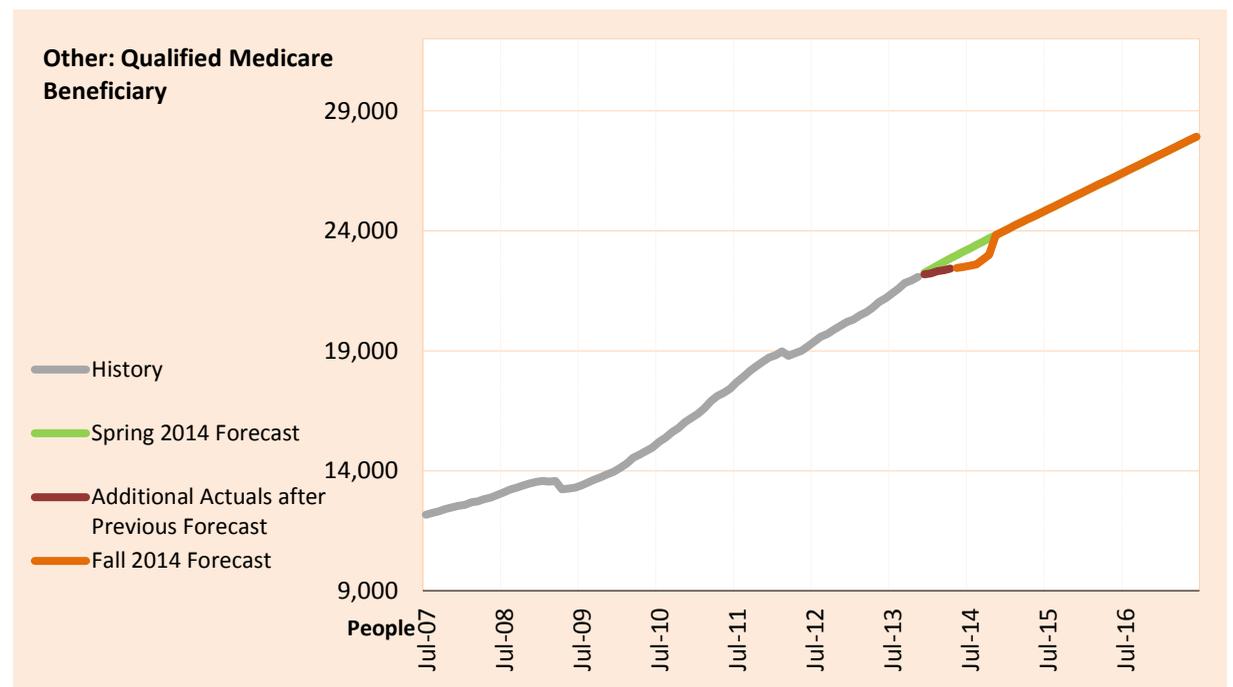
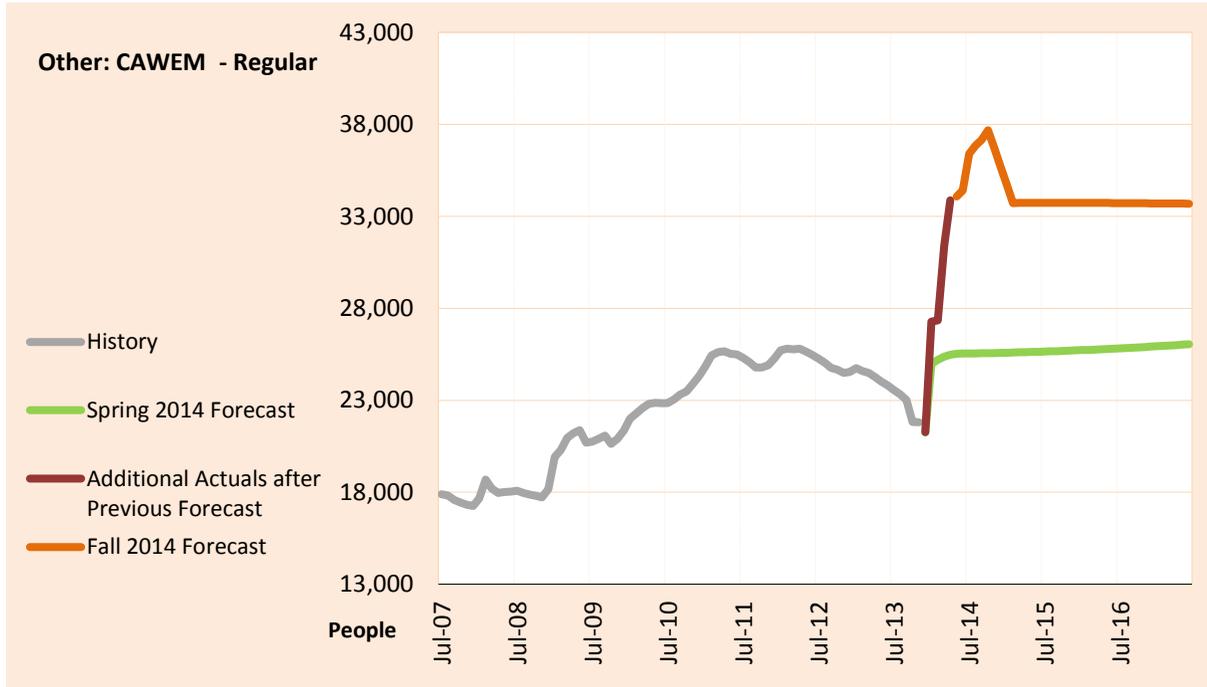


OHP Plus: Foster, Substitute and Adoption Care



OHP Plus: Children's Health Insurance Program





Medical Assistance and KidsConnect Biennial Average Forecast comparison

	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
OHP Plus						
ACA Adults with children	71,085	64,033	-9.9%	64,033	81,433	27.2%
ACA Adults without children	141,411	182,642	29.2%	182,642	233,567	27.9%
Total ACA Adults	212,496	246,675	16.1%	246,675	315,000	27.7%
Parent/Caretaker Relative ¹	NA	74,859	NA	74,859	69,512	-7.1%
Old Age Assistance	37,280	37,442	0.4%	37,442	39,944	6.7%
Pregnant Woman Program ²	14,098	16,611	17.8%	16,611	14,780	-11.0%
Children's Medicaid Program ³	NA	308,052	NA	308,052	307,000	-0.3%
Children's Health Insurance Program (CHIP)	72,382	77,127	6.6%	77,127	75,245	-2.4%
Foster, Substitute & Adoption Care	18,683	18,753	0.4%	18,753	18,753	0.0%
Aid to the Blind & Disabled	84,657	83,797	-1.0%	83,797	85,456	2.0%
Previously used caseloads						
TANF Medical ^{1, 3}	188,538	NA	NA	NA	NA	NA
Poverty Level Medical - Children ³	179,103	NA	NA	NA	NA	NA
Total OHP Plus	807,237	863,316	6.9%	863,316	925,690	7.2%
Other Medical Assistance Programs						
Citizen-Alien Waived Emergent Medical - Regular	24,747	31,127	25.8%	31,127	33,719	8.3%
Citizen-Alien Waived Emergent Medical - Prenatal	2,150	2,186	1.7%	2,186	2,349	7.5%
Qualified Medicare Beneficiary	23,166	22,942	-1.0%	22,942	26,402	15.1%
Breast & Cervical Cancer program	915	804	-12.1%	804	597	-25.7%
Other Subtotal	50,978	57,059	11.9%	57,059	63,067	10.5%
OHP Standard⁴	15,444	15,444	0.0%	15,444	NA	NA
Total Medical Assistance Programs	873,659	935,819	7.1%	935,819	988,757	5.7%

1. Parent/Caretaker Relative is a new caseload group for adults under 42% FPL. This caseload used to be part of the TANF Medical caseload.

2. Pregnant Woman Program is a new name for Poverty Level Medical - Women.

3. Children's Medicaid Program is a new caseload group for children who were previously in TANF Medical, Poverty Level Medical - Children, and CHIP under 133% FPL.

4. OHP Standard program closed on Dec 31, 2013 and participants were moved into the ACA Adults caseload.

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 clients who have been criminally or civilly committed, to receive mental health services. This forecast captures three distinct groups: (1) clients who are currently committed; (2) clients who were previously committed but no longer are; and (3) clients who have never been committed. Within the committed group, there are three populations: (1) Aid and Assist, served at the Oregon State Hospital; (2) Guilty Except for Insanity (GEI), served at the Oregon State Hospital and in the community; and (3) Civilly Committed individuals, also served at both the Oregon State Hospital and in the community.

Mandated mental health services are provided through community programs, including residential care and the Oregon State Hospital. 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 hospital provides 24-hour supervised care to people with the most severe mental health disorders, including people who have been found guilty except for insanity.

The 2013 Oregon Legislative Session identified the need to establish a better system for forecasting AMH caseloads, and workgroups convened to identify new forecasting categories that would represent the demand for services versus utilization of services, which have historically been held at reduced levels. Workgroup members established the new forecasting categories listed above. Data definitions and rule changes transformed the data into caseload categories that could be forecast. One of the major changes made was in how the Civilly Committed group is counted. Past rules included Post Civil Commit clients, whereas the new rules put the Post Civil Commit clients into the Previously Committed category and out of the Committed category. Another change occurred in the forecasting process. With the new way of forecasting, clients are counted in only one group each month.

The result is lower counts for the various caseload categories. The order of priority for the five forecasted group is:

Mandated

1. Aid and Assist
2. Guilty Except for Insanity
3. Civil Commitment

Non Mandated

4. Previously Committed
5. Never Committed

The Fall 2014 forecast is the first edition using the new definitions, the categories listed above, and a hierarchy for forecasting. Ideally, it more accurately portrays the populations receiving mental health services.

Total Mandated Mental Health Services — The mandated caseload encompasses the committed caseload (Aid and Assist, GEI, and Civilly Committed). The biennial average forecast for 2013-15 is 1,788 clients. The 2015-17 biennial average is 1,753 clients, 2.0 percent lower than the 2013-15 biennial average.

Aid and Assist — This caseload exhibited steady growth throughout 2013 and into 2014. The Fall 2014 biennial average forecast for 2013-15 is 158 clients, 11.2 per-cent lower than the Spring 2014 forecast, which used the old way of counting clients. As AMH moves toward mobile forensic evaluation teams, Aid and Assist in the State Hospital will likely decrease, but the timing of this is unknown. Additionally, the 2013 legislative session increased funding for community mental health services, including, but not limited to, crisis services, supported housing, and jail diversion. As these services are implemented the Aid and Assist caseload may decrease. The 2015-17 biennial average is 168 clients, 6.3 percent higher than the biennial average forecast for 2013-15.

Guilty Except for Insanity (GEI) — These clients are under the jurisdiction of the Psychiatric Security Review Board and State Hospital Review Panel. For the past several years, the Total GEI caseload in Oregon has steadily declined. The Fall 2014 biennial average forecast for 2013-15 is 610, 9.4 percent lower than the Spring 2014 forecast, which used the old way of counting clients. The 2015-17 biennial average is 595, 2.5 percent lower than the biennial average forecast for 2013-15.

Civil Commitments — As mentioned above, this category was substantially modified as a result of new data definitions. For civilly committed clients being served in the community, after 180 days their status is changed to Previously Committed, and they are taken out of this category. Consequently, the Fall 2014 biennial average forecast for 2013-15 is 1,020, 76 percent lower than the Spring 2014 forecast. The Fall 2014 forecast anticipates that the average caseload for the 2015-17 biennium will be 990 clients, a decrease of 2.9 percent from the biennial average forecast for 2013-15.

Previously Committed caseload — This caseload captures clients receiving mental health services who have been civilly or criminally committed at some time since the year 2000. About 80 percent of these clients are served in non-residential settings only, and the rest are served in residential settings, the Oregon State Hospital, or Acute Care hospital settings. The biennial average forecast for 2013-15 is 2,787 clients. The 2015-17 biennial average is 2,927 clients, 5.0 percent higher than the biennial average forecast for 2013-15.

