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EXECUTIVE SUMMARY

The Supplemental Nutrition Assistance Program (SNAP) Biennial Average Forecast for 2013–15 is 437,890 households, 0.1 percent higher than the Fall 2014 forecast. The forecast average for the 2015–17 biennium is 419,753 households, 4.1 percent lower than the forecast average for 2013–15.

The Temporary Assistance to Needy Families (TANF) Biennial Average Forecast for 2013–15 is 32,212 families, 2.2 percent lower than the Fall 2014 forecast. The forecast average for the 2015–17 biennium is 28,050 families, 12.9 percent lower than the forecast average for 2013–15.

The Child Welfare Biennial Average Forecast for 2013–15 is 21,195 children, 0.7 percent lower than the Fall 2014 forecast. The forecast average for the 2015–17 biennium is 21,177 children, 0.1 percent lower than the forecast average for 2013–15.

The Vocational Rehabilitation Biennial Average Forecast for 2013–15 is 8,922 clients, 0.2 percent lower than the Fall 2014 forecast. The forecast average for the 2015–17 biennium is 10,100 clients, 13.2 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 30,799 clients, 2.0 percent higher than the Fall 2014 forecast. The forecast average for the 2015–17 biennium is 34,071 clients, 10.6 percent higher than the forecast average for 2013-15.

The Intellectual and Developmental Disabilities Case Management Biennial Average Forecast for 2013–15 is 22,383 clients, 0.4 percent higher than the Fall 2014 forecast. The forecast average for the 2015–17 biennium is 24,438 clients, 9.2 percent higher than the forecast average for 2013–15.

The total Medical Assistance Programs Biennial Average Forecast for 2013–15 is 971,405 clients, 3.8 percent higher than the Fall 2014 forecast. The forecast average for the 2015–17 biennium is 1,023,600 clients, 5.4 percent higher than the forecast average for 2013–15. The current caseloads are higher than expected due to deferred redeterminations.

The total Adult Mental Health Biennial Average Forecast for the 2013–15 biennium is 62,766 clients served. This includes clients who are currently committed (2,144 people), who were committed sometime in the past (3,393 people), and who have never been committed (57,229 people). The forecast average for the 2015–17 biennium is 67,534 clients, 7.6 percent higher than the Spring 2015 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 Spring 2015 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 Intellectual 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. The annual forecast quality report, which compares forecast accuracy across programs and over time, is also available.  

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.
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 passed a milestone in November 2014 when total nonfarm employment surpassed pre-recession levels. This growth, however, has not been evenly distributed among economic sectors. In December 2014 there were 24,000 fewer construction jobs (-24%) and 21,300 fewer durable goods manufacturing jobs (-14%) than in December 2007. At the other end of the spectrum, there were 32,300 more jobs in health care and social assistance (+17%) and, 8,900 more jobs in more jobs in accommodation and food services (+6%). 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 who were 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 for 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 than manufacturing or construction employment. Such employment dynamics explain why, for example, Oregon’s SNAP caseload has remained stubbornly high in spite of overall job gains.

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. Some of the major risks listed in the first quarter 2015 edition are 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.

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.
Department of Human Services
## Total Department of Human Services Biennial Average Forecast Comparison

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Current Biennium</th>
<th>% Change Between Current Biennial Forecast Comparison</th>
<th>Spring 15 Forecast</th>
<th>% Change Between Biennia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fall 14 Forecast</td>
<td>Spring 15 Forecast</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self Sufficiency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suppliment Nutrition Assistance Program (households)</td>
<td>437,387</td>
<td>437,890</td>
<td>0.1%</td>
<td>437,890</td>
</tr>
<tr>
<td>Temporary Assistance for Needy Families - Basic and UN</td>
<td>32,953</td>
<td>32,212</td>
<td>-2.2%</td>
<td>32,212</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Welfare (children served)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adoption Assistance</td>
<td>11,101</td>
<td>11,146</td>
<td>0.4%</td>
<td>11,146</td>
</tr>
<tr>
<td>Guardianship Assistance</td>
<td>1,382</td>
<td>1,380</td>
<td>-0.1%</td>
<td>1,380</td>
</tr>
<tr>
<td>Out-of-Home Care</td>
<td>7,319</td>
<td>7,206</td>
<td>-1.5%</td>
<td>7,206</td>
</tr>
<tr>
<td>Child In-Home</td>
<td>1,543</td>
<td>1,463</td>
<td>-5.2%</td>
<td>1,463</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vocational Rehabilitation Services</td>
<td>8,936</td>
<td>8,922</td>
<td>-0.2%</td>
<td>8,922</td>
</tr>
<tr>
<td>Aging and People with Disabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Care: In-Home</td>
<td>14,438</td>
<td>14,994</td>
<td>3.9%</td>
<td>14,994</td>
</tr>
<tr>
<td>Long-Term Care: Community-Based</td>
<td>11,526</td>
<td>11,530</td>
<td>0.0%</td>
<td>11,530</td>
</tr>
<tr>
<td>Long-Term Care: Nursing Facilities</td>
<td>4,219</td>
<td>4,275</td>
<td>1.3%</td>
<td>4,275</td>
</tr>
<tr>
<td>Intellectual and Developmental Disabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Case Management Enrollment</td>
<td>22,303</td>
<td>22,383</td>
<td>0.4%</td>
<td>22,383</td>
</tr>
<tr>
<td>Total I/DD Services</td>
<td>16,067</td>
<td>16,169</td>
<td>0.6%</td>
<td>16,169</td>
</tr>
</tbody>
</table>
Self Sufficiency Programs

Supplemental Nutrition Assistance Program (SNAP) — There were 434,924 households (773,893 persons) receiving SNAP benefits in January 2015, 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 26,561 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 437,890 households, 0.1 percent higher than the Fall 2014 forecast. The Spring 2015 Forecast average for the 2015–17 biennium is 419,753 households, 4.1 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 29,604 families receiving TANF benefits in January 2015. 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 7,007 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 32,212 families, 2.2 percent lower than the Fall 2014 forecast. The current forecast average for the 2015–17 biennium is 28,050 families, 12.9 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 as a result of the current legislative session. The TANF caseload also could be affected by the issues stated in the “Forecast environment and risks” section, above.

Pre-SSI - The Spring 2015 forecast for the 2013–15 biennium is 501 families, 0.2 percent lower than the Fall 2014 forecast. The caseload is expected to average 470 families during the 2015–17 biennium, 6.2 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 Spring 2015 forecast for the 2013–15 biennium is 452 families, 0.7 percent higher than the Fall 2014 forecast. The caseload is expected to average 465 families during the 2015–17 biennium, 2.9 percent higher than the forecast for the current biennium.
<table>
<thead>
<tr>
<th>Category</th>
<th>Current Biennium</th>
<th>% Change Between Biennia</th>
<th>Spring 15 Forecast</th>
<th>% Change Between Biennia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fall 14 Forecast</td>
<td>Spring 15 Forecast</td>
<td>2013-15</td>
<td>2015-17</td>
</tr>
<tr>
<td>Supplemental Nutrition Assistance Program (households)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self Sufficiency</td>
<td>316,190</td>
<td>317,297</td>
<td>0.4%</td>
<td>317,297</td>
</tr>
<tr>
<td>Aging and People with Disabilities</td>
<td>121,197</td>
<td>120,593</td>
<td>-0.5%</td>
<td>120,593</td>
</tr>
<tr>
<td>Total SNAP</td>
<td>437,387</td>
<td>437,890</td>
<td>0.1%</td>
<td>437,890</td>
</tr>
<tr>
<td>Temporary Assistance for Needy Families (families: cash/grants)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic</td>
<td>27,589</td>
<td>26,949</td>
<td>-2.3%</td>
<td>26,949</td>
</tr>
<tr>
<td>UN</td>
<td>5,364</td>
<td>5,263</td>
<td>-1.9%</td>
<td>5,263</td>
</tr>
<tr>
<td>Total TANF</td>
<td>32,953</td>
<td>32,212</td>
<td>-2.2%</td>
<td>32,212</td>
</tr>
<tr>
<td>Pre-SSI (families)</td>
<td>502</td>
<td>501</td>
<td>-0.2%</td>
<td>501</td>
</tr>
<tr>
<td>Temporary Assistance for Domestic Violence Survivors (families)</td>
<td>449</td>
<td>452</td>
<td>0.7%</td>
<td>452</td>
</tr>
</tbody>
</table>
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. Additionally, data definitions for some of these caseloads continue to evolve.

