SPRING 2020 ODHS-OHA CASELOAD FORECAST

Budget Planning and Analysis
Office of Forecasting, Research and Analysis

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DHS
Oregon Department of Human Services

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Oregon Health Authority

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Executive Summary

The 2019-21 **Supplemental Nutrition Assistance Program (SNAP**) biennial average forecast is 393,479 households, which is 3.8 percent lower than the Fall 2020 forecast. The 2021-23 biennial average forecast is 398,370 households, which is 1.2 percent higher than the 2019-21 forecast average.

The 2019-21 **Temporary Assistance to Needy Families (TANF)** biennial average forecast is 18,118 families, which is 8.5 percent lower than the Fall 2020 forecast. The 2021-23 biennial average forecast is 15,895 families, which is 12.3 percent lower than the 2019-21 forecast average.

The 2019-21 **Child Welfare (CW)** biennial monthly average forecast is 20,541 children, which is 1.0 percent lower than the Fall 2020 forecast. The 2021-23 biennial monthly average forecast is 20,197 children, which is 1.7 percent lower than the 2019–21 forecast average.

The 2019-21 **Aging and People with Disabilities Long–Term Care (LTC)** biennial average forecast is 35,375 clients, which is 0.4 percent lower than the Fall 2020 forecast. The 2021-23 biennial average forecast is 36,084 clients, which is 2.0 percent higher than the 2019-21 forecast average.

The 2019-21 **Intellectual and Developmental Disabilities Case Management (I/DD**) biennial average forecast is 30,753 clients, which is 0.1% lower than the Fall 2020 forecast. The 2021-23 biennial average forecast is 33,180 clients, which is 7.9 percent higher than the 2019-21 forecast average.

The 2019-21 **Vocational Rehabilitation (VR)** biennial average forecast is 8,955 clients, which is 3.6 percent lower than the Fall 2020 forecast. The 2021-23 biennial average forecast is 9,518 clients, which is 6.3 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 1,136,442 clients, which is 6.5% higher than the Spring 2020 Forecast. The 2021-23 biennial average forecast is 1,167,276 clients.

The 2019-21 **Mental Health (MH)** biennial average forecast is 56,266 adults. This includes 51,425 Never Committed clients, 2,949 Previously Committed clients, 955 Civilly Committed clients, and 937 Forensic clients. The forensic count includes 609 clients who are under the Psychiatric Security Review Board and 328 Aid and Assist clients. The 2021-23 biennial forecast average is 56,686 adults, which is 0.7 percent higher than the 2019-21 forecast average.

Introduction

Continuing Impact of COVID-19

The spread of the novel corona virus (SARS-CoV-2) and the orders to limit physical distancing to mitigate its spread have impacted every area we forecast, from major changes to caseload counts to indirect effects which may reduce forecast accuracy. These impacts have required the forecasting team to rely on important assumptions about public policy, operations, and the economy. Some of these assumptions are continuations of the assumptions built into the Fall 2020 forecast. Others are introduced for the first time in this forecast cycle or are revisions to previously held assumptions. Because of these changes, there may be greater variance than usual between the Fall 2020 forecast and the current forecast.

We have attempted at every step to be clear about our assumptions, both in this document and to the stakeholders who make budgetary and operational decisions based on our work. The likelihood that one or more of these assumptions proves to be wrong is fairly high, but that is unavoidable in this unstable period in which we find ourselves.

One obvious area of continued uncertainty is the timetable for "getting back to normal." Currently, there is a promising increase in the availability of vaccinations against COVID-19, but how fast Oregonians can become immunized and whether there will be an interaction between the vaccination rate and the spread of a new, more communicable variant of the disease is unknown.

As with the prior forecast document, this introduction will summarize changes in the way human services are delivered due to the COVID emergency. Not all of these changes will have a caseload impact, but we would be remiss if we did not review the changes as we know them, with the knowledge that there could be unintended consequences to some of these changes that will impact the caseload at some point in the future.

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

OPERATIONS

Field Services

Physical distancing has temporarily changed the way multiple programs operate during the pandemic. Field offices for ODHS 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, so 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 current evidence that these physical distancing measures have changed the rate of applications, however experience with other processes suggests that these quick changes may have unintended consequences, modifying patterns of entry and exit.

Vocational Rehabilitation (VR) was to some extent shuttered in the early days of the stay at home order. VR is by its nature a high-contact operation. In-person assessments by VR staff and medical professionals which are necessary to enter the program were halted for a time. Meanwhile, many VR clients that had been placed in meaningful employment were laid off and returned to the program. 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 have been laid off.

Referrals from SNAP and TANF to the Employment Department's work readiness tasks were suspended after the emergency declaration. Clients removed from the program in the two weeks prior to the declaration for failure to meet work readiness requirements were contacted and reinstated. Work readiness tasks have now been reengaged. Screenings for job-readiness and other compliance measures were reinstated for TANF as of September 1. Sanctions for non-compliance which could lead to a case closure were reinstated on October 1. However, some types of training and other activities may remain contraindicated by physical distancing rules.

Throughout the spring and summer of 2020, the number of child abuse allegations received by the hotline was much lower than usual. Unfortunately, this does not mean that children were not suffering from abuse or neglect. As children return to in-person school, the number of child abuse or neglect allegations leading to an investigation may increase.

Congregate Care

All programs providing congregate care had been modified to meet the requirements of virus mitigation. This was especially true of people in Long-Term Care. People with disabilities have been prioritized for COVID vaccination, but the timetable for ending these modifications is unknown, as is the response of potential clients. Consumer behavior has always played a strong part in the decisions about when and in what way people receive Long-Term Care services. Given that Long-Term Care facilities were hotspots for COVID outbreaks, attitudes toward disability care may be permanently changed. Some clients who have moved back home or in with family may remain there permanently.

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. Slowdowns in court processes are also reducing children's moves to permanency. 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 emphasizes 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.

Integrated Eligibility

Although a change to the eligibility system is unrelated to COVID-19, it has an operational impact. The new Integrated Eligibility (I.E.) System has completed initial rollout (as of February 2021). What began as the Medicaid enrollment system for means-tested case types (the ONE system) now covers all OHA programs and multiple ODHS program areas. The system is currently in a state of flux, with code fixes occurring at a high rate. System instability is most acutely felt in Self-Sufficiency, which among ODHS programs is most dependent upon the I.E. system for the determination of eligibility.

In addition to moving case records into a new system, the rollout included applying the I.E. "rules engine" to all cases as they transferred. The rules engine is essentially an algorithm that determines eligibility for a person or family based on income, assets, household size, and other factors. Because the I.E. system contained improvements over the legacy system, the rules engine changed eligibility decisions for some cases. These changes will be reviewed by staff for correctness before being considered final.

Integrating systems between ODHS and OHA has the positive side-effect of improving the accuracy of information about people and families receiving services. In certain cases, comparisons between ODHS records and OHA records yielded a more complete record, and a change to services. This was especially true of disability status.

Because of the need to review the status of records that were modified during the rollout, and the continuous code fixes being implemented, the most recent data – especially in Self-Sufficiency – must be considered preliminary and subject to change. Therefore, forecasting decisions were made without taking sudden pattern shifts occurring during the rollout phase into account. A more complete accounting of case status changes will be available for the Fall 2021 forecast, when system stability allows for baseline measures to be taken.

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 (or FFCRA, H.R. 6021), as of March 19 2020, 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 have left the state.[1] 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 the income limit; 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 have led the number of cases exiting the program to be severely reduced, resulting in a large caseload increase which remains ongoing.

Although the relaxation of the income verification rule undoubtedly allowed some people to enter the caseload who otherwise would not, there has been no pronounced increase in entries related to this change. There were spikes in entries that coincided with people suddenly losing their jobs in March and April 2020, and a second spike during open enrollment for private insurance through the federal marketplace (i.e. "Obamacare") at the end of 2020. However, it is primarily the reduced exit rate that is responsible for the pronounced increase in Medicaid experienced through most of 2020 and into 2021.

The changes to Medicaid eligibility enacted by the FFCRA will continue until the formal end of the Public Health Emergency. In the Fall 2020 forecast document, it was not clear as to when the state of emergency would end, and federal Health and Human Services was not definitive as to an end-date. This led us to include a set of scenarios illustrating different end-dates and the resulting change in the caseload. Since then, a memorandum of understanding from the Secretary of Health and Human Services was issued which committed the federal government to continue the Public Health Emergency through 2021. This allows the Medicaid forecast to be built around a specific set of assumptions, which are discussed the Health Systems/Medicaid section of this document.

Ambiguity still exists within this forecast, however. It is not clear as to how quickly the Medicaid eligibility system can be re-formatted to begin processing cases using the old rules. Equally important is how quickly the Health Authority can address the backlog of cases in need of review for possible closure (either due to an attached adverse action or because of an overdue renewal). OFRA has been in consultation with the eligibility and enrollment policy and operations staff to develop the most responsible scenario based on the facts. But until federal guidance is issued, ambiguity concerning the timeline for resumption of "normal case processing" and addressing the case backlog will remain.

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 required all insurance companies to postpone policy cancellations and non-renewals, extended a grace period for premium payments, and extended deadlines for reporting claims. This allowed the temporarily furloughed to keep coverage, avoiding the need to apply for Medicaid. This temporary order expired on September 20, 2020.

1. A recent clarification from the federal government has also added Medicaid obtained through administrative error or proven fraud to the list of reasons for removal.

Self-Sufficiency

As part of the American Rescue Plan Act of 2021, Oregon will continue to waive the SNAP interview requirements through June 30, 2021. New applications will require an interview. Income verification can be waived if an applicant can show hardship due to unemployment related to social distancing orders.

The income/asset resource limit for SNAP that was expanded after the declaration of state of emergency was returned to the pre-emergency level on December 1.

SNAP recipients continue to receive the maximum allotment of SNAP benefits, regardless of income. Patterns of SNAP exits in the past have shown that clients tend to end SNAP enrollment when their benefit amount, prorated for income, is low (ten dollars a month, for example) but that disincentive for remaining on SNAP has been removed for now. This could lead to families remaining on the caseload longer.

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 2020. This reduced exits from the caseload in those months given that recertifications and redeterminations are a key mechanism for closing cases. These cases were reviewed in October and November, which temporarily increased exits.

Able Bodied Adults Without Dependents (ABAWD), a group made up of non-disabled clients without dependents between 18 and 49, were slated for removal from SNAP in rural parts of Oregon in 2020 – urban counties had ABAWD clients removed previously. That policy has been temporarily suspended, and clients who had been previously removed in urban areas 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. However, the improved employment picture through 2021 may lead to a reversal of this policy at some point in the future.

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 childcare will be needed as furloughed workers are brought back. This is not a caseload we forecast, however the availability of ERDC may allow parents to go back to work, keeping them off TANF.

Economics

The current environment contains 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, which makes events difficult to predict.

The current economic conditions are not linked to a traditional recession. Jobs were lost and productivity hampered by virus mitigation efforts, not the usual business cycle. Some economic pain was relieved rather quickly as people returned to work in areas that had been shut down. This initial “bounce-back” was sharp, but it will take time to fully recover, and the pace of the full recovery will depend upon the success of the current vaccination program and other variables. Because some portion of those people laid off in the initial downturn will have their job eliminated, a traditional recession pattern is expected to take over after the quick recovery period ends.

The American Rescue Plan Act of 2021 contained a large number of short-term reforms and provided stimulus payments to families. Among the increases in federal aid were:

- An extension in unemployment assistance, subsidies to small businesses and increased SNAP benefits until September 2021,
- An expansion of the Special Supplemental Nutrition Program for Women Infants and Children (WIC),
- A continuation of funding for nutrition assistance to children who would be receiving reduced or free school lunches but are not back in school full-time,
- Subsidies for people to make ACA private insurance more affordable, and subsidies to help people pay COBRA payments to maintain existing insurance after a layoff.

In addition, a re-opening of enrollment for Affordable Care Act (ACA) insurance products through the Spring may increase the number of Oregonians who are referred from the federal marketplace to enrollment in the Oregon Health Plan.

These developments occurred after the completion of the forecast and their impacts must be considered a risk to forecast accuracy.

The currently proposed (but not as of this writing passed) infrastructure bill (known as the American Jobs Plan) contains housing affordability funds which could impact the need for means-tested programs in the future, if passed as initially written.

The risk to forecast accuracy is high. OFRA is currently coordinating with ODHS, OHA and other state agencies and decision-makers to understand, as best we can, the nature of this economic downturn and the nature of the recovery.

The Spring 2021 Forecast

This document summarizes the Spring 2021 forecasts of client caseloads for ODHS and OHA. OFRA issues these forecasts in the spring and fall each year. The Spring 2021 caseload forecast is based on data (whether preliminary or final) available through February 2021.

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.[2]

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 2021 forecast. They will be noted in the text for each section of the document.

2. More information about the forecasting process and current monthly variance reports can be found on the OFRA web page: http://www.oregon.gov/ODHS/BUSINESS-SERVICES/OFRA/Pages/index.aspx

Oregon Department of Human Services

Total Oregon Department of Human Services Biennial Average Forecast Comparison

	2019-21 Biennium			*% Change Between Forecasts*	Spring 2021 Forecast			*% Change Between Biennia*
	Fall 20 Forecast	**Spring 21 Forecast**	**Change**		**2019-21**	**2021-23**	**Change**	
Self Sufficiency								
Supplemental Nutrition Assistance Program (Households)	409,205	393,479	-15,726	-3.8%	393,479	398,370	4,891	1.2%
Temporary Assistance for Needy Families (Families: Cash/Grants)	19,806	18,118	-1,688	-8.5%	18,118	15,895	-2,223	-12.3%
Child Welfare (children served)								
Adoption Assistance	10,698	10,630	-68	-0.6%	10,630	10,581	-49	-0.5%
Guardianship Assistance	2,267	2,272	5	0.2%	2,272	2,339	67	2.9%
Out of Home Care[1]	6,308	6,230	-78	-1.2%	6,230	5,793	-437	-7.0%
Child In-Home	1,472	1,409	-63	-4.3%	1,409	1,484	75	5.3%
Aging & People with Disabilities								
Long-Term Care: In Home	18,800	18,774	-26	-0.1%	18,774	19,145	371	2.0%
Long-Term Care: Community Based	12,274	12,210	-64	-0.5%	12,210	12,522	312	2.6%
Long-Term Care: Nursing Facilities	4,427	4,391	-36	-0.8%	4,391	4,417	26	0.6%
Intellectual and Developmental Disabilities								
Total Case Management Enrollment[2]	30,782	30,753	-29	-0.1%	30,753	33,180	2,427	7.9%
Total I/DD Services	19,965	20,338	373	1.9%	20,327	21,231	904	4.4%
Vocational Rehabilitation	9,286	8,955	-331	-3.6%	8,955	9,518	563	6.3%

1. Includes residential and foster care.

2. Some clients enrolled in Case Management do not receive any additional I/DD services.

Self-Sufficiency Programs (SSP)

It has been over a year since the United States declared Public Health Emergency, February 3rd, 2020, due to COVID-19. In Oregon, the governor's emergency order was declared on March 8th, 2020 which influenced both economic activity and social behavior. The economic fallout of temporarily closing high-contact businesses increased unemployment and initial claims for unemployment insurance (UI). Social distancing practices designed to reduce the virus spread included an end to in-person schooling. Work from home has been adopted whenever possible, however many jobs cannot be done from home. Some parents who have to choose between aiding their children through this distance-learning era and going back to work are staying home and are therefore jobless. The unemployment rate in Oregon reached a seasonally adjusted 13.2 percent in April 2020, the highest rate ever recorded in the state, even higher than the worst month of the 1981-1982 double-dip recession. Approximately 13.8 percent of workers lost their jobs comparing April 2020 to February 2020. Economic reopening starting in June 2020 led employees back to work, and by November 2020 149,700 more workers were employed than in April 2020. However, this accounted for only 94 percent of pre-COVID employment. Self-sufficiency programs, especially SNAP and TANF, have been impacted by these changes.

General Assumptions for the Self-Sufficiency Forecast and a Contrast to the Prior Forecast

Federal Policy

The prior forecast (Fall 2020) was completed in October 2020. It contained the assumption that there would be no extension of Federal Pandemic Unemployment Compensation (FPUC) beyond its original end date on July 31st and no extension of the Pandemic Unemployment Assistance program (PUA), which ended at the close of 2020. The result of ending these programs was forecast to increase enrollment in SNAP and TANF.

However, after the expiration of the FPUC, a temporary $300 in UI benefits were paid for six additional weeks. By the passage of the Consolidated Appropriation Act (CAA), and the American Rescue Plan Act (ARPA) in 2021, both FPUC and PUA were extended through the week ending on or before September 6, 2021. This reduced the likelihood of increases in enrollment due to lost income from federal unemployment supports. These supports are incorporated into the assumptions behind the Spring 2021 forecast, along with the assumption that no additional supports will be enacted.

The CAA has also temporarily expanded SNAP eligibility to include students enrolled at least half-time in an institution of higher education. This temporary exemption will be in effect until 30 days after the COVID-19 public health emergency is lifted. This policy may lead to an increase in new cases.