Never Committed caseload — This caseload captures clients receiving mental health services who have not been civilly or criminally committed since the year 2000. About 97 percent of these clients are served in non-residential settings only, and 2 percent are served in Acute Care hospital settings. The rest are served in residential settings or the Oregon State Hospital. The biennial average forecast for 2013-15 is 43,416 clients. The 2015-17 biennial average is 49,201 clients, 13.3 percent higher than the biennial average forecast for 2013-15.

Risks and Assumptions

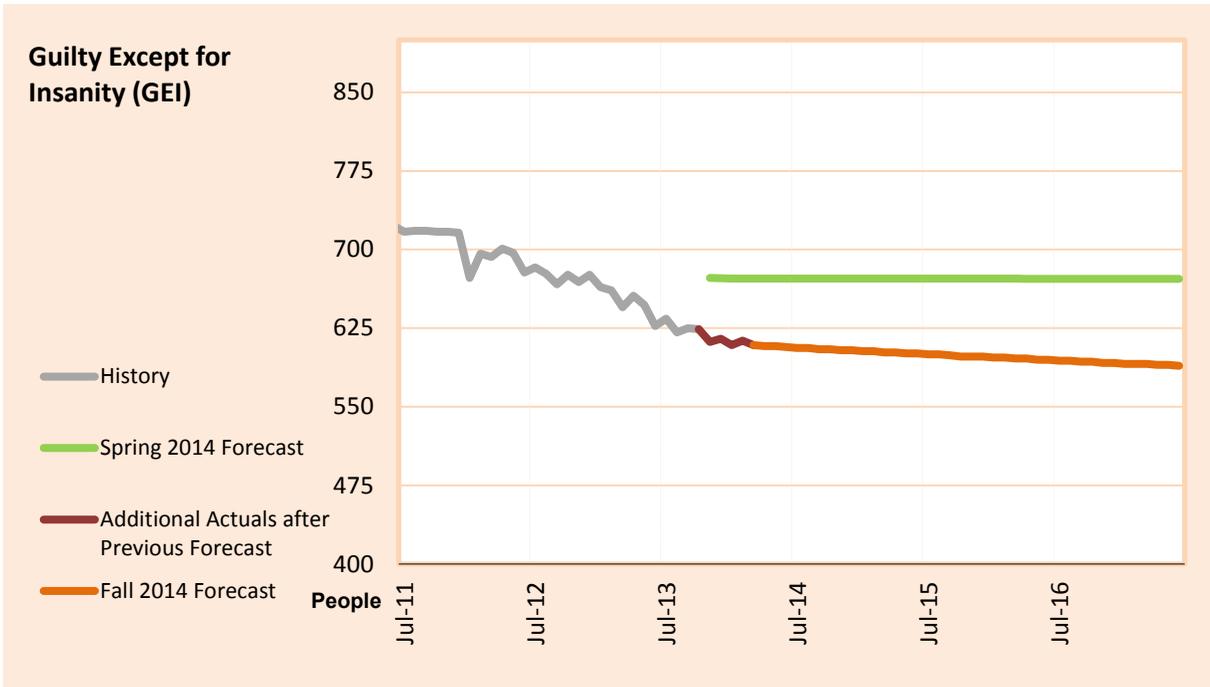
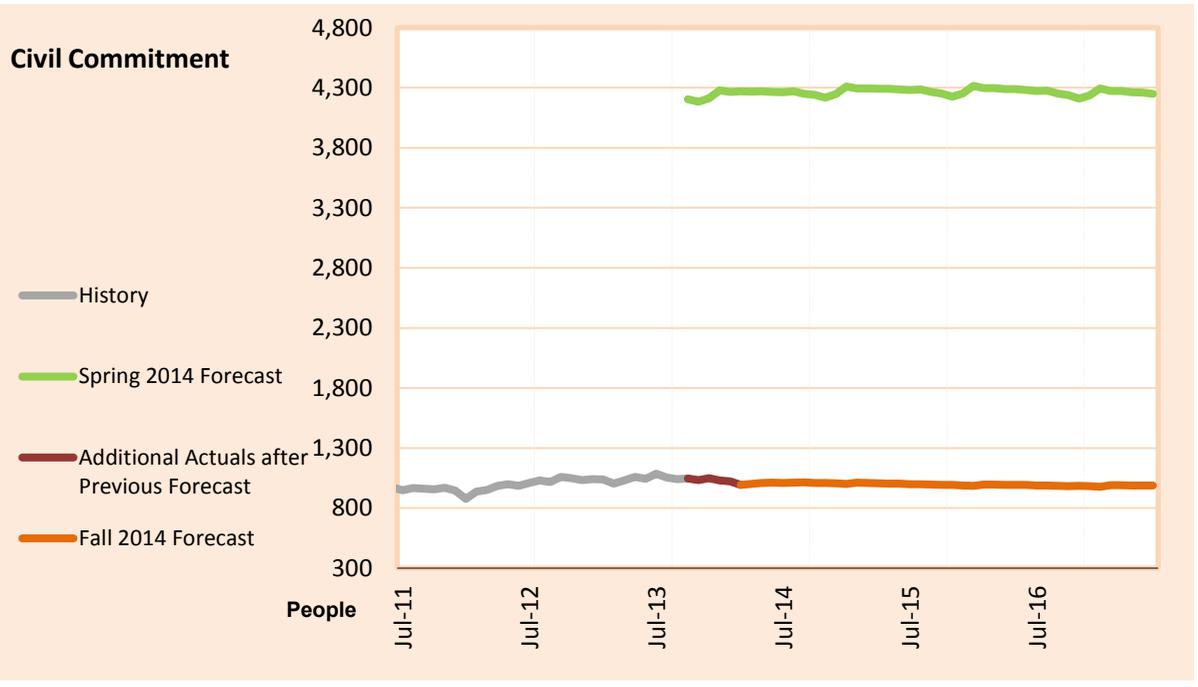
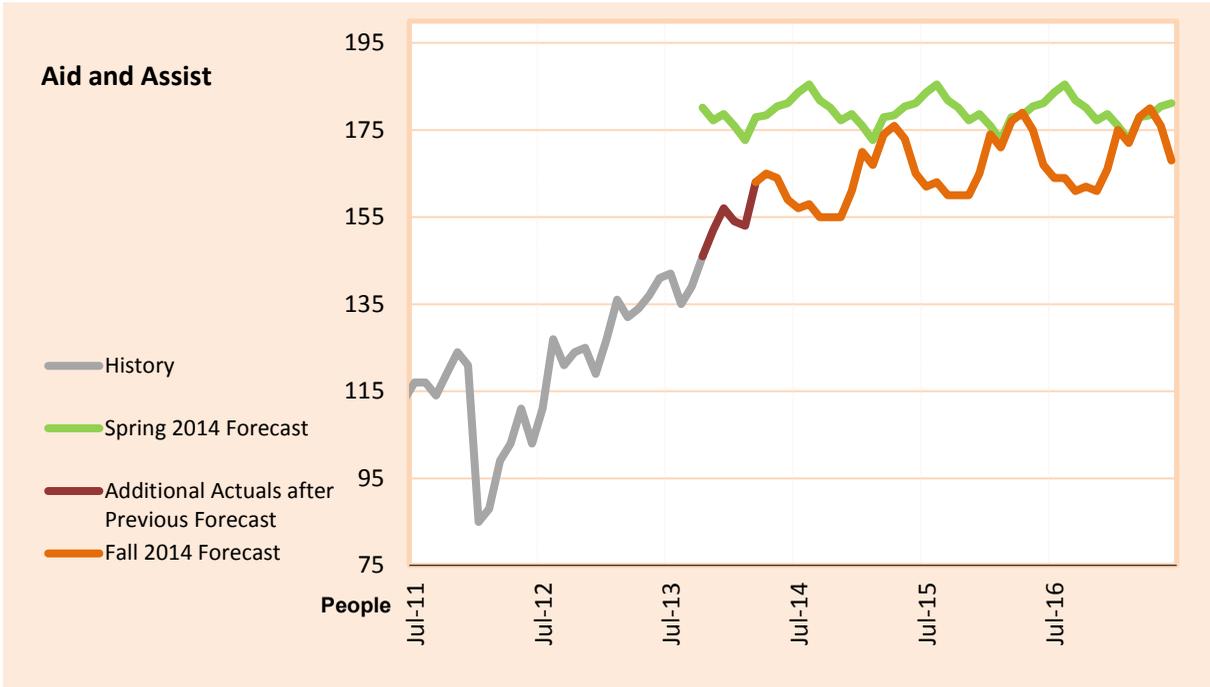
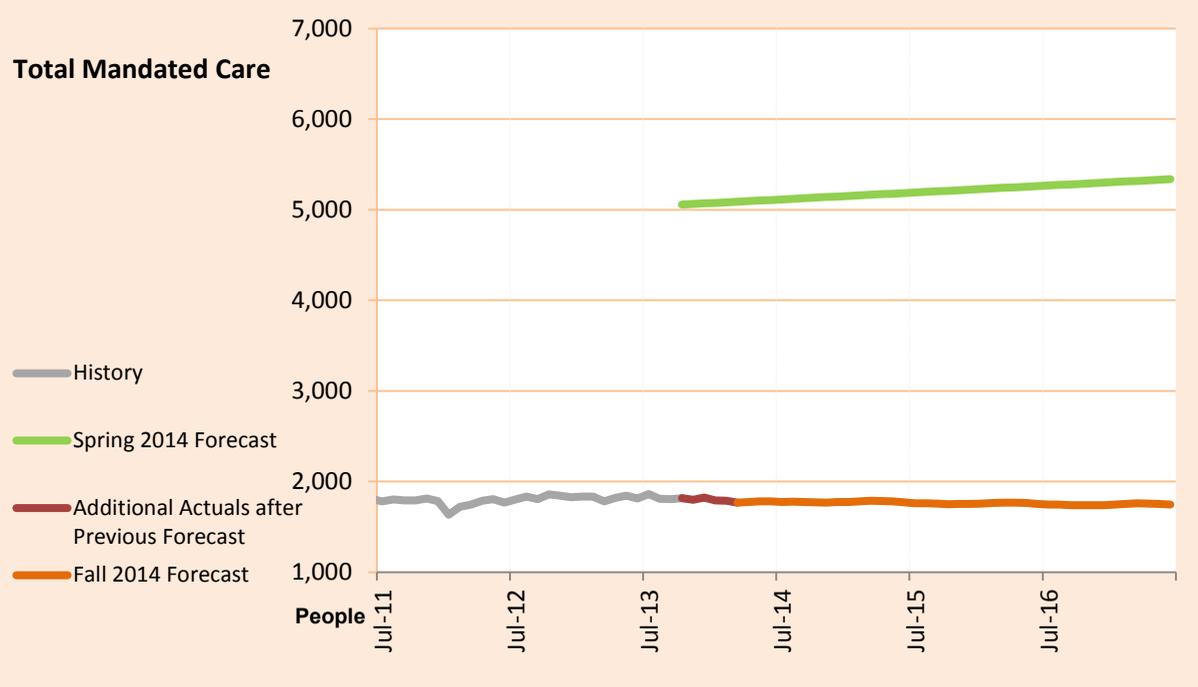
These forecasts were developed using common statistical methods based on month-to-month changes in caseload history.

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.