**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. Following the Fall 2014 forecast, caseload growth has been moderate, increasing 1.1 percent between April and October 2014. The caseload is expected to average 11,146 for the 2013-15 biennium, 0.4 percent higher than the Fall 2014 forecast. The caseload is expected to average 11,322 over the 2015-17 biennium, 1.6 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. The caseload grew 5.6 percent between January and October 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 Spring 2015 forecast reflects this expected growth. The caseload is expected to average 1,380 for the 2013-15 biennium, 0.1 percent lower than the Fall 2014 forecast. The caseload is expected to average 1,569 over the 2015-17 biennium, 13.7 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 October 2014, the caseload decreased 12 percent. During this time some of the residential programs closed and there were fewer beds available. There are also 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 caseload is expected to average 7,206 for the 2013-15 biennium, 1.5 percent lower than the Fall 2014 forecast. The caseload is expected to average 6,972 over the 2015-17 biennium, 3.2 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. Since implementation of the OR-Kids data system, the caseload has exhibited an almost continuous slow decline. A workgroup was convened recently to revise the definition of children served in-home. When the new definition is incorporated into the data system, the caseload will likely be higher than the current count. However, in the meantime, the caseload is expected to continue its recent leveling trend as the data about children gradually becomes more precise. The caseload is expected to average 1,463 for the 2013-15 biennium, 5.2 percent lower than the Fall 2014 forecast. The caseload is expected to average 1,314 over the 2015-17 biennium, 10.2 percent lower than the biennial average forecast for 2013-15.
Risk and Assumptions

Risks to this forecast include expansion 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 any of the Child Welfare caseloads.

Risks to the Out of Home Care caseload mainly involve the treatment foster care program. Providers may close suddenly or not accept referrals. They also face challenges recruiting foster parents. There may be a need for services but a lack of people to provide those services. As new programs start, it is unknown how quickly the beds will fill.

Additionally, as mentioned above, there is a group working to re-define the Child in Home caseload. New definitions for Child in Home will likely affect which children are counted as part of the caseload, and the caseload may jump by 100 to 200 children. Another risk is the influence of over-due or unclosed assessments; if not entered in the system, Child in Home numbers could be affected.
NOTE: There are no historical observations from Aug 11- Oct 11 for Child In Home due to the start of ORKids data and the end of Legacy data.
## Child Welfare Biennial Average Forecast comparison

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Current Biennium</th>
<th>% Change Between Forecasts</th>
<th>Spring 15 Forecast</th>
<th>% Change Between Biennia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fall 14 Forecast</td>
<td>Spring 15 Forecast</td>
<td>2013-15</td>
<td>2015-17</td>
</tr>
<tr>
<td>Adoption Assistance</td>
<td>11,101</td>
<td>11,146</td>
<td>0.4%</td>
<td>11,146</td>
</tr>
<tr>
<td>Guardianship Assistance</td>
<td>1,382</td>
<td>1,380</td>
<td>-0.1%</td>
<td>1,380</td>
</tr>
<tr>
<td>Out-of-Home Care</td>
<td>7,319</td>
<td>7,206</td>
<td>-1.5%</td>
<td>7,206</td>
</tr>
<tr>
<td>Child In-Home</td>
<td>1,543</td>
<td>1,463</td>
<td>-5.2%</td>
<td>1,463</td>
</tr>
<tr>
<td><strong>Total Child Welfare</strong></td>
<td><strong>21,345</strong></td>
<td><strong>21,195</strong></td>
<td><strong>-0.7%</strong></td>
<td><strong>21,195</strong></td>
</tr>
</tbody>
</table>
From 2006 through 2008 the VR 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 2009 caseload averaged 6,000 clients per month and the waiting list averaged 3,350 clients per month. Since then, VR has avoided placing clients on the waiting list and the caseload has averaged 8,700 clients over the past three years. The Spring 2015 forecast for the 2013–15 biennium is 8,922 clients, about the same as the Fall 2014 forecast. The caseload is expected to average 10,100 clients during the 2015–17 biennium, 13.2 percent higher than in 2013–15. Executive Order 15-01 requires DHS to serve an average of 800 additional clients each year through FY 2022. This increase has been incorporated into the Spring 2015 forecast. Risks include the effects of EO 15-01, the outcome of the Disability Rights Oregon lawsuit, and a possible Order of Selection. The Workforce Innovation and Opportunity Act (PL 113-128) was signed into law in July 2014 and is scheduled to take effect July 1, 2015. This new federal law as well as the other identified risks may lead to significant changes in the VR program over the next several years.
## Vocational Rehabilitation Services Biennial Average Forecast comparison

<table>
<thead>
<tr>
<th></th>
<th>Current Biennium</th>
<th>% Change Between Forecasts</th>
<th>Spring 15 Forecast</th>
<th>% Change Between Biennia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fall 14 Forecast</td>
<td>Spring 15 Forecast</td>
<td>2013-15</td>
<td>2015-17</td>
</tr>
<tr>
<td>Total receiving service</td>
<td>8,936</td>
<td>8,922</td>
<td>-0.2%</td>
<td>8,922</td>
</tr>
</tbody>
</table>
Historically, Oregon’s LTC services were provided under the authority of a Medicaid 1915 (c) Home and Community-Based Services (HCBS) Waiver. Starting in July 2013, Oregon began offering services through the Community First Choice Option under 1915 (k) of the Social Security Act (referred to as “K Plan”); and at this time, most services are provided via K Plan rather than the HCBS Waiver.

Over the last thirteen years, the Total Long-Term Care (LTC) caseload has varied from a high of 31,400 in November 2002 to a low of 25,900 in May 2008; with slightly over half of that decline occurring between November 2002 and June 2003 when the LTC eligibility rules were modified to cover only clients in Service Priority Levels 1 to 13. From 2008 to 2013 the caseload grew by only 2.7 percent a year, despite a serious recession and significant growth in the number of Oregon seniors. However, in late 2013 the caseload growth rose to 6.9 percent a year due to factors such as the implementation of K Plan, expansion of Medicaid, and various changes made by APD to make in-home care more attractive. Whether this is a level shift or a new trend is not yet clear.

**Total Long-Term Care** — A total of 31,500 clients received long-term care services in October 2014. The biennial average forecast for 2013-15 is 30,799, 2.0 percent higher than the Fall 2014 forecast. The biennial average forecast for 2015-17 is 34,071 clients, 8.4 percent higher than 2013-15. By June 2017 In-Home Care is forecasted to be 54.5 percent of total LTC.

Recent growth in the In-Home Care caseload may be due to several factors including implementation of K Plan, expansion of Medicaid, and implementation 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 – an amount that was difficult to live on. 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 lead more individuals to request In-Home Care.

**Community-Based Care (CBC)** — In October 2014, 11,581 clients received Community-Based Care, which accounted for 36.5 percent of total LTC at that time. The biennial average forecast for 2013-15 is 11,530 clients, essentially unchanged from the Fall 2014 forecast. The biennial average forecast for 2015-17 is 11,913 clients, a 3.3 percent increase from 2013-15. By June 2017 Community-Based Care is forecasted to be 34 percent of total LTC.
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 forecast, while Adult Foster Care (AFC) became smaller. Several factors may be contributing to the recent decline in AFC caseload: policy changes that make In-Home Care more attractive may reduce demand for foster care; providers apparently consider the current reimbursement rate inadequate and often request exception rates – but the exception approval process is cumbersome; workforce unionization 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 October 2014, 4,263 clients received Nursing Facility Care, which accounted for 13.5 percent of total LTC at that time. The biennial average forecast for 2013-15 is 4,275, 1.3 percent higher than the Fall 2014 forecast. The biennial average forecast for 2015-17 is 4,043, 5.4 percent lower than 2013-15. By June 2017 Nursing Facility Care is forecasted to be 11.5 percent of total LTC.

**Risk and Assumptions**

Implementation of the Patient Protection and Affordable Care Act of 2010 (ACA) changed the playing field for long-term care in Oregon and introduced significant new risks to the forecast. By shifting from operating under the HCBS Waiver to the K Plan in late 2013, the eligibility rules for long-term care were loosened. Then the expansion of Medicaid to a much larger pool of low income adults pushed the door open wider. To qualify for LTC under the HCBS Waiver, clients had to meet four criteria: 1) be assessed as needing the requisite Level of Care, 2) be over 65 years old or have an official determination of disability, 3) have income below 300 percent of SSI (roughly 2.25 times FPL), and 4) have very limited assets. However, under K Plan, clients only need to meet two criteria: 1) be assessed as needing the requisite Level of Care, and 2) have income below 138 percent of FPL. While the HCBS Waiver allows clients to have a higher income, K Plan has no asset limits and no requirement to be either officially determined disabled or over 65 years old.