To reduce food insecurity, federal SNAP policy suspended recertification periods in March, April, and June 2020 for six months. Beginning in July 2020, SNAP resumed the recertification process. This resumption was incorporated into the prior forecast. However, federal policy extended the certification period again for cases to be recertified in October, November, and December 2020 for six months. These cases will be reviewed in May 2021. Under the periods of suspension of recertifications, the exit rate of the Self-Sufficiency portion of SNAP ranged from 1 to 2 percent – significantly lower than the 5 to 7 percent in regular months. When these cases are due for review, a temporary increase in exits will likely occur. This assumption is incorporated into the current forecast. It is also assumed that no additional extensions of recertifications will occur in 2021.

After the Great Recession, a rule limiting SNAP participation for Able-Bodied Adults without Dependents (ABAWD) was waived. The rule was reinstated for metro areas of the state as the economy improved and was due to be reinstated for rural areas in 2020. Due to high unemployment related to the COVID-19 pandemic, the ABAWD rule was waived for the whole state again by September 30, 2020. Oregon counties will remain exempted so long as they meet certain criteria related to employment and unemployment. This forecast assumes that the time limits for ABAWD will continue to be waived due to high unemployment, which will persist through the 2021-2023 biennium.

Federal policies have also improved access to SNAP by waiving the requirement that in-person interviews be part of the SNAP application process. This waiver has been in effect since late April 2020. The interview waiver has been extended several times and the most recent revision extends through the end of June 2021. It is not known if this waiver will be extended again.

SNAP households receiving less than the maximum food benefit have received an Emergency Allotment (EA) that brings all households to the maximum benefit. Although benefit amount is not directly related to enrollment in SNAP, it often influences when families leave the program. Usually, when a family's allotment reaches a low benefit amount, they will exit SNAP rather than go through the recertification process. So long as the benefit amount remains at the maximum value regardless of income, the motivation to remain on the program will be high. It is important to note that people can lose the SNAP benefit for being over-income. The EA policy simply means that all families will receive the maximum allotment regardless of income so long as they still qualify.

Oregon currently requests approval for EA payments every month to the U.S. Department of Agriculture. So far, Oregon has received permission to provide the EA amount each time it is requested. It is unknown when this approval process will end.

Economic

The current forecast was developed using the first-quarter economic and revenue forecast prepared by the Oregon Office of Economic Analysis (OEA) in March 2021. The forecast assumes that employment will rapidly rise with a reopening economy and waning the COVID-19 pandemic influenced by widespread vaccinations. OEA forecasted that Oregon employment might get back to a pre-pandemic level in the first quarter of 2023, which is a quarter earlier than the previous forecast. The rate of employment recovery is projected to vary by industry. Some industries such as Transportation/ Warehousing/Utilities and Professional/Technical Services already reached a record high in employment in February 2021, influenced by consumers preferring deliveries and working from home to in-person purchases and office work. However, Leisure and Hospitality had the biggest loss, greater than 50 percent drop from its peak employment level in February 2020. Leisure and Hospitality is still 68 percent of its pre-pandemic level as of February 2021. Semi-skilled and non-skilled work in the service sector was hit hardest due to the restrictions in business activity necessitated due to the COVID-19 pandemic.

Integrated Eligibility Program

The implementation of the Integrated Eligibility (I.E) system combined the Oregon Health Authority's ONE system with the ODHS eligibility systems. The rollout began in November 2020 and was primarily completed in February 2021. However, data anomalies and modifications are still occurring, creating conditions that make it difficult to verify caseload accuracy. Although most caseloads appear to be correctly represented in the new system, review processes remain underway, influencing the accuracy of different caseload counts in different ways. Revisions to the recent months' caseload counts may occur.

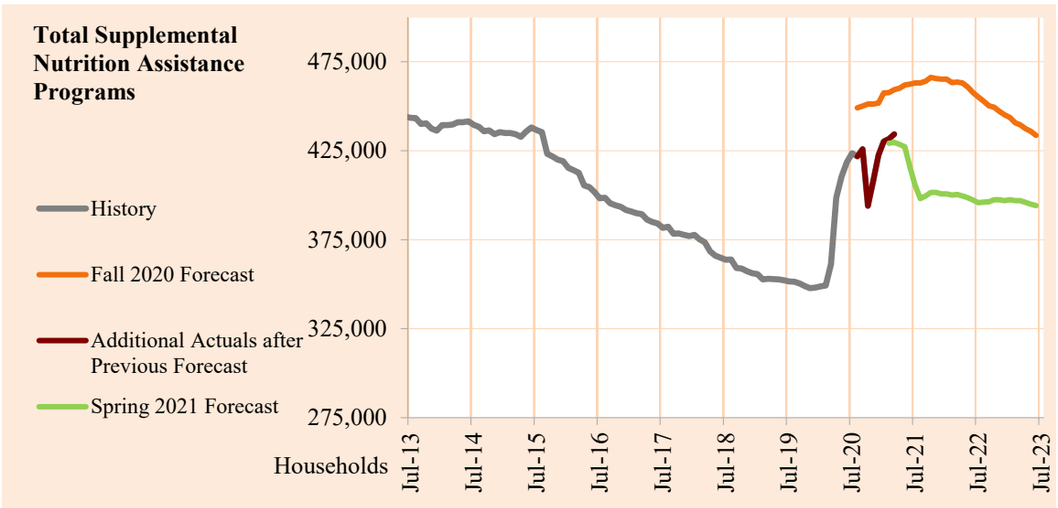
The most obvious impact of the rollover to I.E. was experienced in the TA-DVS with payment caseload category. TA-DVS with payment has shown inconsistent intake and exit patterns compared to historical data. Due to this instability, the last three-months of caseload data have been excluded from this forecast.

In addition to instabilities, the I.E. system includes intentional changes in case processing. It will apply a new rule to assign SNAP cases to either APD or SSP programs. In the past, SNAP cases with an adult over the age of 60 were defined as APD SNAP and managed through an Aging and People with Disabilities (APD) field office or an Area Agency on Aging (AAA) office.

Today, SNAP cases are allocated based on the geographical location of the field office, regardless of type. Clients are assigned to whichever field office is closest unless disability or some other categorical eligibility factor requires them to be assigned to an APD field office or AAA. As a result, new cases are being assigned to APD SNAP at a higher percentage than before. Because disability status is one of the areas being reviewed as cases are being converted to the I.E. system, it is uncertain whether the proportional changes seen so far will continue or will revert to the previous trend. In addition, the demographic influence on the APD SNAP caseload (the proportion of Oregonians 60 and older) may no longer play a part in this category's future enrollment patterns. Because APD SNAP may contain a larger and larger proportion of younger adults, exit patterns may also change. Historically, APD SNAP clients stay in the program longer than SSP SNAP clients given that the elderly and near-elderly are less likely to experience changes to their family's income level.

As cases were rolled over from the legacy system to Integrated Eligibility, the I.E. system reviewed the case status based on the criteria contained in the eligibility algorithm, commonly called the "rules engine." The result of this reapplication of the rules engine was to modify some cases as a more complete record (a combination of OHA and ODHS records) for a client was available. This influenced the disability status of some clients. In addition, the I.E. rules engine applied all federal TANF rules to cases during rollover. Some federal rules could not be applied through the old system. This influenced the status of some TANF cases. Changes created by the I.E. rules engine are required to be verified by staff before becoming permanent and must be considered a source of instability in monthly counts until the review process is complete.

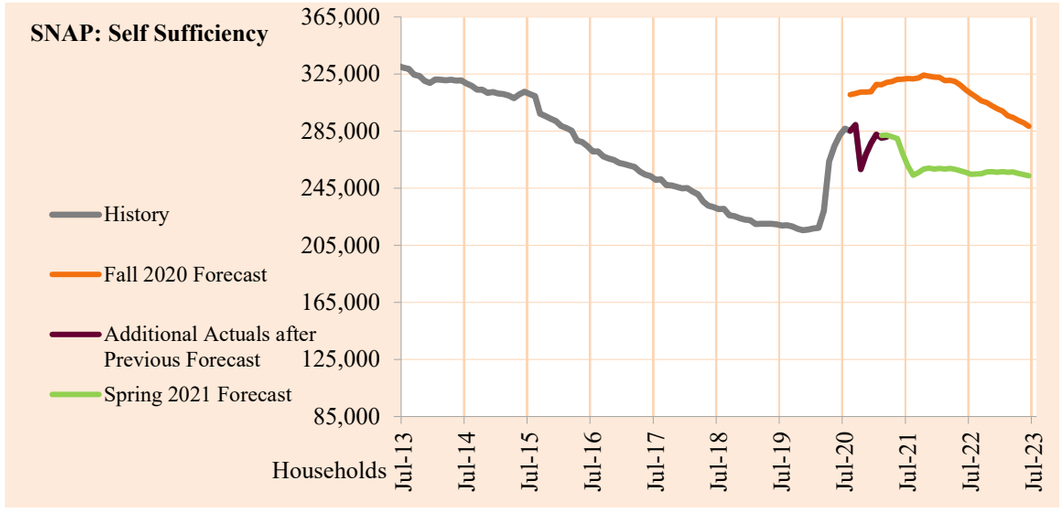
Supplemental Nutrition Assistance Program (SNAP) – In January 2021, there were 430,507 households (731,015 persons) receiving SNAP benefits. This constitutes approximately 17.1 percent of all Oregonians. The caseload increased by 22.6 percent compared to January 2020. The total SNAP monthly average forecast for the 2019-21 biennium is 393,479 households, which is 3.8 percent lower than the Fall 2020 forecast. The projected biennial monthly average for the 2021-23 biennium is 398,370 households, which is 1.2 percent higher than the 2019-21 biennial average forecast.



Self-Sufficiency portion of SNAP (SSP SNAP) which is designed for adults under 60 and families, fell almost continuously from autumn 2012 through the start of 2019 and then hovered at about 218,000 households through most of the year. Due to the unemployment related to the stay-at-home order, the number of new clients entering SSP SNAP more than doubled in March and tripled in April compared to February 2020. At the same time, the exit ratio (the number of exits relative to the total caseload) dropped to less than one percent due to the delay in recertifications mandated by the CARES Act. Prior to this, the exit ratio was between five and six percent of the total caseload. The increase in new clients and the reduction in exits kept the caseload high through July 2020. Resumed recertifications and redeterminations in July 2020 increased exit rates to their customary level. Wildfire in September 2020 contributed to temporary surges and plunges in the caseload in September and October. The second round of SNAP recertification and redetermination suspensions between October and December 2020 reduced exit rates again, increasing the caseload.

The current forecast assumes that exit rates will revert to normal when the recertification and redetermination processes are resumed, and this coupled with the economic recovery will slowly reduce the caseload.

The Spring 2021 SSP SNAP biennial average forecast for 2019-21 is 255,290 households, which is 6.5 percent lower than the Fall 2020 forecast, which was calculated based on the assumption of a strong relationship between UI payouts and eligibility for SNAP. The SSP SNAP biennial average for 2021-23 is 256,730, which is 0.6 percent higher than the 2019-21 biennial average forecast.



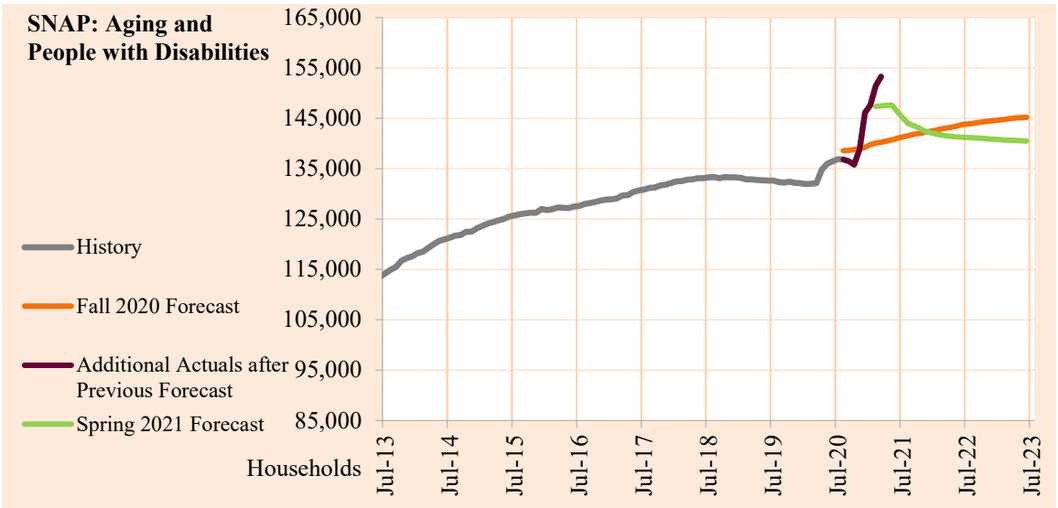
Aging and People with Disability portion of SNAP (APD SNAP) is designed for people aged 60 and older, rose steadily from late 2006 to mid-2018 due to a combination of demographic and economic changes. However, that rate of increase stopped at the end of 2018, and the caseload began decreasing slightly from the start of 2019 until the emergency order was issued in March 2020. In April the APD SNAP caseload was 134,606 households, an increase of 2,636 from the previous month.

The caseload continually increased through August 2020 due to low exits related to the suspension of recertifications under the CARES act. Resuming recertification and redetermination led to increasing exits in September and October 2020 but the second round of suspensions again reduced the exits in November and December 2020. At the same time, the implementation of the new Integrated Eligibility (I.E.) system led to an increase in cases being assigned to APD SNAP starting in November 2020 (see the section on Integrated Eligibility for more information).

System changes, temporary regulations, and the economic environment caused an increase in APD SNAP cases.

The APD SNAP caseload in January 2021 was 147,791 households, which is 12 percent higher than a year ago, and 5,678 greater than August 2020, which was the peak of caseload increases related to the COVID-19 pandemic. With the expected economic reopening and the resumption of recertifications and redeterminations, it is assumed that the APD SNAP caseload will see an increase in exits. This is likely to be modest compared to SSP SNAP, since the APD portion of SNAP contains the elderly and near-elderly who are less likely to seek employment.

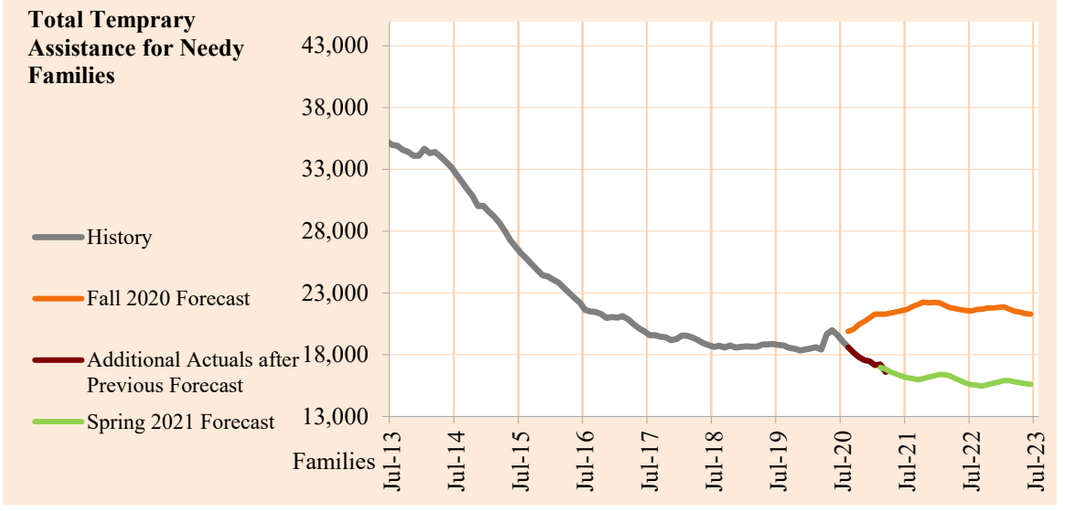
The Spring 2021 APD SNAP average monthly forecast for the 2019-21 biennium is 138,189 households, which is 1.4 percent higher than the Fall 2020 forecast. The projected average monthly caseload for the 2021-23 biennium is 141,640 households, which is 2.5 percent higher than the 2019-21 biennial average forecast.



