SPRING 2020 DHS-OHA CASELOAD FORECAST

Budget Planning and Analysis
Office of Forecasting, Research and Analysis

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Special Statement About the COVID-19 Pandemic and Introduction

The Spring 2020 caseload forecast is based on data (whether preliminary or final) available through February 2020. The resulting forecasts do not account for the rapid changes that occurred due to the Governor’s Emergency Order mandating physical distancing or the economic effects of a global pandemic. The changes in public policy, behavior, and economics due to the current crisis will be accounted for in subsequent forecasts.

The spread of the novel corona virus (SARS-CoV-2) and the orders to limit physical distancing to mitigate its spread have had effects on the nation and the state that are notable for their speed and severity. Things are changing quickly and may change again after the publication of this document. The Office of Forecasting Research and Analysis (OFRA) would be remiss of not to list what is now, as of this publication, known about how this unfolding public health emergency is influencing the caseloads we forecast.

We have organized this list of impacts in three broad areas: (1) Operations, (2) Public Policy, and (3) Economic. These three categories are not mutually exclusive, but they provide an opportunity to distinguish the influences of the COVID-19 disaster which may cut across multiple caseloads we forecast.

Operations

Integrated Eligibility

OFRA has been watching closely the roll-out of the new Integrated Eligibility (I.E.) System, which expanded on the Medicaid enrollment system (the ONE system) to cover all DHS and OHA program areas. Currently, the original I.E. rollout plan has been shifted to a new timeline which will resume in July and continue through February 2021.

Field Services

Physical distancing has at least temporarily changed the way multiple programs operate during the pandemic. Field offices for DHS programs and partner agencies (such as Agency Areas on Aging) have modified their lobbies to reduce clients congregating in close proximity. As much as possible, programs are asking clients to apply for services online, however program rules have had to be adjusted to allow for non-in-person attestations of income and other specifics. Electronic or verbal signatures which were previously out of policy are now being accepted to complete the application process. This includes hospital staff who are filling out Medicaid applications on behalf of patients.

There is no certainty that these physical distancing measures will slow the application process; in fact, in some cases it may speed it up. Past changes to the application process, which have occurred in a more deliberate process outside a state of emergency, suggests that these quick changes may have unintended consequences, modifying patterns of entry and exit.

Vocational Rehabilitation (VR) has to some extent been shuttered. In-person assessments by VR staff and medical professionals which are necessary to enter the program are impossible during the state of emergency. Many VR clients placed in meaningful employment are being laid off and must return to the program. Because of the disruptions in employment felt by VR clients, the program has re-instituted the “Order of Selection” process which triages VR clients, determining an order in which a client is wait-listed for available employment. Laid-off VR clients will be given priority for employment as soon as the program is able to begin placement activities.

Intellectual/Developmentally Disabled (I/DD) clients placed in employment have by and large been required to suspend employment. Employment assistance and transportation services provided by non-profits are no longer needed, and assistants are being laid off.

Referrals from SNAP and TANF to the Employment Department’s work readiness tasks have been suspended. Training and other activities may be contraindicated by physical distancing rules, and the Employment Department is currently applying all available resources to processing Unemployment Insurance claims. TANF clients removed from the program in the two weeks prior to the emergency declaration due to failure to meet work readiness requirements are being contacted and reinstated.
Currently, the number of child abuse allegations received by the hotline is much lower than usual. Unfortunately, this does not mean that children are not suffering from abuse or neglect. Currently, children are not being seen by teachers, doctors, school nurses, dentists and other mandatory reporters whose observations often initiate the abuse/neglect investigation. There may be a spike in new reports when the state of emergency is lifted.

**Congregate Care**

All programs providing congregate care are being modified to meet the requirements of virus mitigation. This is especially true of people in Long Term Care. People with a disability who would be placed in a Long-Term Care setting immediately upon discharge from hospitals are being delayed until the client is determined to be free of the novel coronavirus. Congregate care facilities for people with a disability have been hot spots for COVID-19 outbreaks, and clients may be moved out of a facility with COVID-positive clients into other settings or may choose to move back home or in with family, perhaps permanently.

In-Home Care, which could potentially limit the number of contacts seniors or disabled persons are subjected to, will be stressed for clients. Customer choice, a key part of Long-Term Care, may be permanently biased toward In-Home Care as a result of the spread of the coronavirus.

Children in Foster Care are being “virtually visited” by Child Welfare workers and other therapeutic staff via Zoom or other tools. This may slow activities that could move a child to permanency, whether it be reunification or adoption. Although the program is satisfied that congregate care in group homes and residential treatment facilities can be managed in the virus mitigation environment, additional cleaning and other sanitary steps required to keep the virus from spreading in any enclosed space may take time away from therapeutic activities.

County mental health associations and the state hospital are also required to engage in additional cleaning and sanitary steps to keep the virus at bay, modifying daily activities. The behavioral health system is stressing keeping space open for Aid and Assist clients, who may be transferred in larger than normal numbers from jails because of the need to reduce the number of people in correctional facilities. By increasing capacity for Aid and Assist, space usually available for Civilly Committed cases may be lacking, delaying transfers.

**Public Policy**

The state and national declarations of emergency have led to a large number of changes to the policies that govern means-tested portions of Medicaid and Self-Sufficiency.

**Medicaid**

As a result of the Families First Coronavirus Response Act (H.R. 6021), as of March 19, anyone whose eligibility is based purely on income (as opposed to a categorical eligibility, such as a disability), women in the Breast and Cervical Cancer Treatment Program and those entering via Hospital Presumptive Eligibility (in which hospital staff engage in the application process on behalf of a patient) will not be removed from the caseload due to the recording of an “adverse action.” In essence, no client will be removed from Medicaid for any reason except death, incarceration, requests to terminate coverage, or confirmation that they’ve left the state. This will continue until the last day of the month in which the state of emergency is lifted.

New intakes will still be processed as normal, and denials will occur if clients fail to provide appropriate information or if people are over-income, however verification of income is not required for intakes to be completed. In order to deal with the new intake rules and the expected extra volume of applications, renewals have been suspended.

These new policies will lead the number of cases exiting the program to be severely reduced, resulting in a large caseload increase. The relaxation of the income verification rule will almost certainly increase entries, irrespective of the economic factors that will increase the caseload.

Actions of other agencies in a time of emergency can influence Medicaid caseloads. To support consumers during the crisis, the Oregon Department of Consumer and Business Services (DCBS) issued a temporary emergency order that requires all insurance companies to postpone policy cancellations and non-renewals, extend grace periods for premium payments, and extend deadlines for reporting claims. These policies will allow holders of private health insurance some time to re-establish employment in cases of short-term job loss due to the Governor’s Emergency Order, avoiding the need to apply for Medicaid. This temporary order has been extended through May 23, and may be extended again as necessary.
Self-Sufficiency

SNAP eligibility rules have not been modified; however, income verification can be waived if an applicant can show hardship due to unemployment related to social distancing orders.

Recertifications (that is, six-month check-ins) and redeterminations of eligibility were suspended for the last two weeks of March and the months of April and May. This will reduce exits from the caseload given that recertifications and redeterminations are a key mechanism for closing cases. These cases will be reviewed in October and November, potentially leading to a temporary spike in exits.

Able Bodied Adults Without Dependents (ABAWD), a group made up of non-disabled clients between 18 and 49, were slated for removal from SNAP in rural parts of Oregon this year. That policy has been temporarily suspended. Clients who had been previously removed for being ABAWD may be awarded SNAP if they re-apply during this suspension period. ABAWD exclusions were suspended during the Great Recession due to high unemployment, and that mechanism may come into play again, for a period longer than the state of emergency.

The Employment Related Day Care (ERDC) program has made changes to eligibility and provider payments in reaction to COVID-19 in order to support providers as well as families. These policies assume that child care will be needed immediately upon the lifting of social distancing rules and layoffs. This is not a caseload we forecast, however the availability of ERDC may keep parents off TANF, as they will be able to smoothly return to work.

Economics

The current environment is one great uncertainty, as opposed to risk. Risk is highlighted in this publication regularly and refers to quantifiable elements which may impact forecast accuracy. The current situation contains unknowns we cannot fully quantify. This environment of uncertainty acknowledges a fundamental degree of ignorance and limited knowledge. Events are difficult to predict in this environment.

This is not a traditional recession. Jobs are being lost and productivity hampered by virus mitigation efforts, not the usual business cycle. It is expected that some amount of economic pain will be relieved rather quickly as emergency orders are lifted, but how much and how quickly is not known. In addition, the economic disruption felt at home and around the world will likely lead to a traditional recession pattern after the initial disruption in employment and other economic activity is resolved and the economy experiences a “bounce back.”

Enhanced unemployment payments will likely help keep some Oregonians from needing means-tested human services assistance, however delays in receiving unemployment insurance payouts from an overwhelmed system may lead them onto the caseload. One-time economic impact payments and the “Paycheck Protection Loans” to small businesses may also reduce the need for services, however the roll-out of the small business loans has been less than perfect and may not impact a large segment of the unemployed.

This environment makes the risk to forecast accuracy high. OFRA is currently coordinating with DHS, OHA and other state agencies and decision-makers to understand, as best we can, the nature of this economic downturn and the impacts of public policy, operational changes, and human behavior that will impact our caseloads.

The Spring 2020 Forecast

This document summarizes the Spring 2020 forecasts of client caseloads for DHS and OHA. OFRA issues these forecasts in the spring and fall each year. The Spring 2020 caseload forecast is based on data (whether preliminary or final) available through February 2020. The resulting forecasts do not account for the rapid changes that occurred due to the Governor’s Emergency Order mandating physical distancing or the economic effects of a global pandemic.

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, and through the annual forecast quality report which compares forecast accuracy across programs and over time.¹

¹ More information about the forecast process and current monthly variance reports can be found on the OFRA web page: http://www.oregon.gov/DHS/BUSINESS-SERVICES/OFRA/Pages/index.aspx
General Assumptions

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, both during recessions and during recoveries. The most immediate and dramatic effects on caseloads, however, 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.

Specific risks and assumptions relevant to each program area were taken into account in the preparation of the Spring 2020 forecast. They will be noted in the text for each section of the document.
Executive Summary

The 2019-21 **Aging and People with Disabilities Long–Term Care (LTC)** biennial average forecast is 35,840 clients, which is 0.2 percent higher than the Fall 2019 forecast. The 2021-23 biennial average forecast is 36,454 clients, which is 1.7 percent higher than the 2019-21 forecast average.

The 2019-21 **Child Welfare (CW)** biennial average forecast is 20,939 children, which is 0.7 percent lower than the Fall 2019 forecast. The 2021-23 biennial average forecast is 21,133 children, which is 0.9 percent higher than the 2019–21 forecast average.

The 2019-21 **Health Systems Medicaid (HSM)** biennial average forecast for Total Medicaid (which does not include the non-Medicaid Cover All Kids group) is 1,067,085 clients, which is 0.3% higher than the Fall 2019 Forecast. The 2021-23 biennial average forecast is 1,072,253 clients.

The 2019-21 **Intellectual and Developmental Disabilities Case Management (I/DD)** biennial average forecast is 30,524 clients, which is slightly lower than the Fall 2019 forecast. The 2021-23 biennial average forecast is 32,673 clients, which is 7.0 percent higher than the 2019-21 forecast average.

The 2019-21 **Mental Health (MH)** biennial average forecast is 55,752 adults. This includes 50,894 Never Committed clients, 2,987 Previously Committed clients, 943 Civilly Committed clients, and 928 Forensic clients. The forensic count includes 610 clients who are Guilty Except for Insanity and 318 Aid and Assist clients. The 2021-23 biennial forecast average is 55,807 adults, which is 0.1 percent higher than the 2019-21 forecast average.

The 2019-21 **Supplemental Nutrition Assistance Program (SNAP)** biennial average forecast is 350,235 households, which is 0.7 percent lower than the Fall 2019 forecast. The 2021-23 biennial average forecast is 348,633 households, which is 0.5 percent lower than the 2019-21 forecast average.

The 2019-21 **Temporary Assistance to Needy Families (TANF)** biennial average forecast is 18,490 families, which is 0.4 percent lower than the Fall 2019 forecast. The 2021-23 biennial average forecast is 18,083 families, which is 2.2 percent lower than the 2019-21 forecast average.