K Plan’s reduced requirement may also open the door to clients whose needs are relatively short in duration. Recent changes in the pattern of new entrants to long-term care indicate that ACA (K Plan and Medicaid expansion) is causing the long-term care caseload to grow. What is not yet clear is whether we are undergoing a level shift (one-time), or have changed to a new growth pattern (ongoing).

Another significant risk was 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. In contrast, 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.

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

- History
- Fall 2014 Forecast
- Additional Actuals after Previous Forecast
- Spring 2015 Forecast

Total In-Home Services

- History
- Fall 2014 Forecast
- Additional Actuals after Previous Forecast
- Spring 2015 Forecast

Total Nursing Facility Care

- History
- Fall 2014 Forecast
- Additional Actuals after Previous Forecast
- Spring 2015 Forecast

Total Community-Based Care

- History
- Fall 2014 Forecast
- Additional Actuals after Previous Forecast
- Spring 2015 Forecast
CBC: Assisted Living

CBC: Residential Care Total

CBC: Adult Foster Care

CBC: Program of All-Inclusive Care for the Elderly
## Aging and People with Disabilities Biennial Average Forecast comparison

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Current Biennium</th>
<th>% Change Between Biennia</th>
<th>Spring 15 Forecast</th>
<th>% Change Between Biennia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fall 14</td>
<td>Spring 15 Forecast</td>
<td>2013-15</td>
<td>2015-17</td>
</tr>
<tr>
<td></td>
<td>Forecast</td>
<td>Forecast</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Home Hourly without SPPC</td>
<td>9,136</td>
<td>9,494</td>
<td>3.9%</td>
<td>9,494</td>
</tr>
<tr>
<td>In-Home Agency without SPPC</td>
<td>1,387</td>
<td>1,483</td>
<td>6.9%</td>
<td>1,483</td>
</tr>
<tr>
<td>In-Home Live-In</td>
<td>1,892</td>
<td>1,916</td>
<td>1.3%</td>
<td>1,916</td>
</tr>
<tr>
<td>In-Home Spousal Pay</td>
<td>92</td>
<td>95</td>
<td>3.3%</td>
<td>95</td>
</tr>
<tr>
<td>Independent Choices</td>
<td>294</td>
<td>316</td>
<td>7.5%</td>
<td>316</td>
</tr>
<tr>
<td>Specialized Living</td>
<td>180</td>
<td>181</td>
<td>0.6%</td>
<td>181</td>
</tr>
<tr>
<td><strong>In-Home K Plan Subtotal</strong></td>
<td>12,981</td>
<td>13,485</td>
<td>3.9%</td>
<td>13,485</td>
</tr>
<tr>
<td>In-Home Hourly with State Plan Personal Care</td>
<td>1,149</td>
<td>1,189</td>
<td>3.5%</td>
<td>1,189</td>
</tr>
<tr>
<td>In-Home Agency with State Plan Personal Care</td>
<td>308</td>
<td>320</td>
<td>3.9%</td>
<td>320</td>
</tr>
<tr>
<td><strong>In-Home Non-K Plan Subtotal</strong></td>
<td>1,457</td>
<td>1,509</td>
<td>3.6%</td>
<td>1,509</td>
</tr>
<tr>
<td><strong>Total In-Home</strong></td>
<td>14,438</td>
<td>14,994</td>
<td>3.9%</td>
<td>14,994</td>
</tr>
<tr>
<td>Assisted Living</td>
<td>4,211</td>
<td>4,246</td>
<td>0.8%</td>
<td>4,246</td>
</tr>
<tr>
<td>Adult Foster Care</td>
<td>3,073</td>
<td>3,044</td>
<td>-0.9%</td>
<td>3,044</td>
</tr>
<tr>
<td>Contract Residential Care</td>
<td>2,158</td>
<td>2,163</td>
<td>0.2%</td>
<td>2,163</td>
</tr>
<tr>
<td>Regular Residential Care</td>
<td>1,042</td>
<td>1,031</td>
<td>-1.1%</td>
<td>1,031</td>
</tr>
<tr>
<td>Program of All-Inclusive Care for the Elderly (PACE)</td>
<td>1,042</td>
<td>1,046</td>
<td>0.4%</td>
<td>1,046</td>
</tr>
<tr>
<td><strong>Community-Based Care Subtotal</strong></td>
<td>11,526</td>
<td>11,530</td>
<td>0.0%</td>
<td>11,530</td>
</tr>
<tr>
<td>Basic Nursing Facility Care</td>
<td>3,615</td>
<td>3,640</td>
<td>0.7%</td>
<td>3,640</td>
</tr>
<tr>
<td>Complex Medical Add-On</td>
<td>505</td>
<td>539</td>
<td>6.7%</td>
<td>539</td>
</tr>
<tr>
<td>Enhanced Care</td>
<td>55</td>
<td>52</td>
<td>-5.5%</td>
<td>52</td>
</tr>
<tr>
<td>Pediatric Care</td>
<td>44</td>
<td>44</td>
<td>0.0%</td>
<td>44</td>
</tr>
<tr>
<td><strong>Nursing Facilities Subtotal</strong></td>
<td>4,219</td>
<td>4,275</td>
<td>1.3%</td>
<td>4,275</td>
</tr>
<tr>
<td><strong>Total Long-Term Care</strong></td>
<td>30,183</td>
<td>30,799</td>
<td>2.0%</td>
<td>30,799</td>
</tr>
</tbody>
</table>
Intellectual and Developmental Disabilities

Historically, Oregon’s I/DD services were provided under the authority of a Medicaid 1915 (c) Home and Community-Based Services (HCBS) Waiver. Starting in July 2013, Oregon began offering services through the Community First Choice Option under 1915 (k) of the Social Security Act (referred to as K Plan); and at this time, most services are provided via K Plan rather than the HCBS Waiver.

Case Management Enrollment is an entry-level eligibility, evaluation, and coordination service delivered to all individuals with intellectual and developmental disabilities. There were 22,771 clients enrolled in Case Management in October 2014, (of which over 73 percent received additional I/DD services). The biennial average forecast for 2013–15 is 22,383 clients, 0.4 percent higher than the Fall 2014 forecast. The forecast for the 2015–17 biennium is 24,438 clients, a 9.2 percent increase from 2013-15.

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

Adult Services include:

Brokerage Enrollment — K Plan requires that services be provided to all eligible applicants either through Brokerages or Community Developmental Disability Programs (CDDPs). The last three forecasts (Fall 2013 – Fall 2014) assumed that demand for Brokerage services would follow its historical pattern, topping out at 7,805 (the contracted number of slots), at which time new clients would be diverted to county CDDPs and served primarily through Comprehensive In-Home Services (CIHS). However, after growing by five percent in 2013, the Brokerage caseload has hovered in the low 7,600’s, while the CIHS caseload has continued to grow. Consequently, the two caseloads are now being forecast independently of one another.

The Brokerage caseload is forecast to grow very slowly with most new clients expected to enroll in CIHS. The biennial average forecast for 2013-15 is 7,583 clients, 0.9 percent less than the Fall 2014 forecast. And the biennial average forecast for 2015-17 is 7,691 clients, a 1.4 percent decrease from 2013-15.

24-Hour Residential Care — The biennial average forecast for 2013–15 is 2,696 clients, essentially unchanged from the Fall 2014 forecast. The biennial average forecast for the 2015–17 biennium is 2,791 clients, a 3.5 percent increase from 2013-15.

Supported Living - The biennial average forecast is 710 clients for 2013–15, and 716 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. While the rise in this caseload has been anticipated for some time, the exact timing and magnitude has been difficult to project. Caseload was 312 in mid-2013, 371 in mid-2014; and is forecast to be 893 in mid-2015, 1,168 in mid-2016, and 1,364 in mid-2017. The biennial average forecast for 2013–15 is 545 clients, 47.7 percent higher than the Fall 2014 forecast. The forecast for the 2015–17 biennium is 1,164 clients, a 113.6 percent increase from 2013-15.

I/DD Foster Care — This caseload serves both adults and children, with children representing approximately 18 percent. When the Children Proctor Care program closed in December 2013, most proctor care clients transferred to foster care, raising the foster care caseload by roughly 40. The biennial average forecast for 2013–15 is 3,070 clients, 0.3 percent lower than the Fall 2014 forecast. The biennial average forecast for 2015-17 is 3,196 clients, a 4.1 percent increase from 2013-15.