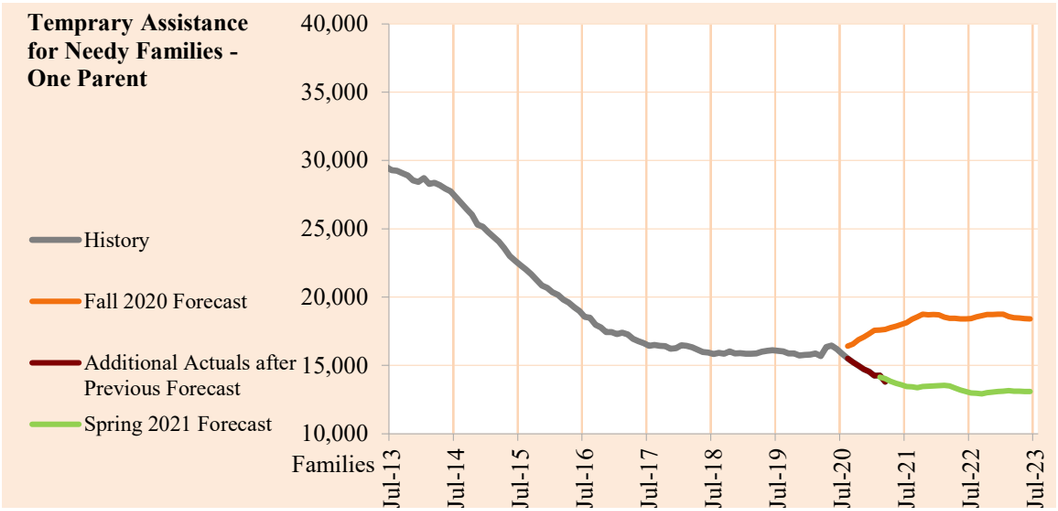
Temporary Assistance for Needy Families (TANF) – In January 2021, 17,148 families were receiving TANF benefits, representing 45,083 persons. The TANF caseload underwent nearly uninterrupted growth from January 2008 until February 2013. The caseload then declined rapidly until July 2016 when it stabilized at about 18,500 cases (a 49 percent drop compared to its February 2013 peak). This state of affairs continued until the emergency order. The caseload increased from March to April 2020 by 6.8 percent to 19,662 families, primarily due to an increase in new clients. Increased exits in June and July led to a slow reduction in the caseload.

Exits come from two sources: program exits and transfers. Program exits account for 60 percent of the total exits in most months. In June and July, program exits accounted for over 75 percent of the total exits, indicating that a larger portion of TANF cases did not meet income eligibility. Cases entering in April accounted for 27.7 percent of exits in June and July. These exits were likely related to eligibility for unemployment insurance, payroll protection payments, or re-employment after layoff. From May 2020 to January 2021 the caseload decreased by 2,831 families.

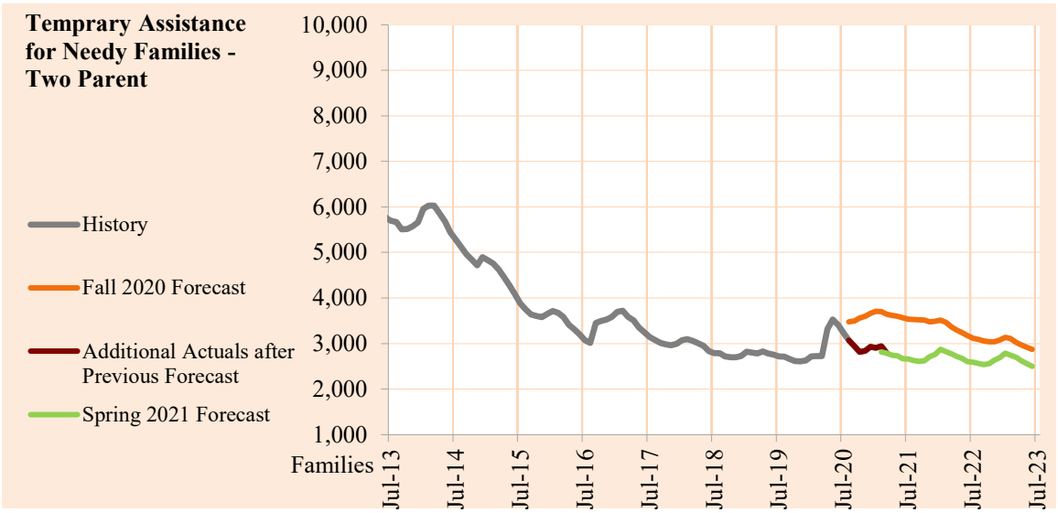
The TANF average monthly forecast for the 2019-2021 biennium is 18,118 families, which is 8.5 percent lower than the prior forecast, which was completed under the assumption of a strong correlation between unemployment and SSP programs. This downward revision reflects a caseload trend in the fall which was influenced by the OEA's forecasted economic expansion and an assessment of temporary federal policy changes. Under the assumption of economic reopening, the exit rate will remain high with regular seasonal variations. Along with the economic expansion, extended FPUC and PUA will lead to a stable number of new TANF clients. The average monthly caseload for the 2021-23 biennium is projected to be 15,895 families, a 12.3 percent decrease from the 2019-21 biennium.



TANF One Parent - The 2019-21 biennial average monthly caseload is 15,251 families, which is 8.1 percent lower than the previous forecast. The average monthly caseload for the 2021-23 biennium is expected to be 13,231, a decrease of 13.2 percent from the 2019-21 biennium. TANF One-Parent is expected to remain low through the 2021-23 biennium, as Oregon returns to normal economic activity.

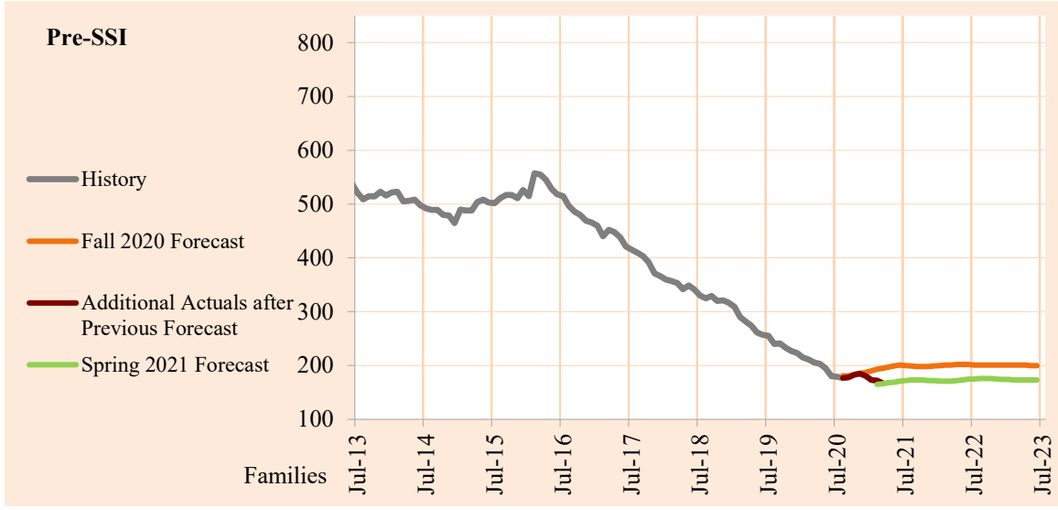


TANF Two-Parent caseload in January 2021 was 2,898, 627 lower than May 2020 - the peak month of TANF caseload increase related to the economic disruption caused by the COVID-19 pandemic. However, the caseload remains 6.6 percent higher than the previous year. The 2019-21 biennial average caseload for TANF Two-Parent is expected to be 2,867 families, a 10.9 percent decrease from the prior forecast. The average monthly caseload for 2021-23 is expected to be 2,664 cases, a 7.1 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. Two factors primarily drive the Pre-SSI caseload: the percentage of TANF cases moving to Pre-SSI and the total volume of TANF exits. After the Great Recession, the percentage moving to Pre-SSI from TANF reduced from four percent in 2009 to less than one percent in 2019. Also, the total volume of TANF cases has been dropping since 2013. These two factors led to a decline in the caseload. Furthermore, the Social Security Administration (SSA) has become more stringent in its interpretation of disability criteria – most recently their mental health criteria.

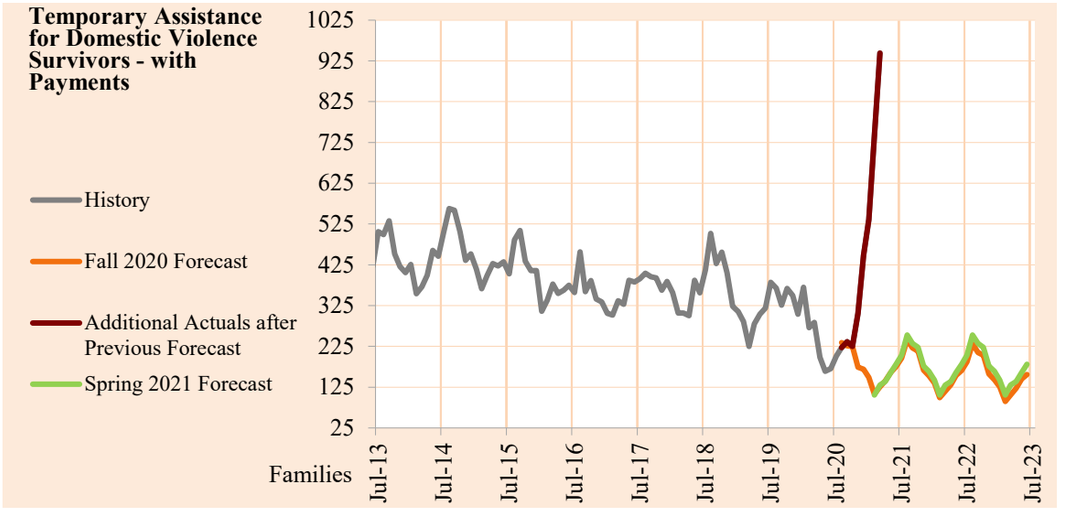
The Pre-SSI caseload has been flat since the start of the COVID-19 pandemic. The caseload fell faster than anticipated during the 2019-2021 biennium, with a 2.9 percent average month over month drop for the twelve months leading up to the pandemic. The average month-to-month change rate fell more slowly after the pandemic began, by 1.8 percent. The current forecast assumes that the caseload will slightly decrease through the rest of the 2019-21 biennium, reflecting the decreased TANF caseload related to economic recovery. The caseload will then stabilize in the 2021-23 biennium. The 2019-21 biennial average forecast for Pre-SSI is 197 families, which is 3.9 percent lower than the previous forecast. The 2021-23 biennial average caseload is 173 families, a decrease of 12.2 percent from the 2019-21 biennium.

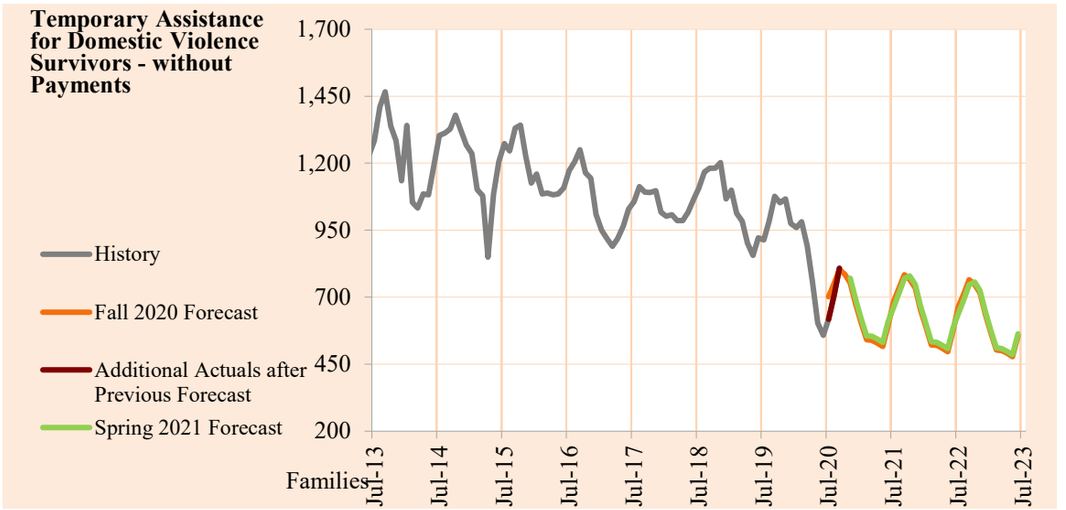


Temporary Assistance for Domestic Violence Survivors (TA-DVS) –The rollout of the Integrated Eligibility (I.E.) system has led to instability in the counts of some SSP programs. This is especially true for TA-DVS. Therefore, the current forecast is based on an abbreviated amount of data. The TA-DVS forecast uses only the last four months of data rather than the total six months applied to other areas of Self-Sufficiency.

The TA-DVS with-payment caseload is a relatively small caseload that had been falling steadily amid strong seasonal fluctuations. With the COVID-19 pandemic, the average monthly caseload from January to July 2020 was 237, compared to an average of 301 from January to July 2019. This is likely due to people being willing to shelter in place even with an abusive partner. The average monthly caseload for the current biennium is forecasted to be 269 families per month, which is 14.5 percent higher than the previous forecast. The caseload was revised due to a recent increase in entries. The caseload is expected to continue to rise slowly due to in-person schooling and economic reopening. The 2021-23 biennial average caseload is 171 families, a reduction of 34.6 percent from the 2019-21 biennium.

The TA-DVS without-payment caseload fell to an unprecedented low point in the months after the emergency order was issued in March 2020. This shift-down incorporates regular seasonality but deeper than a normal variation, a decrease of 300 caseloads on average. The caseload usually has a seasonal pattern related to the school year. Despite the structural change due to the emergency order, the seasonal patterns persisted. For instance, the recent data show the usual seasonal increase in late summer. The current forecast assumes a weaker seasonal pattern going forward. The 2019-21 biennial average is 776 cases per month, an increase of 0.1 percent compared to the previous forecast. The caseload is expected to drop to a monthly average of 624 cases in the 2021-23 biennium, a decrease of 19.6 percent.





Forecast Environment and Risks

The current SNAP and TANF caseload forecasts face similar uncertainties to the Fall 2020 forecast, including whether or not there will be other extensions of the temporary policies related to the COVID-19 pandemic (see the introduction to the SSP section for more information). Forecasts are always based on current law and policy, however laws and policies have been changing quickly during the COVID-19 pandemic and state of emergency.

Another uncertainty is the timeline for the vaccinations of the COVID-19 and the effectiveness of the vaccines. As the pace of vaccinations increased, the number of confirmed cases was slowly reduced until the middle of March 2021 when cases increased again. The current employment forecast from the OEA assumes that the vaccinations will accelerate economic reopening and reemployment. The longer the recovery takes, the more likely businesses may permanently close. Workers who were brought back to their jobs after furloughs could lose their jobs again, increasing SNAP and TANF beyond what was forecast.

As was stated in the introduction to the SSP section, Integrated Eligibility represents a significant change to case processing. As of this publication, baseline functionality of the new system has not been achieved. Some of the modifications to case status will address errors. Other modifications will represent improvements to record-keeping. In either case, it is possible that caseload counts between November 2020 and the first half of 2021 will be revised, either a little or a lot, and be different for different caseload categories. This represents a unique risk to forecast accuracy.

Self-Sufficiency Biennial Average Forecast Comparison

	2019-21 Biennium			*% Change Between Forecasts*	Spring 2021 Forecast			*% Change Between Biennia*
	Fall 20 Forecast	**Spring 21 Forecast**	**Change**		**2019-21**	**2021-23**	**Change**	
SELF SUFFICIENCY PROGRAMS								
Supplemental Nutrition Assistance Program (Households)								
Children, Adults and Families	272,934	255,290	-17,644	-6.5%	255,290	256,730	1,440	0.6%
Aging and People with Disabilities	136,271	138,189	1,918	1.4%	138,189	141,640	3,451	2.5%
Total SNAP	**409,205**	**393,479**	**-15,726**	**-3.8%**	**393,479**	**398,370**	**4,891**	**1.2%**
Temporary Assistance for Needy Families (Families: Cash/Grants)								
One-Parent	16,589	15,251	-1,338	-8.1%	15,251	13,231	-2,020	-13.2%
Two-Parent	3,217	2,867	-350	-10.9%	2,867	2,664	-203	-7.1%
Total TANF	**19,806**	**18,118**	**-1,688**	**-8.5%**	**18,118**	**15,895**	**-2,223**	**-12.3%**
TANF Employment Payments	1,490	1,466	-24	-1.6%	1,466	1,310	-156	-10.6%
Pre-SSI	205	197	-8	-3.9%	197	173	-24	-12.2%
Temp. Assist. For Dom. Violence Survivors (Families)								
TA-DVS: with Payment	235	269	34	14.5%	269	176	-93	-34.6%
TA-DVS: without Payment	775	776	1	0.1%	776	624	-152	-19.6%
Total TA-DVS	**1,010**	**1,045**	**35**	**3.5%**	**1,045**	**800**	**-245**	**-23.4%**

Child Welfare (CW)

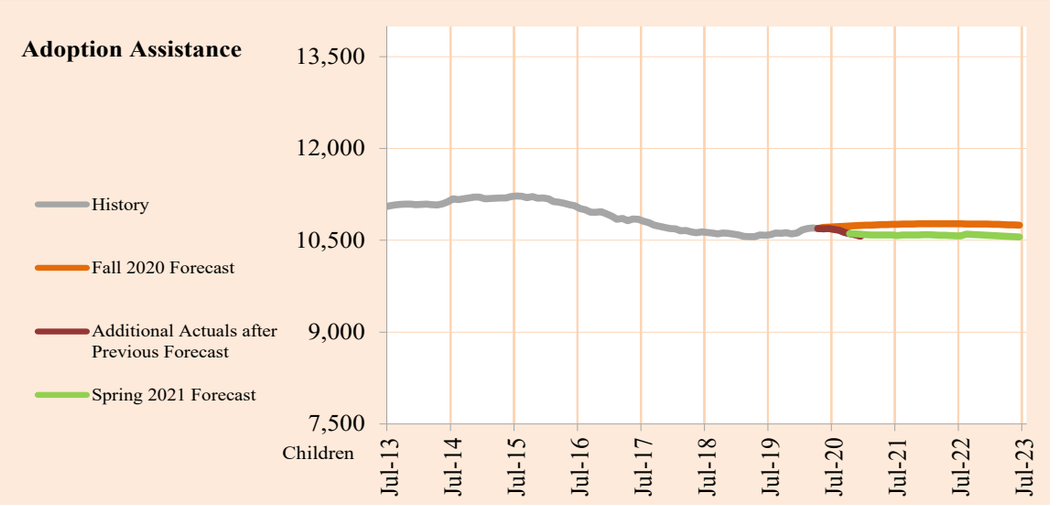
Four main groups are forecast for Child Welfare: Adoption Assistance, Guardianship Assistance, Out of Home Care, and Child In-Home. Children may move between these groups and typically first enter the Child Welfare system via an Assessment. There is an executive directive for branches to complete assessments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