The 2019-21 **Vocational Rehabilitation (VR)** biennial average forecast is 10,181 clients, which is 2.1 percent lower than the Fall 2019 forecast. The 2021-23 biennial average forecast is 10,359 clients, which is 1.7 percent higher than the 2019-21 forecast average.
Department of Human Services
## Total Department of Human Services Biennial Average Forecast Comparison

<table>
<thead>
<tr>
<th>Service Area</th>
<th>2019-21 Biennium</th>
<th>% Change Between Forecasts</th>
<th>Spring 2020 Forecast</th>
<th>% Change Between Biennia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fall 19 Forecast</td>
<td>Spring 20 Forecast</td>
<td>Change</td>
<td>2019-21</td>
</tr>
<tr>
<td><strong>Aging &amp; People with Disabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Care: In Home</td>
<td>19,077</td>
<td>19,077</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Long-Term Care: Community Based</td>
<td>12,240</td>
<td>12,319</td>
<td>79</td>
<td>0.6%</td>
</tr>
<tr>
<td>Long-Term Care: Nursing Facilities</td>
<td>4,439</td>
<td>4,444</td>
<td>5</td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>Child Welfare (children served)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adoption Assistance</td>
<td>10,539</td>
<td>10,690</td>
<td>151</td>
<td>1.4%</td>
</tr>
<tr>
<td>Guardianship Assistance</td>
<td>2,266</td>
<td>2,264</td>
<td>-2</td>
<td>-0.1%</td>
</tr>
<tr>
<td>Out of Home Care¹</td>
<td>6,745</td>
<td>6,549</td>
<td>-196</td>
<td>-2.9%</td>
</tr>
<tr>
<td>Child In-Home</td>
<td>1,542</td>
<td>1,436</td>
<td>-106</td>
<td>-6.9%</td>
</tr>
<tr>
<td><strong>Intellectual and Developmental Disabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Case Management Enrollment²</td>
<td>30,564</td>
<td>30,524</td>
<td>-40</td>
<td>-0.1%</td>
</tr>
<tr>
<td>Total I/DD Services</td>
<td>20,631</td>
<td>20,542</td>
<td>-89</td>
<td>-0.4%</td>
</tr>
<tr>
<td><strong>Self Sufficiency</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Nutrition Assistance Program (Households)</td>
<td>352,543</td>
<td>350,235</td>
<td>-2,308</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Temporary Assistance for Needy Families (Families: Cash/Grants)</td>
<td>18,566</td>
<td>18,490</td>
<td>-76</td>
<td>-0.4%</td>
</tr>
<tr>
<td><strong>Vocational Rehabilitation</strong></td>
<td>10,398</td>
<td>10,181</td>
<td>-217</td>
<td>-2.1%</td>
</tr>
</tbody>
</table>

1. Includes residential and foster care.
2. Some clients enrolled in Case Management do not receive any additional I/DD services.
Aging and People with Disabilities (APD)

The Spring 2020 caseload forecast is based on data (whether preliminary or final) available through February 2020. The resulting forecasts do not account for the rapid changes that occurred due to the Governor’s Emergency Order mandating physical distancing or the economic effects of a global pandemic. The changes in public policy, behavior, and economics due to the current crisis will be accounted for in subsequent forecasts.

Historically, Oregon’s Long-Term Care (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 now most services are provided through the K Plan rather than the HCBS Waiver.

Prior to 2008, there was a large decline in the caseload between November 2002 and June 2003 when the LTC eligibility rules were modified to cover only clients in Service Priority Levels 1 to 13. During the last 10 years, the total Long-Term Care (LTC) caseload has varied from a low of 25,900 clients in May 2008 to a high of 34,900 clients in June 2017. From 2008 to 2013 the caseload grew by an average of 2.5 percent a year, driven in part by a significant growth in the number of Oregon seniors, and in part due to the Great Recession. Between 2013 and 2016, the average annual caseload grew by 5.3 percent due to factors such as implementation of the K Plan, expansion of Medicaid, policy changes to make in-home care more attractive, and continued growth in the number of Oregon seniors.

The LTC forecast is divided into three major categories: In-Home, Community-Based Care (CBC), and Nursing Facilities. Most of the projected increase from July 2015 through June 2021 is in In-Home Care. In-Home Care continues to be a popular placement choice, particularly since 2013 when APD implemented several changes designed to make In-Home services comparatively more attractive to clients. However, starting in October 2017, APD implemented new guidelines for the Client Assessment and Planning System (CAPS) Assessment. Because of these changes, many clients had their In-Home service hours reduced or became ineligible for In-Home services. CBC is still forecasted to grow, although at a reduced rate to reflect the anticipated shift toward In-Home Care. CBC will continue to be a stable placement choice for many LTC clients because this type of care is easier to set up and coordinate than In-Home Care, and because hospitals prefer discharging patients to higher service settings to reduce the risk of repeat emergency visits or readmission. On the other hand, Medicaid reimbursement rates continue to lag private market rates, thus making Medicaid clients relatively less attractive to CBC providers.
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 relinquish 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.

However, in recent years this caseload growth has slowed down considerably and grew by 7.0 percent between January 2016 and September 2017. Between October and November 2017, the In-home care caseload declined by 2.1 percent because of implementation of new guidelines regarding CAPS assessment criteria. However, the caseload then increased by 2.8% between November 2017 to November 2019. For additional information, see the "Additional Risks and Assumptions" section below.

In-Home Care – In November 2019, 18,854 clients received In-Home Care, which accounted for 53.0 percent of total LTC services. The caseload is expected to average 19,077 over the 2019-21 biennium, which is unchanged from the Fall 2019 forecast. The In-Home Care caseload is projected to average 19,429 clients per month over the 2021-23 biennium.

From July 2013 to December 2015, In-Home Care caseload grew by 29 percent. The In-Home Care caseload growth is attributed to several factors including implementation of the 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.
Community-Based Care (CBC) – In November 2019, 12,230 clients received Community-Based Care, which accounted for 34.4 percent of total LTC. The caseload is expected to average 12,319 over the 2019-21 biennium, which is 0.6 percent higher than the Fall 2019 forecast. The caseload is expected to average 12,581 over the 2021-23 biennium.

Community-Based Care includes several different types of services. Each caseload type is revised to more accurately reflect clients' recent, actual utilization of services. Consequently, All-Inclusive Care for the Elderly and Residential Care have become a larger portion of the forecast, while Adult Foster Care (AFC) became smaller.

Several factors are contributing to the recent decline in AFC caseload: policy changes that make In-Home Care more attractive; providers’ perception of inadequate reimbursement rates; increasing adversarial relationship between workers and providers; and declining capacity as individual providers retire.
Nursing Facility Care

Revisions to the Nursing Facility Care Forecast Process

LTC caseloads come from monthly expenditure data claimed by service providers. Providers can claim bills up to twelve months after the service is provided. This suggests that caseload counts updated each month may not reflect revised billing information. Although the forecasting model takes into consideration billing claim delays with a three month waiting period, the billing claims from nursing facilities (mostly from Basic care and Complex Medical Add-On) take longer to reconcile than other LTC program providers. This leads to significant differences between caseloads in the monthly variance reports and revised historical values used for forecasting, as shown in Figure 1 below. For this reason, Basic and Complex Medical monthly caseloads have been revised with actuals which take into account this lag in reconciliation. This change will provide accurate monthly caseloads and improve forecasting accuracy.

Figure 1. Monthly Caseload Comparisons of Basic and Complex Medical Add-On
In November 2019, 4,424 clients received Nursing Facility Care, which accounted for 12.6 percent of total LTC. The caseload is expected to average 4,444 over the 2019-21 biennium, which is 0.1 percent higher than the Fall 2019 forecast. The caseload is expected to average 4,444 over the 2021-23 biennium.

**Affordable Care Act (ACA) Long-Term Care**

Starting in January 2014, a new population of individuals became eligible for medical and long-term care services under the Affordable Care Act of 2010 (ACA). When discussed in the forecast, these clients will be referred to as “ACA LTC” clients. ACA LTC clients are, by definition, citizens aged 18-64 with income under 138 percent of FPL and who require the institutional Level of Care (LOC) of a hospital or skilled nursing facility. Under Oregon’s CMS waiver, these clients may be served through any of the approved long-term care channels – nursing facilities, community-based care, or in-home.

These clients constitute a small subset of the total LTC population, but their funding sources are significantly different. Consequently, OFRA is tracking these clients separately within the LTC population. The ACA LTC data accounted for about 3.8 percent of the total LTC caseload in November 2019.

**Forecast Environment and Risks**

See the Introduction to this document for a synopsis of the changes that have been enacted since the finalization of this forecast.

**Additional Risks and Assumptions**

**Patient Protection and Affordable Care Act of 2010**

Implementation of ACA changed the playing field for long-term care in Oregon and introduced significant new risks to the forecast. Also, by shifting from operating under the HCBS Waiver to the K Plan in late 2013, the eligibility rules for long-term care were changed.

At roughly the same time, Oregon chose to extend Medicaid coverage (including long-term care) to a significantly larger pool of low-income adults. To qualify for LTC under the prior HCBS Waiver, clients had to meet four separate 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 225 percent of the Federal Poverty Level or FPL); and 4) have very limited assets. However, under the ACA’s K Plan option, clients only need to meet two criteria: 1) be assessed as needing requisite Level of Care; and 2) have income below 138 percent of FPL. Note that the HCBS Waiver allows clients with higher incomes than the K Plan; but the K Plan has no asset limits and no requirement that clients be over 65 or officially determined disabled. Recent changes in the pattern of new clients entering long-term care indicates that the ACA (the combined effects of the K Plan and Medicaid expansion) is contributing to long-term care caseload growth.

**In-Home Care Policy and Program Changes**

Another significant risk was created by policy and program changes regarding In-Home Care services. Four key changes were made: 1) Changes to existing rules regarding the Activities of Daily Living (ADL) assessment; 2) Adjustments to In-Home hours; 3) Transition from Live-in to Hourly services; and 4) In-Home Care workers’ two-week service authorization.

Because of the changes to ADL rules, some clients may no longer meet the new assessment criteria. This may also reduce hours for other In-Home clients, and many of the clients that do not meet the new assessment criteria may receive new transition services. At the time of this reporting, these changes have been newly implemented and the impact remains to be measured. APD, in response to the complaints by initial groups of clients who lost service eligibility, reviewed the assessments of those clients considered ineligible, and as a result, services and hours were restored, moving the caseload upward. New clients and those who are due for annual reassessment, however, will be assessed using the new criteria.
This process has continued, and will continue, to have a dampening effect on the In-Home Care caseload and be a large risk to the in-home caseload forecast.

**Oregon Demographic Shift**

In addition to internal policy and program related changes, external changes such as demographic shifts in Oregon’s population also pose a risk to the forecast’s accuracy over the longer term (for example, more seniors living longer, or the financial or physical health of those seniors). Oregon’s population is aging, and elderly Oregonians are among the fastest growing segments of the state population. The elderly aged 65 years and over accounted for 13% of the total population in 2002, and rose to 18% of the total population in 2019. Oregonians with multiple chronic conditions in the 85 and older age group also risk depleting their resources, which will increase the likelihood they will become eligible for Long-Term Care programs.
### Aging and People with Disabilities Biennial Average Forecast Comparison

<table>
<thead>
<tr>
<th>Service Type</th>
<th>2019-21 Biennium</th>
<th>2020 Forecast</th>
<th>% Change Between Forecasts</th>
<th>2020 Forecast</th>
<th>% Change Between Biennia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fall 19</td>
<td>Spring 20</td>
<td>Change</td>
<td>Spring 20</td>
<td>Change</td>
</tr>
<tr>
<td>In-Home Hourly without SPPC</td>
<td>14,202</td>
<td>14,097</td>
<td>-105</td>
<td>-0.7%</td>
<td>14,097</td>
</tr>
<tr>
<td>In-Home Agency without SPPC</td>
<td>2,112</td>
<td>2,243</td>
<td>131</td>
<td>6.2%</td>
<td>2,243</td>
</tr>
<tr>
<td>In-Home Spousal Pay</td>
<td>27</td>
<td>19</td>
<td>-8</td>
<td>-29.6%</td>
<td>19</td>
</tr>
<tr>
<td>Independent Choices</td>
<td>550</td>
<td>546</td>
<td>-4</td>
<td>-0.7%</td>
<td>546</td>
</tr>
<tr>
<td>Specialized Living</td>
<td>192</td>
<td>197</td>
<td>5</td>
<td>2.6%</td>
<td>197</td>
</tr>
<tr>
<td><strong>In-Home K Plan Subtotal</strong></td>
<td>17,083</td>
<td>17,102</td>
<td>19</td>
<td>0.1%</td>
<td>17,102</td>
</tr>
<tr>
<td>In-Home Hourly with State Plan Personal Care</td>
<td>1,579.0</td>
<td>1,522</td>
<td>-57</td>
<td>-3.6%</td>
<td>1,522</td>
</tr>
<tr>
<td>In-Home Agency with State Plan Personal Care</td>
<td>415</td>
<td>453</td>
<td>38</td>
<td>9.2%</td>
<td>453</td>
</tr>
<tr>
<td><strong>In-Home non-K Plan Subtotal</strong></td>
<td>1,994</td>
<td>1,975</td>
<td>-19</td>
<td>-1.0%</td>
<td>1,975</td>
</tr>
<tr>
<td><strong>Total In-Home</strong></td>
<td>19,077</td>
<td>19,077</td>
<td>0</td>
<td>0.0%</td>
<td>19,077</td>
</tr>
<tr>
<td>Adult Foster Care</td>
<td>2,301</td>
<td>2,356</td>
<td>55</td>
<td>2.4%</td>
<td>2,356</td>
</tr>
<tr>
<td>Assisted Living</td>
<td>4,213</td>
<td>4,260</td>
<td>47</td>
<td>1.1%</td>
<td>4,260</td>
</tr>
<tr>
<td>Contract Residential and Memory Care</td>
<td>3,287</td>
<td>3,210</td>
<td>-77</td>
<td>-2.3%</td>
<td>3,210</td>
</tr>
<tr>
<td>Regular Residential Care</td>
<td>864</td>
<td>868</td>
<td>4</td>
<td>0.5%</td>
<td>868</td>
</tr>
<tr>
<td>Program of All-Inclusive Care for the Elderly</td>
<td>1,575</td>
<td>1,625</td>
<td>50</td>
<td>3.2%</td>
<td>1,625</td>
</tr>
<tr>
<td><strong>Community-Based Care Subtotal</strong></td>
<td>12,240</td>
<td>12,319</td>
<td>79</td>
<td>0.6%</td>
<td>12,319</td>
</tr>
<tr>
<td>Basic Nursing Facility Care</td>
<td>3,696</td>
<td>3,685</td>
<td>-11</td>
<td>-0.3%</td>
<td>3,685</td>
</tr>
<tr>
<td>Complex Medical Add-On</td>
<td>669</td>
<td>711</td>
<td>42</td>
<td>6.3%</td>
<td>711</td>
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<tr>
<td>Enhanced Care</td>
<td>42</td>
<td>32</td>
<td>0</td>
<td>0.0%</td>
<td>32</td>
</tr>
<tr>
<td>Pediatric Care</td>
<td>32</td>
<td>16</td>
<td>0</td>
<td>0.0%</td>
<td>16</td>
</tr>
<tr>
<td><strong>Nursing Facilities Subtotal</strong></td>
<td>4,439</td>
<td>4,444</td>
<td>5</td>
<td>0.1%</td>
<td>4,444</td>
</tr>
<tr>
<td><strong>Total Long-Term Care</strong></td>
<td>35,756</td>
<td>35,840</td>
<td>84</td>
<td>0.2%</td>
<td>35,840</td>
</tr>
</tbody>
</table>
The Spring 2020 caseload forecast is based on data (whether preliminary or final) available through February 2020. The resulting forecasts do not account for the rapid changes that occurred due to the Governor’s Emergency Order mandating physical distancing or the economic effects of a global pandemic. The changes in public policy, behavior, and economics due to the current crisis will be accounted for in subsequent forecasts.