Stabilization and Crisis Unit — This category also serves both adults and children, with children representing approximately 12 percent. This caseload is expected to remain at the current level of 100 to 108 through 2015-17.
Children's Services:

In-Home Support for Children - This caseload started growing rapidly following K Plan implementation in late 2013, and is forecasted to continue increasing throughout the forecast horizon. While the rise in this caseload has been anticipated for some time, the exact timing and magnitude has been difficult to project. The Fall 2014 assumptions are still considered valid and the timing has been adjusted to reflect recent actuals. Caseload was 187 in mid-2013, 872 in mid-2014; and is forecast to be 1,771 in mid-2015, 2,030 in mid-2016, and 2,289 in mid-2017. The biennial average forecast for 2013-15 is 911 clients, 1.7 percent higher than the Fall 2014 forecast; and the biennial average forecast for 2015-17 is 2,041 clients, a 124.0 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 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 387 children, and the biennial average for 2015-17 is 411 children.


Other Services:

Employment and Day Support Activities - The biennial average forecast for 2013-15 is 4,230 clients, 0.7 percent lower than the Fall 2014 forecast. The biennial average forecast for 2015-17 is 4,416 clients, a 4.4 percent increase from 2013-15.

As part of the Employment First initiative (EFI), 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. Implementation of EFI may cause the caseload to exceed the current forecast; it will also lead to the category being redefined in the future.

Transportation - This caseload is based on payment data which does not include services funded by local match. Since the Spring 2014 forecast, more clients have been covered by local match. The biennial average forecast for 2013–15 is 1,837 clients, 2.2 percent lower than the Fall 2014 forecast. The biennial average forecast for 2015–17 biennium is 1,833 clients, essentially unchanged from the Fall 2014 forecast.

Crisis Services - Crisis service is closed in July 2014.

Risks and Assumptions

The biggest forecast risks for the I/DD caseloads result from Oregon’s decision to utilize the new Medicaid State Plan (K) Option (K Plan) available under the Patient Protection and Affordable Care Act of 2010. K Plan requires the state to provide service to all eligible individuals who wish to be served, and changes the rules under which I/DD children are determined eligible.

K Plan implementation most directly impacts two caseloads: Comprehensive In-Home Services (for adults) and In-Home Support for Children.

Comprehensive In-Home Services - Since adults are served primarily through two channels – Brokerages and CDDPs – and the brokerages are nearly at capacity: most of the adult caseload growth will be in the Comprehensive In-Home Services. However, since the Brokerage caseload is constrained by the number of contracted slots, contract changes (e.g. increasing the number of contracted slots, or shifting unutilized seats to brokerages with waiting lists) could impact both the Brokerage Enrollment caseload and Comprehensive In-Home Service caseload.
In-Home Support for Children - K Plan’s biggest impact for children is that eligibility is based on the child’s income, not the family’s income – thereby making most I/DD children eligible for service. Since most previously unserved I/DD children live with their families, the caseload most impacted by the change is In-Home Support for Children. The In-Home Support for Children caseload averaged fewer than 200 prior to K Plan, but had already grown to 1,300 by October 2014, and is expected to exceed 2,000 by the end of 2015-17.

To forecast the likely volume of In-Home Support for Children cases, the 6 largest CDDPs were surveyed in spring 2014 about their current and anticipated service volume. A forecast was then developed based on 1) the estimated pool of potential applicants, 2) CDDP survey results prorated to reflect the full state, 3) extensive discussion with the I/DD Caseload Forecast Advisory Committee, and 4) forecaster’s judgment. The subsequent forecasts – Fall 2014 and Spring 2015 – were adjusted modestly to reflect additional data available. Accurately estimating the caseload increase is difficult for a variety of reasons. Application processing began slowly in November 2013, escalated rapidly in early 2014, and is already starting to slow. New data patterns may not stabilize for quite some time, and CPMS processing backlogs have complicated the picture by increasing the lag time needed before caseloads can be considered final. It should also be noted that there may be families with I/DD children who, having not enrolled in Case Management, were not represented in the pool of eligible clients.

It should be noted that implementation of K Plan also created capacity challenges for 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, making the CDDPs workload backlog even larger, and obscuring any new data patterns. On a positive note, an electronic I/DD Plan of Care that is compatible with the K Plan eligibility requirements was rolled out in September 2014 and is expected to be completed by April 2015; this will improve I/DD staff efficiency.
The sharp decline of caseload in July 2011 is due to exclusion of local match population using Transportation services (about 695).
### Intellectual and Developmental Disabilities Biennial Average Forecast comparison

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Current Biennium</th>
<th>Fall 14 Forecast</th>
<th>Spring 15 Forecast</th>
<th>% Change Between Forecasts</th>
<th>Spring 15 Forecast</th>
<th>% Change Between Biennia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Case Management Enrollment¹</td>
<td>22,303</td>
<td>22,383</td>
<td>0.4%</td>
<td>22,383</td>
<td>24,438</td>
<td>9.2%</td>
</tr>
<tr>
<td>Adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brokerage Enrollment</td>
<td>7,650</td>
<td>7,583</td>
<td>-0.9%</td>
<td>7,583</td>
<td>7,691</td>
<td>1.4%</td>
</tr>
<tr>
<td>24-Hour Residential Care</td>
<td>2,698</td>
<td>2,696</td>
<td>-0.1%</td>
<td>2,696</td>
<td>2,791</td>
<td>3.5%</td>
</tr>
<tr>
<td>Supported Living</td>
<td>706</td>
<td>710</td>
<td>0.6%</td>
<td>710</td>
<td>716</td>
<td>0.8%</td>
</tr>
<tr>
<td>Comprehensive In-Home Services²</td>
<td>369</td>
<td>545</td>
<td>47.7%</td>
<td>545</td>
<td>1,164</td>
<td>113.6%</td>
</tr>
<tr>
<td>I/DD Foster Care³</td>
<td>3,079</td>
<td>3,070</td>
<td>-0.3%</td>
<td>3,070</td>
<td>3,196</td>
<td>4.1%</td>
</tr>
<tr>
<td>Stabilization and Crisis Unit³</td>
<td>106</td>
<td>105</td>
<td>-0.9%</td>
<td>105</td>
<td>108</td>
<td>2.9%</td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Home Support for Children²</td>
<td>896</td>
<td>911</td>
<td>1.7%</td>
<td>911</td>
<td>2,041</td>
<td>124.0%</td>
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<tr>
<td>Children Intensive In-Home Support</td>
<td>400</td>
<td>387</td>
<td>-3.3%</td>
<td>387</td>
<td>411</td>
<td>6.2%</td>
</tr>
<tr>
<td>Children Residential Care</td>
<td>151</td>
<td>150</td>
<td>-0.7%</td>
<td>150</td>
<td>160</td>
<td>6.7%</td>
</tr>
<tr>
<td>Children Proctor Care³</td>
<td>12</td>
<td>12</td>
<td>0.0%</td>
<td>12</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>Total I/DD Services</td>
<td>16,067</td>
<td>16,169</td>
<td>0.6%</td>
<td>16,169</td>
<td>18,278</td>
<td>13.0%</td>
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<tr>
<td>Other DD Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Employment &amp; Day Support Activities</td>
<td>4,258</td>
<td>4,230</td>
<td>-0.7%</td>
<td>4,230</td>
<td>4,416</td>
<td>4.4%</td>
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<tr>
<td>Transportation</td>
<td>1,879</td>
<td>1,837</td>
<td>-2.2%</td>
<td>1,837</td>
<td>1,833</td>
<td>-0.2%</td>
</tr>
</tbody>
</table>