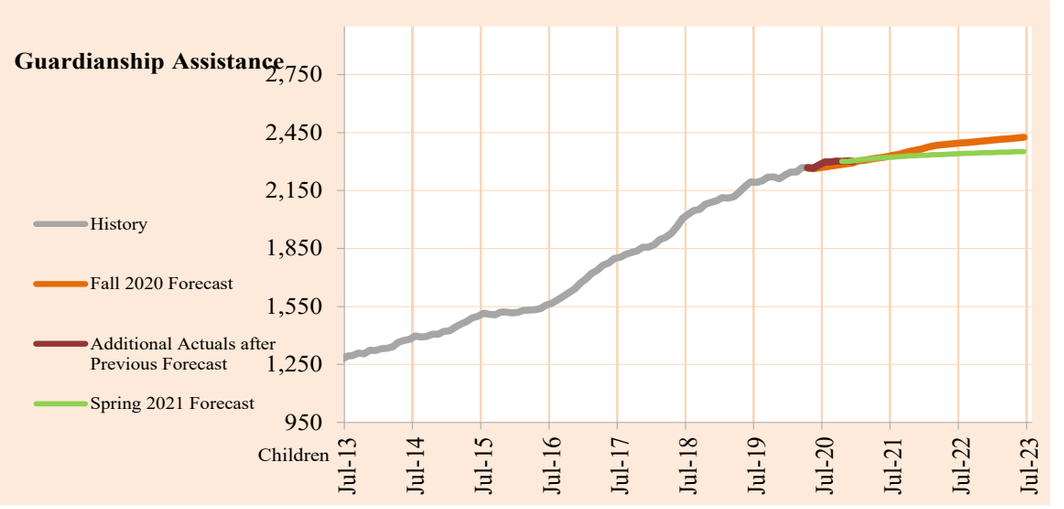
General Assumptions for the Child Welfare Forecast

The state of emergency related to the spread of COVID-19 has changed the way systems operate in the state (see the Introduction for more information). ODHS caseloads are usually impacted by internal decisions and/or federal guidelines. During the COVID crisis, Child Welfare was primarily impacted by systems external to the program. Specifically, disruptions to in-person schooling and visits to doctors have reduced the number of children seen by mandatory reporters of child abuse and neglect, reducing reports. Courts have also been disrupted, which influences permanency decisions. The Child Welfare program cannot control the timing of plans to reopen courts to full operation, which represents a risk to forecast accuracy.

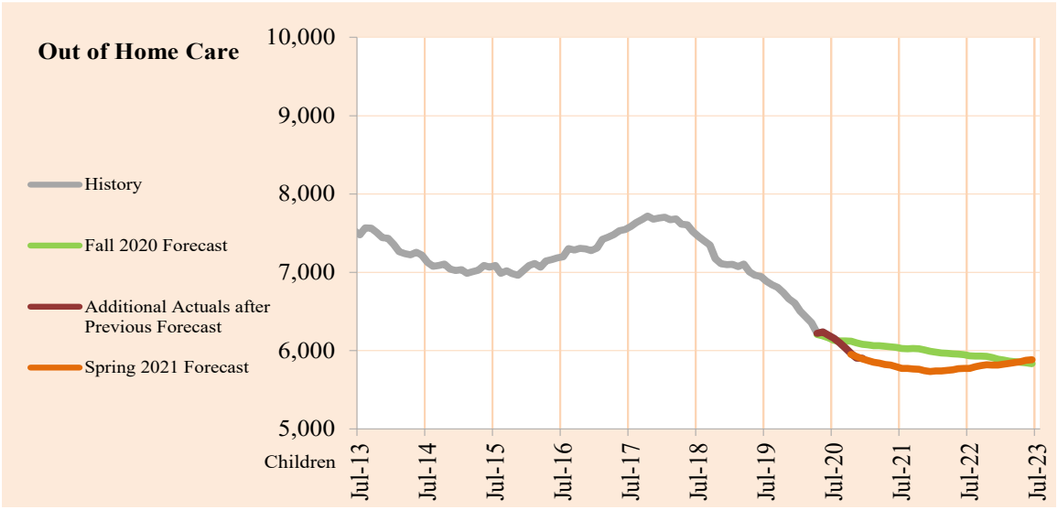
Adoption Assistance – This caseload gradually decreased between 2016 and mid-2019. In April 2019, the caseload started slowly climbing again, until the pandemic and state of emergency modified the program and people's reactions to it starting in April 2020. Since then, the caseload has been decreasing. One reason for this decrease is the increase in Guardianship Assistance as an alternative, with more relatives utilizing subsidized Guardianship Assistance. The pandemic effects on this caseload will be more obvious with decreases throughout 2021, due to the slow-down in cases moving through the court system. Court system delays have affected finalizations of both Adoptions and Guardianship. In addition, almost all new clients entering Adoption Assistance are from paid foster care, so impacts on the foster care caseload can directly increase or decrease the Adoption Assistance caseload. The paid foster care caseload has been on a downward trajectory since late 2017. The Adoption Assistance caseload is expected to average 10,630 children per month for the remainder of the 2019-21 biennium. Over the 2021-23 biennium the caseload is expected to average 10,581 children per month, a decrease of 0.5 percent from the current biennium.

Guardianship Assistance – This caseload has exhibited steady growth for most of its entire history. Policies are in place to shorten the length of time to reach a permanent placement, so this caseload has grown as children move out of foster care. However, with pandemic-related court closures, the finalization of cases has been affected, beginning in April 2020. The new forecast for Guardianship Assistance is expected to average 2,272 children per month for the remainder of the 2019-21 biennium. Over the 2021-23 biennium, the caseload is expected to average 2,339 children per month, which is 2.9 percent higher than the 2019-21 forecasted average.

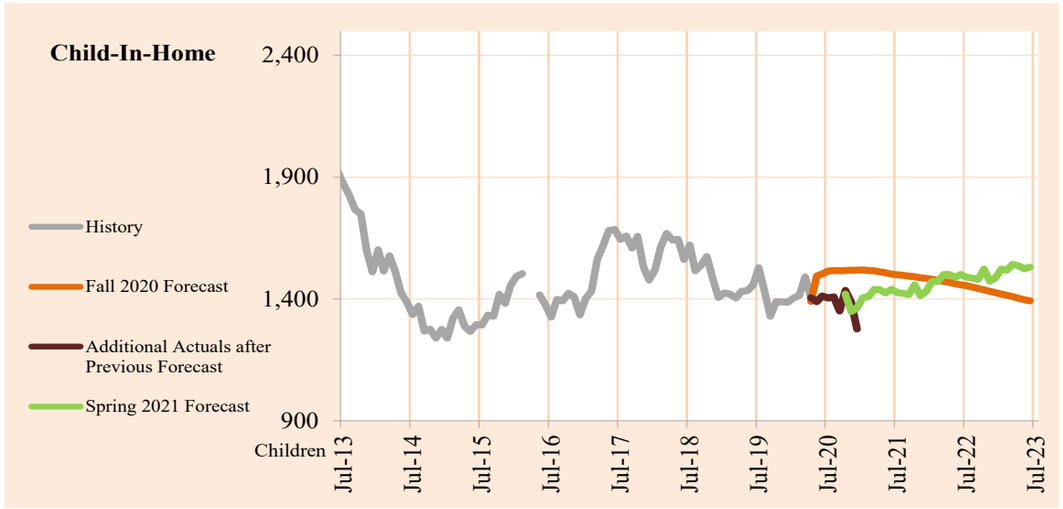


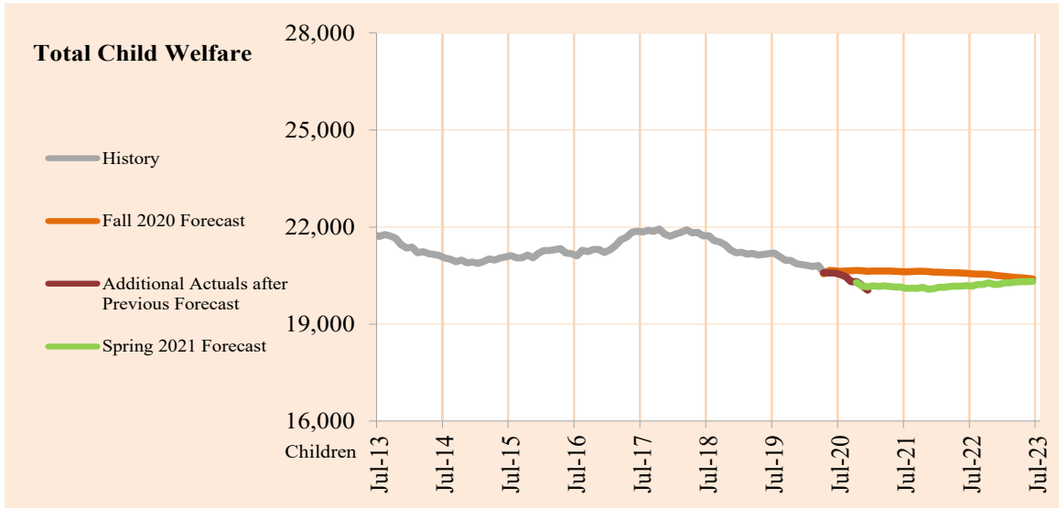


Out of Home Care – This caseload is comprised of paid foster care, non-paid foster care (including trial home visits), and residential care. Paid foster care is the largest portion of the group. The total Out of Home Care caseload decreased 11.0 percent between September 2019 and September 2020. This downward trend has been unrelated to the pandemic. The caseload is expected to average 6,230 children per month for the remainder of the 2019-21 biennium. Over the 21-23 biennium, the caseload is expected to average 5,793 children per month, which is 7.0 percent lower than the 2019-21 forecasted average.



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. When the OR-Kids case management system was developed in 2011, Child In-Home relied on a case plan. Since 2017, the definition of Child In-Home has been based on safety plans, not case plans. It is possible that we are serving children in home that are not counted in the Child In-Home caseload, due to the way the Child In-Home population is defined. The Safety Program is still working with the Districts to identify and potentially correct Child In-Home data. The Child In-Home caseload is expected to average 1,409 children per month for the remainder of the 2019-21 biennium. Over the 2021-23 biennium, the caseload is expected to average 1,484 children per month, which is 5.3 percent higher than the 2019-21 forecasted average.





Forecast Environment and Risks

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. There has also been an increase in conversations, workgroups, and trainings with communities across the state, with the focus on preventing children from entering foster care.

One risk to the Out of Home Care caseload is related to the capacity for psychiatric residential care. 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 pandemic led to a focus on minimizing the utilization of group care. It is expected that there will be decreased utilization of this kind of care through the forecast horizon.

The main risk to the Child In-Home caseload is the way the data are defined and captured. These counts are based on the safety plan rather than the case plan, and a case cannot move forward until a caseworker enters an initial safety plan. This may impact the number of children counted in this caseload.

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.

As was stated in the introductory part of this section, the timing and roll-out of normalization of court processes is a risk to the forecast, as it is as yet unplanned and may be dependent upon vaccination rates and the rate of infection in Oregon.

Child Welfare Biennial Average Forecast Comparison

	2019-21 Biennium			*% Change Between Forecasts*	Spring 2021 Forecast			*% Change Between Biennia*
	Fall 20 Forecast	**Spring 21 Forecast**	**Change**		**2019-21**	**2021-23**	**Change**	
CHILD WELFARE (Children)								
Adoption Assistance	10,698	10,630	-68	-0.6%	10,630	10,581	-49	-0.5%
Guardianship Assistance	2,267	2,272	5	0.2%	2,272	2,339	67	2.9%
Out of Home Care[1]	6,308	6,230	-78	-1.2%	6,230	5,793	-437	-7.0%
Child In-Home	1,472	1,409	-63	-4.3%	1,409	1,484	75	5.3%
Total Child Welfare	**20,745**	**20,541**	**-204**	**-1.0%**	**20,541**	**20,197**	**-344**	**-1.7%**

1. Includes residential and foster care.

Aging and People with Disabilities (APD)

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") under the Affordable Care Act (ACA); and now most services are provided through K-Plan rather than the HCBS Waiver. By shifting from operating under the HCBS Waiver to K-Plan in late 2013, the eligibility rules for long-term care were changed.

The ACA was enacted in 2010 and expanded Medicaid coverage for low-income and uninsured patients. 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 the Supplemental Security Income – or SSI – threshold (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 K-Plan; but K-Plan has no asset limits and no requirement that clients be over 65 or officially determined to have a disability. New clients entering long-term care between 2013 and 2016 indicated that the ACA (the combined effects of K-Plan and Medicaid expansion) contributed to long-term care caseload growth.

All LTC clients are assessed for need-based on disability – a score referred to as Service Priority Level. 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. Between 2008 and 2019, the total LTC caseload has varied from a low of 25,900 clients in May 2008 to a high of 35,136 clients in December 2019. From 2008 to 2013 the caseload grew by an average of 2.5 percent a year, driven in part by 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 the implementation of K-Plan, expansion of Medicaid, policy changes to make in-home care more attractive, and continued growth in the number of Oregon seniors. From 2016 to 2019, the caseload growth was stable, with an annual average growth rate of 0.9 percent. At the beginning of 2020, the increased caseload pattern was continued before the COVID-19 pandemic outbreak. The caseload between April and June 2020 was 0.9 percent lower than the caseload between January and March 2020.

The LTC forecast is divided into three major categories: In-Home, Community-Based Care (CBC), and Nursing Facilities. 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. Starting in October 2017, APD implemented new guidelines for the way that Activities of Daily Living (ADL) scores are derived, called the Client Assessment and Planning System (CA/PS). Although many clients had their In-Home service hours reduced or became ineligible for In-Home services due to the change, In-Home still accounts for 53 percent of the total LTC count.

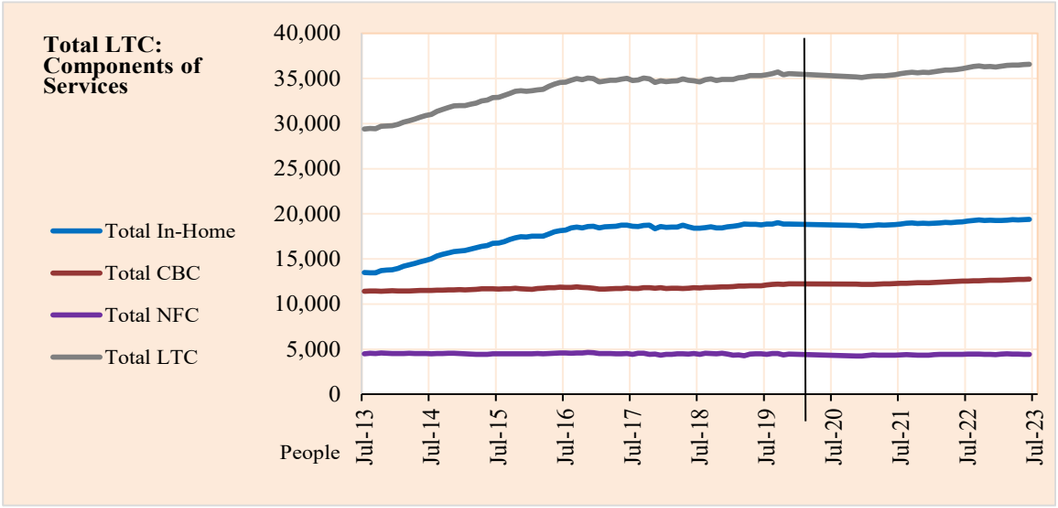
CBC is still forecasted to grow, although at a reduced rate to reflect the anticipated shift toward In-Home Care in July 2013. CBC will continue to be a stable placement choice for many LTC clients because this type of care is easier to set up and coordinate than In-Home, and because hospitals prefer 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.