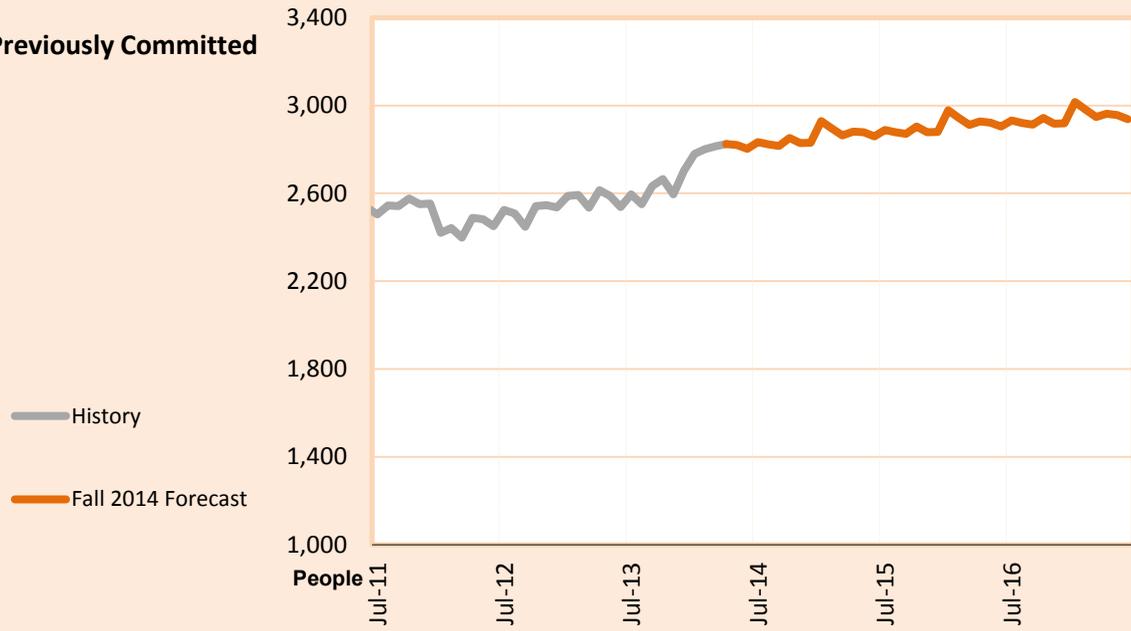
Implementation of the Patient Protection and Affordable Care Act of 2010 (ACA) will significantly impact delivery of mental health services in Oregon. In January 2014, Medicaid enrollment was extended to adults 18-64 with incomes up to 138 percent of FPL. This change alone is expected to provide medical coverage, including mental health services, to more than 300,000 previously 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 (CCOs) 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. The Blue Mountain Recovery Center, a 60-bed campus of the Oregon State Hospital closed in March 2014. Oregon State Hospital will open the 174-bed facility in Junction City in March 2015, at which time it will close the 72-bed campus in Portland. At the main Oregon State Hospital campus in Salem, additional units were opened during the 2013-15 biennium. It's possible that these changes will reduce pressure on the civil commitment waiting list and acute care settings.

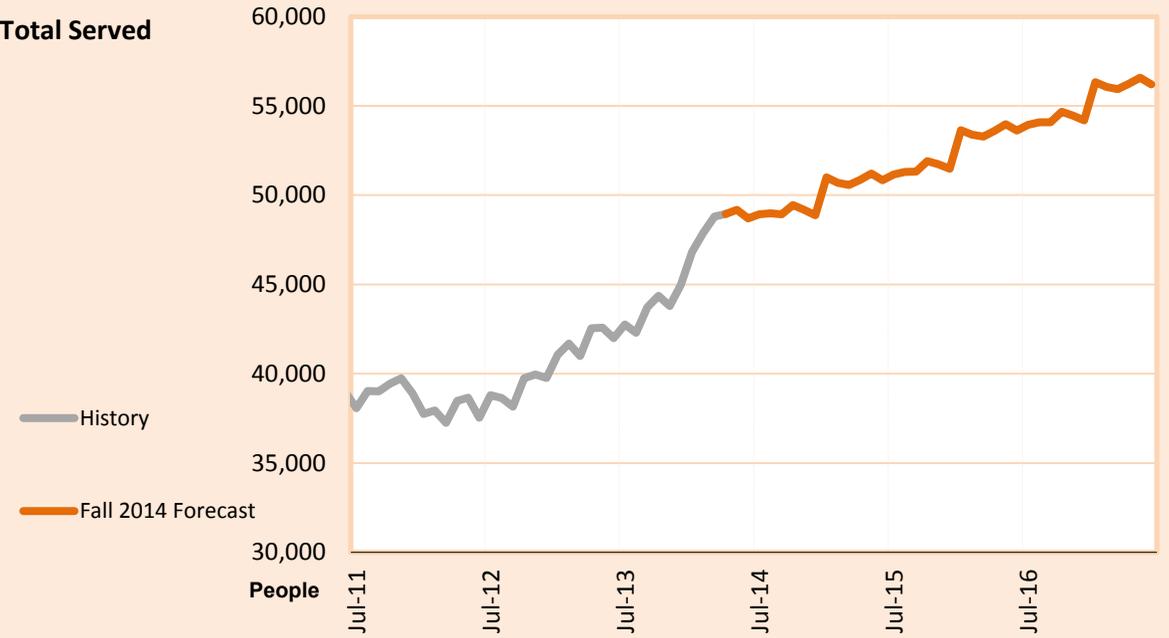
Finally, the economic environment can also influence mental health caseloads. When the economy is doing poorly, individuals experience more stress than during good periods, and this may impact demand for mental health services.



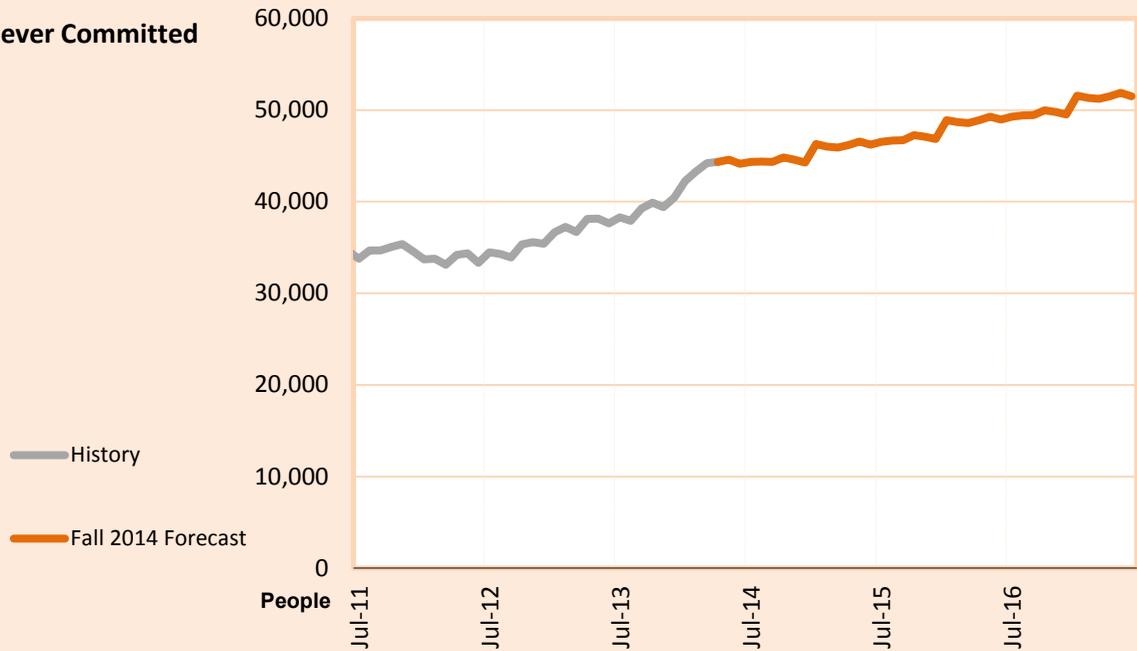
Previously Committed



Total Served



Never Committed



Addictions and Mental Health Biennial Average Forecast comparison

	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Under Commitment						
Aid and Assist ¹	178	158	NA	158	168	6.3%
Guilty Except for Insanity (GEI) ¹	673	610	NA	610	595	-2.5%
Civil Commitment ^{1,2}	3,289	1,020	NA	1,020	990	-2.9%
Total Mandated Care	5,115	1,788	NA	1,788	1,753	-2.0%
Previously Committed³	NA	2,787	NA	2,787	2,927	5.0%
Never Committed³	NA	43,416	NA	43,416	49,201	13.3%
Total Served	NA	47,991	NA	47,991	53,881	12.3%

Starting with the Fall 2014 forecast cycle, the Mental Health caseload categories have been redefined.

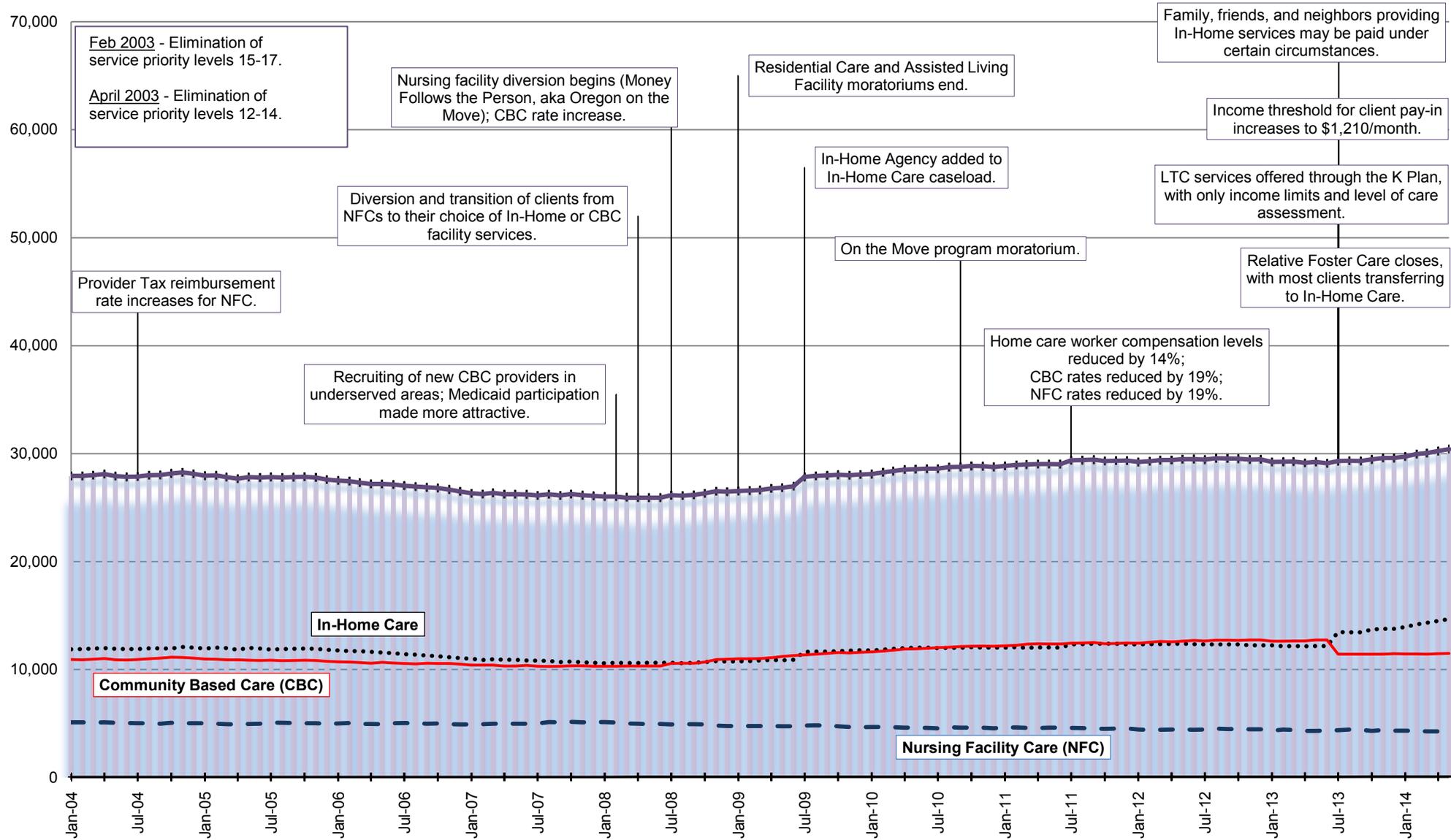
1. Prior forecasts counted clients in every category they received service, so some clients were counted more than once. With the new definitions, each client is counted only once for any given month. Consequently, the new counts are lower than the old ones because some clients will inevitably move between categories.
2. The old Civil Commitment caseload included everyone receiving service who had been previously committed. The new definition counts only clients who are currently under civil commitment (although a proxy rule is being used to estimate the end date for clients' mandated service).
3. Prior forecasts did not include these two caseload categories.