1. Total I/DD Services and Other I/DD Services do not add up to Total Case Management Enrollment.
2. Caseloads for both Comprehensive In-Home Services and In-Home Support for Children are expected to increase significantly in 2015-17 due to K Plan, although the exact timing and magnitude are difficult to forecast. The Spring 2015 forecast projects faster growth than either the Fall 2014 or Spring 2014 forecasts.
3. Foster Care and the Stabilization and Crisis Unit serve both adults and children: (I/DD FC - 82% / 18%; SACU - 88% / 12% respectively).
4. 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
### Medical Assistance Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Fall 14 Forecast</th>
<th>Spring 15 Forecast</th>
<th>% Change Between Forecasts</th>
<th>Spring 15 Forecast</th>
<th>% Change Between Biennia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OHP Plus</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACA Adults</td>
<td>246,675</td>
<td>275,980</td>
<td>11.9%</td>
<td>275,980</td>
<td>369,083</td>
</tr>
<tr>
<td>Parents/Caretaker Relative</td>
<td>74,859</td>
<td>68,264</td>
<td>-8.8%</td>
<td>68,264</td>
<td>48,607</td>
</tr>
<tr>
<td>Old Age Assistance</td>
<td>37,442</td>
<td>37,787</td>
<td>0.9%</td>
<td>37,787</td>
<td>41,969</td>
</tr>
<tr>
<td>Pregnant Woman Program</td>
<td>16,611</td>
<td>17,921</td>
<td>7.9%</td>
<td>17,921</td>
<td>15,431</td>
</tr>
<tr>
<td>Aid to the Blind &amp; Disabled</td>
<td>83,797</td>
<td>83,490</td>
<td>-0.4%</td>
<td>83,490</td>
<td>84,192</td>
</tr>
<tr>
<td>Children's Medicaid Program</td>
<td>308,052</td>
<td>326,747</td>
<td>6.1%</td>
<td>326,747</td>
<td>316,500</td>
</tr>
<tr>
<td>Children's Health Insurance Program</td>
<td>77,127</td>
<td>69,107</td>
<td>-10.4%</td>
<td>69,107</td>
<td>66,063</td>
</tr>
<tr>
<td>Foster, Substitute &amp; Adoption Care</td>
<td>18,753</td>
<td>18,812</td>
<td>0.3%</td>
<td>18,812</td>
<td>18,753</td>
</tr>
<tr>
<td><strong>Total OHP Plus</strong></td>
<td>863,316</td>
<td>898,108</td>
<td>4.0%</td>
<td>898,108</td>
<td>960,598</td>
</tr>
<tr>
<td><strong>Total Other Medical Assistance Programs</strong></td>
<td>57,059</td>
<td>57,853</td>
<td>1.4%</td>
<td>57,853</td>
<td>63,002</td>
</tr>
<tr>
<td>OHP Standard†</td>
<td>15,444</td>
<td>15,444</td>
<td>1.4%</td>
<td>15,444</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Total Medical Assistance Programs</strong></td>
<td>935,819</td>
<td>971,405</td>
<td>3.8%</td>
<td>971,405</td>
<td>1,023,600</td>
</tr>
</tbody>
</table>

### Addictions and Mental Health‡

<table>
<thead>
<tr>
<th>Program</th>
<th>Fall 14 Forecast</th>
<th>Spring 15 Forecast</th>
<th>% Change Between Forecasts</th>
<th>Spring 15 Forecast</th>
<th>% Change Between Biennia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aid &amp; Assist</td>
<td>158</td>
<td>190</td>
<td>NA</td>
<td>190</td>
<td>203</td>
</tr>
<tr>
<td>Guilty Except for Insanity (GEI)</td>
<td>610</td>
<td>651</td>
<td>NA</td>
<td>651</td>
<td>625</td>
</tr>
<tr>
<td>Civilly Commited†</td>
<td>1,020</td>
<td>1,303</td>
<td>NA</td>
<td>1,303</td>
<td>1,364</td>
</tr>
<tr>
<td><strong>Total Mandated Care</strong></td>
<td>1,788</td>
<td>2,144</td>
<td>NA</td>
<td>2,144</td>
<td>2,192</td>
</tr>
</tbody>
</table>

1. OHP Standard program closed on Dec. 31, 2013 and participants were moved into the ACA Adults caseload.
2. Since the Fall 2014 forecast (which introduced new mental health categories), the data used for forecasting has been updated and improved, resulting in a significant increase in our count of people served by these programs. Future forecasts (the next 1 to 2 cycles) may continue to shift as the new MOTS system becomes standardized as the source for caseload data. These numbers represent adults served.
3. Since clients' actual civil commitment end date is not available, a proxy rule is used to estimate the end date for mandated service.
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 caseload from about 408,000 clients prior to the recession to about 1,009,000 clients in January 2014, for a net increase of 601,000 clients (147 percent increase). The caseload continued growing throughout most of 2014 due to deferred redeterminations, reaching 1,100,000 in October 2014. The Spring 2015 forecast predicts caseload will drop to 1,021,000 by fall 2015 and will grow slowly thereafter.

Despite downward pressure on MAP caseloads from the improving economy, implementation of ACA added more than 366,000 adults to the OHP Plus caseload (including 60,000 who transferred from the discontinued OHP Standard program) and about 12,000 adults to the Citizen/Alien Waived Emergent Medical group. ACA impacts include:

1. Expansion of Medicaid coverage to adults (aged 18-64) with incomes up to 138 percent of the Federal Poverty Level.
2. Expansion of CHIP coverage to children in families with incomes up to 300 percent of the Federal Poverty Level.
3. “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 Program, Children’s Medicaid Program, and CHIP caseloads all experienced some welcome mat effect due to ACA. The exact magnitude, however, is hard to estimate due to other factors such as deferred redetermination and crowd out (see below).
4. Deferred redeterminations – ACA implementation created workload challenges, resulting in postponement of scheduled redeterminations, backlogs of applications, and other technical issues. Consequently, caseloads increased because fewer people exited than normal, and reduced transfers further disrupted the normal caseload patterns. Almost all caseloads were impacted by the delays. Least impacted were: Foster, Substitute Care & Adoption Assistance; Aid to the Blind & Disabled; Old Age Assistance; Breast & Cervical Cancer Treatment Program; and Qualified Medicare Beneficiary.
5. “Crowd Out” effect – Some caseloads declined because the expansion of Medicaid coverage to more low income adults reduced the need for these services. This effect is observed in Parent/Caretaker Relative, Aid to the Blind & Disabled, and Breast & Cervical Cancer Treatment Program.

Risks and Assumptions

ACA implementation is still creating a lot of uncertainty and forecast risk. The biggest known risks for the current forecast are: 1) deferred redeterminations and 2) data quality.

The first major risk arises from temporary changes made to eligibility redetermination practices. Typically, a client is enrolled for a six or twelve-month period, and at the end of that coverage the case is scheduled for a review, and 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 was an intensive period of redeterminations in fall 2014. Due to the large number of cases that needed to be reviewed, an expedited redetermination process was used for most cases. The backlog of deferred redeterminations has been resolved, but two issues remain:

1. The majority of case closures since December 2014 were postponed due to technical and logistical issues. More time was needed to compare the people scheduled for closure with the applications received from Federal Exchange and other avenues. At the time of this forecast, the closure of unmatched cases is expected to occur in March 2015.
2. Starting in April of 2015, some cases that went through the expedited renewal process will reach 18-months since their last full redetermination and according to federal
rules will have to go through a full redetermination process. Thus, there will be another period with increased volume of redeterminations from April through August 2015.

To the extent possible, the Spring 2015 forecast incorporates the impact and the consequences of 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 delays or when redeterminations resume.

The second 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 implementation severely impacted the time series for all three of these components:

1. Exits were disrupted by deferred redeterminations.

2. Transfers were impacted by creation of the new ACA Adults caseload, as well as reorganization of some existing caseloads. In addition, deferred redeterminations disrupted transfer patterns because most transfers occur at the time of eligibility redetermination.

3. New clients were impacted by creation of the new ACA Adults caseload, since individuals enrolled as ACA Adults may not need services they would have used in the past (e.g. Breast & Cervical Cancer Treatment Program, Aid to the Blind & Disabled), or will enter as transfers rather than as new clients (e.g. Pregnant Women, Parent/Caretaker Relative). In addition, deferred redeterminations disrupted new client patterns by reducing “churn”. That is, since redeterminations were not required, fewer people dropped off caseloads temporarily (30-90 days) due to incomplete paperwork.

ACA Adults, the new OHP Plus caseload group, is expected to peak at roughly 426,000 in March 2015. Since the delayed closures are planned to take place at the end of March, a large drop of 26,000 is expected in April. Smaller declines are expected from May through September as 90,000 ACA Adults who enrolled in 2014 via full application (MAGI determination) go through the expedited redetermination process. The caseload is expected to drop to 366,000 by September 2015 and to grow very slowly thereafter. Once leveled out, this caseload will account for 38 percent of the total OHP Plus caseload.

Parent/Caretaker Relative Program, previously known as TANF Medical adults, had a caseload of 76,700 in October 2014. The caseload dropped to 53,000 in December of 2014 after the first wave of intensive redeterminations took place. Then, as a result of delayed closures, the caseload started to grow again. The caseload is expected to reach 59,500 in April 2015, after which it will decline again as the second period of intensive redeterminations begins. By September 2015, the caseload will drop to 51,000 and is expected to continue declining slowly throughout the forecast horizon. By the end of 2015, this caseload will account for 5.3 percent of the total OHP Plus caseload.