General Assumptions for the Aging and People with Disabilities Long-Term Care Caseload

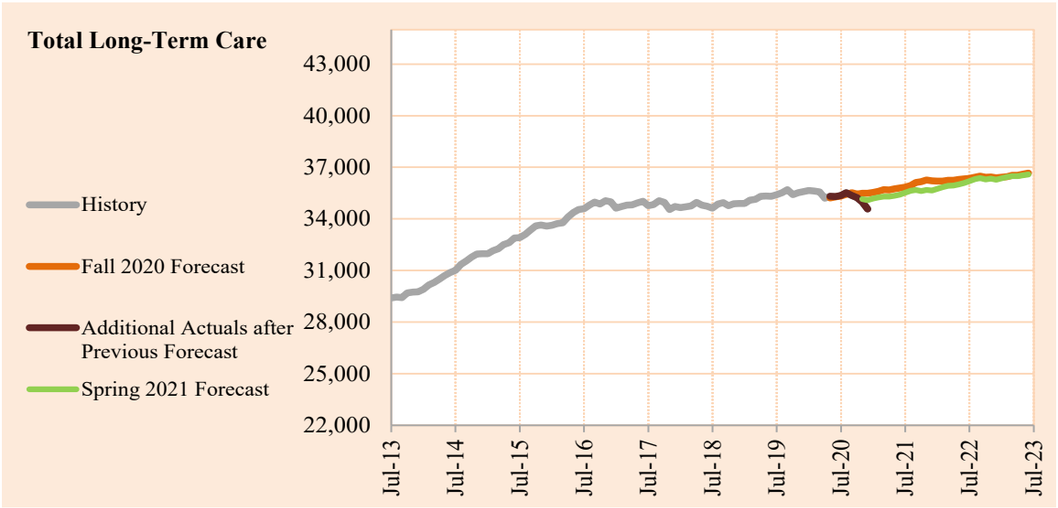
After the first COVID-19 confirmed case in the United States on January 21, 2020, long-term care facilities, in particular nursing-home care, were considered especially vulnerable to deaths due to coronavirus exposure. Increased confirmed cases in facilities shrank consumers' demand for services. Although the impact varies across programs, clients receiving In-Home service showed higher exits than usual based on April 2020 data.

LTC clients' exit due to death was 2.3 percent higher comparing March through October 2020 to the same period in 2019. There are reporting delays related to the reporting of date of death, and it is not definitive that this increase was due to COVID-19 infections or related causes (such as hospital capacity issues), but this does illustrate the unique vulnerability of seniors in LTC.

Oregon started COVID-19 vaccinations in January 2021. LTC eligible clients were expected to be vaccinated by the end of April 2021. The current forecast assumes that increased vaccinations will help alleviate any hesitancy of the disabled to enter Long Term Care. OFRA is using the Oregon Office of Economic Analysis (OEA) first-quarter Economic and Revenue Forecast as a general guide. OEA's forecast assumes that the pandemic will continue to wane, therefore the current forecast assumes that demand for long-term care will slowly recover, with caseloads reaching levels equal to pre-COVID projections by the end of the 2021-23 biennium.



Total Long-Term Care (LTC) – A total of 35,136 clients received long-term care services in October 2020. Of the three major services, the emergency order had the most impact on In-Home Care. The LTC caseload is expected to average 35,375 cases per month over the 2019-21 biennium, which is 0.4 percent lower than the Fall 2020 forecast. The caseload is expected to average 36,084 cases per month over the 2021-23 biennium, an increase of 2.0 percent compared to the 2019-21 biennium.



In-Home Care – From July 2013 to December 2015, the In-Home Care caseload grew by 29 percent. This caseload growth is attributed to several factors, including 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. But the largest impact was likely the implementation of K-Plan. For example, under the old rules, clients who applied for In-Home services were required to contribute to their support by relinquishing to the State all income over $710 per month – an amount that was difficult to live on. Under K-Plan, the limit for how much a client can keep is $1,210 per month. Clients who may have been reluctant to relinquish some of their limited income in the past, 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.

After the initial rapid growth, increases in this caseload moderated considerably. In-Home Care grew by 7.0 percent between January 2016 and September 2017. Then the caseload began to decline – by 2.1 percent between October and November 2017. This was due to the implementation of new guidelines regarding CA/PS assessment criteria and related services-per-benefit. The CA/PS changes included:

1) changes to existing rules regarding the calculation of the ADL assessment;

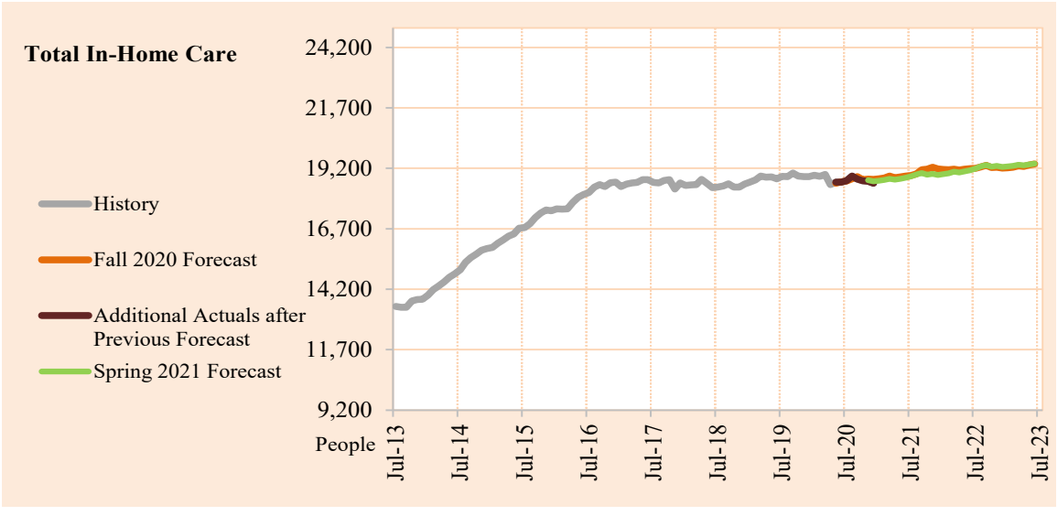
2) adjustments to In-Home hours;

3) transition from Live-in to Hourly services; and

4) In-Home Care workers' two-week service authorization.

The impact of these changes was felt in October and November 2017, after which the pattern of In-Home case exits and intakes returned to the pre-CA/PS levels, and the caseload increased by 3.3 percent between December 2017 to March 2020.

In April 2020, 18,529 clients received In-Home Care, which accounted for 52.8 percent of total LTC services. April clients are 2.2 percent lower than March. Over 1,000 clients left the service in April which is approximately double the average exits prior to the COVID-19 emergency order. From May, the caseload slowly recovered due to low exits and a stable flow of new intakes. This is likely to continue through the current biennium. The In-Home Care caseload is expected to average 18,774 per month over the 2019-21 biennium, which is 0.1 percent lower than the prior forecast. The In-Home Care caseload is projected to average 19,145 clients per month over the 2021-23 biennium.



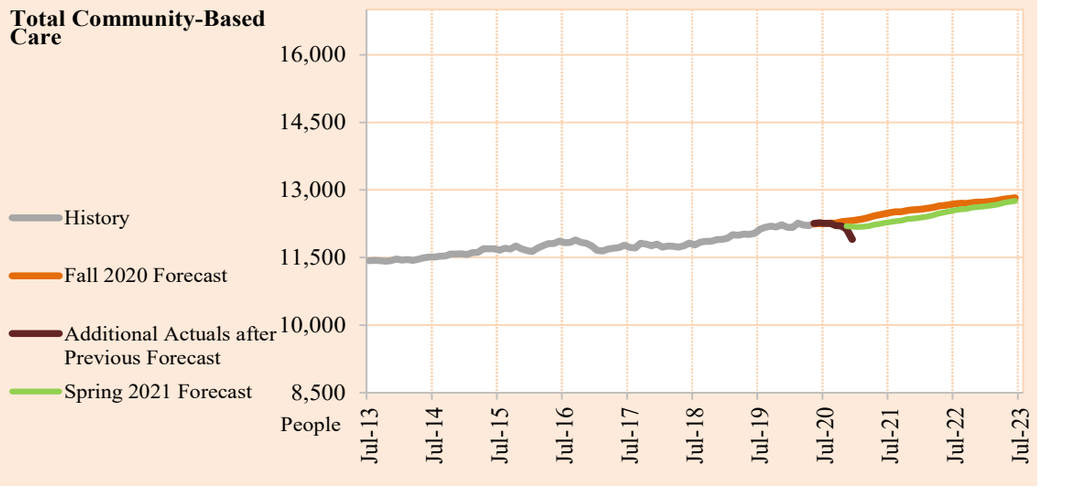
Community-Based Care (CBC) – Community-Based Care includes several different types of services. Caseload counts are designed to accurately reflect a clients' actual utilization of services. Consequently, the Program of All-Inclusive Care for the Elderly (PACE) and Residential Care have been revised to become a larger portion of the forecast, while Adult Foster Care (AFC) and Assisted Living Facility (ALF) have become smaller. A new provider of PACE will began offering services in Southern Oregon in April 2021. High demand for the program is forecasted to lead to a rapid increase in clients until the facility reaches capacity, which will increase the CBC caseload during the 2021-23 biennium.

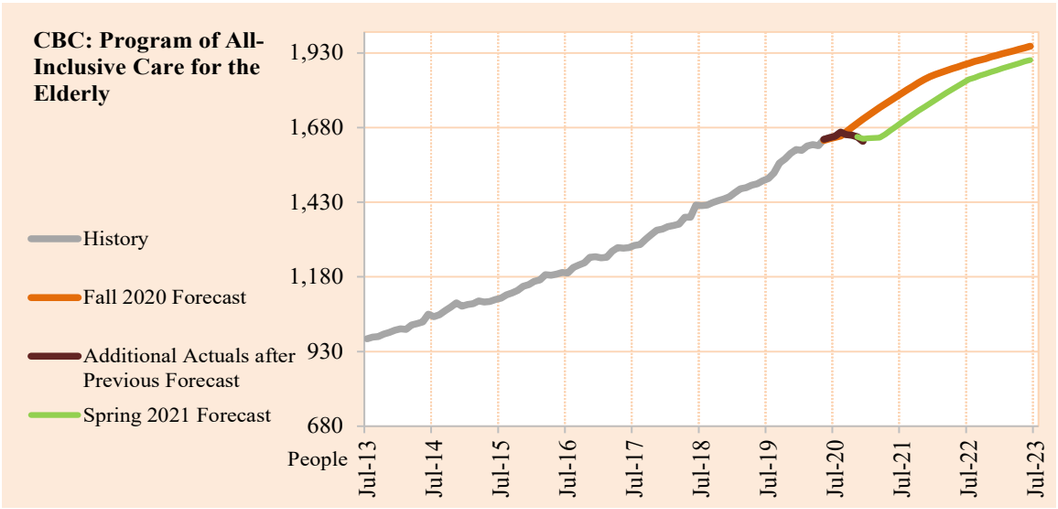
Several factors are contributing to the decline in the AFC caseload from August 2013 to July 2019: policy changes that make In-Home Care more attractive; providers' perception of inadequate reimbursement rates; increasing adversarial relationship between workers and providers; and declining capacity as individual providers retire. Since August 2019, the caseload has hovered at around 2,300 clients. Clients in AFC services are less likely to move out from the program, and some LTC clients prefer small-group services during the COVID-19 pandemic. Although this slightly increased the caseload from 2,327 in March 2020 to 2,378 in October, clients in AFC may move to other services when the COVID-19 risk fades.

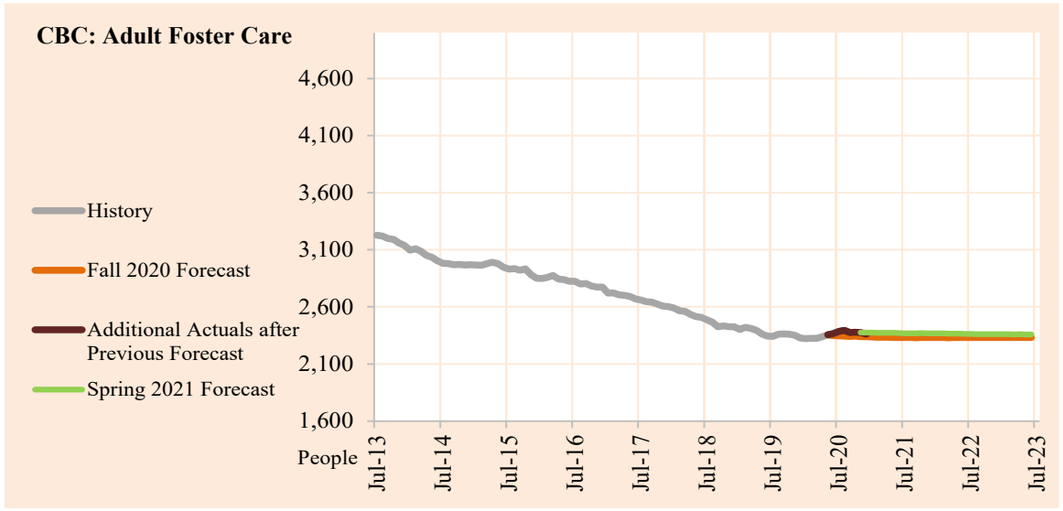
Assisted Living Facility (ALF) providers may prefer clients paying at market rates compared to Medicaid reimbursement rates, limiting the number of beds available. This dynamic has led to volatility in the caseload and greater risk to forecast accuracy than with other areas of LTC.

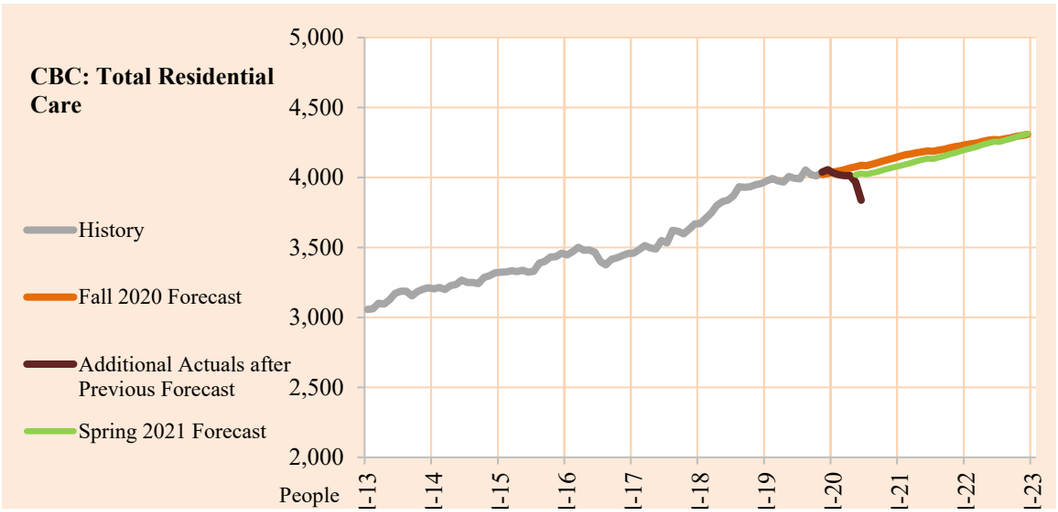
Overall, the caseload increased until September 2017, with fluctuations. The caseload then decreased from October 2017 to January 2019, increased again through September 2019, and then began to continually decrease. In particular, the number of clients exiting Assisted Living Facilities continually increased from April to September 2020. Even though clients are expected to come back when the COVID-19 risk fades, there is a chance that consumer behavior has been permanently influenced.

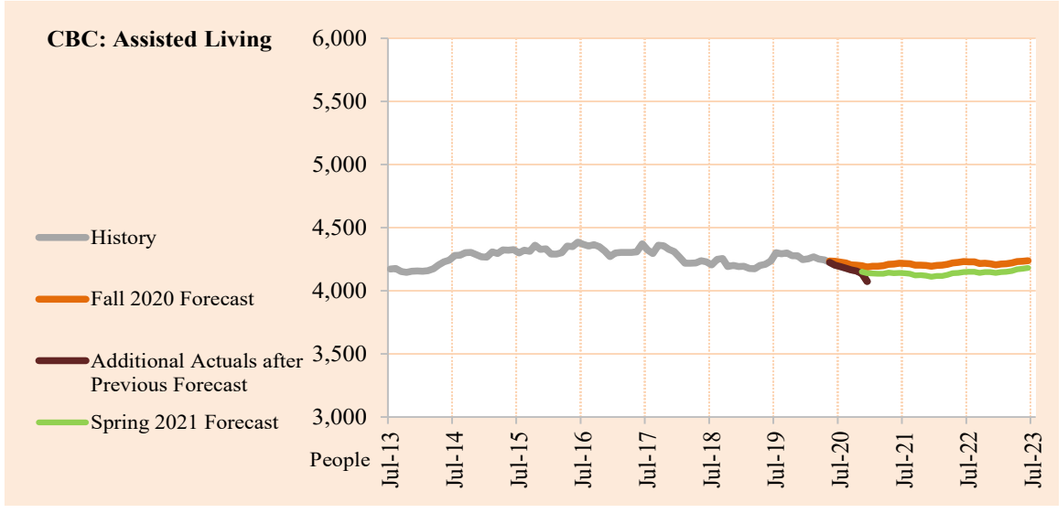
In October 2020, 12,202 clients received Community-Based Care, which accounted for 34.7 percent of total LTC. The caseload is expected to average 12,210 cases per month over the 2019-21 biennium, which is 0.5 percent lower than the prior forecast. The caseload is expected to average 12,522 cases per month over the 2021-23 biennium, an increase due to the establishment of a new provider of PACE.