Four main groups are forecast for Child Welfare: Adoption Assistance, Guardianship Assistance, Out of Home Care, and Child In-Home. Children may move between these groups and typically first enter the Child Welfare system via an Assessment. There is an executive directive for branches to complete assessments in less than sixty days.

**Adoption Assistance** – This caseload gradually decreased between 2016 and mid-2019. Between April 2019 and October 2019 the caseload increased 0.6 percent. An initiative is currently in place to finalize placements for children who are ready to transition, and the expectation is that there will be an increase in finalized placements for at least the first half of 2020. Almost all new clients entering adoption assistance are from paid foster care, so changes to the foster care caseload can directly increase or decrease this caseload. The paid foster care caseload has been on a downward trajectory since late 2017. The adoption assistance caseload is expected to average 10,690 children per month for the 2019-21 biennium. Over the 2021-23 biennium the caseload is expected to average 10,772 children per month, an increase of 0.8 percent from the current biennium.

**Guardianship Assistance** – This caseload has exhibited steady growth for its entire history. Policies are in place to shorten the length of time to reach a permanent placement, so this caseload will continue to increase as children move out of foster care. Between April 2019 and October 2019, the caseload increased 3.6 percent. Actuals tracked the Fall 2019 caseload forecast closely. The new forecast for guardianship assistance is expected to average 2,264 children per month for the 2019-21 biennium. Over the 2021-23 biennium, the caseload is expected to average 2,353 children per month, which is 3.9 percent higher than the 2019-21 forecasted average.

**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 the largest portion of the group. The total foster care caseload decreased 3.8 percent between April 2019 and October 2019. The caseload is expected to average 6,549 children per month for the 2019-21 biennium. Over the 21-23 biennium, the caseload is expected to remain relatively flat.
**Child In-Home** – This caseload is comprised of two groups: children with prior foster care and children without prior foster care. Transfers into the “without prior foster care” group are mainly from Assessments. For the past several years, the Child In-Home caseload has risen and fallen unpredictably. One reason for the fluctuations may be the way the data are captured in OR-Kids. Since 2017, the data definition in OR-Kids has been based on safety plans, not case plans. Therefore, it’s possible that we are serving children in home that are not counted in the Child In-Home caseload, due to the way the In-Home population is defined. The Safety Program is still working with the Districts to identify and potentially correct Child In-Home data. The caseload is expected to average 1,436 children per month for the 2019-21 biennium. Over the 2021-23 biennium, the caseload is expected to be 1.8 percent higher than the current forecast.
Forecast Environment and Risks
See the Introduction to this document for a synopsis of the changes that have been enacted since the finalization of this forecast.

Additional Risks and Assumptions
More than any demographic factor that can be counted or measured, the Child Welfare caseload is impacted by policy changes and program level interventions. In recent years the Child Welfare Program has been highly scrutinized by the public and has been a priority for the Governor. The Oregon Child Abuse Hotline, statewide centralized screening available 24 hours a day, 365 days a year, has been in effect statewide since April 2019.

One risk to the Out of Home Care caseload is related to the capacity for psychiatric residential care. Continued in-state residential capacity expansion is expected. There is always the risk that providers may close suddenly or not accept referrals. As new programs start, it is unknown how quickly the beds will fill. It can be challenging to recruit foster parents as well as find people to provide services to high needs children. These children are currently being served in Behavior Rehabilitation Services, family foster care, or out of state. The out of state population decreased 57 percent between early 2019 and November 2019.

As mentioned above, the definition of Child In-Home is based on the safety plan rather than the case plan. There has also been a change in the way OR-Kids operates, so that a case cannot move forward until a caseworker enters an initial safety plan. This may impact the number of children counted in this caseload. An investigation is underway to determine the number of children who are getting services but are not being counted in either the child in-home or foster care caseloads. We expect to be counting these “non-placement services” by the Fall 2020 forecast. Another risk to the forecast of the child in-home caseload is the number of overdue or unclosed assessments that have not been entered into the data system. If, and when, overdue assessments are closed, the child in-home caseload may increase.
## Child Welfare Biennial Average Forecast Comparison

<table>
<thead>
<tr>
<th></th>
<th>2019-21 Biennium</th>
<th>2020 Forecast</th>
<th>% Change Between Forecasts</th>
<th>2019-21</th>
<th>2021-23</th>
<th>Change</th>
<th>% Change Between Biennia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fall 19</td>
<td>Spring 20</td>
<td>Change</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHILD WELFARE (Children)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adoption Assistance</td>
<td>10,539</td>
<td>10,690</td>
<td>151</td>
<td>1.4%</td>
<td>10,690</td>
<td>10,772</td>
<td>82</td>
</tr>
<tr>
<td>Guardianship Assistance</td>
<td>2,266</td>
<td>2,264</td>
<td>-2</td>
<td>-0.1%</td>
<td>2,264</td>
<td>2,353</td>
<td>89</td>
</tr>
<tr>
<td>Out of Home Care&lt;sup&gt;1&lt;/sup&gt;</td>
<td>6,745</td>
<td>6,549</td>
<td>-196</td>
<td>-2.9%</td>
<td>6,549</td>
<td>6,546</td>
<td>-3</td>
</tr>
<tr>
<td>Child In-Home</td>
<td>1,542</td>
<td>1,436</td>
<td>-106</td>
<td>-6.9%</td>
<td>1,436</td>
<td>1,462</td>
<td>26</td>
</tr>
<tr>
<td><strong>Total Child Welfare</strong></td>
<td><strong>21,092</strong></td>
<td><strong>20,939</strong></td>
<td><strong>-153</strong></td>
<td><strong>-0.7%</strong></td>
<td><strong>20,939</strong></td>
<td><strong>21,133</strong></td>
<td><strong>194</strong></td>
</tr>
</tbody>
</table>

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<sup>1</sup> Includes residential and foster care.
Intellectual and Developmental Disabilities (I/DD)

The Spring 2020 caseload forecast is based on data (whether preliminary or final) available through February 2020. The resulting forecasts do not account for the rapid changes that occurred due to the Governor’s Emergency Order mandating physical distancing or the economic effects of a global pandemic. The changes in public policy, behavior, and economics due to the current crisis will be accounted for in subsequent forecasts.

Historically, Oregon provided I/DD services under a Medicaid 1915 (c) Home and Community-Based Services (HCBS) Waiver. However, starting in July 2013 Oregon began offering services through the Community First Choice Option in 1915 (k) of the Social Security Act (referred to as the K Plan), and now most I/DD services are delivered under the K Plan. Implementation of the K Plan required adjustments to program policies related to both eligibility and program delivery. As a result, more individuals with I/DD have chosen to enroll in Case Management and to request services.

Case Management Enrollment

This is an entry-level eligibility, evaluation, and coordination service available to all individuals determined as having intellectual and developmental disabilities, regardless of income level. Starting in the Fall of 2018, Case Management Enrollment has included State Children (SE 248) who did not have I/DD Case Management enrollment. In addition, Oregon’s Office of Developmental Disabilities Services (ODDS) has initiated a review of I/DD enrollees in the case management category without a case management contact or without other I/DD services billed in a year. The review of I/DD enrollees with open record, but without I/DD services, were closed back to the date they stopped receiving I/DD services. This cleanup process has reduced the Case Management Enrollment caseload slightly is projected to grow until most I/DD individuals have enrolled. Human Services Research Institute (HSRI), under the contract with ODDS, has estimated the “natural limit,” where the caseload would plateau, by applying national prevalence estimates to Oregon’s youth and adult populations through 2023.

Case Management Enrollment is projected to be an average of 30,524 cases per month in the 2019-21 biennium, which is slightly lower than the Fall 2019 forecast. The caseload is expected to average 32,673 over the 2021-23 biennium. Case Management Enrollment is projected to grow until most I/DD individuals living in the state have enrolled. Human Services Research Institute (HSRI), under the contract with ODDS, has estimated the “natural limit,” where the caseload would plateau, by applying national prevalence estimates to Oregon’s youth and adult populations through 2023.

Adult Services

I/DD adult services was reorganized in the Fall of 2017 to combine Comprehensive In-Home Services and Brokerage Services as a new caseload category: Adult In-Home Support. Sixty-nine percent of this caseload category is Brokerage Services and 31 percent is Community Developmental Disabilities Programs (CDDP) In-Home Services. OFRA does not report a separate forecast for Brokerage enrollment.

Adult In-Home Support – The Adult In-Home Support caseload category combines CDDP In-Home services and Brokerage services. This caseload category combines all In-Home services for adults, previously known as Comprehensive In-Home Services and Brokerage Services, without the employment and transportation services, and are grouped based on plan of care.

The Adult In-Home Support caseload is projected to average 8,940 cases per month in 2019-21 which is slightly lower than the Fall 2019 forecast. The caseload is expected to average 9,278 cases per month over the 2021-23 biennium.
24-Hour Residential Care – This caseload is projected to average 2,957 cases a month in the 2019-2021 biennium, which is slightly higher than the Fall 2019 forecast. The caseload is expected to average 3,035 over the 2021-23 biennium.

Supported Living – The 2019-21 caseload is projected to be an average of 732 cases per month which is 3.7 percent higher than the Fall 2019 forecast. The caseload is expected to average 736 over the 2021-23 biennium.

I/DD Foster Care – I/DD Foster Care serves both adults and children, with children representing approximately 12.0 percent of the caseload. The 2019-21 total IDD Foster Care average monthly caseload is 3,447, which is slightly higher than the Fall 2019 forecast. The caseload is expected to average 3,543 over the 2021-23 biennium.

Stabilization and Crisis Unit – The Stabilization and Crisis Unit serves both adults and children, with children representing approximately 17.0 percent of the caseload. This caseload is limited by bed capacity and is expected to remain at the current level of 99 for both 2019-21 and 2021-23.
Children Services

In-Home Support for Children (IHSC) – This caseload started growing rapidly in late 2013 as the K Plan was implemented. The caseload grew a dramatic fifteen-fold from 187 clients in mid-2013 to 2,790 by mid-2016. This caseload growth has slowed considerably to monthly average of 3,089 by mid-2017. This caseload continued to grow on slower pace and is expected to an average monthly caseload of 3,787 over the 2019-21 biennium, which is 2.5 percent lower than the Fall 2019 forecast. The caseload is expected to average 3,937 per month over the 2021-23 biennium.