Pregnant Woman Program, previously known as Poverty Level Medical – Woman (PLMW), had a caseload of 22,700 in October 2014. After the first wave of intensive redeterminations, the caseload dropped to 19,600 in December 2014. It started to grow again afterwards as a result of delayed closures and is expected to reach 20,750 in March 2015. The first large drop of 2,750 is anticipated in April. By September 2015, the caseload will drop to 16,160 and is expected to continue declining very slowly. By the end of 2015, this caseload will account for 1.7 percent of the total OHP Plus caseload.

Children’s Medicaid Program replaces the caseload previously known as Poverty Level Medical – Children (PLMC). Along with the title change, the caseload was redefined to include children who would previously have been part of the TANF Medical caseload, as well as children 6-18 years of age with family incomes under 133 percent FPL who would previously have been part of the CHIP caseload. The first wave of intensive redeterminations produced a drop of 20,000 in November 2014. However, as with other caseloads, it started to grow again afterward due to delayed closures. The Spring 2015 forecast predicts the caseload will peak at 350,000 in March 2015, after which it will start declining. The caseload is expected to level out at 316,000 by September 2015 and will account for 33 percent of the total OHP Plus caseload.
Children’s Health Insurance Program (CHIP) is expected to be 66,000 in September 2015 and will account for 6.9 percent of the total OHP Plus caseload.

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

Aid to the Blind and Disabled (ABAD) is expected to be 84,100 by September 2015 and to account for 8.8 percent of the total OHP Plus caseload. Although this caseload has grown consistently over many years, slower growth is forecast going forward due to ACA impacts that are hard to accurately quantify. General consensus is that the number of clients entering this caseload will be lower than the historical pattern (slowing the overall rate of growth) since low income adults are now eligible for medical coverage without having to first be officially determined to be disabled. This change represents a risk to the forecast.

Old Age Assistance (OAA) is expected to be 40,700 by September 2015 and will account for 4.2 percent of the total OHP Plus caseload. This caseload is driven by population dynamics as well as economic conditions. Oregon’s elderly population is projected to increase by roughly 4 percent per year. The caseload is forecast to grow steadily through the foreseeable future.

Other Medical Assistance Programs

Citizen-Alien Waived Emergent Medical (CAWEM) declined by about 2,000 in November 2014 after the first wave of intensive redeterminations. However, as with other caseloads, it started to grow again afterwards due to delayed closures. The Spring 2015 forecast predicts that this caseload will be at 42,800 in March 2015 after which it will start declining. The caseload is expected to level out at 36,070 by October of 2015 and will account for 58.3 percent of 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 25,300 by October 2015 and will account for 40.1 percent of Other MAP caseload. This caseload has grown consistently since January of 2009 and is expected to continue growing through the forecast horizon.

Breast and Cervical Cancer Treatment Program (BCCTP) is expected to be 518 in October 2015 and will account for 0.8 percent of Other MAP caseload. This caseload is forecast to continue declining since ACA has reduced the number of uninsured adults who might qualify for the program.
OHP Plus: Children’s Medicaid Program

- History
- Fall 2014 Forecast
- Additional Actuals after Previous Forecast
- Spring 2015 Forecast

OHP Plus: Foster, Substitute and Adoption Care

- History
- Fall 2014 Forecast
- Additional Actuals after Previous Forecast
- Spring 2015 Forecast

OHP Plus: Children’s Health Insurance Program

- History
- Fall 2014 Forecast
- Additional Actuals after Previous Forecast
- Spring 2015 Forecast
## Medical Assistance Programs Biennial Average Forecast comparison

### OHP Plus

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Current Biennium</th>
<th>% Change Between Forecasts</th>
<th>Spring 15 Forecast</th>
<th>% Change Between Biennia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fall 14 Forecast</td>
<td>Spring 15 Forecast</td>
<td>2013-15</td>
<td>2015-17</td>
</tr>
<tr>
<td><strong>ACA Adults with children</strong></td>
<td>64,033</td>
<td>74,209</td>
<td>15.9%</td>
<td>74,209</td>
</tr>
<tr>
<td><strong>ACA Adults without children</strong></td>
<td>182,642</td>
<td>201,771</td>
<td>10.5%</td>
<td>201,771</td>
</tr>
<tr>
<td><strong>Total ACA Adults</strong></td>
<td>246,675</td>
<td>275,980</td>
<td>11.9%</td>
<td>275,980</td>
</tr>
<tr>
<td><strong>Parent/Caretaker Relative</strong></td>
<td>74,859</td>
<td>68,264</td>
<td>-8.8%</td>
<td>68,264</td>
</tr>
<tr>
<td><strong>Old Age Assistance</strong></td>
<td>37,442</td>
<td>37,787</td>
<td>0.9%</td>
<td>37,787</td>
</tr>
<tr>
<td><strong>Pregnant Woman Program</strong></td>
<td>16,611</td>
<td>17,921</td>
<td>7.9%</td>
<td>17,921</td>
</tr>
<tr>
<td><strong>Children's Medicaid Program</strong></td>
<td>308,052</td>
<td>326,747</td>
<td>6.1%</td>
<td>326,747</td>
</tr>
<tr>
<td><strong>Children's Health Insurance Program (CHIP)</strong></td>
<td>77,127</td>
<td>69,107</td>
<td>-10.4%</td>
<td>69,107</td>
</tr>
<tr>
<td><strong>Foster, Substitute &amp; Adoption Care</strong></td>
<td>18,753</td>
<td>18,812</td>
<td>0.3%</td>
<td>18,812</td>
</tr>
<tr>
<td><strong>Aid to the Blind &amp; Disabled</strong></td>
<td>83,797</td>
<td>83,490</td>
<td>-0.4%</td>
<td>83,490</td>
</tr>
<tr>
<td><strong>Total OHP Plus</strong></td>
<td>863,316</td>
<td>898,108</td>
<td>4.0%</td>
<td>898,108</td>
</tr>
</tbody>
</table>

### Other Medical Assistance Programs

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Current Biennium</th>
<th>% Change Between Forecasts</th>
<th>Spring 15 Forecast</th>
<th>% Change Between Biennia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citizen-Alien Waived Emergent Medical - Regular</td>
<td>31,127</td>
<td>32,291</td>
<td>3.7%</td>
<td>32,291</td>
</tr>
<tr>
<td>Citizen-Alien Waived Emergent Medical - Prenatal</td>
<td>2,186</td>
<td>2,093</td>
<td>-4.3%</td>
<td>2,093</td>
</tr>
<tr>
<td>Qualified Medicare Beneficiary</td>
<td>22,942</td>
<td>22,700</td>
<td>-1.1%</td>
<td>22,700</td>
</tr>
<tr>
<td>Breast &amp; Cervical Cancer Treatment Program</td>
<td>804</td>
<td>769</td>
<td>-4.4%</td>
<td>769</td>
</tr>
<tr>
<td><strong>Other Subtotal</strong></td>
<td>57,059</td>
<td>57,853</td>
<td>1.4%</td>
<td>57,853</td>
</tr>
<tr>
<td><strong>OHP Standard</strong></td>
<td>15,444</td>
<td>15,444</td>
<td>0.0%</td>
<td>15,444</td>
</tr>
<tr>
<td><strong>Total Medical Assistance Programs</strong></td>
<td>935,819</td>
<td>971,405</td>
<td>3.8%</td>
<td>971,405</td>
</tr>
</tbody>
</table>

1. 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 criminally and civilly committed patients, 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 State Hospital; (2) Guilty Except for Insanity (GEI), served at the State Hospital and in the community; and (3) Civilly Committed individuals, also served at both the State Hospital and in the community.

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

The 2013 Oregon Legislative Session identified the need to establish a better system for forecasting AMH caseloads. A workgroup was 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 rules 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 groups is:

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

**Non Mandated**
4. Previously Committed
5. Never Committed

The Spring 2015 forecast is the second edition using new definitions, the categories listed above, and a hierarchy for forecasting. A different method of de-duplicating the data was used for this iteration which produced a higher count of individuals served. 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 clients). The biennial average forecast for 2013-15 is 2,144 clients. The 2015-17 biennial average is 2,192 clients, 2.2 percent higher than the 2013-15 biennial average.