CBC: Program of All-Inclusive Care for the Elderly
1,930
1,680
1,430
1,180
930
680
People
History
Fall 2020 Forecast
Additional Actuals after Previous Forecast
Spring 2021 Forecast
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19
Jul-20
Jul-21
Jul-22
Jul-23


CBC: Adult Foster Care
4,600
4,100
3,600
3,100
2,600
2,100
1,600
People
History
Fall 2020 Forecast
Additional Actuals after Previous Forecast
Spring 2021 Forecast
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19
Jul-20
Jul-21
Jul-22
Jul-23


CBC: Total Residential Care
5,000
4,500
4,000
3,500
3,000
2,500
2,000
People
History
Fall 2020 Forecast
Additional Actuals after Previous Forecast
Spring 2021 Forecast
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19
Jul-20
Jul-21
Jul-22
Jul-23


CBC: Assisted Living
6,000
5,500
5,000
4,500
4,000
3,500
3,000
People
History
Fall 2020 Forecast
Additional Actuals after Previous Forecast
Spring 2021 Forecast
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19
Jul-20
Jul-21
Jul-22
Jul-23

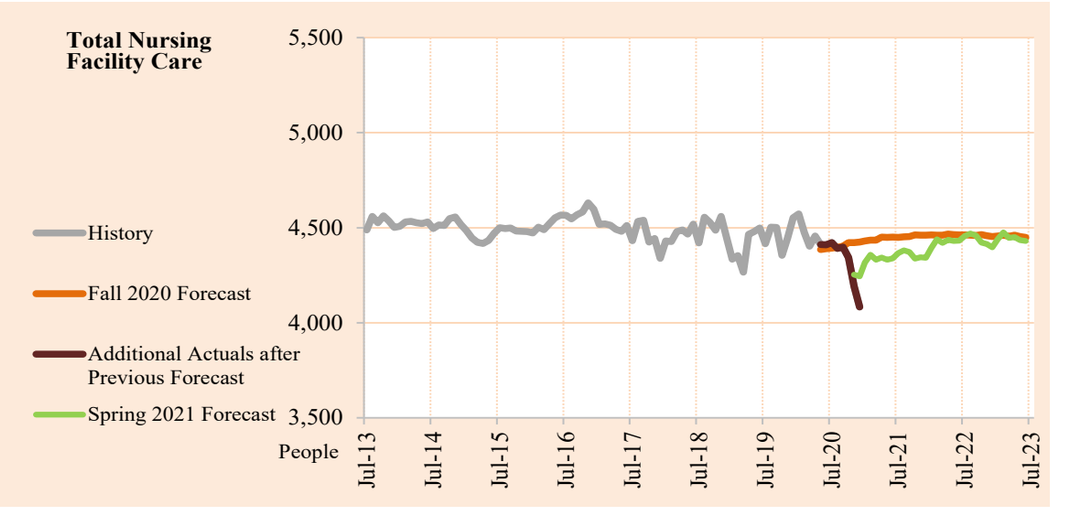
Nursing Facilities

Nursing Facility Care (NFC) includes four different types of service: Basic Care, Complex Medical Add-On, Enhanced Care, and Pediatric Care. Approximately 99 percent of NFC clients receive Basic Care or Complex Medical Add-On services.

Clients in NFC currently account for 12.1 percent of total LTC. NFC clients represented close to 20 percent of all LTC clients at the beginning of 2000. Clients receiving NFC services reached a high of 5,800 in 2002, before dropping continuously through April 2013. The decreased NFC share of LTC is not only due to fewer clients receiving NFC services but also increases in clients seeking In-Home Care and CBC. From May 2013 on, clients ranged from 4,300 to 4,600 before the COVID-19 pandemic outbreak.

LTC caseload counts are derived 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 provided 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 Medial Add-On) take longer to reconcile than other LTC program providers. This leads to significant differences between caseloads calculated monthly (and published by OFRA in the monthly variance reports) and revised historical values which are more accurate. For this reason, Basic and Complex Medical Add-On services will be forecasted with revised values which accommodate this lag in reconciliation. This change will produce a more accurate forecast.

In October 2020, 4,307 clients received NFC services, which is approximately 1.1 percent lower than a year ago. The caseload has continually decreased by 0.7 percent per month since January 2020, the first coronavirus case confirmed in the U.S. The caseload is expected to average 4,391 per month over the 2019-21 biennium, which is 0.8 percent lower than the prior forecast. The caseload is expected to average 4,417 per month over the 2021-23 biennium, which is 0.6 percent higher than the 2019-21 biennium.



Affordable Care Act (ACA) and 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). 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 share of ACA LTC continually decreased from 3.8 percent in May 2020 to 2.6 percent in October 2020.

Forecast Environment and Risks

In-Home Care providers are required to implement the Electronic Visit Verification (EVV) system by January 1, 2023, according to Section 12006(a) of the 21st Century Cures Act. EVV will track when a caregiver arrives at and leaves a location and the individual receives services. As part of this requirement, participants in the Independent Choice Program (ICP) were asked to select EVV to continue participating in the ICP by September 30, 2020. If consumers did not wish to follow the EVV requirement, they switched to other eligible services.

As a result, clients who received ICP services decreased by 2 percent from August 2020 to October 2020. The current forecast assumes that clients that have moved to other programs may not come back to ICP immediately. However, by implementing EVV to other In-Home programs, clients may come back to ICP, or clients receiving other In-Home services may move to ICP depending on the timeline of the EVV implementation.

A new PACE provider in Southern Oregon delayed its enrollment month several times, from September 2020 to April 2021. Although the current forecast assumed that the facility provides the services from the beginning of April 2021, there is a possibility that the provider moves the enrollment month further later due to the COVID-19.

A temporary suspension of Adverse Actions attached to any Medicaid case – including APD Medicaid Cases – was put into effect on March 19, 2020, as part of the Families First Coronavirus Response Act (H.R. 6201). Adverse Actions are a key mechanism for closures of Medicaid case closures. This suspension of Adverse Actions allows the current APD clients to receive the services they need without interruption. The temporary policy may reduce the clients moving out from the program under the policy. This forecast assumes that this rule remains in place through 2021.

The COVID-19 pandemic has changed APD customers' sentiments toward LTC programs. Prior to the COVID-19 pandemic, the number of clients was gradually increasing in most LTC programs. Right after the pandemic started, clients exiting from In-Home services increased and new clients entering to NFC and CBC decreased. In particular, clients in AFC have increased while clients decreased in ALF. Although speeding up the COVID vaccination rate will change this pattern, it is uncertain as to whether consumer sentiment has been temporarily changed or permanently changed.

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 percent of the total population in 2002 and rose to 18 percent 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

	2019-21 Biennium			*% Change Between Forecasts*	Spring 2021 Forecast			*% Change Between Biennia*
	Fall 20 Forecast	**Spring 21 Forecast**	**Change**		**2019-21**	**2021-23**	**Change**	
AGING AND PEOPLE WITH DISABILITIES								
In-Home Hourly without SPPC	13,840	13,805	-35	-0.3%	13,805	14,066	261	1.9%
In-Home Agency without SPPC	2,287	2,387	100	4.4%	2,387	2,507	120	5.0%
In-Home Spousal Pay	18	17	-1	-5.6%	17	17	0	0.0%
Independent Choices	545	533	-12	-2.2%	533	535	2	0.4%
Specialized Living	201	201	0	0.0%	201	203	2	1.0%
In-Home K Plan Subtotal	**16,891**	**16,943**	**52**	**0.3%**	**16,943**	**17,328**	**385**	**2.3%**
In-Home Hourly with State Plan Personal Care	1,462	1,400	-62	-4.2%	1,400	1,389	-11	-0.8%
In-Home Agency with State Plan Personal Care	447	431	-16	-3.6%	431	428	-3	-0.7%
In-Home non-K Plan Subtotal	**1,909**	**1,831**	**-78**	**-4.1%**	**1,831**	**1,817**	**-14**	**-0.8%**
Total In-Home	**18,800**	**18,774**	**-26**	**-0.1%**	**18,774**	**19,145**	**371**	**2.0%**
Adult Foster Care	2,341	2,360	19	0.8%	2,360	2,364	4	0.2%
Assisted Living	4,235	4,206	-29	-0.7%	4,206	4,142	-64	-1.5%
Contract Residential and Memory Care	3,214	3,202	-12	-0.4%	3,202	3,424	222	6.9%
Regular Residential Care	831	818	-13	-1.6%	818	772	-46	-5.6%
Program of All-Inclusive Care for the Elderly	1,653	1,624	-29	-1.8%	1,624	1,820	196	12.1%
Community-Based Care Subtotal	**12,274**	**12,210**	**-64**	**-0.5%**	**12,210**	**12,522**	**312**	**2.6%**
Basic Nursing Facility Care	3,640	3,607	-33	-0.9%	3,607	3,628	21	0.6%
Complex Medical Add-On	734	729	-5	-0.7%	729	736	7	1.0%
Enhanced Care	33	34	0	0.0%	34	33	-1	-2.9%
Pediatric Care	20	21	0	0.0%	21	20	-1	-4.8%
Nursing Facilities Subtotal	**4,427**	**4,391**	**-36**	**-0.8%**	**4,391**	**4,417**	**26**	**0.6%**
Total Long-Term Care	**35,501**	**35,375**	**-126**	**-0.4%**	**35,375**	**36,084**	**709**	**2.0%**

Intellectual and Developmental Disabilities (I/DD)

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 K-Plan), and now most I/DD services are delivered under K-Plan. Implementation of 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.

General Assumptions for the Intellectual and Developmental Disabilities Forecast

The COVID-19 emergency has led to caseload decreases, specifically in In-Home Services (Adult and Children). These caseloads are forecasted to rebound quickly to pre-COVID-19 levels by October 2021.

I/DD Employment and Day Support Activities (DSA) and Transportation services have experienced a significant disruption due to the COVID-19 pandemic and restrictions on in-person interactions, and will have slower recovery to pre-COVID-19 levels due to an expected slow recovery in the employment of I/DD clients. Therefore, it is assumed that I/DD Employment and DSA and Transportation services will return to pre-COVID-19 patterns towards the end of 2021-23 biennium.

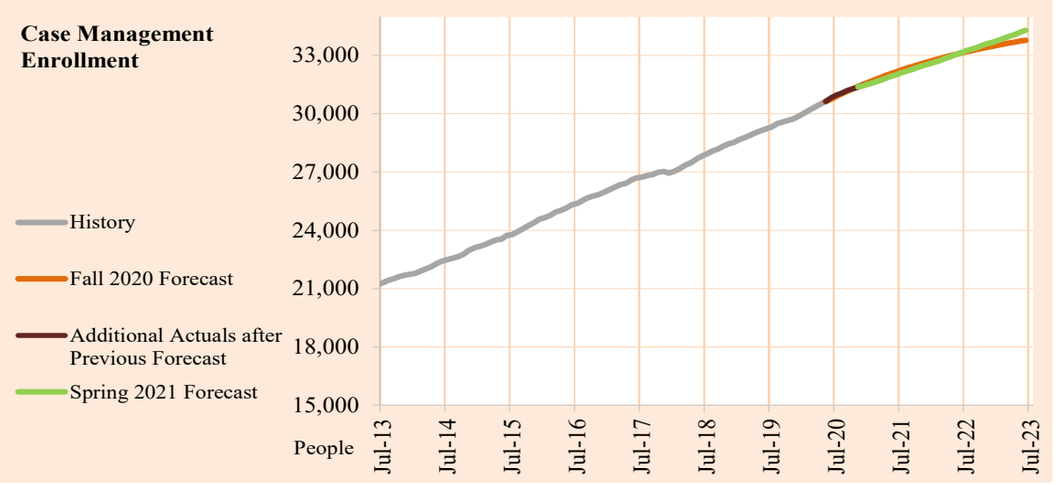
Case Management Enrollment

This is an entry-level eligibility, evaluation, and coordination service available to all individuals determined to have intellectual and developmental disabilities, regardless of income level. Starting in the Fall of 2018, Case Management Enrollment has included State Children (SE 248) who previously could not enroll in I/DD Case Management. 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 an 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.

Case Management Enrollment is projected to average 30,753 cases per month through the rest of the 2019-21 biennium, which is slightly lower than the Fall 2020 forecast. The caseload is expected to average 33,180 over the 2021-23 biennium. Case Management Enrollment is projected to grow until most I/DD individuals living in the state have enrolled.

The Human Services Research Institute (HSRI), under a 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.

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

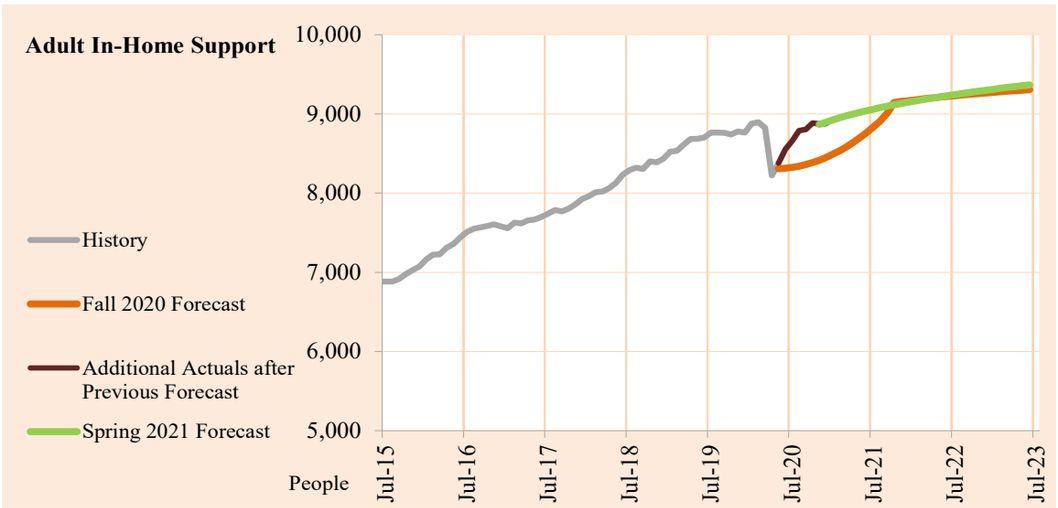


Adult Services

I/DD Adult Services were 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 employment and transportation services, and are grouped based on plan of care.

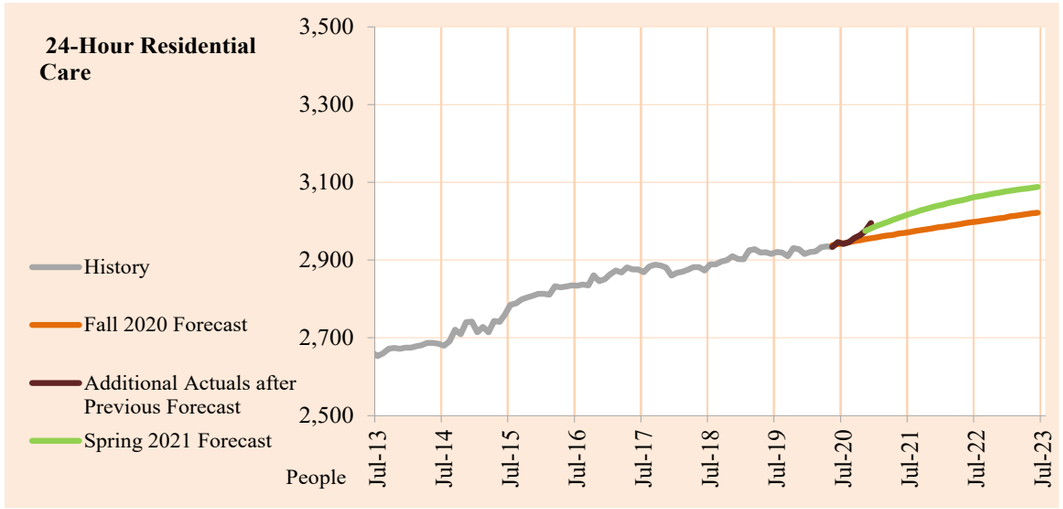
The Adult In-Home Support caseload is projected to average 8,798 cases per month through the remainder of the 2019-21 biennium, which is 2.5 percent higher than the Fall 2020 forecast. This caseload has significantly declined since the Spring 2020 forecast due to the COVID-19 pandemic. However, by the end of 2020 this caseload rebounded to higher level than indicated in the Fall 2020 forecast. This caseload is expected to average of 9,231 clients per month in the 2021-23 biennium, which is a 4.9 percent increase compared to the 2019-21 biennial average.