Growth in this caseload is primarily due to implementation of the Community First Choice Option (K Plan), which allows individuals eligible for the Oregon Health Plan to receive In-Home services if they have an extended need for assistance with Activities of Daily Living. In addition, the income criteria used for children no longer considers family resources. The forecasted growth for this caseload incorporates assumptions about the historical pattern for children entering Case Management and the percentage of children enrolled in Case Management who will apply for services. However, the K Plan is a significant change and our assumptions may not be correct. For this and other reasons, this caseload was especially complex to forecast, and the risk of error is high. For additional information, see the “Additional Risks and Assumptions” section below.
Children Intensive In-Home Services (CIIHS) – This caseload includes Medically Fragile Children Services, Intensive Behavior Programs, and Medically Involved Program. The 2019-21 total CIIHS caseload is expected to average 402 per month in 2019-21 biennium. This caseload is limited by capacity and is expected to grow gradually to 421 by October 2020 and remain at that level through the 2021-23 biennia.

Children Residential Care – This caseload is expected to grow from its current monthly average of 158 cases to reach an average of 179 per month in 2019-21 biennium. It is expected to gradually grow to 190 cases per month and remain at that level through the 2021-23 biennia.

There is a crisis in residential resources for children, including overlap with children served by Child Welfare and Developmental Disabilities. Children have been placed in inappropriate or unsafe placements, including hotels, DHS offices, hospital emergency rooms, and in family homes where family members and providers feel unsafe. In response to this crisis, several new group homes licensed for 28 new beds will be opened in 2019-21 to serve children/youth with significant behavioral challenges who are not able to be supported in their family home or in foster care.

Other Services

Employment and Day Support Services – In order to better reflect recent changes in I/DD program, the definition of employment services has been revised. The new definition is broader, including all services previously counted as well as new services offered under Employment First and Plan of Care. However, Employment claims data have a significantly longer lag time than the customary three months due to delayed billing and claims processing. Therefore, OFRA has based the current forecast on estimated preliminary actuals. The preliminary actuals account for the difference between the initially observed caseload and the caseload observed at later date, after claims have been fully processed.

The steps involved in the calculation of preliminary actuals include:

1. Calculate the ratios of the previous 10 months of actuals to 3 month matured reported actuals,
2. Calculate a three-month moving average of the ratios,
3. Apply the moving average ratios to initially reported actuals to create the new estimated actuals.
The Employment and Day Support Activities are projected to average 6,476 cases over the 2019-21 biennium, which is 1.0 percent higher than the Fall 2019 forecast. The caseload is expected to average 6,604 over the 2021-23 biennium.

Employment and Day Support Activities will be reported together as Total Employment and Day Support Services. Recent history shows that gradually higher share of clients in this caseload utilized Day Support Services with or without employment services. Starting the Fall 2019, the clients who need attendant care on the job will likely to enrolled in the Day Support Services.

Transportation – Historically, this caseload included only services paid with state funds, not those using local match funding. To provide a more complete picture, the definition of services counted in the Transportation caseload has been expanded to include all services previously counted, plus transportation services provided under Plan of Care (e.g. transit passes and non-medical community transportation). Estimated Preliminary actuals for Transportation services are calculated starting in the Spring 2020. The rationale for calculating preliminary actuals for Transportation services and its methodology are the same as described under the Employment and Day Support Activities.

The Transportation caseload is projected to average 7,470 per month in 2019-21 which is slightly lower than the Fall 2019 forecast. The caseload is expected to average 7,647 per month over the 2021-23 biennium.

Total Transportation Services will be reported as Total Transportation and Other Transportation Services. Recent history shows that about 17.9 percent of clients in this caseload utilized Other Transportation Services.

Forecast Environment and Risks
See the Introduction to this document for a synopsis of the changes that have been enacted since the finalization of this forecast.

Additional Risks and Assumptions
There are a variety of additional factors that create risks for all I/DD caseload forecasts.

Although the K Plan started in July 2013, initial work began slowly at first and work accelerated in 2014 with most CDDPs experiencing higher caseloads and more requests for services than prior to July 2013. The increase in requests for services and higher caseloads caused some delays in access to service. Many of the CDDPs have recently hired new staff because of funding based on the workload model. With additional staff added, this may result in quicker entry of new individuals with I/DD. All these practical operational changes mean that new service use patterns are not yet stable and may continue to fluctuate for some time. In addition, the estimate may be low if improved staffing levels lead more Parents with I/DD children to enroll in Case Management.
The increase in people requesting I/DD services has created capacity challenges for CDDPs and their provider networks. To receive funded services, enrollees’ Medicaid eligibility must be established, a level of care and assessment completed, and an Individual Support Plan developed.

The caseloads most directly impacted by K Plan implementation are those where the individual lives in their own home or with family members - Adult In-Home Support Services and the In-Home Support for Children.

**Adult In-Home Support** – Adults can be served through two channels – Brokerages or CDDPs. At present, most caseload growth is occurring in the CDDP In-Home Services, while Brokerage Services remain fairly flat. The Brokerage Services caseload is a little over three times larger than the CDDP In-Home services. Growth in adult caseloads generally comes from children who age into adult services, or previously unserved adults who are newly interested. Since this caseload is growing rapidly and without precedent, the forecast is highly sensitive to the assumptions used to produce it, and the risk of error is higher than usual. In addition, due to client choice for CDDP or Brokerage In-Home services, it is difficult to make reasonable assumptions without any established pattern of their service choices.

**In-Home Support for Children** – the K Plan implementation expanded the availability of services for many children. Prior to the implementation of the K Plan, children were only able to receive limited in-home services and could only access additional services if they met crisis criteria. A child may now access significant in-home support without meeting crisis criteria, if they are eligible for I/DD services and Medicaid. As a result, a significantly larger number of children may now access in-home services. Also, under Oregon’s comprehensive waiver, additional children are now eligible for Medicaid services based solely on having a disability (meeting SSI standards), while not accounting for family financial resources. This may also increase the number of children who are able to access in-home services through the K Plan.
## Intellectual and Developmental Disabilities Biennial Average Forecast Comparison

<table>
<thead>
<tr>
<th></th>
<th>2019-21 Biennium</th>
<th>% Change Between Forecasts</th>
<th>Spring 2020 Forecast</th>
<th>% Change Between Biennia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fall 19 Forecast</td>
<td>Spring 20 Forecast</td>
<td>Change</td>
<td>2019-21</td>
</tr>
<tr>
<td><strong>Total Case Management Enrollment</strong></td>
<td>30,564</td>
<td>30,524</td>
<td>-40</td>
<td>-0.1%</td>
</tr>
<tr>
<td><strong>Adult</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult In-Home Support</td>
<td>8,982</td>
<td>8,940</td>
<td>-42</td>
<td>-0.5%</td>
</tr>
<tr>
<td>I/DD Foster Care</td>
<td>3,016</td>
<td>3,040</td>
<td>24</td>
<td>0.8%</td>
</tr>
<tr>
<td>24 hrs Residential Care</td>
<td>2,940</td>
<td>2,957</td>
<td>0</td>
<td>0.6%</td>
</tr>
<tr>
<td>Supported Living</td>
<td>706</td>
<td>732</td>
<td>26</td>
<td>3.7%</td>
</tr>
<tr>
<td>Stabilization and Crisis Unit</td>
<td>99</td>
<td>98</td>
<td>0</td>
<td>-1.0%</td>
</tr>
<tr>
<td><strong>Total I/DD Services</strong></td>
<td>20,631</td>
<td>20,542</td>
<td>-89</td>
<td>-0.4%</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I/DD Foster Care</td>
<td>418</td>
<td>407</td>
<td>-11</td>
<td>-2.6%</td>
</tr>
<tr>
<td>In-Home Support for Children</td>
<td>3,885</td>
<td>3,787</td>
<td>-98</td>
<td>-2.5%</td>
</tr>
<tr>
<td>Children Intensive In-Home Services</td>
<td>405</td>
<td>402</td>
<td>-3</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Children Residential Care</td>
<td>180</td>
<td>179</td>
<td>-1</td>
<td>-0.6%</td>
</tr>
<tr>
<td><strong>Total I/DD Services</strong></td>
<td>20,631</td>
<td>20,542</td>
<td>-89</td>
<td>-0.4%</td>
</tr>
<tr>
<td><strong>Other I/DD Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment &amp; Day Support Activities</td>
<td>6,410</td>
<td>6,476</td>
<td>66</td>
<td>1.0%</td>
</tr>
<tr>
<td>Transportation</td>
<td>7,510</td>
<td>7,470</td>
<td>-40</td>
<td>-0.5%</td>
</tr>
</tbody>
</table>

1. Some clients enrolled in Case Management do not receive any additional I/DD services.
2. Employment and DSA actuals are estimated to account for under reporting of delayed claims.
3. Transportation actuals are estimated to account for under reporting of delayed claims.
Self Sufficiency Programs (SSP)

The Spring 2020 caseload forecast is based on data (whether preliminary or final) available through February 2020. The resulting forecasts do not account for the rapid changes that occurred due to the Governor’s Emergency Order mandating physical distancing or the economic effects of a global pandemic. The changes in public policy, behavior, and economics due to the current crisis will be accounted for in subsequent forecasts.

Supplemental Nutrition Assistance Program (SNAP) In February 2020 there were 349,244 households (585,807 persons) receiving SNAP benefits, which constitutes approximately 13.8 percent of all Oregonians.

Oregon's economy influences SNAP can be seen in revisions to the employment forecast prepared by the Oregon Office of Economic Analysis in February 2020. Although the overall economy continues to create new jobs, the employment forecast was revised by 0.2 percent lower than the December 2019 forecasts due to the weakness in the labor market. In particular, SNAP clients tend to exit the caseload due to employment in several weakened areas, including Construction, Leisure/Hospitality, Manufacturing, Professional/Business Services (where temp employment is counted), and Retail. The employment forecasts in Construction, Manufacturing, and Retail revised to 1.2 percent lower than the December forecast. In August 2019, retail employment was approximately 210,000 or 1.2 percent lower than a year ago.

The Self-Sufficiency portion of SNAP fell almost continuously from autumn 2012 through the start of 2019, and then abruptly changed direction, increasing just slightly and then tapering back off. The reason for this reversal is caseload exits. Over the past few years of economic expansion, exits have exceeded entries, moving the caseload down. Exits were especially high in April and September, as spring and autumn hiring would move people into higher incomes and off the caseload. In 2019, however, this pattern did not occur. In some months, entries exceeded exits, moving the caseload up. In others, exits were essentially equal to entries. This left the caseload hovering at about 218,000 families through 2019. The Self-Sufficiency portion of SNAP have stalled at a point not much higher than before the Great Recession. In September 2006, SNAP SSP served 9.6 percent of all Oregonians; in February 2020 it served 10.4 percent.

The current forecast for SSP SNAP assumes that the time limits for Able Bodied Adults without Dependents (ABAWD) would be inacted in October 2020 (beginning of Federal Fiscal Year 2021) for 25 counties in Oregon. Due to the coronavirus state of emergency, this process is currently on hold (see Introduction). The impact was incorporated into the Spring forecast, and calculated to affect less than 1.0 percent of the total caseload.

The Spring 2020 SSP SNAP caseload forecast for 2019-21 is 0.7 percent lower than the previous forecast, which had assumed continuous caseload reductions. The SNAP SSP caseload is expected to fall modestly in the 2021-23 biennium, reducing the caseload by only 1.1 percent.

The smaller APD SNAP caseload (designed for people aged 60 and older) rose steadily from late 2006 to mid-2018 due to a combination of demographic and economic changes. However, that rate of increase has now stopped, and the caseload has stabilized at just over 133,000 cases.

The current combined 2019-21 SNAP biennial average forecast is 350,235 households, which is 0.7% percent lower than the Fall 2019 forecast. The projected biennial average for 2021-2023 is 348,633 households, which is 0.5 percent lower than the 2019-2021 biennial average forecast.
Temporary Assistance for Needy Families (TANF) – In February 2020, 18,591 families were receiving TANF benefits, representing 48,492 persons. The TANF caseload underwent nearly uninterrupted growth from January 2008 until February 2013. The caseload then declined rapidly and is currently about 18,000 cases below its February 2013 peak, a 49 percent drop.

The 2019-2021 TANF biennial average forecast is 18,490 families, which is 0.4 percent lower than the prior forecast. This modest downward revision reflects the most recent six months’ caseload trend, in which exits overtook entries. During the economic expansion from 2013 to 2018, a summer hiring pattern moved people off of the TANF caseloads. This trend did not materialize in 2019. On the other hand, entries also gradually decreased. The TANF One-Parent caseload increased in the summer of 2019 due to weak hiring, but the caseload in fall 2019 fell due to a lower rate of entries. The caseload is expected to go back to its usual pattern of increases in winter months (when entries overtake exits) followed by modest reductions in the summer (when the pattern of entries and exits reverses).

The 2019-2021 biennial average caseload for TANF One Parent is 15,879 families, which is 0.8 percent lower than the previous forecast. The average monthly caseload for the 2021-2023 biennium is expected to be 15,820, a reduction of 0.4 percent from the 2019-21 biennium. TANF One-Parent is still expected to remain below pre-recession levels through the forecast horizon.