Appendix I

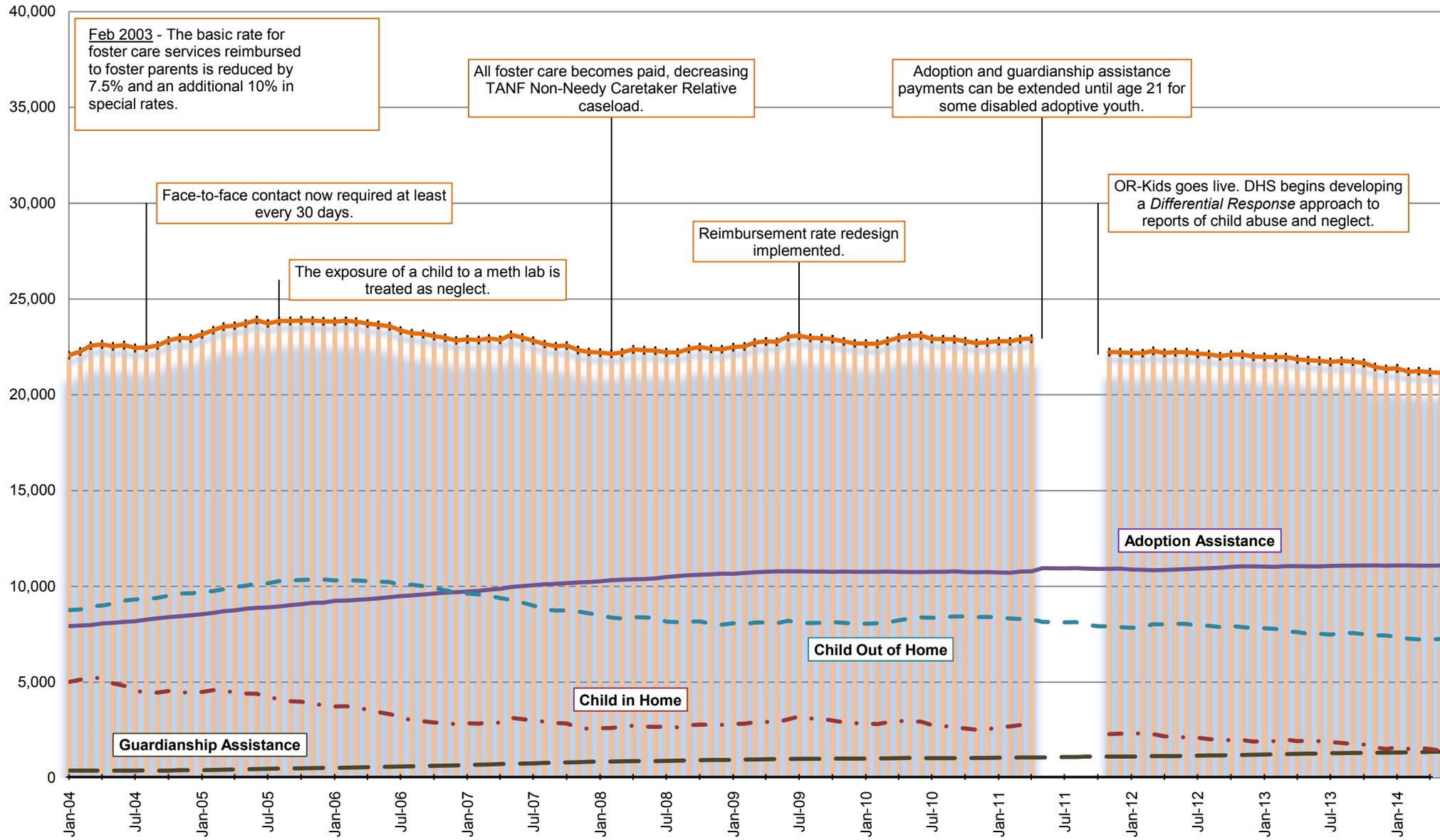
DHS Caseload History & Definitions



Aging and People with Disabilities (APD) Caseload

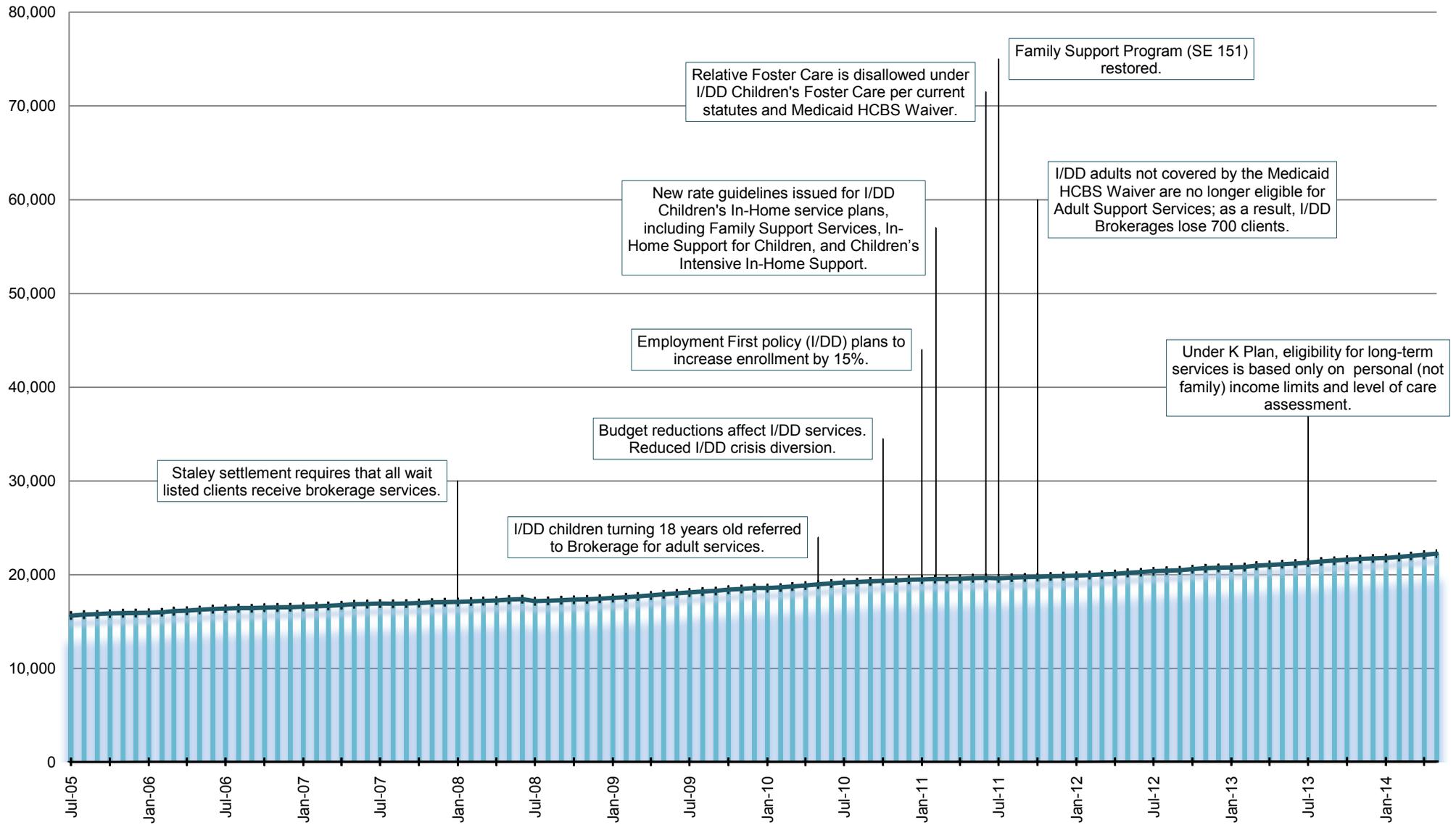


Child Welfare (CW) Caseload

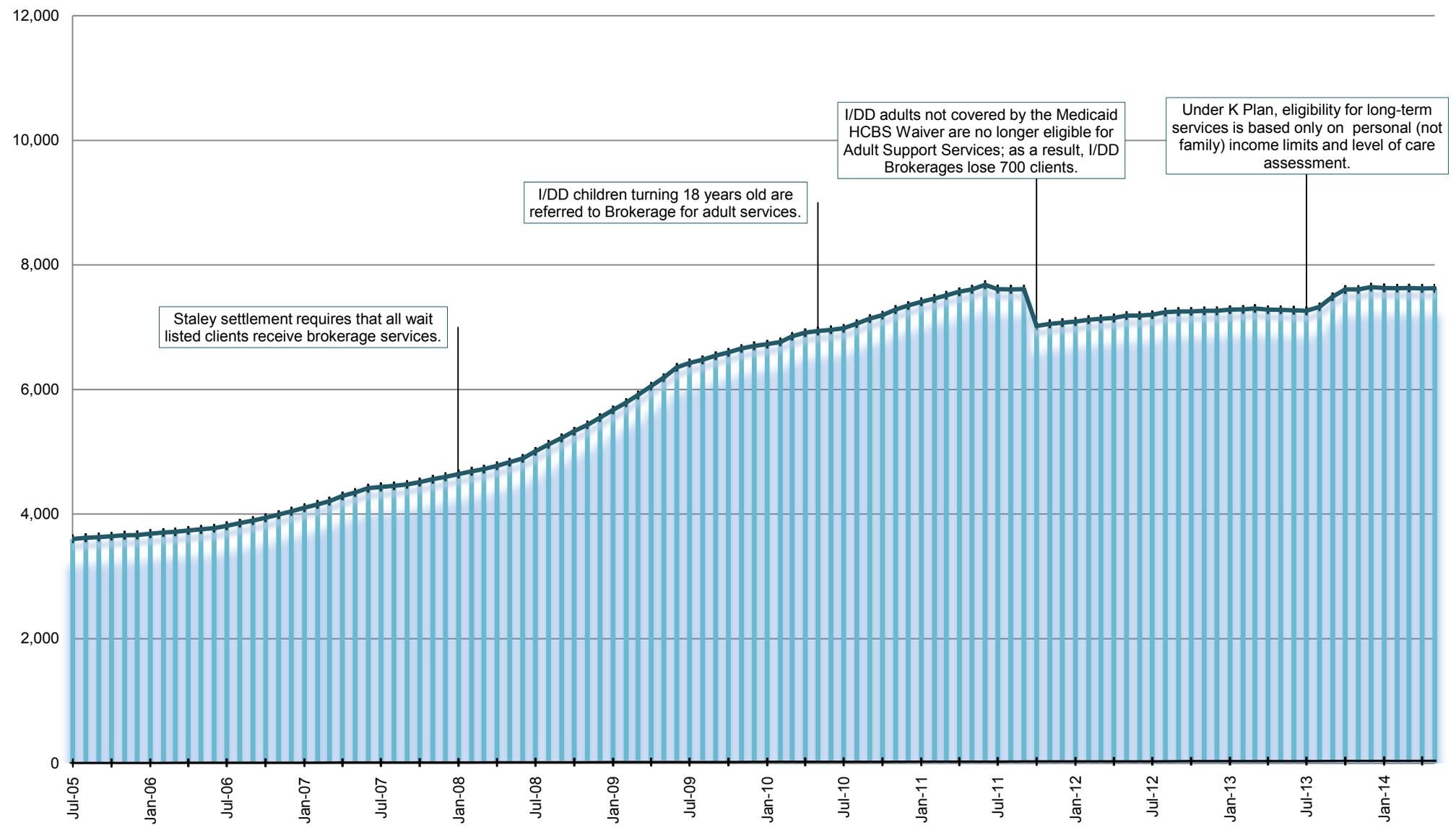


NOTE: There is no historical observations from May - Nov. 11 due to the start of ORKids data and the end of Legacy data.