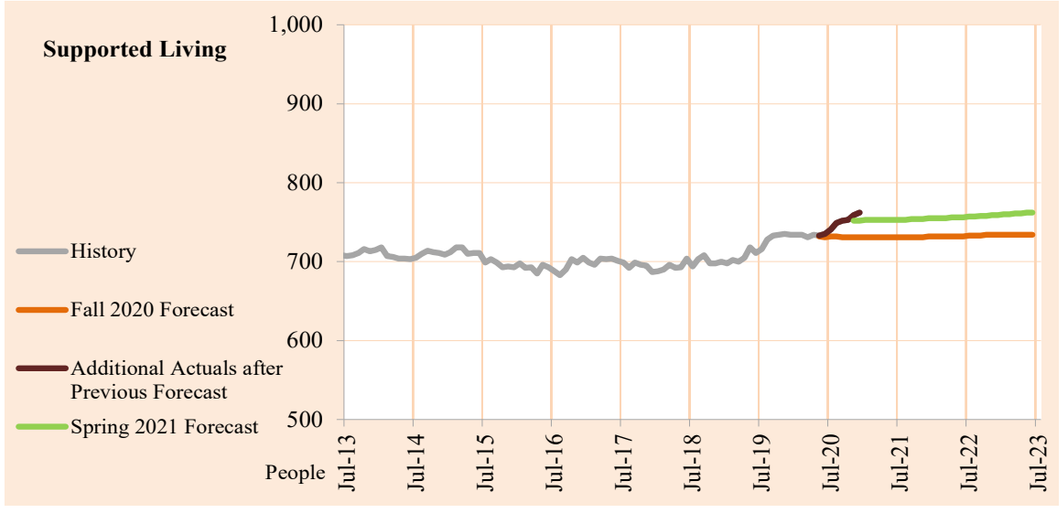


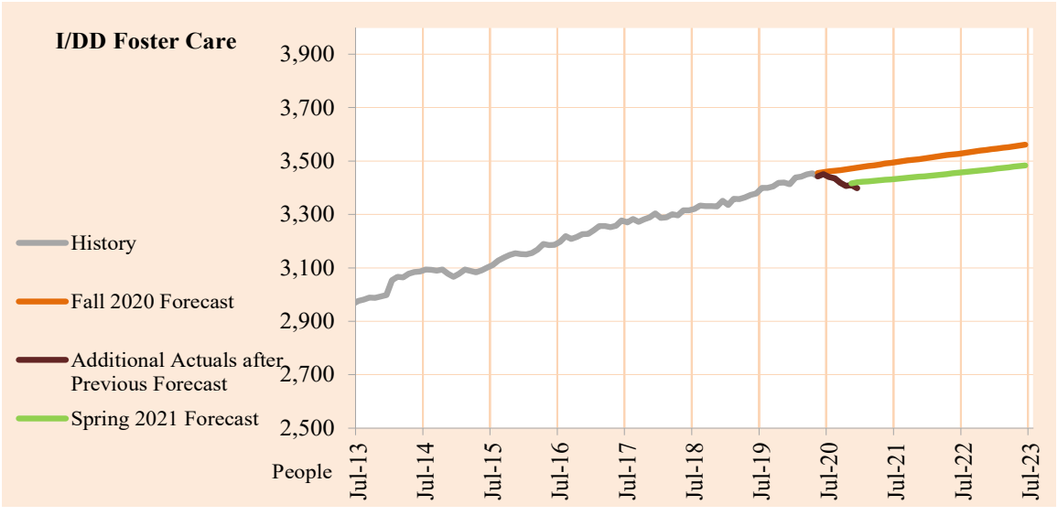
24-Hour Residential Care – This caseload is projected to average 2,953 cases a month through the remainder of the 2019-2021 biennium, which is slightly higher than the Fall 2020 forecast. The caseload is expected to average 3,058 cases per month over the 2021-23 biennium.

Supported Living – For the remainder of the 2019-21 biennium this caseload is projected to average 742 cases per month which is 1.5 percent higher than the Fall 2020 forecast. The caseload is expected to average 755 cases over the 2021-23 biennium.

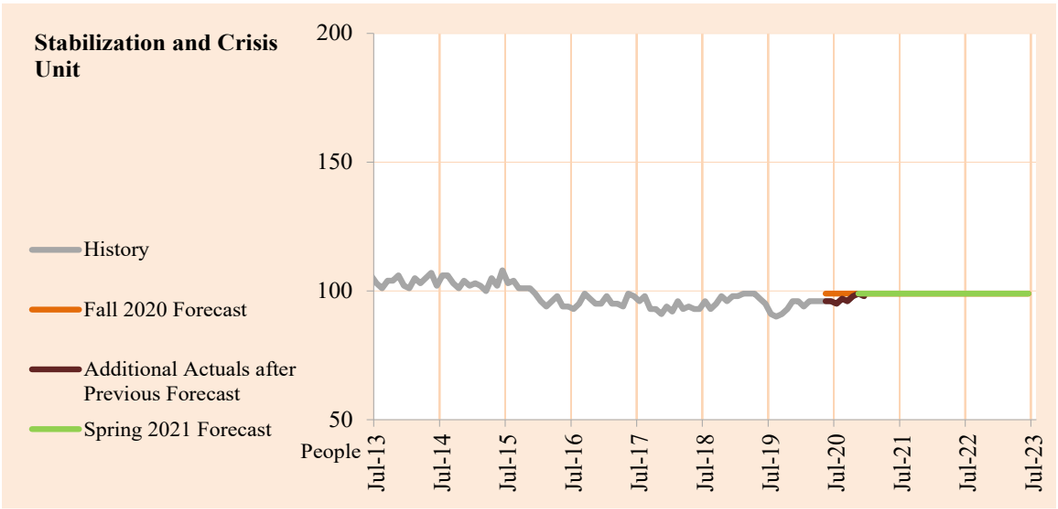
I/DD Foster Care – I/DD Foster Care serves both adults and children, with children representing approximately 11.0 percent of the caseload. The remainder of the 2019-21 biennium is expected to average 3,426 cases per month, which is slightly lower than the Fall 2020 forecast. The caseload is expected to average 3,458 cases per month over the 2021-23 biennium.







Stabilization and Crisis Unit – The Stabilization and Crisis Unit serves both adults and children, with children representing approximately 16.0 percent of the caseload. This caseload is limited by bed capacity and is expected to remain at the current level of 99 for both the 2019-21 and 2021-23 biennia.

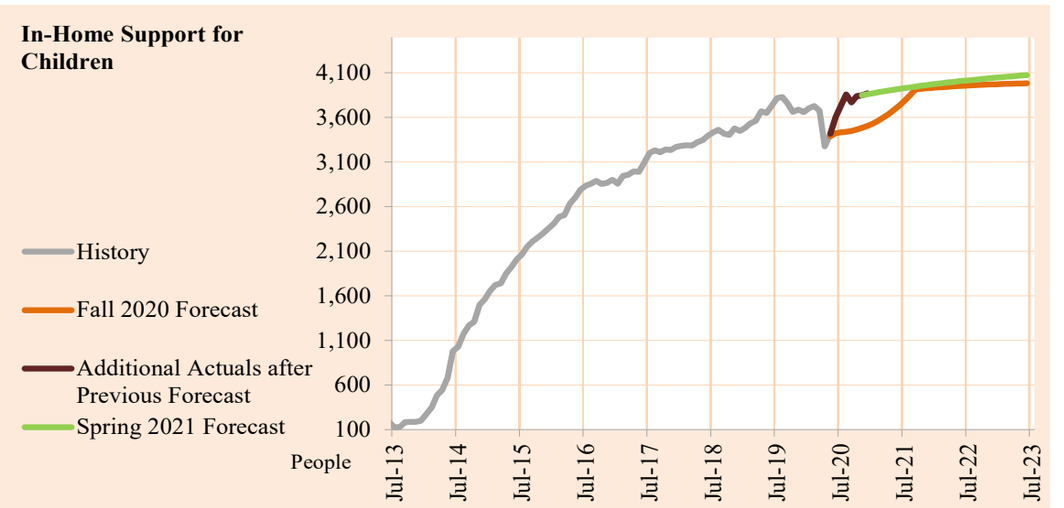


Children Services

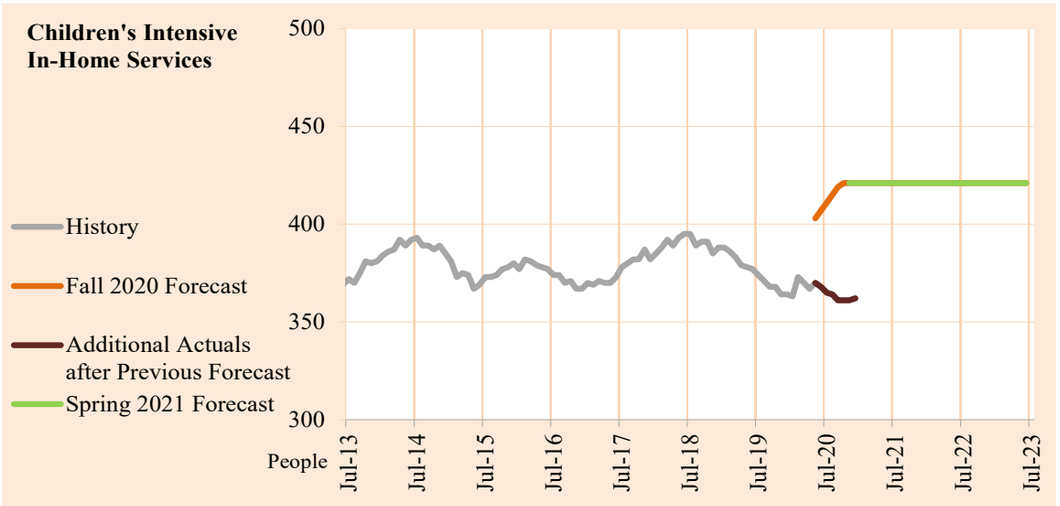
In-Home Support for Children (IHSC) – This caseload started growing rapidly in late 2013 as K-Plan was implemented. The caseload grew fifteen-fold from 187 clients in mid-2013 to 2,790 by mid-2016. This caseload growth has slowed considerably to a monthly average of 3,089 since mid-2017.

The In-Home Support for Children caseload is projected to average 3,753 cases per month for the remainder of the 2019-21 biennium, which is 4.6 percent higher than the Fall 2020 forecast. This caseload has significantly declined since the Spring 2020 forecast due to the COVID-19 pandemic. However, the caseload has rebounded and quickly increased to pre-COVID levels by the end of 2020. This caseload is expected to average of 4,008 clients per month in 2021-23 biennium, which is a 6.8 percent increase compared to the 2019-21 biennial average.

Growth in this caseload is primarily due to the 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 when determining eligibility. 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. For additional information, see the "Additional Risks and Assumptions" section below.

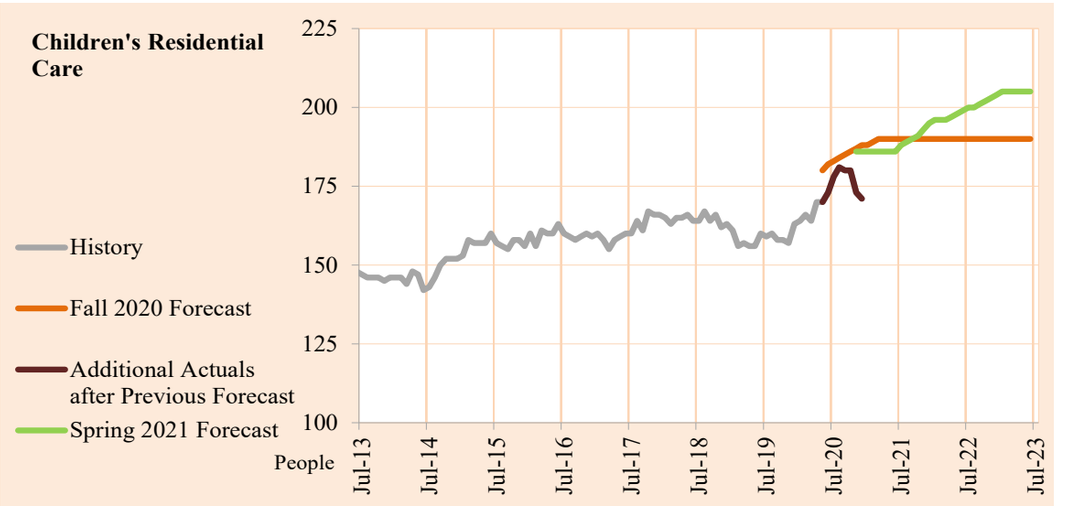


Children Intensive In-Home Services (CIIHS) – This caseload includes Medically Fragile Children Services, Intensive Behavior Programs, and Medically Involved Program. The total CIIHS caseload is expected to average 385 clients per month in the remainder of the 2019-21 biennium. This caseload is limited by capacity and is expected to grow gradually to 421 cases per month and remain at that level through the 2021-23 biennium.



Children Residential Care – This caseload is expected to average around 185 per month in the remainder of the 2019-21 biennium. It is expected to gradually grow to 199 cases per month and remain at that level through the 2021-23 biennium.

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, ODHS 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 are being opened in the 2019-21 biennium 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

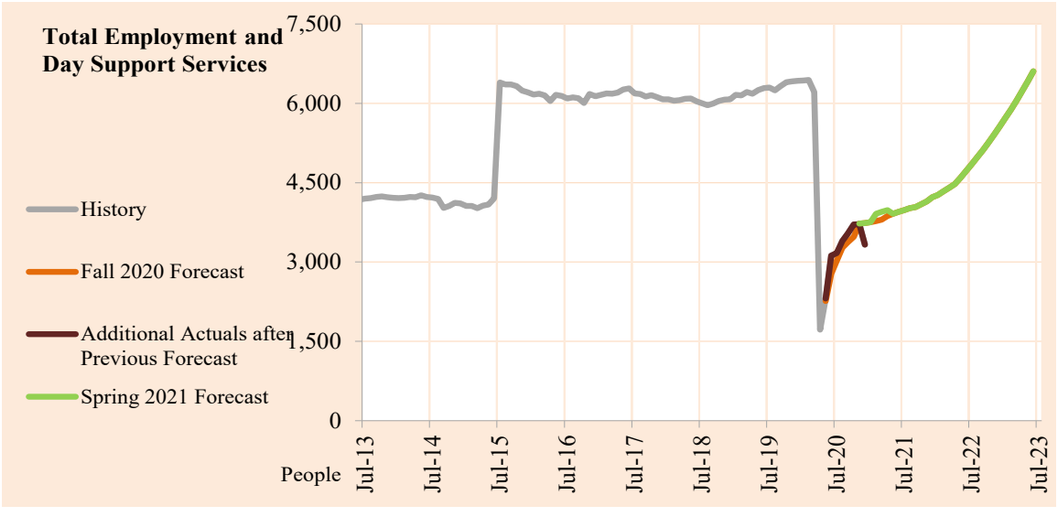
Total Employment and Day Support Services – In order to better reflect recent changes in I/DD program, the definition of employment services has been revised. The new definition is broader, including all services previously counted as well as new services offered under Employment First and Plan of Care. 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 a later date, after claims have been fully processed.

The steps involved in the calculation of preliminary actuals include:

1. A calculation of the ratios of the previous 10 months of actuals to 3 month matured reported actuals;
2. A calculation of the three-month moving average of the ratios;
3. Apply the moving average ratios to initially reported actuals to create the new estimated actuals.

Employment Activities and Day Support Activities will be reported together as Total Employment and Day Support Services. Due to the COVID-19 pandemic, the demand for DSA services has decreased by about 20 percent, as clients reduced employment and activities involving travel in order to decrease their chances of contracting the disease.

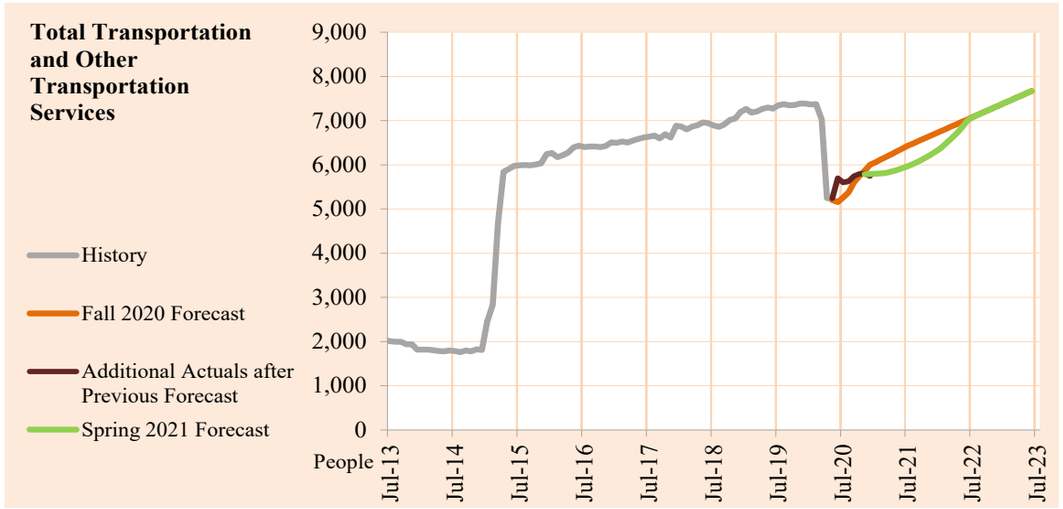
Total Employment and Day Support Services are projected to average 4,528 cases over the remainder of the 2019-21 biennium, which is 1.4 percent higher than the Fall 2020 forecast. The caseload is expected to average 4,974 clients per month over the 2021-23 biennium.



Total Transportation and Other Transportation Services – 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.