The TANF Two-Parent caseload is still higher than it was pre-recession. It has continued to fall through 2019, but at a slower pace than in previous years. From December 2019, the caseload started to increase, which reflects the regular seasonal pattern due to the weak winter hiring. The 2019-2021 biennial average caseload for TANF Two-Parent is expected to be 2,610 families, a 1.9 percent increase from the prior forecast, which anticipated a more vigorous draw-down of cases in line with prior years. The average monthly caseload for 2021-2023 is expected to be 2,264 cases, a 13.3 percent decrease from the 2019-21 biennium.
Pre-SSI – provides temporary assistance for families while they apply for Supplemental Security Income, a benefit for the aged, blind, and disabled who have little or no income. Almost all Pre-SSI cases are transfers from TANF, and the percentage of TANF cases moving to Pre-SSI has been steadily going down, from four percent in 2009 to less than one percent in 2019. In addition, there are simply fewer TANF exits, given that the total volume of TANF cases has been dropping since 2013. These two factors have led to a long-term pattern of decline in the caseload, except for a short period where a backlog of applications was addressed. Furthermore, the Social Security Administration (SSA) has become more stringent in their interpretation of disability criteria – most recently their mental health criteria.

The Pre-SSI caseload has fallen faster than anticipated over the past six months, and the current forecast assumes that reductions will continue through the 2019-2021 biennium, after which the caseload will stabilize in the 2021-2023 biennium. The 2019-2021 biennial average forecast for Pre-SSI is 205 families, which is 1.5 percent lower than the previous forecast. The 2021-2023 biennial average caseload is 173 families, which is 15.4 percent lower than the forecast for the current biennium.
Temporary Assistance for Domestic Violence Survivors (TA-DVS) – The TA-DVS without-payment caseload is a relatively small caseload that had been falling steadily amid strong seasonal fluctuations. That extreme seasonal pattern calmed a bit in 2017 but reasserted itself in 2018 and is expected to continue. The average caseload for the current biennium is forecasted to be 328 families per month, which is 14.4 percent higher than the previous forecast. The revision is resulted from the modestly increased caseloads after the previous forecasts. The caseload is expected to continue to fall modestly but continuously, to an average of 313 families per month during the 2021-2023 biennium, a reduction of 4.6 percent.

In the first half of 2019, the TA-DVS without-payment caseload fell to a relatively low point before increasing somewhat. Although summer increases are usual in this caseload, the increase was much more modest than in past years. The current forecast assumes a weaker seasonal pattern going forward, with an average of 943 cases per-month through the 2019-2021 biennium, a decrease of 3.1 percent compared to the previous forecast. The caseload is expected to drop a little to a monthly average of 908 cases in the 2021-2023 biennium, a decrease of 3.7 percent.

Forecast Environment and Risks
See the Introduction to this document for a synopsis of the changes that have been enacted since the finalization of this forecast.
# Self Sufficiency Biennial Average Forecast Comparison

<table>
<thead>
<tr>
<th></th>
<th>2019-21 Biennium</th>
<th>% Change Between Forecasts</th>
<th>Spring 2020 Forecast</th>
<th>% Change Between Biennia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fall 19 Forecast</td>
<td>Spring 20 Forecast</td>
<td>Change</td>
<td>2019-21</td>
</tr>
<tr>
<td><strong>SELF SUFFICIENCY PROGRAMS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Nutrition Assistance Program (Households)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children, Adults and Families</td>
<td>219,748</td>
<td>218,114</td>
<td>-1,634</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Aging and People with Disabilities</td>
<td>132,795</td>
<td>132,122</td>
<td>-673</td>
<td>-0.5%</td>
</tr>
<tr>
<td><strong>Total SNAP</strong></td>
<td>352,543</td>
<td>350,235</td>
<td>-2,308</td>
<td>-0.7%</td>
</tr>
<tr>
<td><strong>Temporary Assistance for Needy Families (Families: Cash/Grants)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One-Parent</td>
<td>16,005</td>
<td>15,879</td>
<td>-125</td>
<td>-0.8%</td>
</tr>
<tr>
<td>Two-Parent</td>
<td>2,561</td>
<td>2,610</td>
<td>49</td>
<td>1.9%</td>
</tr>
<tr>
<td><strong>Total TANF</strong></td>
<td>18,566</td>
<td>18,490</td>
<td>-76</td>
<td>-0.4%</td>
</tr>
<tr>
<td>TANF Employment Payments</td>
<td>1,889</td>
<td>1,889</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Pre-SSI</td>
<td>208</td>
<td>205</td>
<td>-3</td>
<td>-1.5%</td>
</tr>
<tr>
<td><strong>Temp. Assist. For Dom. Violence Survivors (Families)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TADVS: with Payment</td>
<td>287</td>
<td>328</td>
<td>41</td>
<td>14.4%</td>
</tr>
<tr>
<td>TADVS: without Payment</td>
<td>914</td>
<td>943</td>
<td>29</td>
<td>3.2%</td>
</tr>
<tr>
<td><strong>Total TADVS</strong></td>
<td>1,201</td>
<td>1,271</td>
<td>70</td>
<td>5.9%</td>
</tr>
</tbody>
</table>
Vocational Rehabilitation (VR)

The Spring 2020 caseload forecast is based on data (whether preliminary or final) available through February 2020. The resulting forecasts do not account for the rapid changes that occurred due to the Governor’s Emergency Order mandating physical distancing or the economic effects of a global pandemic. The changes in public policy, behavior, and economics due to the current crisis will be accounted for in subsequent forecasts.

Vocational Rehabilitation (VR) assists individuals with disabilities to get and keep a job that matches their skills, interests, and abilities. VR staff work in partnership with the community and businesses to develop employment opportunities for people with disabilities. VR services are individualized to help each eligible person receive services that are essential to their employment success.

In the last few years, there have been several important program changes. The Workforce Innovation and Opportunity Act (WIOA) was passed by Congress in 2014 and regulations were completed in July 2016. Among other things, it mandates provision of services to school-age youth, with joint responsibility between Local Education Agencies and VR. State Executive Order 15-01 instituted an Employment First policy to increase competitive integrated employment of people living with Intellectual and Developmental Disabilities (I/DD). The Lane vs. Brown settlement set specific numeric targets for moving clients out of sheltered workshops and into competitive integrated employment, and for providing services to transition age clients.

These changes are all complex and interwoven, and when combined they have a substantial impact on the VR caseload. Caseload increases started around January of 2015 and peaked in May 2018 before gradually reducing. This trend is expected to continue through at least the current biennium.

The changes in VR noted above impacted the composition of total VR caseload in terms of types of clients entering the program. For this reason, caseload groups are now based on the primary disability type of the entrant:

- Cognitive Impairments
- Psychosocial & Other Mental Impairments
- I/DD in Prior 12 Months
- Deafness/Blindness
- Physical Impairments

The caseload groups are assigned as follows:

1) First, clients who had an I/DD record in the 12 months prior to applying for VR services are identified by matching VR clients to I/DD eligibility and enrollment records.
2) The remaining VR clients are placed into one of the other four caseload groups based on their primary disability type (Cognitive Impairments, Psychosocial & Other Mental Impairments, Deafness/Blindness, and Physical Impairments).

Forecasts are developed stage by stage. First, application forecasts are developed for all five disability-based caseloads. Second, using application forecasts as an input, the eligibility forecasts are developed. And, finally, in plan forecasts are developed using the eligibility forecasts as an input. We also forecast Post-Employment Services. It is not broken down by disability-based caseloads because it is very small. Individual forecasts are added up to produce the following stage-based summary forecasts:

- **In Application** – count of clients who were in the application stage on the last day of the month or exited VR during the given month without advancing to the next stage.
- **In Eligibility** – count of clients who were in the eligibility stage on the last day of the month or exited VR during the given month without advancing to the next stage.
- **In Plan** – count of everyone who was in plan at any time in a given month

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2. See "Definition" section of this publication for more details.
The **Total Vocational Rehabilitation** (Total VR) forecast is the sum of In Application, In Eligibility, In Plan, and Post-Employment Services. It can also be derived as a sum of total caseloads in all five disability-based caseload groups and Post-Employment Services.

**Total Vocational Rehabilitation**—The average count of clients in VR for the 2019-21 biennium is expected to be 10,181 clients per month, a 2.1 percent lower compared to the Fall 2019 forecast. Moderate growth is expected through the 2021-23 biennium, with an average of 10,359 clients per month, a 1.7 percent increase compared to the 2019-21 biennial average.

**In Application** – The average count of clients in the application stage for the 2019-21 biennium is anticipated to be 1,172 clients per month, a 7.4 percent decrease compared to the Fall 2019 forecast. It is expected to average 1,143 cases per month for the 2021-23 biennium.

**In Eligibility** – The average count of clients in the eligibility stage for the 2019-21 biennium is anticipated to be 2,385 clients per month, a 5.3 percent increase compared to the Fall 2019 forecast. It is expected to average 2,453 for the 2021-23 biennium.
In Plan – The average count of clients in plan stage for the 2019-21 biennium is anticipated to be 6,510 clients per month, 3.7 percent lower than the Fall 2019 forecast. It is expected to grow slightly through the forecast horizon and average 6,651 for the 2021-23 biennium.

Post-Employment Services – The average count of clients in the Post-Employment Services (PES) stage for the 2019-21 biennium is anticipated to be 114 clients per month. The average for the 2021-23 biennium is expected to be 113.

Vocational Rehabilitation Disability Types:

Cognitive Impairments – The average count of clients in this caseload group for the 2019-21 biennium is anticipated to be 1,776 clients per month, a 3.8 percent decrease compared to the Fall 2019 forecast. It is expected to increase slightly through the forecast horizon and average 1,802 for the 2021-23 biennium.

Psychosocial & Other Mental Impairments – The average count of clients in this caseload group for the 2019-21 biennium is anticipated to be 2,665 clients per month, a 6.0 percent decrease compared to the Fall 2019 forecast. It is expected to remain flat through the forecast horizon and average 2,670 for the 2021-23 biennium.

I/DD in Prior 12 Months – The average count of clients in this caseload group for the 2019-21 biennium is anticipated to be 2,923 clients per month, a slight decrease compared to the Fall 2019 forecast. It is expected to grow through the forecast horizon and average 3,107 for the 2021-23 biennium.

Deafness/Blindness – The average count of clients in this caseload group for the 2019-21 biennium is anticipated to be 890 clients per month, a 2.3 percent decrease compared to the Fall 2019 forecast. It is expected to grow modestly through the forecast horizon and average 925 for the 2021-23 biennium.

Physical Impairments – The average count of clients in this caseload group for the 2019-21 biennium is anticipated to be 1,813 clients per month, a 3.0 percent increase compared to the Fall 2019 forecast. It is expected to average 1,742 for the 2021-23 biennium.
Forecast Environment and Risks

See the Introduction to this document for a synopsis of the changes that have been enacted since the finalization of this forecast.

Additional Risks and Assumptions

1. VR can provide services to any child with an Individual Education Plan (IEP) in schools between ages 14 and 24. VR, when invited to IEP meetings, can then work with school districts to identify certain employment and pre-employment service needs of these students with disabilities. This process helps to identify the number of youth with disabilities that will need services with finding jobs in the future as they become adults. VR then provides pre-employment transition services to those students. This youth population’s potential entry into VR services may cause upward pressure to our current caseload forecast.

2. Lane vs Brown requires that state provide employment services through OVRS to people with disabilities between the ages of 14 and 24 including at an individualized employment plan. The VR caseload was driven up when the DD population was incorporated into the VR caseload, and the forecast assumes that the VR population with IDD services in the prior 12 will continue to increase. But it is possible that a plateau has been reached.