Intellectual & Developmental Disabilities (I/DD): Case Management Enrollment



Intellectual & Developmental Disabilities (I/DD): Brokerage Enrollment (Adult)



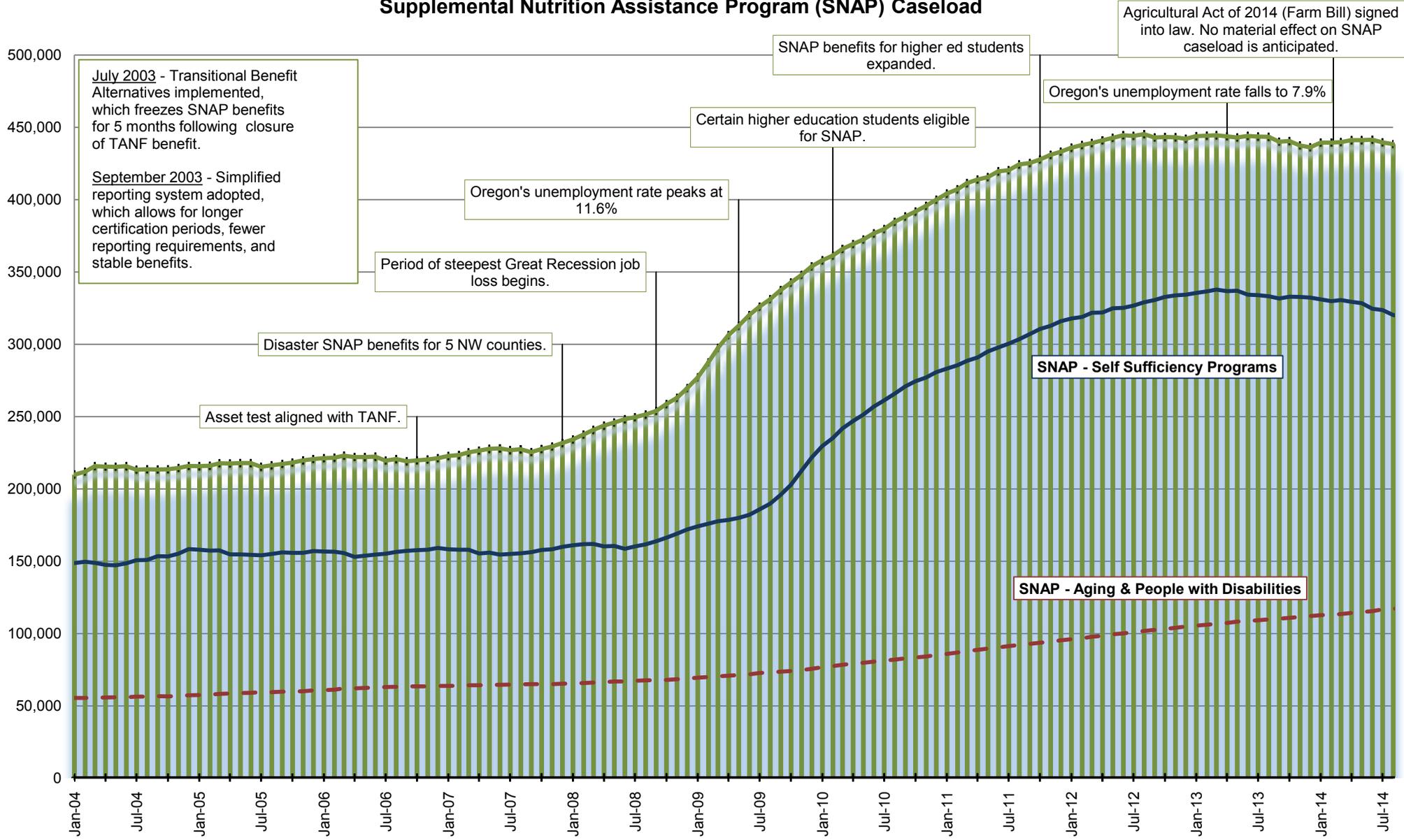
Staley settlement requires that all wait listed clients receive brokerage services.

I/DD children turning 18 years old are referred to Brokerage for adult services.

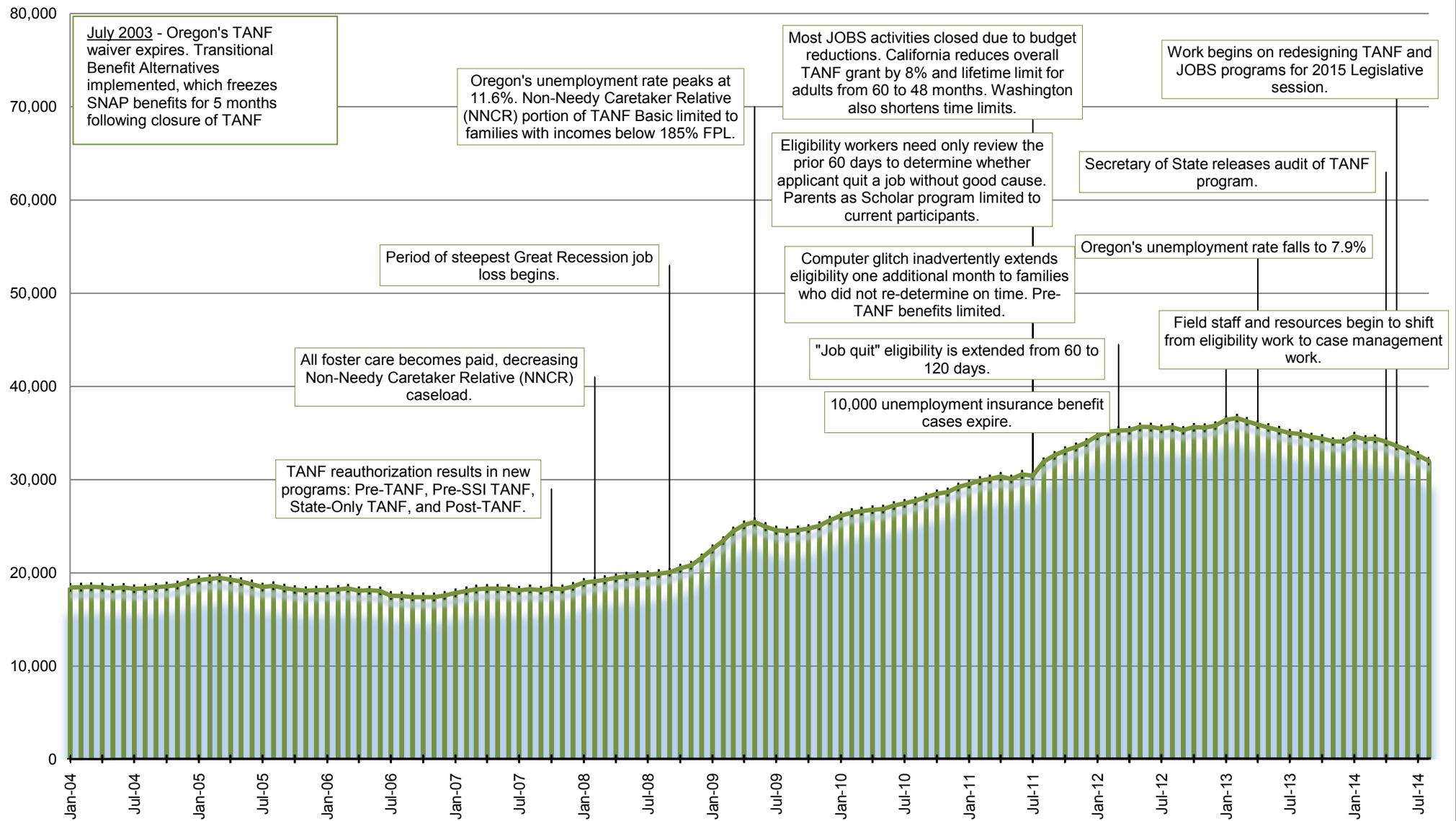
I/DD adults not covered by the Medicaid HCBS Waiver are no longer eligible for Adult Support Services; as a result, I/DD Brokerages lose 700 clients.

Under K Plan, eligibility for long-term services is based only on personal (not family) income limits and level of care assessment.

Self Sufficiency Programs (SSP): Supplemental Nutrition Assistance Program (SNAP) Caseload



Self Sufficiency Programs: 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.

Historically, Oregon's LTC services were provided under the authority of a Medicaid 1915 (c) Home and Community-Based Services (HCBS) Waiver (under the Omnibus Budget Reconciliation Act of 1981), which allows the State to provide home and community-based care alternatives to institutional care such as nursing facilities.

Beginning in July 2013, using a new option available due to the Patient Protection and Affordable Care Act of 2010 (ACA), Oregon also began offering services through the Community First Choice Option under 1915 (k) of the Social Security Act (referred to as the K Plan).

To qualify for LTC clients must meet financial and non-financial requirements which vary depending on whether the individual will be covered under the Waiver or 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 K Plan, there are fewer requirements: income limits (but no asset limits) and a level of care assessment (but no need to be determined "disabled").

The LTC caseloads are grouped into three major categories: In-Home, Community-Based Care, and Nursing Facilities.

IN-HOME PROGRAMS

In-Home Programs provide personal 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.

In-Home Agency

In-Home Agency is an alternative way to purchase in-home care. 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.

Live-In

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 clients who choose to have their paid care provided by their spouse. Spouses are paid for the services they provide.

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 the services they've purchased.

Specialized Living

Specialized Living provides care in a home-like setting 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.

State Plan Personal Care (Non-K Plan Medicaid Services)

State Plan Personal Care services are available to people who are eligible for Medicaid, but not eligible for waived services. Services supplement the individual's own personal abilities and resources, but 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 residential settings. Services include assistance with ADLs, medication oversight, and social activities. Services can also include nursing and behavioral supports to meet complex needs.

Assisted Living Facilities

Assisted Living Facilities are licensed 24-hour care settings serving six or more residents that provide private apartments and focus on resident independence and choice.

Adult Foster Care

Adult Foster Care provides long-term care in home-like settings licensed for five or fewer unrelated people. These facilities are open to clients who are not related to the care provider.

Residential Care Facilities

Residential Care Facilities (Regular or Contract) are licensed 24-hour care settings serving six or more residents. These facilities range in size from six beds to over 100. "Contract" facilities are licensed to provide specialized Alzheimer care.

Program of All-Inclusive Care for the Elderly (PACE)

PACE is a capitated Medicare/Medicaid program providing all-inclusive care. 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 (NFC)

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

Basic Care

Basic Care clients need comprehensive, 24-hour care for assistance with ADLs 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 require 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.

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD)

Intellectual and Developmental Disabilities Programs provide support to qualified adults and children with intellectual and developmental disabilities through a combination of case management and services. Intellectual and 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 Intellectual and 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 Enrollment provides entry-level eligibility evaluation and coordination services.

The other caseloads are grouped into three broad categories: adult services, children's services, and other services.

Adult services include:

Brokerage Enrollment

Brokerage Enrollment provides planning and coordination of services that allow clients to live in their own home or in their family's home.

24-Hour Residential Care

24-Hour Residential Care provides 24-hour supervised care, training and support services delivered in neighborhood homes.

Supported Living

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

Comprehensive In-Home Services (CIHS)

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

I/DD Foster Care

Foster Care provides 24-hour care, supervision, provision of room and board, and assistance with activities of daily living for both adults and children (approximately 82 percent and 18 percent respectively).

Stabilization and Crisis Unit

Stabilization and Crisis Unit (previously called State Operated Community Programs) offers safety net services and support to the most vulnerable, intensive, medically and behaviorally challenged I/DD clients when no other community based option is available to them. The program serves both adults and children (approximately 89 percent and 11 percent respectively).