**Aid and Assist** — This caseload exhibited steady growth throughout 2013 and into 2014. The Spring 2015 biennial average forecast for 2013-15 is 190 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. Although the numbers in the State Hospital will decrease, the number served will increase, so it will be important to track them in the community. The 2015-17 biennial average is 203 clients, 7.0 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. Nationally, violent crimes are down despite population growth. For the past several years the Total GEI caseload in Oregon has steadily declined. The Spring 2015 biennial average forecast for 2013-15 is 651. The 2015-17 biennial average is 625, 4.0 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. The Spring 2015 biennial average forecast for 2013-15 is 1,303. The Spring 2015 forecast anticipates that the average caseload for the 2015-17 biennium will be 1,364 clients, an increase of 4.7 percent over the biennial average forecast for 2013-15.

Previously Committed caseload — This caseload captures clients receiving mental health services that had been civilly or criminally committed at some time since the year 2000. About 85 percent of these clients are served in non-residential settings, and the rest are served in residential settings, the State Hospital, or Acute Care hospital settings. The biennial average forecast for 2013-15 is 3,393 clients. The 2015-17 biennial average is 3,470 clients, 2.3 percent higher than the biennial average forecast for 2013-15.

Never Committed caseload — This caseload captures clients receiving mental health services that have not been civilly or criminally committed since the year 2000. About 99 percent of these clients are served in non-residential settings. The rest are served in residential settings, Acute Care hospitals, or the State Hospital. The biennial average forecast for 2013-15 is 57,229 clients. The 2015-17 biennial average is 61,871 clients, 8.1 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.

In January 2014, Medicaid enrollment was extended to adults 18-64 years old with incomes up to 138 percent of FPL – thereby extending mental health coverage to over 300,000 previously uninsured adults. Integration of mental health services under the new Coordinated Care Organizations (CCOs) is expected to improve both access to and the effectiveness of mental health services. Unknowns involved with how CCOs will use the community based system, including reporting and referrals, constitutes a risk to the caseload forecast. However, with better access to mental health services, the need for mandated mental health services may be reduced, possibly even within the time horizon of this forecast.

The Aid and Assist caseload may be impacted by legislation being considered this session. One legislative concept would send probation violators back to the State Hospital without going through the Court system. If passed, this would significantly increase the Aid and Assist caseload in the State Hospital. In addition, program leadership is promoting the idea that Aid and Assist can be provided locally, not just at the Oregon State Hospital. To the extent this idea gains traction, caseload would under count the actual number served since data is not currently available for Aid and Assist clients served at other locations.

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, and the 90 bed Portland campus is slated for closure. The 174 bed facility in Junction City is expected to open in March 2015. At the main Oregon State Hospital campus in Salem additional units were opened during the 2013-2015 biennium. It’s possible that these changes will reduce pressure on the civil commit waiting list and acute care settings.
Government funding for community housing programs can also impact mental health caseloads. With reductions in community capacity, there are corresponding limitations to prevention homes, which are built with the intention of keeping clients out of the Oregon State Hospital civil commitment units. In addition, 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.

Another risk is related to the timeliness of reporting. Provider input delays, especially concerning civil commitment data, can lead to artificially low caseload numbers.
Total Mandated Care

Aid and Assist

Civil Commitment

Guilty Except for Insanity (GEI)
### Addictions and Mental Health Biennial Average Forecast comparison

<table>
<thead>
<tr>
<th>Category</th>
<th>Current Biennium</th>
<th>% Change Between Forecasts</th>
<th>Spring 15 Forecast</th>
<th>% Change Between Biennia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fall 14 Forecast</td>
<td>Spring 15 Forecast</td>
<td>2013-15</td>
<td>2015-17</td>
</tr>
<tr>
<td>Under Commitment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aid and Assist</td>
<td>158</td>
<td>190</td>
<td>NA</td>
<td>190</td>
</tr>
<tr>
<td>Guilty Except for Insanity (GEI)</td>
<td>610</td>
<td>651</td>
<td>NA</td>
<td>651</td>
</tr>
<tr>
<td>Civilly Committed²</td>
<td>1,020</td>
<td>1,303</td>
<td>NA</td>
<td>1,303</td>
</tr>
<tr>
<td>Total Mandated Care</td>
<td>1,788</td>
<td>2,144</td>
<td>NA</td>
<td>2,144</td>
</tr>
<tr>
<td>Previously Committed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2,787</td>
<td>3,393</td>
<td>NA</td>
<td>3,393</td>
</tr>
<tr>
<td>Never Committed</td>
<td>43,416</td>
<td>57,229</td>
<td>NA</td>
<td>57,229</td>
</tr>
<tr>
<td>Total Served</td>
<td>47,991</td>
<td>62,766</td>
<td>NA</td>
<td>62,766</td>
</tr>
</tbody>
</table>

1. Since the Fall 2014 forecast (which introduced new mental health categories), the data used for forecasting has been updated and improved, resulting in a significant increase in our count of people served by these programs. Future forecasts (the next 1 to 2 cycles) may continue to shift as the new MOTS system becomes standardized as the source for caseload data. These numbers represent adults served.

2. Since clients’ actual civil commitment end date is not available, a proxy rule is used to estimate the end date for mandated service.
Appendix I
DHS Caseload History & Definitions
Provider Tax reimbursement rate increases for NFC.

Recruiting of new CBC providers in underserved areas; Medicaid participation made more attractive.

Diversion and transition of clients from NFCs to their choice of In-Home or CBC facility services.

Nursing facility diversion begins (Money Follows the Person, aka Oregon on the Move); CBC rate increase.

Residential Care and Assisted Living Facility moratoriums end.

In-Home Agency added to In-Home Care caseload.

On the Move program moratorium.

Relative Foster Care closes, with most clients transferring to In-Home Care.

LTC services offered through the K Plan, with only income limits and level of care assessment.

Home care worker compensation levels reduced by 14%; CBC rates reduced by 19%; NFC rates reduced by 19%.

Income threshold for client pay-in increases to $1,210/month.

Family, friends, and neighbors providing In-Home services may be paid under certain circumstances.

Feb 2003 - Elimination of service priority levels 15-17.

April 2003 - Elimination of service priority levels 12-14.


Families are encouraged to put clients into appropriate services (i.e. In-Home Care, CBC, NFC) through a state managed program.
Face-to-face contact now required at least every 30 days.

The exposure of a child to a meth lab is treated as neglect.

All foster care becomes paid, decreasing TANF Non-Needy Caretaker Relative caseload.

Adoption and guardianship assistance payments can be extended until age 21 for some disabled adoptive youth.

Reimbursement rate redesign implemented.

OR-Kids goes live. DHS begins developing a Differential Response approach to reports of child abuse and neglect.

Feb 2003 - The basic rate for foster care services reimbursed to foster parents is reduced by 7.5% and an additional 10% in special rates.

NOTE: There is no historical observations from May - Nov. 11 due to the start of ORKids data and the end of Legacy data.
Staley settlement requires that all waitlisted clients receive brokerage services.

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

Budget reductions affect I/DD services. Reduced I/DD crisis diversion.

Employment First policy (I/DD) plans to increase enrollment by 15%.

New rate guidelines issued for I/DD Children's In-Home service plans, including Family Support Services, In-Home Support for Children, and Children’s Intensive In-Home Support.

Relative Foster Care is disallowed under I/DD Children's Foster Care per current statutes and Medicaid HCBS Waiver.

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.

Family Support Program (SE 151) restored.

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

Staley settlement requires that all waitlisted clients receive brokerage services.

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

0 10,000 20,000 30,000 40,000 50,000 60,000 70,000 80,000

Jul-05 Jan-06 Jul-06 Jan-07 Jul-07 Jan-08 Jul-08 Jan-09 Jul-09 Jan-10 Jul-10 Jan-11 Jul-11 Jan-12 Jul-12 Jan-13 Jul-13 Jan-14
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.
Asset test aligned with TANF.

Disaster SNAP benefits for 5 NW counties.

Period of steepest Great Recession job loss begins.

Oregon's unemployment rate peaks at 11.6%.

Certain higher education students eligible for SNAP.

SNAP benefits for higher ed students expanded.

Oregon's unemployment rate falls to 7.9%.

Agricultural Act of 2014 (Farm Bill) signed into law. No material effect on SNAP caseload is anticipated.

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

July 2003 - Transitional Benefit Alternatives implemented, which freezes SNAP benefits for 5 months following closure of TANF benefit.

September 2003 - Simplified reporting system adopted, which allows for longer certification periods, fewer reporting requirements, and stable benefits.