3. Pre-employment Transition Services started in October 2014. This is a mandate of the Workforce Investment and Opportunity Act (W.I.O.A.) designed to help high school students with disabilities make the transition to employment or higher education. This mandate includes a 15 percent set aside of Federal dollars each year to be spent on specific services. The five core services are:
   - Job exploration counseling
   - Work-based learning experiences
   - Counseling on opportunities for enrollment in comprehensive transition or postsecondary educational programs at institutions of higher education
   - Workplace readiness training to develop social skills and independent living
   - Instruction in self-advocacy

Federal regulation changes about PES payment reporting structure may potentially impact the PES count.
## Vocational Rehabilitation Biennial Average Forecast Comparison

<table>
<thead>
<tr>
<th></th>
<th>2019-21 Biennium</th>
<th>% Change Between Biennia</th>
<th>Spring 2020 Forecast</th>
<th>% Change Between Forecasts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fall 19 Forecast</td>
<td>Spring 20 Forecast</td>
<td>Change</td>
<td>2019-21</td>
</tr>
<tr>
<td><strong>VOCATIONAL REHABILITATION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Impairments</td>
<td>1,846</td>
<td>1,776</td>
<td>-70</td>
<td>-3.8%</td>
</tr>
<tr>
<td>Psychosocial &amp; Other Mental Impairments</td>
<td>2,835</td>
<td>2,665</td>
<td>-170</td>
<td>-6.0%</td>
</tr>
<tr>
<td>IDD in Prior 12 Months</td>
<td>2,940</td>
<td>2,923</td>
<td>-17</td>
<td>-0.6%</td>
</tr>
<tr>
<td>Deafness/Blindness</td>
<td>911</td>
<td>890</td>
<td>-21</td>
<td>-2.3%</td>
</tr>
<tr>
<td>Physical Impairments</td>
<td>1,761</td>
<td>1,813</td>
<td>52</td>
<td>3.0%</td>
</tr>
<tr>
<td>Post Employment Services</td>
<td>105</td>
<td>114</td>
<td>9</td>
<td>8.6%</td>
</tr>
<tr>
<td><strong>Total Vocational Rehabilitation</strong></td>
<td>10,398</td>
<td>10,181</td>
<td>-217</td>
<td>-2.1%</td>
</tr>
<tr>
<td>In Application</td>
<td>1,265</td>
<td>1,172</td>
<td>-93</td>
<td>-7.4%</td>
</tr>
<tr>
<td>In Eligibility</td>
<td>2,265</td>
<td>2,385</td>
<td>120</td>
<td>5.3%</td>
</tr>
<tr>
<td>In Plan</td>
<td>6,763</td>
<td>6,510</td>
<td>-253</td>
<td>-3.7%</td>
</tr>
</tbody>
</table>
Oregon Health Authority
## Total Oregon Health Authority Biennial Average Forecast Comparison

<table>
<thead>
<tr>
<th>Health Systems - Medicaid</th>
<th>2019-21 Biennium</th>
<th>% Change Between Forecasts</th>
<th>Spring 2020 Forecast</th>
<th>% Change Between Biennia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fall 19 Forecast</td>
<td>Spring 20 Forecast</td>
<td>Change</td>
<td>2019-21</td>
</tr>
<tr>
<td>Health Systems - Medicaid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OHP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's Medicaid</td>
<td>292,298</td>
<td>292,997</td>
<td>699</td>
<td>0.2%</td>
</tr>
<tr>
<td>Children's Health Insurance Program</td>
<td>93,588</td>
<td>91,842</td>
<td>-1,745</td>
<td>-1.9%</td>
</tr>
<tr>
<td>Foster, Substitute and Adoption Care</td>
<td>19,634</td>
<td>19,734</td>
<td>100</td>
<td>0.5%</td>
</tr>
<tr>
<td>Aid to the Blind and Disabled</td>
<td>83,422</td>
<td>84,620</td>
<td>1,199</td>
<td>1.4%</td>
</tr>
<tr>
<td>Old Age Assistance</td>
<td>48,296</td>
<td>48,246</td>
<td>-50</td>
<td>-0.1%</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>9,458</td>
<td>9,069</td>
<td>-389</td>
<td>-4.1%</td>
</tr>
<tr>
<td>Parent, Caretaker Relative</td>
<td>87,181</td>
<td>86,433</td>
<td>-748</td>
<td>-0.9%</td>
</tr>
<tr>
<td>ACA Adults</td>
<td>364,311</td>
<td>367,369</td>
<td>3,058</td>
<td>0.8%</td>
</tr>
<tr>
<td><strong>Total OHP</strong></td>
<td><strong>998,187</strong></td>
<td><strong>1,000,311</strong></td>
<td><strong>2,125</strong></td>
<td><strong>0.2%</strong></td>
</tr>
<tr>
<td>Other Medical Assistance Total</td>
<td>66,044</td>
<td>66,774</td>
<td>730</td>
<td>1.1%</td>
</tr>
<tr>
<td>Cover All Kids</td>
<td>6,803</td>
<td>6,688</td>
<td>-116</td>
<td>-1.7%</td>
</tr>
<tr>
<td><strong>Total Medical Assistance</strong></td>
<td><strong>1,071,034</strong></td>
<td><strong>1,073,772</strong></td>
<td><strong>2,738</strong></td>
<td><strong>0.3%</strong></td>
</tr>
<tr>
<td>Mental Health †</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under Commitment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Forensic Care</td>
<td>909</td>
<td>928</td>
<td>19</td>
<td>2.1%</td>
</tr>
<tr>
<td>Civilly Committed</td>
<td>906</td>
<td>943</td>
<td>37</td>
<td>4.1%</td>
</tr>
<tr>
<td>Previously Committed</td>
<td>3,008</td>
<td>2,987</td>
<td>-21</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Never Committed</td>
<td>48,728</td>
<td>50,894</td>
<td>2,166</td>
<td>4.4%</td>
</tr>
<tr>
<td><strong>Total Served</strong></td>
<td><strong>53,551</strong></td>
<td><strong>55,752</strong></td>
<td><strong>2,201</strong></td>
<td><strong>4.1%</strong></td>
</tr>
</tbody>
</table>

1. Numbers reported represent adults only.
The Spring 2020 caseload forecast is based on data (whether preliminary or final) available through February 2020. The resulting forecasts do not account for the rapid changes that occurred due to the Governor’s Emergency Order mandating physical distancing or the economic effects of a global pandemic. The changes in public policy, behavior, and economics due to the current crisis will be accounted for in subsequent forecasts.

The expansion of Medicaid through the Affordable Care Act (ACA) beginning in January 2014 led the HSM caseload to grow in fits and starts related to two issues: open enrollment and delayed redeterminations. This led to a pattern of increases (due to a pause in processing redeterminations) and decreases (due to processing the backlog of redeterminations) from March 2016 through August 2017.

Additionally, since the ACA expansion, the number of new or returning entrants to Medicaid has shown yearly increases related to the open enrollment period of the Federal Marketplace. The exact timing of that bump has varied from year-to-year and seems loosely correlated with the exact start and stop dates of the open enrollment period.

Automated Renewals
Starting with the renewals scheduled for the end of February 2018, Oregon transitioned to a system of automated renewals (sometimes called passive or ex parte renewals). Automated Renewals is a system under which OHA automatically renews a client’s Medicaid Eligibility if they have all the required information and the client is eligible. This system is in place in most states and is required by the federal Centers for Medicare and Medicaid Services (CMS). If OHA cannot verify eligibility with the available data, the client will go through the normal, active renewal process that does require a response.

We can observe the impact of changing to automated renewals in the data; in particular, we see a decrease in the rate at which clients exit the caseload at the twelfth and twenty fourth month in certain programs when their cases are renewed. The largest impact turned out to be in the Parent, Caretaker, Other Relative (PCR) caseload. We also saw shifts in the ACA Adult caseload and smaller impacts in the CAWEM – Adult caseload and Children’s Medicaid. We have used the available data since automated renewals started more than two years ago to refine our estimates of the exit rates for the Spring 2020 forecast. We continue to see slight changes in the exit rates for those clients that have gone through two automated renewals and we may continue to see additional shifts in the long run for clients that have gone through the automated renewals process multiple times.

Cover All Kids
We now have more than two years of data for the Cover All Kids program. It includes the recent entries, exits and transfers for Cover All Kids, which we use to build the forecast model.

There has been a slight decrease in caseload growth in the last few months. We believe that there was a bump at the start of 2019 related to the Kaiser Charity cases being transferred over. However, starting in November 2019 we have seen a decrease in new enters. That is what accounts for the slower growth in the forecast compared to Fall 2019.

Outreach efforts to encourage eligible Oregonians to sign up for this program are contending with a difficult national environment and recent expansion of the use of the public charge rule at the federal level may have decreased the number of new people signing up. The forecast assumes that about half the estimated population of potentially eligible children will be on the caseload after 3 years. We still believe there is a pool of roughly 15,000 eligible children in the state of Oregon. The Cover All Kids forecast is an estimate of how many we think will be served under current circumstances.

This forecast does continue to have a lot of uncertainty. It has a very short history and is likely sensitive to political rhetoric, in addition to outreach efforts and policy changes.

Caseload Actuals and Trends
As of November 2019, the Medicaid caseload was 1,061,361 and the preliminary estimate for February 2020 is 1,069,923. In this forecast, caseloads are expected to grow slowly with small seasonal bumps related to open enrollment in the Federally-facilitated Marketplace.
Children’s Medicaid – This caseload has shown a slow decline over the last two years. The most recent preliminary estimate for February 2020 shows 296,827 clients on this caseload. By the end of 2019-2021 biennium there will be 286,034 clients on this caseload, and it will account for about 26.8 percent of the total Medicaid caseload. The average monthly caseload forecast for the 2021-23 biennium is expected to be 4.3 percent lower than 2019-21.

Children’s Health Insurance Program (CHIP) – The most recent preliminary estimate for February 2020 shows 91,305 children on this caseload. Most of the growth in this program comes from transfers from Children’s Medicaid, which shows a lot of recent variance and increases the uncertainty of this caseload forecast. The caseload is expected to continue to grow going forward, with 92,682 by the end of 2019-2021 biennium and by then it will account for 8.7 percent of the total Medicaid caseload. This caseload is expected to continue to grow slightly through the 2021-23 biennium.

Foster, Substitute and Adoption Care – The most recent preliminary estimate for February 2020 shows 19,857 children on this caseload. This caseload has been declining for the last two years. This decline is linked to the number of children placed in foster care and will be driven by current and future policy changes in that area. By the end of 2019-2021 biennium there is projected to be 19,419 clients on this caseload, and it will account for 1.8 percent of the total Medicaid caseload. This caseload is expected to steadily decline through the 2021-23 biennium.
Aid to the Blind and Disabled (ABAD) – The most recent preliminary estimate for February 2020 shows 84,752 clients on this caseload. Historically, this caseload grew steadily; however, the ACA reform caused a temporary lull by reducing the number of new people entering, due to: 1) the availability of health insurance to low income, non-disabled adults (the ACA Adults caseload) and 2) the availability of K-Plan (for more information about K-Plan changes, see the APD portion of this document). New enters started increasing again after the ACA expansion in 2014, but from a new, lower baseline. This shift in new enters caused the caseload to dip at first and then in 2016 it started growing again. However, the slow, steady growth in new enters appears to have leveled off and started to decline around January 2018. This is most likely linked to a tightening of disability determinations by federal administrative law judges, coupled with changes to rules for In-Home disability care (see the APD portion of this document). There was a one-time level shift up in November 2019 related to a cleanup that moved people in other caseloads into ABAD. This caseload is expected to continue to increase through the 2021-2023 biennium to reach 50,945 cases by June 2023.

Old Age Assistance (OAA) – The most recent preliminary estimate for February 2020 shows 47,871 clients on this caseload. The caseload is projected to grow slowly, but steadily in line with the elderly population growth through the foreseeable future. The caseload is expected to be 49,263 by the end of 2019-2021 biennium and will account for 4.6 percent of the total Medicaid caseload. This caseload is expected to continue to increase through the 2021-2023 biennium to reach 50,945 cases by June 2023.
Pregnant Women – The most recent preliminary estimate for February 2020 shows 8,952 women on this caseload. The caseload declined sharply after redeterminations were resumed. It showed a particularly steep drop during the “clean up.” The decline in the number of live births in the state of Oregon over the past two years has also put downward pressure on this caseload, but it is expected to level off and not continue to decrease. The caseload is expected to be 9,039 at the end of 2019-2021 biennium and will account for 0.8 percent of the total Medicaid caseload.

Parent, Other Caretaker, Relative – This caseload showed the largest impact from the change to automated renewals. In the absence of automated renewals, the caseload would have been expected to decline, but instead it is showing significant growth. A large fraction of clients on this caseload have zero income and automated renewal is particularly effective at keeping them on the caseload compared to when they previously were required to return the completed renewal application every year. There is a concern that ultimately new enters for this caseload will decline after all potentially eligible Oregonians are signed up, but this is likely to happen after the forecast horizon for the 2021-2023 biennium is reached. The total volume of people enrolled in the PCR group in a year has actually gone down, even as the average monthly caseload has gone up. This is due to people staying on the caseload longer and not as many clients exiting only to come back later. The most recent preliminary estimate for February 2020 shows 84,650 clients on this caseload. The caseload is expected to grow to 90,298 by the end of 2019-2021 biennium and will account for about 8.4 percent of the total Medicaid caseload. By June of 2023 the caseload is expected to grow to 96,086.

The Impact of Automated Renewals on PCR
The PCR caseload has shown a sharp increase since the start of Automated Renewals. This is primarily due to decreasing exits. Estimates of exits have improved over time, however past forecasts assumed that the number of new enters would decline at the same time. Instead we have seen a seasonal increase in new enters during the summer. We have had only two summers since the change to automated renewals, but so far, we have seen an increase in new enters each August. Additionally, overall transfers, both into and out of PCR has been elevated, with slightly more transfers out and exits than was previously expected. This leads to a current forecast with an increasing caseload that doesn’t level off until the end of the 2021-2023 biennium.

There is a risk that the natural ceiling for this group is lower than forecasted. If there are not enough eligible Oregonians, then the new enters for this caseload could dry up and caseload growth could flatten out. Overall, this caseload continues to show variations in the components of change specifically driven by automated renewals and represents a risk to accuracy that is unique to this forecast group.
**ACA Adults** – This caseload was also impacted by automated renewals, but to a lesser extent. The most recent preliminary estimate for February 2020 shows 369,193 clients on this caseload. The caseload is expected to rise slightly to 369,456 by the end of 2019-2021 biennium and will account for about 34.6 percent of the total Medicaid caseload. The average monthly caseload for ACA Adults is expected to increase by 1.4 percent from the 2019-2021 biennium to 2021-2023.