Children's Services include:

In-Home Support for Children

In-Home Support for Children (also called Long-Term Support) provides services to individuals under the age of 18 in the family home.

Children Intensive In-Home Services

Children Intensive In-Home Services cares for children with intensive medical or behavioral needs in their own 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 in neighborhood homes other than the family home or foster care.

Children Proctor Care (discontinued December 31, 2013)

This program was ended and clients were transferred to other caseloads – primarily to I/DD Foster Care and other children services including In-Home Support.

Other I/DD Services include:

Employment and Day Support Activities

Employment and Day Support Activities are out-of-home employment or community training services and related supports, provided to individuals aged 18 or older, 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 intellectual and developmental disabilities.

Crisis Services

Crisis Services offer temporary out-of-home placement services to I/DD adults and children.

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) (\$44,123 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 benefit 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.

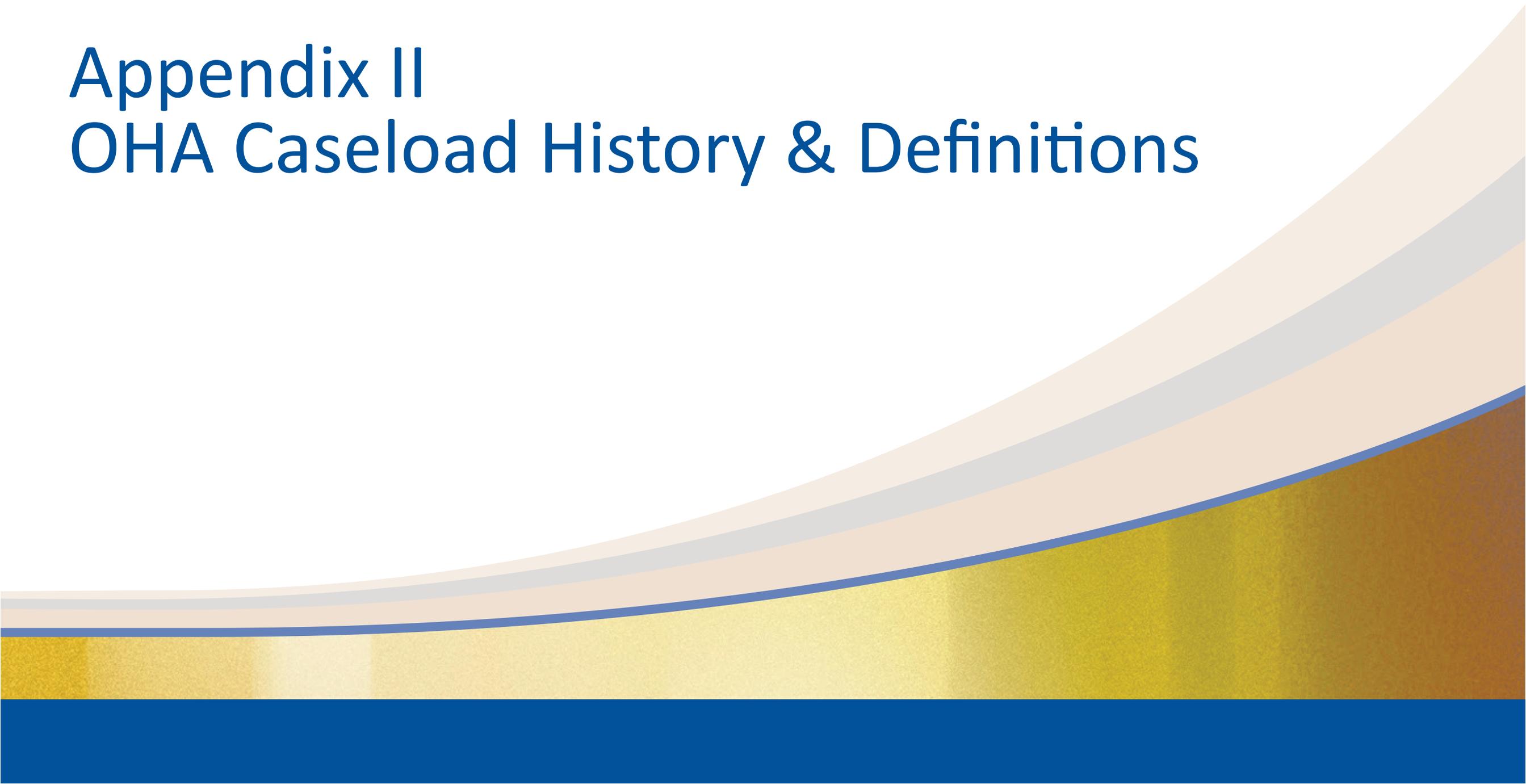
To be eligible for TA-DVS, a survivor must have a current or future risk of domestic violence; be a pregnant woman, or a parent or relative caring for a minor child; and must have income not exceeding TANF limits (40 percent of FPL) TA-DVS only considers income on hand that is available to meet emergency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

VOCATIONAL REHABILITATION

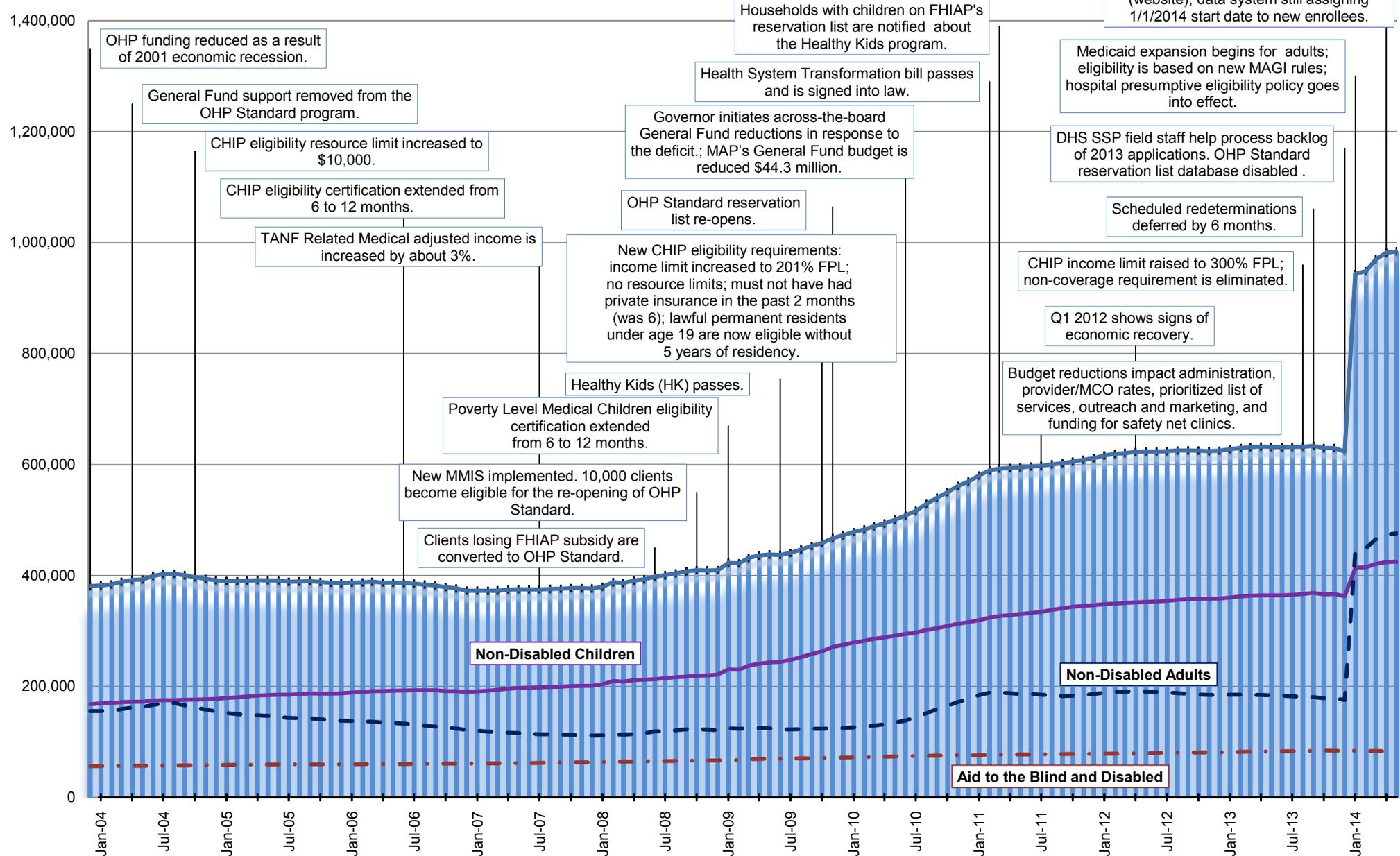
Vocational Rehabilitation Services assess, plan, and coordinate vocational rehabilitation services for people who have physical or mental disabilities and need assistance to obtain and retain employment that matches their skills, potential, and interest. Services are provided through local Vocational Rehabilitation offices across the state. The program provides counseling, training, job placement, assistive technology, and extended services and supports.