Disaster SNAP benefits for 5 NW counties.
TANF reauthorization results in new programs: Pre-TANF, Pre-SSI TANF, State-Only TANF, and Post-TANF. All foster care becomes paid, decreasing Non-Needy Caretaker Relative (NNCR) caseload.

Period of steepest Great Recession job loss begins.

Oregon’s unemployment rate peaks at 11.6%. Non-Needy Caretaker Relative (NNCR) portion of TANF Basic limited to families with incomes below 185% FPL.

Eligibility workers need only review the prior 60 days to determine whether applicant quit a job without good cause. Parents as Scholar program limited to current participants.

Computer glitch inadvertently extends eligibility one additional month to families who did not re-determine on time. Pre-TANF benefits limited.

“Job quit” eligibility is extended from 60 to 120 days.

Oregon’s unemployment rate falls to 7.9%

Secretary of State releases audit of TANF program.

Work begins on redesigning TANF and JOBS programs for 2015 Legislative session.

Field staff and resources begin to shift from eligibility work to case management work.

10,000 unemployment insurance benefit cases expire.

Jan-04 Jul-04 Jan-05 Jul-05 Jan-06 Jul-06 Jan-07 Jul-07 Jan-08 Jul-08 Jun-09 Jul-09 Jan-10 Jul-10 Jan-11 Jul-11 Jan-12 Jul-12 Jan-13 Jul-13 Jan-14 Jul-14

0 10,000 20,000 30,000 40,000 50,000 60,000 70,000 80,000

Self Sufficiency Programs: Temporary Assistance for Needy Families (TANF) Caseload

July 2003 - Oregon’s TANF waiver expires. Transitional Benefit Alternatives implemented, which freezes SNAP benefits for 5 months following closure of TANF.

Most JOBS activities closed due to budget reductions. California reduces overall TANF grant by 8% and lifetime limit for adults from 60 to 48 months. Washington also shortens time limits.

Computer glitch inadvertently extends eligibility one additional month to families who did not re-determine on time. Pre-TANF benefits limited.

Eligibility workers need only review the prior 60 days to determine whether applicant quit a job without good cause. Parents as Scholar program limited to current participants.

Oregon’s unemployment rate falls to 7.9%

Secretary of State releases audit of TANF program.

Work begins on redesigning TANF and JOBS programs for 2015 Legislative session.

Field staff and resources begin to shift from eligibility work to case management work.

10,000 unemployment insurance benefit cases expire.
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.”

2015 Poverty Guidelines for Oregon

<table>
<thead>
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<th>Person in Family/ Household</th>
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<td>8</td>
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Aging and People with Disabilities programs provide Long-Term Care (LTC) services to qualifying people who, due to their age or disabilities, need help with their activities of daily living (ADL), including eating, dressing/grooming, bathing/personal hygiene, mobility, bowel and bladder management, and cognition.

Area Agencies on Aging (AAA) and DHS staff help clients find the appropriate care settings to meet their needs and determine financial eligibility. To qualify, clients must meet financial and non-financial requirements which vary depending on whether the individual will be covered under K Plan or the HCBS Waiver.

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.

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

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 waivered 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 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 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. Changes to this category are anticipated in the near future.

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); 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
OHP funding reduced as a result of 2001 economic recession.

General Fund support removed from the OHP Standard program.

CHIP eligibility resource limit increased to $10,000.

CHIP eligibility certification extended from 6 to 12 months.

TANF Related Medical adjusted income is increased by about 3%.

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

New CHIP eligibility requirements: income limit increased to 201% FPL; no resource limits; must not have had private insurance in the past 2 months (was 6); lawful permanent residents under age 19 are now eligible without 5 years of residency.

Households with children on FHIAP’s reservation list are notified about the Healthy Kids program.

Health System Transformation bill passes and is signed into law.

OHP Standard reservation list re-opens.

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

TANF Related Medical adjusted income is increased by about 3%.

Clients losing FHIAP subsidy are converted to OHP Standard.

New MMIS implemented. 10,000 clients become eligible for the re-opening of OHP Standard.

Scheduled redeterminations deferred by 6 months.

Healthy Kids (HK) passes.

Detection of new CHIP eligibility requirements: income limit increased to 201% FPL; no resource limits; must not have had private insurance in the past 2 months (was 6); lawful permanent residents under age 19 are now eligible without 5 years of residency.

Poverty Level Medical Children eligibility certification extended from 6 to 12 months.

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

Budget reductions impact administration, provider/MCO rates, prioritized list of services, outreach and marketing, and funding for safety net clinics.

Q1 2012 shows signs of economic recovery.

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.

CHIP income limit raised to 300% FPL; non-coverage requirement is eliminated.

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.

Q1 2012 shows signs of economic recovery.

Budget reductions impact administration, provider/MCO rates, prioritized list of services, outreach and marketing, and funding for safety net clinics.

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

DHS SSP field staff help process backlog of 2013 applications. OHP Standard reservation list database disabled.

Scheduled redeterminations deferred by 6 months.

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

DHS SSP field staff help process backlog of 2013 applications. OHP Standard reservation list database disabled.

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Medical Assistance Programs (MAP): Non-Disabled Adults

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

Jan-04, Jul-04, Jan-05, Jul-05, Jan-06, Jul-06, Jan-07, Jul-07, Jan-08, Jul-08, Jan-09, Jul-09, Jan-10, Jul-10, Jan-11, Jul-11, Jan-12, Jul-12, Jan-13, Jul-13, Jan-14, Jul-14

50,000 100,000 150,000 200,000 250,000 300,000 350,000 400,000 450,000 500,000

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OHP funding reduced as a result of 2001 economic recession.

TANF related medical adjusted income is increased by about 3%.

New MMIS implemented.

Q1 2012 shows signs of economic recovery.

Scheduled redeterminations deferred by 6 months.

DHS SSP field staff help process backlog of 2013 applications.

Eligibility is based on new MAGI rules; hospital presumptive eligibility policy goes into effect.

CHIP eligibility resource limit increased to $10,000.

CHIP eligibility certification extended from 6 to 12 months.

Healthy Kids (HK) passes.

Budget reductions impact administration, provider/MCO rates, prioritized list of services, outreach and marketing, and funding for safety net clinics.

Households with children on FHAP's reservation list are notified about the HK program.

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Government System Transformation bill passes and is signed into law.

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Government System Transformation bill passes and is signed into law.

Governors target across-the-board budget reductions; MAP General Fund budget is reduced to $44.3 million.
Coverage restored for Long-Term Care SPL 12-13.

New MMIS implemented.

Q1 2012 shows signs of economic recovery.

Scheduled redeterminations deferred by 3 months; Cover Oregon decides to shift to the Federal Marketplace (website).

Medicaid expansion begins for adults up to 138% FPL. Easy access to coverage may slow ABAD caseload growth.

Scheduled redeterminations deferred an additional 3 months. Governor initiates across-the-board General Fund reductions in response to the deficit; MAP's General Fund budget is reduced $44.3 million.

Health System Transformation bill passes and is signed into law.

Budget reductions impact administration, provider/MCO rates, prioritized list of services, outreach and marketing, funding for safety net clinics.

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

Medicaid expansion begins for adults up to 138% FPL. Easy access to coverage may slow ABAD caseload growth.

Scheduled redeterminations deferred by 6 months.

OHP funding reduced as a result of 2001 economic recession.
CAWEM Prenatal expansion pilot begins in Multnomah and Deschutes counties.

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.

Scheduled redeterminations deferred by 6 months.

Q1 2012 shows signs of economic recovery.

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.

CAWEM Prenatal expands statewide.

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

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.
HB 3100 creates standardized mental health evaluations and SB 420 puts people GEI of non-Measure 11 crimes under OHA jurisdiction while they are at the State Hospital.
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.

2015 Poverty Guidelines for Oregon

<table>
<thead>
<tr>
<th>Persons in Family/ Household</th>
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<tr>
<td>1</td>
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<tr>
<td>2</td>
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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. In the future, 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 75 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 program. 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 75 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 Treatment Program (BCCTP)
Historically, BCCTP provided medical benefits for women diagnosed with breast or cervical cancer through the Breast and Cervical Cancer Program administered by Public Health through county health departments and tribal health clinics. Effective January 1, 2012, women do not need to be enrolled for screening through the Breast and Cervical Cancer Program in order to access BCCTP. 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. This program is available for both citizens and non-citizens/aliens.
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 85 percent of these clients are served in non-residential 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 99 percent of these clients are served in non-residential settings. Clients in the State Hospital are of a voluntary or voluntary by guardian status.