**Other Medical Assistance Programs**

**Breast and Cervical Cancer Treatment Program (BCCTP)** – The most recent preliminary estimate for February 2020 shows 201 clients on this caseload. The caseload dropped during the redetermination and clean-up period in 2016 and 2017, but it appears to have leveled off at a new floor during 2018. This caseload is expected to be 213 by the end of 2019-2021 biennium, and change very little through June 2023.

**Citizen-Alien Waived Emergent Medical - Adult (CAWEMA)** – This caseload was formerly known as CAWEM – Regular and contained both children and adults. However, in January 2018 all the children under age 19 in this caseload (roughly 3,600) moved to the new Cover All Kids caseload. This caused a level shift down. The most recent preliminary estimate for February 2020 shows 34,537 clients on this caseload. The caseload is expected to decrease slowly, reaching 34,029 at the end of 2019-2021 biennium. This caseload is expected to decrease by 1.1 percent comparing the 2019-21 biennium to 2021-23.
Citizen-Alien Waived Emergent Medical - Prenatal (CAWEMP) – The prenatal caseload experienced a level shift up with the inclusion of an additional 2 months of post-partum care starting in April 2018. The number of clients being served did not change significantly, but the additional length of care caused a 35% growth in the caseload. The most recent preliminary estimate for February 2020 shows 2,037 clients on this caseload. The caseload is expected to be 1,987 by the end of 2019-2021 biennium. CAWEMP is expected to decline by 1.6 percent comparing the 2019-21 biennium to 2021-23.

Qualified Medicare Beneficiary (QMB) – The most recent preliminary estimate for February 2020 shows 29,741 clients on this caseload. There was a small level shift down in March 2018 related to Cost of Living Adjustments (COLA) in Social Security payments. This caseload is expected to be 31,601 by the end of 2019-2021 biennium and will account for about 3.0 percent of the Medicaid caseload. This caseload has grown consistently since January of 2009 and is expected to continue growing through the forecast horizon.

Cover All Kids (CAK) – This is a new state funded program that began January 1, 2018. It provides medical assistance like the Oregon Health Plan to all children in Oregon under the age of 19, who are under 300 percent of the Federal Poverty Level (FPL), and are otherwise eligible for Medicaid except for U.S. Residency/Citizenship status. These clients are not counted in the Medicaid caseload even though they receive the same benefits as other Oregon Health Plan clients. For forecasting purposes, they are counted as part of Total Medical Assistance. The most recent preliminary estimate for February 2020 shows 6,433 clients on this caseload. This caseload is expected to grow to 7,241 by the end of 2019-2021 biennium. This caseload is expected to grow more slowly through the 2021-23 biennium.

Medicare Part A/B Premium Assistance Programs

Medicare Part-A Premium Assistance – The most recent preliminary estimate for February 2020 shows 8,060 clients on this caseload. This caseload is expected to grow through the forecast horizon. It is expected to be 8,456 by the end of 2019-2021 biennium, and increase steadily to 8,881 by the end of the 2021-23 biennium.

Medicare Part B Premium Assistance – The most recent preliminary estimate for February 2020 shows 131,817 clients on this caseload. This caseload is projected to continue growing steadily, like other age-related caseloads including OAA and QMB. It is expected to be 136,747 by the end of 2019-2021 biennium and grow to 143,800 by the end of the 2021-23 biennium. Twenty-Nine percent of those receiving Medicare Part-B assistance are in the OAA caseload; 24% are in the ABAD caseload; and 22% are in QMB. Most of the remaining 25% are in the Partial Dual eligible caseloads.
Forecast Environment and Risks

See the Introduction to this document for a synopsis of the changes that have been enacted since the finalization of this forecast.

Additional Risks and Assumptions

The Cover All Kids caseload was revised down slightly on the decrease of recent new enters over the last few months. We have more than a year of data now. It is still very early in the program and additional data may shift estimates more. Until we have more history, there are risks to this forecast.

It has been more than two years since the implementation of Automated Renewals. We have also seen the impact of automated renewals on open enrollment. The greatest remaining risk is that automated renewals have unanticipated long-term impacts on new entries due to the reduction in churn.

There are also other risks associated with switching to automated renewals. Without the yearly verification of a known address, there is some risk of out of state clients not being detected. Changes in family circumstances might also go undetected, including additions or separations, although under the MAGI system, eligibility is determined by Tax Unit (those that file together) mitigating some of that risk. Clients are responsible for reporting any changes in their circumstances which could impact eligibility, but we would certainly not expect 100% compliance or for reported changes to always be timely.
<table>
<thead>
<tr>
<th></th>
<th>HEALTH SYSTEMS - MEDICAID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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Mental Health (MH)

The Spring 2020 caseload forecast is based on data (whether preliminary or final) available through February 2020. The resulting forecasts do not account for the rapid changes that occurred due to the Governor’s Emergency Order mandating physical distancing or the economic effects of a global pandemic. The changes in public policy, behavior, and economics due to the current crisis will be accounted for in subsequent forecasts.

This forecast includes adults who are 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. There are three Mandated populations: (1) Aid and Assist; (2) Guilty Except for Insanity (GEI); and (3) Civilly Committed. The Non-Mandated populations include two groups: (1) Previously Committed individuals; and (2) Never Committed individuals.

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, 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.

Total Mandated Mental Health Services

The mandated caseload encompasses the committed caseload (Aid and Assist, GEI, and Civilly Committed clients). The 2019-21 biennial average forecast is 1,871 clients per month. The 2021-23 biennial average is expected to be 0.3 percent lower than the 2019-21 biennial average. As with all MH categories forecasted in this report, the Mandated population includes only adults.

Total Forensic Mental Health Services

The forensic caseload encompasses the Aid and Assist and GEI clients. The 2019-21 biennial average forecast is 928 clients per month. The 2021-23 biennial average is expected to be 0.3 percent lower than the 2019-21 biennial average.
Aid and Assist – This caseload has been growing since 2013. There was a dip in the second half of 2016, followed by another jump, up to almost 300 clients in October 2016. After that time the caseload fell, fluctuating around 250 cases. Throughout 2019 and into 2020 the caseload has fluctuated between 300 and 350 clients per month. Aid and Assist currently counts only clients served at the State Hospital. The 2019-21 biennial average forecast is 318 clients per month. The 2021-23 biennial average is 1.9 percent lower than the 2019-21 biennial average forecast.

Guilty Except for Insanity (GEI) – These clients are under the jurisdiction of the Psychiatric Security Review Board. This caseload began to drop about 10 years ago, and since 2016 the caseload has hovered around 600 clients per month. In late 2019 the caseload started to slowly climb again, and in January 2020 the caseload was 610 clients. The 2019-21 biennial average forecast is 610 cases per month. The 2021-23 biennial average is 0.5 percent higher than the 2019-21 biennial average forecast.

Civil Commitments – This caseload is subject to the interaction of reporting practices, data system changes, and data warehouse activities. There has been ongoing work to improve data accuracy. Coincident with the expansion of Medicaid, such that more people were eligible for health insurance, the caseload has been declining, almost continuously each month, from early 2014 up to the most recent month of finalized data. The 2019-21 biennial monthly average forecast is 943 clients per month. The 2021-23 biennial monthly average is 0.3 percent lower than the 2019-21 biennial average. 2019-21 biennial average forecast is 906 clients per month. The 2021-23 biennial average is 0.8 percent lower than the 2019-21 biennial average.
Previously Committed – This caseload captures clients receiving mental health services that had been civilly or criminally committed at some time since the year 2000. About 80 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 2019-21 biennial average monthly caseload forecast is 2,987 clients. The 2021-23 biennial monthly average is 3,013 clients, which is 0.9 percent higher than the 2019-21 biennial average.

Never Committed – This caseload captures clients receiving mental health services that have not been civilly or criminally committed since the year 2000. More than 99 percent of these clients are served in non-residential settings. The 2019-21 biennial average caseload forecast is 50,894 clients. The 2021-23 biennial average is 0.1 percent higher than the 2019-21 biennial average.
Forecast Environment and Risks
See the Introduction to this document for a synopsis of the changes that have been enacted since the finalization of this forecast.

Additional Risks and Assumptions
To date, data are only available for Aid and Assist clients served inside the State Hospital. The expectation is that Community Restoration Aid and Assist data (data on clients served outside of the State Hospital) will be developed over the next several years. This is dependent upon complete data submission from the counties. The Aid and Assist caseload is also subject to variation at the county level. For example, differences in decision-making from one jurisdiction to another by law enforcement and the judiciary can affect who is referred to the Aid and Assist caseload.

The Guilty Except for Insanity caseload is subject to review by the Psychiatric Security Review Board. When clients are released by the Board prior to their end of jurisdiction date, the caseload is driven down.

A major risk to the Civilly Committed caseload is related to the timeliness of reporting. Provider input delays, especially concerning civil commitment data, can lead to artificially low caseload numbers.
### Mental Health Biennial Average Forecast Comparison

<table>
<thead>
<tr>
<th></th>
<th>2019-21 Biennium</th>
<th>% Change Between Biennia</th>
<th>Spring 2020 Forecast</th>
<th>% Change Between Forecasts</th>
<th>% Change Between Biennia</th>
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<tr>
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<td>2021-23</td>
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<td>Under Commitment</td>
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<td>Aid and Assist ²</td>
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<td>Guilty Except for Insanity</td>
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<td>Total Forensic Care</td>
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<td>Total Mandated Mental Health Services</td>
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</table>

1. Numbers reported represent adults only.
2. State Hospital only.
Appendix I

DHS Caseload History & Definitions
Recruiting of new CBC providers in underserved areas; Medicaid participation made more attractive.

Diversion and transition of clients from NFC’s to their choice of in-home or CBC facility services.

Nursing facility diversion begins (Money Follows the Person, also known as Oregon on the Move). CBC Rate Increase ($260).

In-Home Agency added the In-Home Care Caseload.

On The Move program moratorium

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

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

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

Home Care Worker compensation levels reduced by 14%, CBC rates reduced by 19%. NF rates reduced by 19%.

Reduced In-home clients service hours or become ineligible to receive In-home services as a result of New CAPS Assessment guidelines

First confirmed case of COVID-19 in Oregon

The residential care facility and assisted living facility licensing moratoriums end.

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

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

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Income threshold for client pay-in rises to $1,210/month.
Guardianship Assistance

Reimbursement rate redesign implemented.

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

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

NOTE: There are no historical observations from May - Nov. 2011 due to the start of ORKids data and the end of Legacy data.
Youth I/DD Services

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.
Reduce I/DD crisis diversion.

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

New rate guidelines are issued for in-home service plans for children with developmental disabilities, including Family Support Services (SE 150), In-Home Support for Children (SE 151), and Children’s Intensive In-Home Supports (CIIS, SE 145).

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

In-Home Support for Children (SE 151) is restored.

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.

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

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

In-Home Support includes In-Home as well as Brokerage services without employment and transportation services.

Adult I/DD Services

Adult In-Home Support includes In-Home as well as Brokerage services without employment and transportation services.

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.
Reduce I/DD crisis diversion.

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

New rate guidelines are issued for in-home service plans for children with developmental disabilities, including Family Support Services (SE 150), In-Home Support for Children (SE 151), and Children’s Intensive In-Home Supports (CIIS, SE 145).

Intellectual & Developmental Disabilities (I/DD):
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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.

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

In-Home Support includes In-Home as well as Brokerage services without employment and transportation services.
SPRING 2020 DHS-OHA CASELOAD FORECAST

- TANF
- SNAP
- Oregon Unemployment Rate
- Minimum Wage
- ABAWD rule
- COVID-19
- Self Sufficiency Programs (SSP)
- SNAP - Self Sufficiency Programs
- SNAP - Aging & People with Disabilities

- Asset test aligned with TANF
- Disaster SNAP benefits for 5 NW counties
- Certain higher education students eligible for SNAP
- Oregon’s unemployment rate peaks at 11.6%
- Period of steepest Great Recession job loss begins
- Oregon’s unemployment rate falls to 7.9%
- SNAP caseload artificially inflated by summer meals program from May-August, 2015.
- SNAP benefits for higher education students expanded
- Oregon Unemployment rate under 5%
- First confirmed case of COVID-19 in Oregon
- Oregon Unemployment rate under 4%
- Minimum Wage Raised: $11.25 in most counties, $11.00 in rural counties.
- Minimum Wage Raised: $10.75 in most counties, $10.50 in rural counties.
- Minimum Wage Raised: $10.25 in most counties, $10.00 in rural counties.
- Minimum Wage Raised: $9.75 in most counties; $9.50 in rural counties.

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

February/March: 10,000 unemployment benefits cases expire.

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

Minimum Wage Raised: $11.25 in most counties, $11.00 in rural counties.