Appendix II

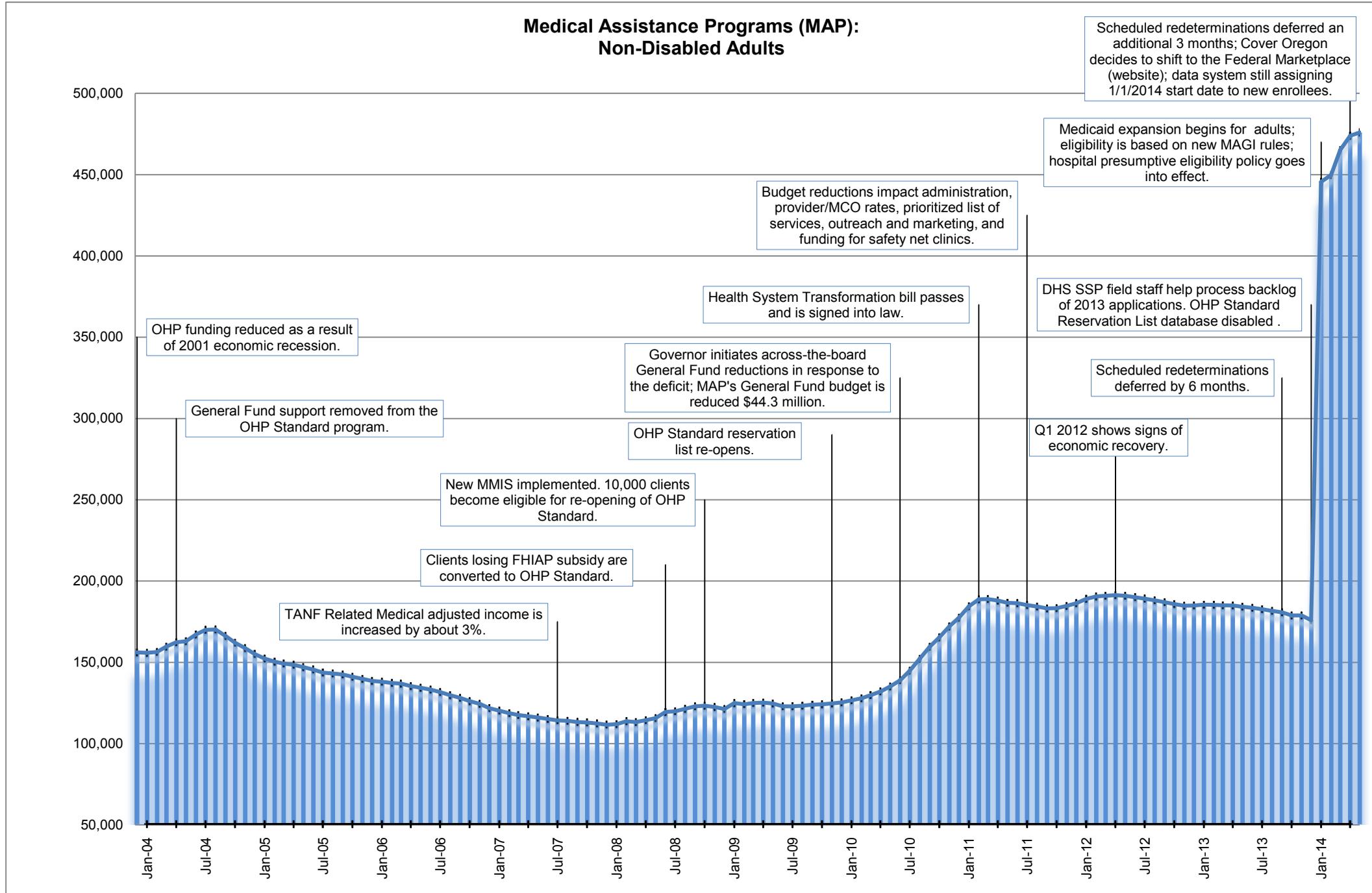
OHA Caseload History & Definitions



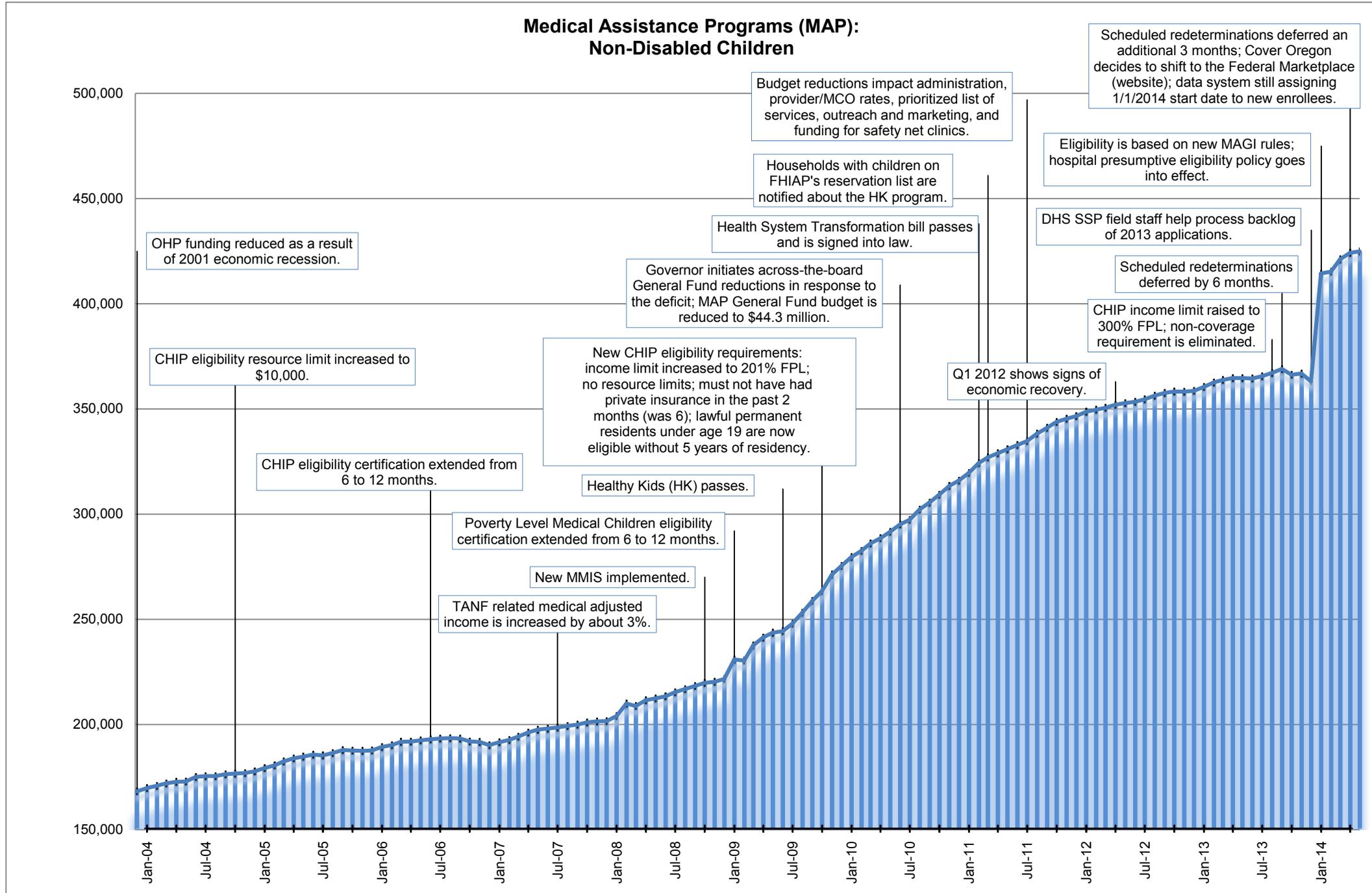
Medical Assistance Plans (MAP): Total Oregon Health Plan - Plus and Standard



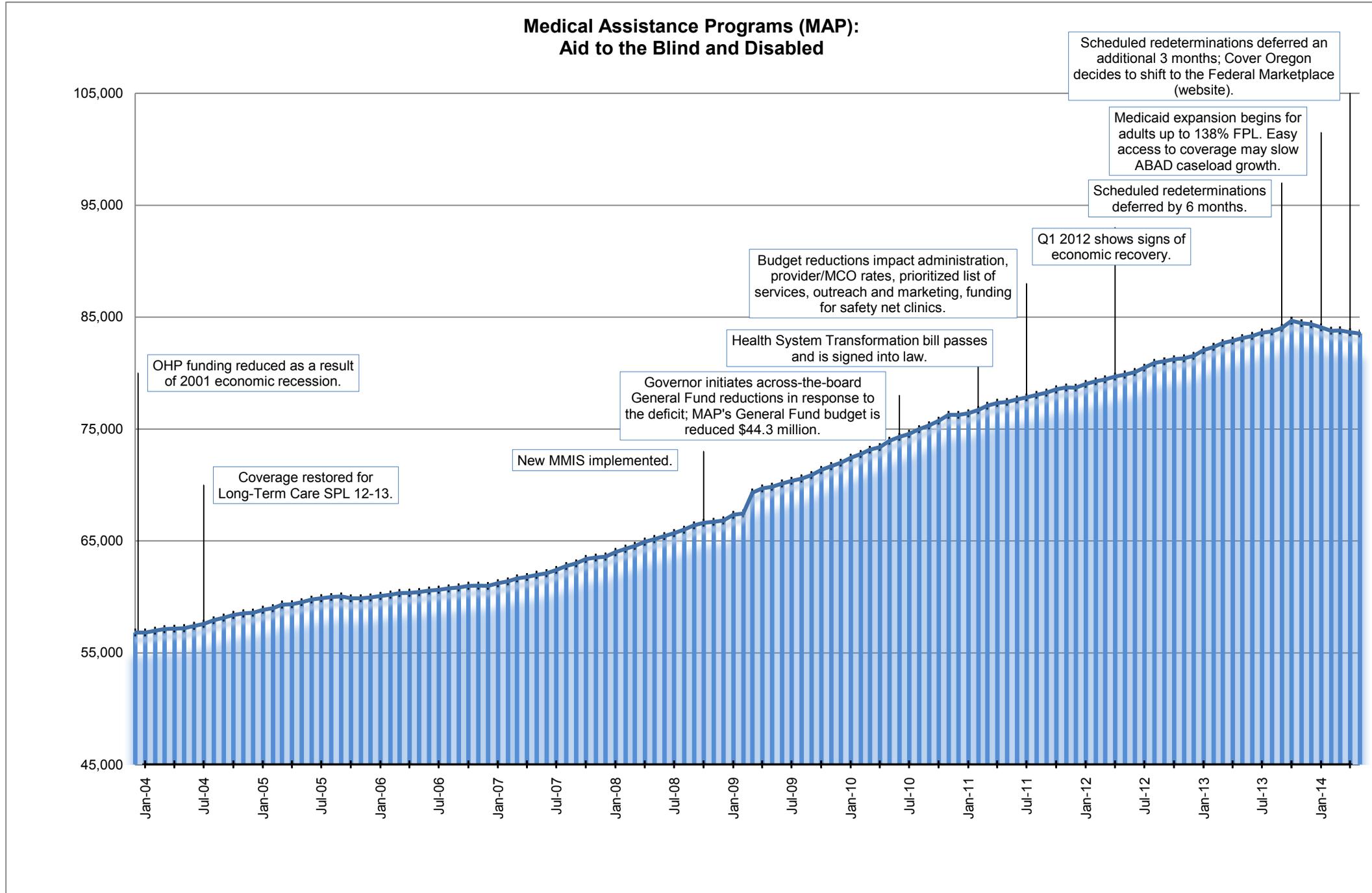
Medical Assistance Programs (MAP): Non-Disabled Adults



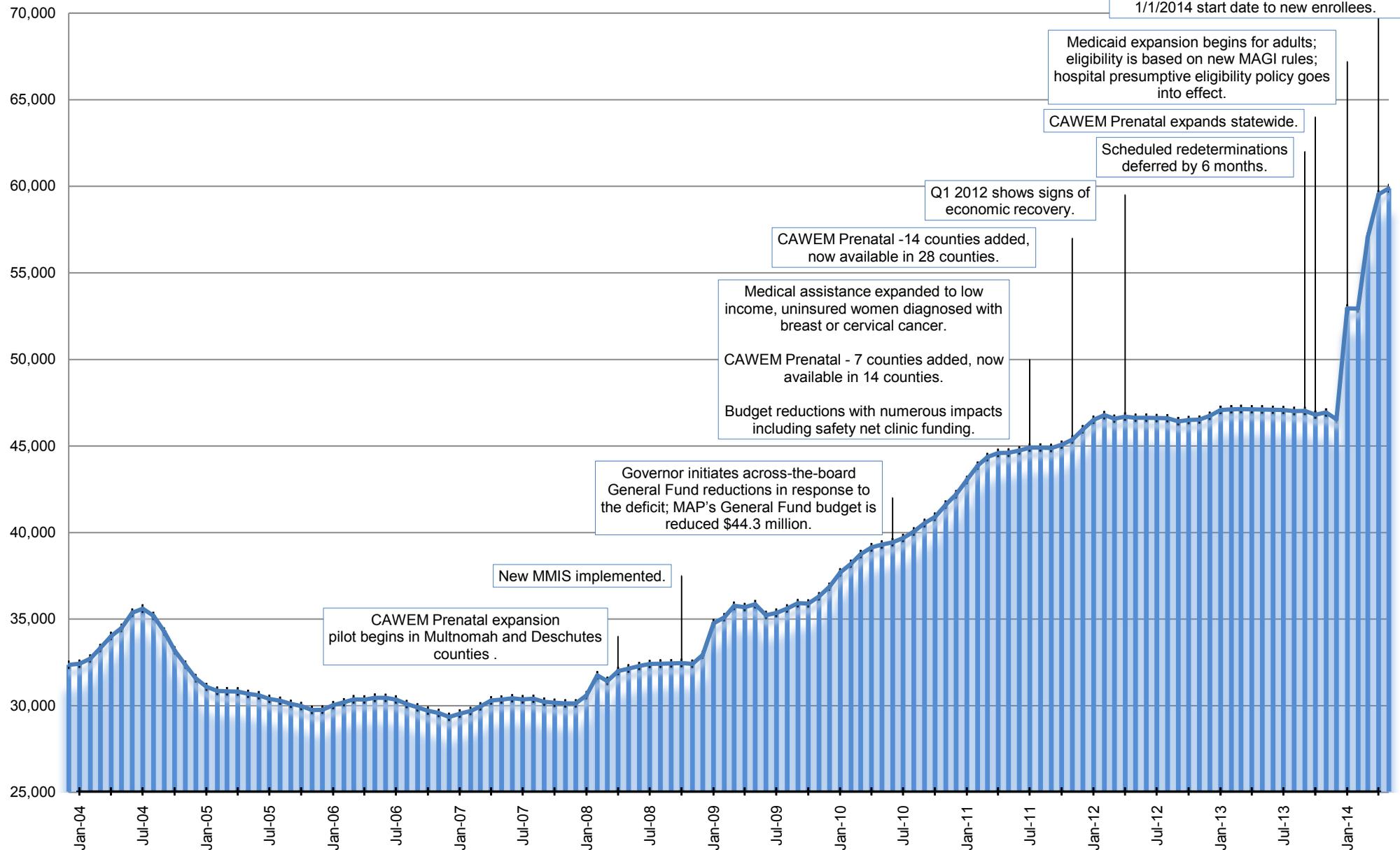
Medical Assistance Programs (MAP): Non-Disabled Children



Medical Assistance Programs (MAP): Aid to the Blind and Disabled



Medical Assistance Programs (MAP): Other



Scheduled redeterminations deferred an additional 3 months; Cover Oregon decides to shift to the Federal Marketplace (website); data system still assigning 1/1/2014 start date to new enrollees.

Medicaid expansion begins for adults; eligibility is based on new MAGI rules; hospital presumptive eligibility policy goes into effect.

CAWEM Prenatal expands statewide.

Scheduled redeterminations deferred by 6 months.

Q1 2012 shows signs of economic recovery.

CAWEM Prenatal - 14 counties added, now available in 28 counties.

Medical assistance expanded to low income, uninsured women diagnosed with breast or cervical cancer.

CAWEM Prenatal - 7 counties added, now available in 14 counties.

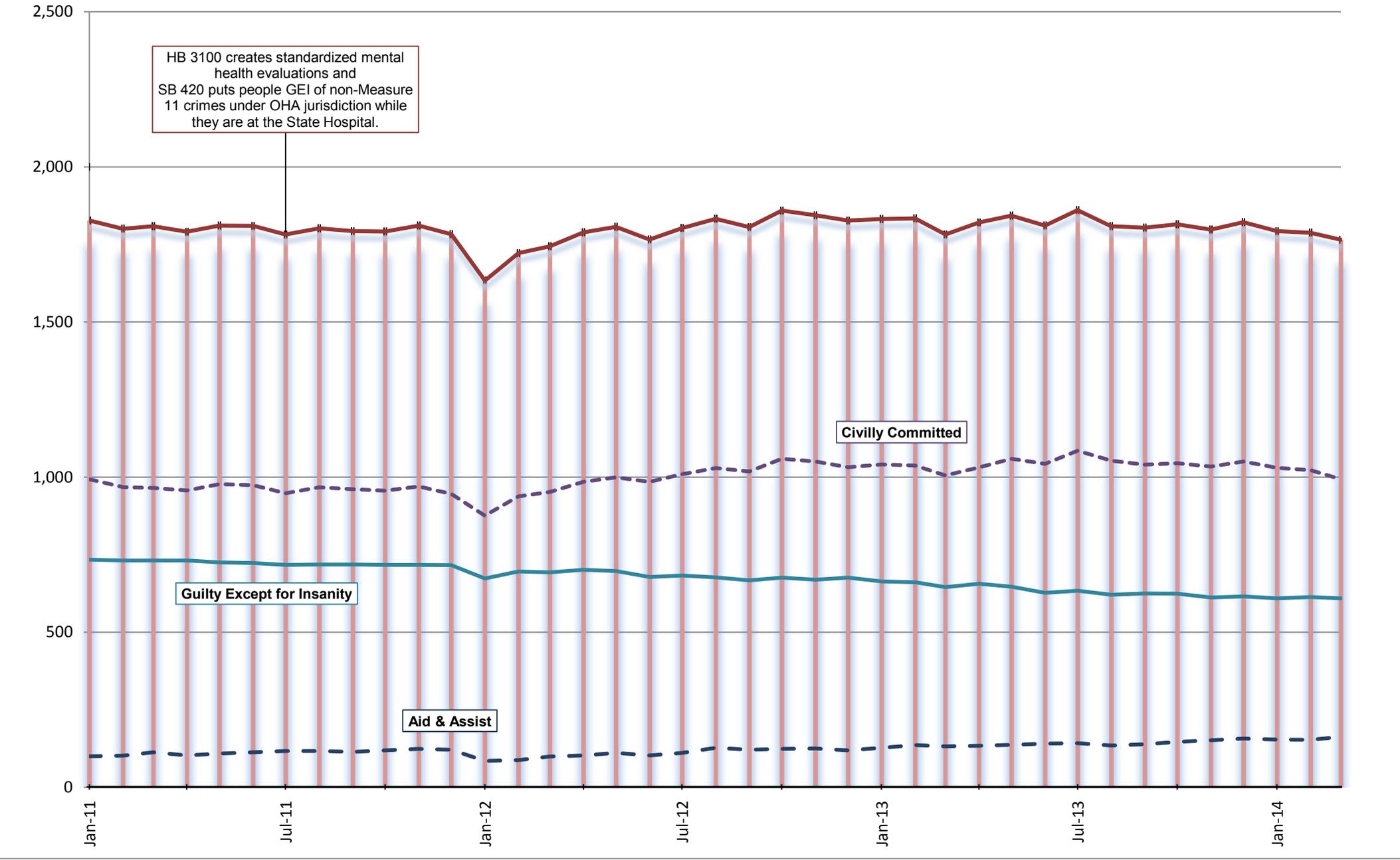
Budget reductions with numerous impacts including safety net clinic funding.

Governor initiates across-the-board General Fund reductions in response to the deficit; MAP's General Fund budget is reduced \$44.3 million.

New MMIS implemented.

CAWEM Prenatal expansion pilot begins in Multnomah and Deschutes counties.

Addictions and Mental Health (AMH): Total Mandated Mental Health 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.

MEDICAL ASSISTANCE PROGRAMS (MAP)

Medical Assistance Programs coordinate the Medicaid portion of the Oregon Health Plan (OHP) and directly administer OHP physical, dental, and mental health coverage.

Historically, MAP programs were 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.
- Other Medical Assistance Programs – programs that provide medical benefits but are not considered part of OHP.

Starting in January 2014 there are only two major categories since OHP Standard was discontinued. At that time, all OHP Standard clients were moved to the new ACA Adults caseload group, where they became eligible for OHP Plus benefits.

OHP Plus Benefit Package

The OHP Plus package offers comprehensive health care services to children and adults who are eligible under CHIP or the traditional, federal Medicaid rules. The new ACA Adults caseload also receives this benefit package.

ACA Adults

This is a new caseload which represents the expansion of Medicaid under the United States Federal Patient Protection and Affordable Care Act of 2010 (ACA). This caseload includes citizens 18 to 64 years old with incomes up to 138 percent of FPL, who are not pregnant or disabled. ACA Adults are currently divided into two subcategories: ACA Adults with Children, and ACA Adults without Children. Starting with the Spring 2015 forecast, the subcategories will be changed to age cohorts.

Pregnant Woman Program

This is the new name for Poverty Level Medical Women (PLMW). The Pregnant Woman Program provides medical coverage to Pregnant Woman with income levels up to 185 percent of the FPL. Coverage is extended for 60 days after childbirth.

Poverty Level Medical Women (PLMW)

This caseload has been renamed Pregnant Woman Program.

Parent/Caretaker Relative

This is a new caseload comprised of adults who would previously have been included in the Temporary Assistance for Needy Families caseloads (TANF Related Medical and TANF Extended). Parent/Caretaker Relative offers OHP Plus medical coverage to adults with children who have incomes not exceeding approximately 42 percent of Federal Poverty Level (FPL).

Temporary Assistance for Needy Families (TANF)

This caseload has been replaced, with clients transferred to two other caseloads. Adults are now included in the Parent/Caretaker Relative caseload; and children are now included in the Children's Medicaid Program caseload.

Children's Medicaid Program

This is a new caseload comprised of children who would previously have been included in three other caseloads: children from the Poverty Level Medical Children caseload (PLMC), children from the TANF Medical caseloads (TANF-RM, TANF-EX), and children from lower income CHIP households. The Children's Medicaid Program offers OHP Plus medical coverage to children from birth through age 18 living in households with income from 0 to 133 percent of Federal Poverty Level (FPL).

Poverty Level Medical Children (PLMC)

This caseload has been renamed Children's Medicaid Program and the income rules were widened to include children previously included in other caseloads.

Children's Health Insurance Program (CHIP)

This caseload has been redefined. This caseload now covers uninsured children from birth through age 18 living in households with income from 134 to 300 percent of FPL. Previously, this caseload covered children from households with income from 100 to 200 percent of FPL.

Foster, Substitute, and Adoption Care

Foster, Substitute, and Adoption Care provides medical coverage through Medicaid for children in foster care and children whose adoptive families are receiving adoption assistance services. Clients are served up to age 21, with the possibility of extending coverage to age 26 depending on client eligibility.

Aid to the Blind and Disabled Program (ABAD)

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). The income limit is 100 percent of the SSI level (roughly 74 percent of FPL), unless the client also meets long-term care criteria, in which case the income limit rises to 300 percent of SSI (roughly 225 percent of FPL).

Old Age Assistance (OAA)

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

OHP Standard Benefit Package (discontinued December 31, 2013)

This program has ended, with clients transferred to the new ACA Adults caseload. Prior to ACA, clients in OHP Standard were not eligible for traditional Medicaid programs. OHP Standard provided a reduced package of services compared to the OHP Plus pro-

gram. OHP Standard also required participants to share some of the cost of their medical care through premiums and co-payments.

Other Medical Assistance Programs (Non-OHP Benefit Packages)

Citizen/Alien Waived Emergent Medical (CAWEM)

Citizen/Alien Waived Emergent Medical is a program that covers emergent medical care for individuals who would qualify for Medicaid if they met the citizenship/residency requirements. 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 postpartum).

Qualified Medicare Beneficiary (QMB)

Qualified Medicare Beneficiary clients meet the criteria for both Medicare and Medicaid participation. Clients in this caseload have incomes from 100 percent of SSI (roughly 74 percent of FPL) to 100 percent of FPL, and 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)

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 full OHP Plus benefits. Clients are eligible until reaching the age of 65, obtaining other coverage, or ending treatment.

KidsConnect (discontinued December 31, 2013)

This program has ended, with clients transferred to the CHIP caseload. KidsConnect was part of the Healthy Kids program, offering private market insurance for children under age 19 with family income levels of 200 to 300 percent of FPL. The program had special funding and required a sliding scale co-pay to participate.

ADDICTIONS AND MENTAL HEALTH (AMH)

The Addictions and Mental Health program provides prevention and treatment options for clients with addictions and/or mental illnesses.

The mental health caseload groups have been redefined starting with the Fall 2014 forecast. The AMH caseload forecast is the total number of clients receiving government paid mental health services per month. AMH provides both Mandated and Non-Mandated mental health services, some of which are residential.

Total Mandated Population

Mandated caseloads include 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.

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.

Guilty Except for Insanity (GEI)

The GEI caseload includes clients who are under the jurisdiction of the Psychiatric Security Review Board as well as clients at the State Hospital who are under the jurisdiction of the State Hospital Review Panel. Clients in GEI 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.

Civil Commitment

This caseload has been redefined to include only individuals currently under commitment (although a proxy rule is currently being used to estimate the end date for clients' mandated service). 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. They may be served at the State Hospital or in the community.

Previously Committed

This is a new caseload. The Previously Committed caseload includes people who were previously either civilly or criminally committed but whose commitment period has ended. These clients continue to receive individual services, counseling, training, and/or living supports. About 80 percent of these clients are served in non-residential settings only, and the rest are served in residential settings, the State Hospital, or Acute Care hospital settings.

Never Committed

This is a new caseload. The Never Committed caseload includes people who have never been either civilly or criminally committed but who are receiving mental health services either in the community or in a residential setting. About 97 percent of these clients are served in non-residential settings only, and 2 percent are served in Acute Care hospital settings. The rest are served in residential settings or the State Hospital. Clients in the State Hospital are of a voluntary or voluntary by guardian status.



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