Oregon Unemployment rate under 4%

First confirmed case of COVID-19 in Oregon
Vocational Rehabilitation

- Entered Order of Selection
- Cleared almost all Clients in Delayed Status
- Lane et al. v. Brown et al. Filed
- Workforce Innovation and Opportunity Act (WIOA) Law Passes
- New Policy, 90 Days to Plan
- New Job Development Contract
- Executive Order 15-01
- Executive Order 13-04
- WIOA Regulations Go Into Effect
- Lane et al. v. Brown et al. Settlement

Application

Eligibility

In Plan


0 2,000 4,000 6,000 8,000 10,000 12,000
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."

Aging and People with Disabilities (APD)

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

Area Agencies on Aging (AAA) and DHS staff help clients find the appropriate care settings to meet their needs and determine financial eligibility. To qualify, 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 caseload includes clients who hire hourly workers to assist them in meeting their ADL needs and other common household tasks.

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 caseload includes clients who hire a live-in home care worker to provide 24-hour care. This service is closed as of October 2017.

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 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 have purchased.

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) 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 ADL, medication oversight, and social activities. Services can also include nursing and behavioral supports to meet complex needs.

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 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 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) 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 (NF)

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 clients need comprehensive, 24-hour care for assistance with ADL and ongoing nursing care due to either age or physical disability.

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

Enhanced Care clients have difficulty managing 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 clients are children under 21 who receive nursing care in pediatric nursing facility units.
Child Welfare (CW)

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 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 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 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 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.
Intellectual and Developmental Disabilities (I/DD)

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

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

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

Case Management Enrollment

Case Management Enrollment provides entry-level eligibility evaluation and coordination services. The other caseloads are grouped into three broad categories: adult services, children services, and other services.

Adult Services Include:

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

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

Adult In-Home Services help individuals aged 18 years or older with intellectual and developmental disabilities to continue to live in their homes. In-Home services can be accessed through CDDP or Brokerages.

I/DD 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 88 percent and 12 percent respectively).

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 83 percent and 17 percent respectively).

Children’s Services Include:

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 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 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.

Other I/DD Services Include:

Employment and Day Support Activities caseload previously known as Employment and Attendant Care has been redefined and given a new title. Employment and Day Support Activities – are out-of-home employment or community training services and related supports provided to individuals 14 or older, to improve the individual’s productivity, independence, and integration in the community. Examples of services covered within this caseload include: discovery, employment path services, initial and on-going job coaching, individual and small group employment support, and certain types of employment related day support activities.

Transportation services have been redefined to include all non-medical transportation services including services provided under Plan of Care (e.g. transit passes and non-medical community transportation).
Self Sufficiency Programs (SSP)

Self Sufficiency programs aids with low-income families to help them become healthy, safe, and economically independent. Except for 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)

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 benefits amounts.

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, and pursuing treatment for drug abuse or mental health as needed. Proof of deprivation (death, absence, incapacity, or unemployment of a parent) will no longer be a requirement of TANF enrollment.

The TANF Basic program has been renamed “TANF One-Parent.” In the past, TANF Basic included one-parent families and two-parent families where at least one parent is disabled and unable to care for children. TANF One-Parent now contains only one-parent families.

The TANF UN program has been renamed “TANF Two-Parent.” It now includes families where both parents can care for their children, or one parent is able to care for the children and the other is disabled.

TANF Employment Payments (EP) are available to those families exiting TANF due to employment. These payments are for three months only. TANF EP was re-authorized for the 2017-19 biennium.

State Family Pre-SSI (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 a 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) 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 (VR)

Vocational Rehabilitation assesses, plans, and coordinates services for people who have physical or mental disabilities and need assistance to obtain and retain employment that matches their skills, potential, and interest. VR Services are provided through local VR offices across the state. VR partners with community resources and local providers to deliver a wide range of services: counseling, training, job placement, assistive technology, and extended services and supports.

**Total Vocational Rehabilitation**

Count of all clients who had an active VR episode at any time in the given month. It is the sum of clients In Application, In Eligibility, In Plan, and Post-Employment Services.

In Application is a count of clients who were in application stage on the last day of the month or exited VR during the given month without advancing to the next stage. VR case is initiated by client submitting his/her application to VR. In this stage, the application is reviewed, and eligibility is assessed.

In Eligibility is a count of clients who were in eligibility stage on the last day of the month or exited VR during the given month without advancing to the next stage. Typically, clients in this stage are either waiting for the final eligibility determination or are in the process of plan developing.

In Plan is a count of clients who had an active plan at any time in a given month. After employment, and if all is going well, a case is normally closed after 90 days.

Post-Employment Services clients can receive Post-Employment Services after their VR case has been closed if they need help keeping their job or advancing within it. These services are intended for short periods of 2-3 months.

Cognitive Impairments caseload includes individuals who are in Application, Eligibility, or In Plan stage and have one of the following primary disability impairments: Cognitive Impairments. Except if counted in I/DD in Prior 12 Months caseload.

Psychosocial & Other Mental Impairments caseload includes individuals who are in Application, Eligibility, or In Plan stage and have one of the following primary disability impairments: psychosocial impairments and other mental impairments. Except if counted in I/DD in Prior 12 Months caseload.

Deafness/Blindness caseload includes individuals who are in Application, Eligibility, or In Plan stage and have one of the following primary disability impairments: blindness; other visual impairments; deafness, communication visual; deafness, communication auditory; hearing loss, communication visual; hearing loss, communication auditory; other hearing impairments; deaf-blindness; and communicative impairments. Except if counted in I/DD in Prior 12 Months caseload.

Physical Impairments caseload includes individuals who are in Application, Eligibility, or In Plan stage and have one of the following primary disability impairments: mobility; manipulation; mobility and manipulation; other orthopedic impairments; respiratory impairments; general physical debilitation; other physical impairments not listed elsewhere; dexterity orthopedic/neurological impairments; and other (no impairment or missing impairment field). Except if counted in I/DD in Prior 12 Months caseload.
Appendix II
OHA Caseload History & Definitions
The Governor initiates across-board General Fund reductions in response to the deficit. DMAP's General Fund budget is reduced $44.3 million.

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Health Transformation bill passed the House and is signed into law.

ACA reform: MAGI based eligibility determination is implemented. Adults up to 138% FPL now eligible for OHP. Similar expansion happened for CAWEM. Hospital presumptive eligibility policy went into effect.

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

The 1st quarter of 2012 shows signs of economic recovery.

Elaboration of the two-month uninsured requirement for CHIP effective August 23. CHIP income limit expanded through 300% FPL.

Letters were mailed to households with children on FHAP's reservation list letting them know about HK program.

Redeterminations were deferred by 6 months. Fast Track letters were mailed.

Emergency Health Transformation bill passed the House and is signed into law.

Redeterminations were delayed again due to issues with receiving and processing FFM files during Open Enrollment.

Redeterminations resume including a releveling process to spread redeterminations throughout the year.

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“Clean Up” process to review legacy clients not handled by normal review during releveling process. Lasts 3 months.

First confirmed case of COVID-19 in Oregon.

Non-disabled Children

Non-disabled Adults

Aid to the Blind and Disabled

Cover Oregon transitions to Federal Marketplace.

Cover Oregon transitions to Federal Marketplace.

First wave of redeterminations.

First wave of redeterminations.

All except Pregnant Women redeterminations are delayed for 3 months due to transitioning to ONE eligibility system.

Automated Renewals start

Automated Renewals start

First confirmed case of COVID-19 in Oregon.
HB 3100 creates standardized mental health evaluations and SB 420 puts people GEI of non-Measure 11 crimes under the jurisdiction of the Oregon Health Authority while they are at the State Hospital.

Client Process Monitoring System (CPMS) data ended. Many Clients had been erroneously counted.

State Hospital Data System Change from OPRCS to AVATAR

Start of Historical Data

Civilly Committed

Guilty Except for Insanity

Aid and Assist

Mental Health (MH):
Total Mandated Mental Health Caseload (Adults)
OHA Caseload Definitions

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.”

<table>
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<tr>
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Add $4,480 for each person over 8

Health Systems - Medicaid (HSM)

The Health Systems Division coordinates physical, oral, and behavioral health services funded by Medicaid.

Historically, pre-ACA, Medicaid 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 Medicaid – programs that provide medical benefits but are not considered part of OHP.

Since 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 benefits (what was previously called OHP Plus).

OHP Benefit Package

The OHP package offers comprehensive health care services to adults and children who are eligible under Medicaid and CHIP, or children otherwise eligible for Medicaid except U.S. Citizenship/Residency requirements under the Cover All Kids program. It was formerly known as OHP Plus to distinguish it from OHP Standard.

Modiﬁed Adjusted Gross Income (MAGI) is an IRS based method for determining income eligibility for most Medicaid Caseloads, including Children’s Medicaid, CHIP, Pregnant Women, PCR, and ACA Adult. It does not apply to those who are categorically eligible, such as due to age, disability, or placement in foster care. Oregon transitioned to MAGI eligibility determination a few months before the 2014 ACA expansion.

Temporary Assistance for Needy Families (TANF) caseload has been replaced, with the clients transferred to two other caseloads. Adults are now included in the Parent, Other Caretaker, Relative caseload; and children are now included in the Children’s Medicaid caseload.

Children’s Medicaid offers OHP medical coverage to children from birth through age 18 living in households with income from 0 to 133 percent of Federal Poverty Level (FPL). A potential ﬁve percent disregard makes the maximum upper limit 138% of FPL for qualifying children. This caseload is comprised of children who would previously have been included in three other older 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.

Poverty Level Medical Children (PLMC) caseload has been renamed to Children’s Medicaid and the income rules were widened to include children previously included in other caseloads.

Children’s Health Insurance Program (CHIP) caseload 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 Care and Adoption Assistance provides medical coverage through Medicaid for children in foster or substitute 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) 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) provides medical coverage through Medicaid for individuals who are age 65 or over and eligible for federal SSI.

Pregnant Women (formerly known as Poverty Level Medical Women (PLMW)) program provides medical coverage to pregnant women with income levels up to 185 percent of the FPL. Coverage is extended for 60 days after childbirth.

Parent, Other Caretaker, Relative (PCR) caseload is 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 medical coverage to adults with children who have incomes not exceeding approximately 42 percent of Federal Poverty Level (FPL).

ACA Adults caseload represented 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.
Other Medicaid (Non-OHP Benefit Packages)

Breast and Cervical Cancer Treatment Program (BCCTP) historically 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. Since January 1, 2012, women have not needed to be enrolled for screening through the Breast and Cervical Cancer Program to access BCCTP. After determining eligibility, the client receives full OHP benefits. Clients are eligible until either reaching the age of 65, obtaining other coverage, or ending treatment. This program is available for both citizens and non-citizens/aliens. Many women who would have been formerly enrolled in this program are not enrolled directly into ACA Adults.

Citizen/Alien Waived Emergent Medical (CAWEM) is a program that covers emergent medical care for individuals who would qualify for Medicaid if they met the U.S. Citizenship/Residency requirements. The program has two subcategories:

- Adult (CAWEMA) which provides only emergency medical care. This was formerly CAWEM – Regular, however the children under age 19 will leave this category and transfer to Non-Medicaid Covered Children and Teens in January 2018.
- Prenatal (CAWEMP) which also covers all pre-natal medical services (plus up to 2 months post-partum).

Up until January 1, 2018, children under the age of 19 were also enrolled in this program, but after that date all eligible children are now enrolled in the Cover All Kids program, which provides full OHP benefits.

Qualified Medicare Beneficiary (QMB) 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. OHA pays for any Medicare Part A and Part B premiums as well as any applicable Medicare coinsurance and/or deductibles not exceeding the Department’s fee schedule.

Medicare Part A/B Premium Assistance Programs

Medicare Part A Premium Assistance coverage is for Inpatient services. This coverage is free for most Medicare eligible individuals, except for those who don’t have sufficient work history. Medicare Part A Premium Assistance program is designed to help low-income individuals (under 100 percent of FPL) pay for the premiums when they do not have sufficient work history to qualify for free coverage.

Medicare Part B Premium Assistance coverage is for Outpatient services. Medicare eligible individuals have an option to subscribe, but they are required to pay a premium. Medicare Part B Premium Assistance program is designed to help low-income individuals (under 133 percent of FPL) pay the premium.

Cover All Kids (CAK) is a new state funded program that began on January 1, 2018. It is not Medicaid, but it provides medical assistance like the Oregon Health Plan to all children in Oregon under the age of 19, who are under 300% of the Federal Poverty Level (FPL) and are otherwise eligible for Medicaid except for U.S. Residency/Citizenship status.
Mental Health (MH)

The Mental Health program provides prevention and treatment options for clients with mental illnesses. The MH caseload forecast is the total number of adult clients receiving government paid mental health services per month. MH provides both Mandated and Non-Mandated mental health services, some of which are residential.

Total Mandated Population 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.

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

Guilty Except for Insanity (GEI) caseload includes clients who are under the jurisdiction of the Psychiatric Security Review Board. Clients in GEI caseloads have been found “guilty except for insanity” of a crime by a court. OHA 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 caseload includes individuals currently under commitment (although a proxy rule is 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 caseload includes people who were previously either civilly or criminally committed but whose commitment period has ended. These clients continue to receive individual services, counseling, training, and/or living supports. About 80 percent of these clients are served in non-residential settings.

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.