Historically, this caseload included only services paid with state funds, not those using matched local 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 were calculated starting with the Spring 2020 forecast. The rationale for calculating preliminary actuals for Transportation services and its methodology are the same as described under the Total Employment and Day Support Services (above).

The Transportation caseload is projected to average 6,312 clients per month in 2019-21 which is 0.8 percent lower than the Fall 2020 forecast. The caseload is expected to average 6,882 clients per month over the 2021-23 biennium



Forecast Environment and Risks

Four I/DD services - In-Home Services (Adult and Children), Employment and DSA, and Transportation have seen a significant caseload decrease due to COVID-19. In-Home Support for Adults and Children provide services to support I/DD clients in the community. These services include visits by care providers, outings and outdoor activities in public parks, libraries and gyms. Due to the need to protect I/DD clients from COVID-19, these normal In-Home care activities have been restricted considerably.

The Family Support services caseload significantly increased starting in April 2020. The increase in this caseload is mainly due to disruption of schooling of I/DD children due to COVID-19.

Employment and DSA and Transportation

Employment and DSA services have been significantly disrupted due to COVID-19. Clients are either not working or are temporarily holding off employment related services as a result of community-wide lockdown, including the shutting down of employers' businesses. Although ODDS has set up remote access to reach clients, these services are often difficult for this population to use, or they don't have access to the technology to engage. Similarly, Transportation services used by I/DD clients are also impacted due to lower ridership in community transportation services.

The patterns of caseload decreases and increases in these areas are dependent upon improving pandemic statistics, the effectiveness of the vaccine rollout, and the return to full-time in-person

schooling. Although it is likely that the state will reach a state of "normalcy" at some point in 2021, the exact timing is unknown, and represents a risk to the 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 accelerated in 2014 with most CDDPs experiencing higher caseloads and more requests for services than in prior years. The increase in requests and higher caseloads caused some delays in access to service. It has also created capacity challenges for the CDDP's 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 In-Home Support for Children.

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 them in Case Management.

Adult In-Home Support – Adults can be served through two channels – Brokerages or CDDPs. At present, most caseload growth is occurring in CDDP In-Home Services, while Brokerage Services remain flat. The Brokerage Services caseload is a little over three times larger than 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 – K-Plan implementation expanded the availability of services for many children. Prior to the implementation of 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 Supplemental Security Income standards for disability defined by the Social Security Administration), while not accounting for family financial resources. This may also increase the number of children who are able to access in-home services through K-Plan.

Intellectual and Developmental Disabilities Biennial Average Forecast Comparison

	2019-21 Biennium			*% Change Between Forecasts*	Spring 2021 Forecast			*% Change Between Biennia*
	Fall 20 Forecast	**Spring 21 Forecast**	**Change**		**2019-21**	**2021-23**	**Change**	
INTELLECTUAL AND DEVELOPMENTAL DISABILITIES								
Total Case Management Enrollment [1]	**30,782**	**30,753**	**-29**	**-0.1%**	**30,753**	**33,180**	**2,427**	**7.9%**
Adult								
Adult In-Home Support	8,584	8,798	214	2.5%	8,798	9,231	433	4.9%
I/DD Foster Care	3,053	3,046	-7	-0.2%	3,046	3,090	44	1.4%
24 hrs Residential Care	2,941	2,953	12	0.4%	2,953	3,058	105	3.6%
Supported Living	731	742	11	1.5%	742	757	15	2.0%
Stabilization and Crisis Unit	97	96	-1	-1.0%	96	99	3	3.1%
Children								
I/DD Foster Care	399	380	-19	-4.8%	380	368	-12	-3.2%
In-Home Support for Children	3,587	3,753	166	4.6%	3,753	4,008	255	6.8%
Children Intensive In-Home Services	397	385	-12	-3.0%	385	421	36	9.4%
Children Residential Care	176	185	9	5.1%	174	199	25	14.4%
Total I/DD Services	**19,965**	**20,338**	**373**	**1.9%**	**20,327**	**21,231**	**904**	**4.4%**
Other I/DD Services								
Employment & Day Support Activities[2]	4,465	4,528	63	1.4%	4,528	4,974	446	9.8%
Transportation[3]	6,361	6,312	-49	-0.8%	6,312	6,882	570	9.0%

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.

Vocational Rehabilitation (VR)

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, the WIOA 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 end of 2021-23 biennium.

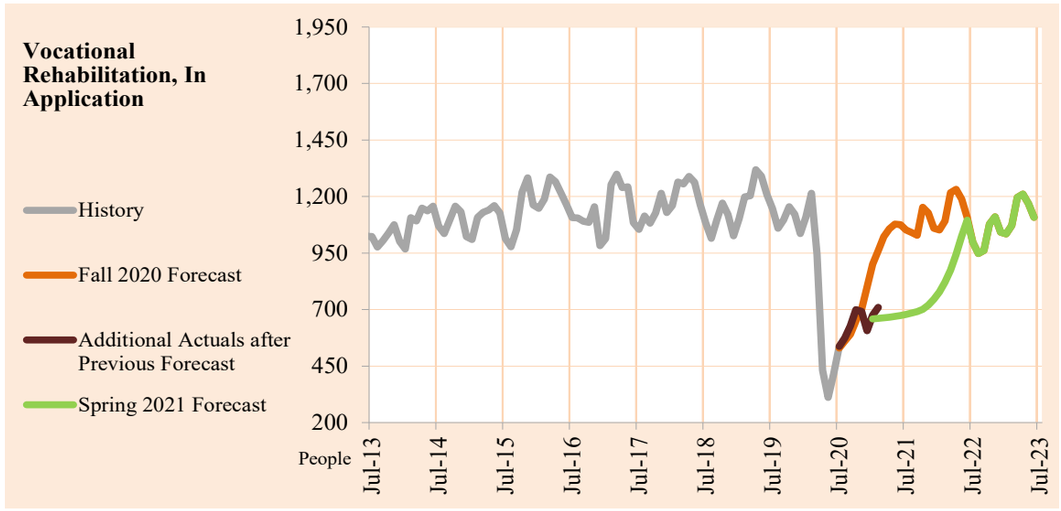
The changes in VR noted above impacted the composition of total VR caseload in terms of types of clients entering the program and moving from application stage to eligibility determination and to in-plan stages. In addition some clients receive post-employment services. The Total Vocational Rehabilitation (Total VR) forecast is the sum of In Application, In Eligibility, In Plan, and Post-Employment Services.

Total Vocational Rehabilitation –The average count of clients in VR for the 2019-21 biennium is expected to be 8,955 per month, a 3.6 percent reduction compared to the Fall 2020 forecast. The total caseload significantly declined in the spring of 2020 due to the COVID-19 pandemic. This was followed by a slower pace of decline and stabilization in the fall. Work with VR clients, which tends to be very contact-heavy, was suspended for a while as staff modified processes and changed the way they interacted with clients. VR has now re-tooled, and the caseload is expected to stabilize and gradually increase to approximately pre-COVID levels, as projected in the Spring 2020 forecast. This will be achieved by the middle of 2022. As a result, the total VR caseload will average 9,518 clients per month in 2021-23 biennium, which is an increase of 6.3 percent compared to the 2019-21 biennial average.

General Assumptions for the Vocational Rehabilitation Forecast

For all of the services described below, a common pattern is expected – volume has dropped dramatically in the spring and summer of 2020, and caseload recovery process has been very slow. Therefore, the caseload recovery plan has been re-adjusted to achieve pre-COVID levels in the middle of 2022, bringing the biennial average values for the 2021-23 biennium closer to prior forecasted values. Because of the coronavirus-related recession and other factors, Post-Employment services will likely to take longer to recover.

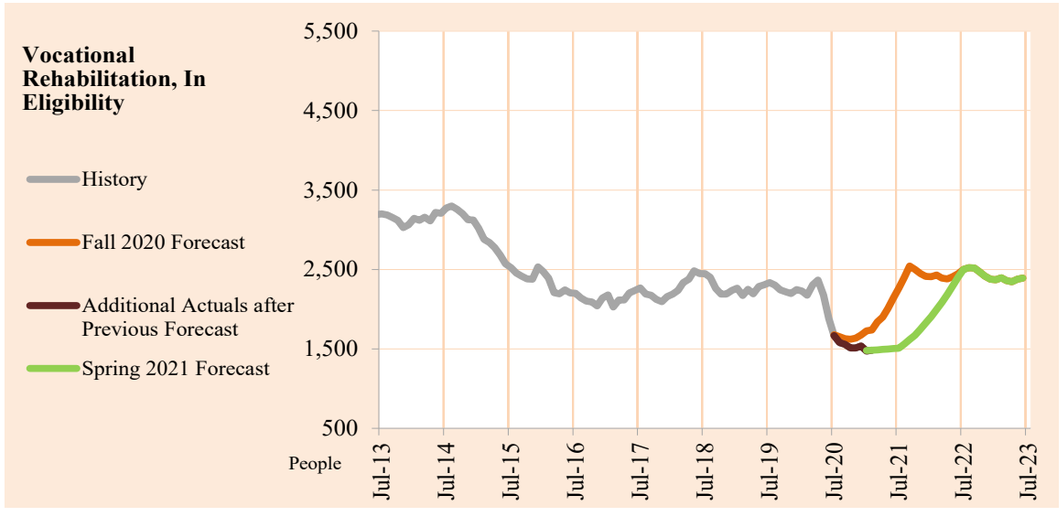
In Application – The average count of clients in the application stage for the remainder of the 2019-21 biennium is anticipated to decrease to 781 clients per month, 10.4 percent lower than the Fall 2020 forecast. Applications volume is expected to recover to pre-COVID levels in the 2021-23 biennium, reaching an average of 945 cases per month.

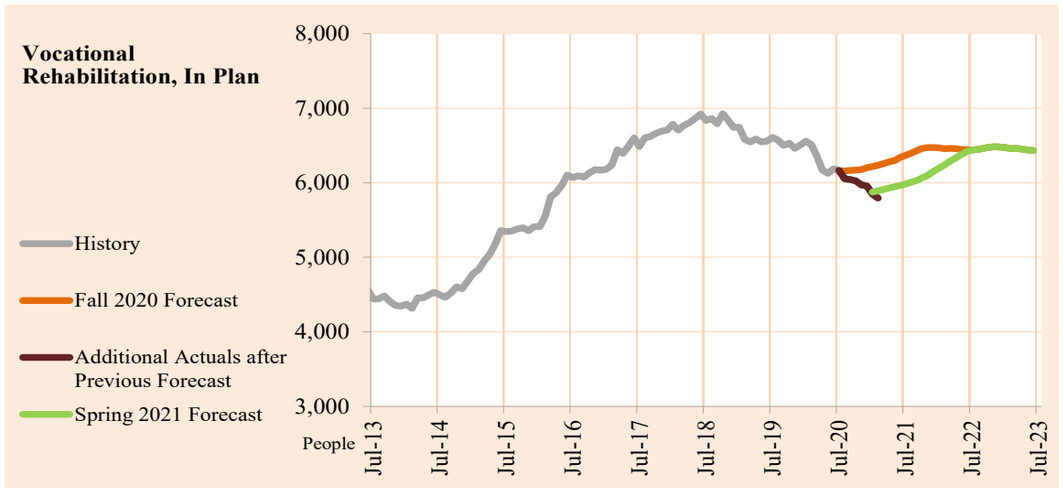


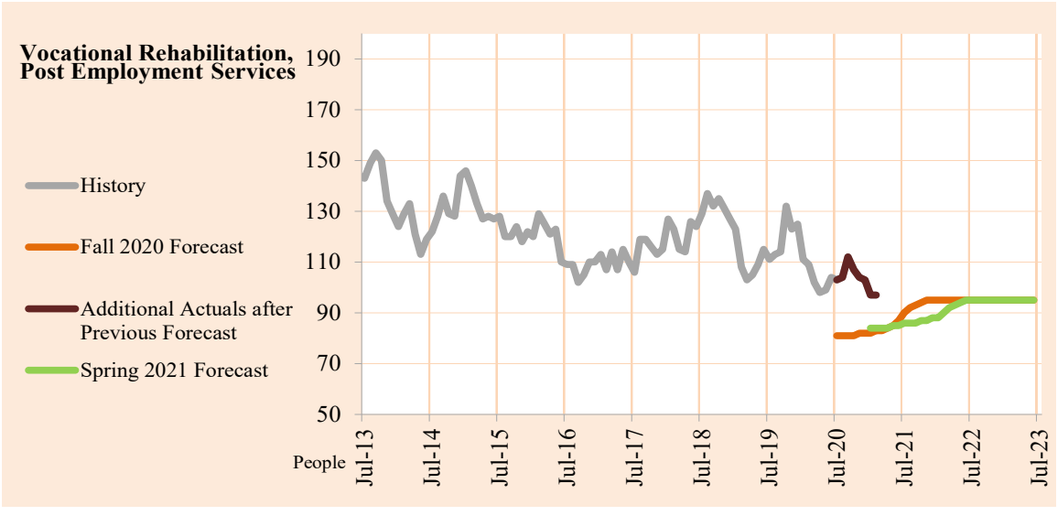
In Eligibility – The average count of clients in the eligibility stage for the remainder of the 2019-21 biennium is anticipated to be 1,874 clients per month, 6.1 percent lower than the Fall 2020 forecast. It is expected to take until the middle of 2022 for the In Eligibility service group to recover to pre-COVID levels. In Eligibility is expected to average 2,161 clients per month for the 2021-23 biennium.

In Plan – The client volume for those In Plan only dropped slightly compared to other service groups. Due to economic factors, this portion of VR services is less likely to fully recover to a level anticipated prior to the Pandemic. The average count of clients in the In Plan stage for the 2019-21 biennium is anticipated to be 6,201 clients per month, 1.9 percent lower than the Fall 2020 forecast. It is expected to grow slightly through the forecast horizon and average 6,320 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 96 clients per month. The average for the 2021-23 biennium is expected to be 92. Demand for Post-Employment services is expected to remain suppressed through the middle of 2023.







Forecast Environment and Risks

The total VR caseload experienced a sharp decline due to COVID-19 between February and July 2020. The caseload decline occurred in all VR services (Application, Eligibility, In Plan and PES). This decline was experienced for multiple reasons, including the public health concern of clients with disabilities and increased underlying health conditions exposing themselves to COVID-19. As a result, many clients have chosen to put their services on hold.

A major change occurred in the VR Intake process. In person services have been replaced by remote contact, causing understandable issues related to adjusting to a virtual connection and working through initial technical difficulties. Accommodations had to be made in the collection of the required signatures on paperwork from both clients and medical professionals. Although the VR program is pursuing an "eSign" or electronic signature capacity, that capability has not yet been obtained or put in place. As a result of this, case processing has slowed down significantly.

Although all signs point to a rapid recovery of the Oregon economy, as reflected in the employment forecast developed by the Office of Economic Analysis, there could be disruptions in VR services, especially work placement. Different parts of the economy were influenced differently by the state of emergency and stay-home orders. Some employers were severely impacted, others were not. And the patterns of recovery for those job sectors most impacted is difficult to estimate. This could lead to difficulties in placing VR clients in the future.

Additional Risks and Assumptions

VR can provide services to any young person between ages 14 and 24 with an Individual Education Plan (IEP) in their school. 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.

Pre-employment Transition Services started in October 2014. This is a mandate of the Workforce Investment and Opportunity Act (WIOA) 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

	2019-21 Biennium			*% Change Between Forecasts*	Spring 2021 Forecast			*% Change Between Biennia*
	Fall 20 Forecast	**Spring 21 Forecast**	**Change**		**2019-21**	**2021-23**	**Change**	
VOCATIONAL REHABILITATION								
In Application	872	781	-91	-10.4%	781	945	164	21.0%
In Eligibility	1,996	1,874	-122	-6.1%	1,874	2,161	287	15.3%
In Plan	6,322	6,201	-121	-1.9%	6,201	6,320	119	1.9%
Post Employment Services	96	99	3	3.1%	99	92	-7	-7.1%
Total Vocational Rehabilitation[1]	**9,286**	**8,955**	**-331**	**-3.6%**	**8,955**	**9,518**	**563**	**6.3%**

1. Starting Spring 2021, VR disability type caseload forecasts have been discontinued.

Oregon Health Authority

Total Oregon Health Authority Biennial Average Forecast Comparison

	2019-21 Biennium			*% Change Between Forecasts*	Spring 2021 Forecast			*% Change Between Biennia*
	Fall 20 Forecast	**Spring 21 Forecast**	**Change**		**2019-21**	**2021-23**	**Change**	
Health Systems - Medicaid								
OHP								
Children's Medicaid	310,609	311,688	1,079	0.3%	311,688	323,917	12,229	3.9%
Children's Health Insurance Program	91,474	93,674	2,200	2.4%	93,674	101,867	8,193	8.7%
Foster, Substitute and Adoption Care	19,642	19,499	-143	-0.7%	19,499	18,377	-1,122	-5.8%
Aid to the Blind and Disabled	84,700	86,823	2,124	2.5%	86,823	96,046	9,223	10.6%
Old Age Assistance	48,762	49,818	1,056	2.2%	49,818	57,786	7,968	16.0%
Pregnant Women	8,764	8,723	-41	-0.5%	8,723	9,071	348	4.0%
Parent, Caretaker Relative	89,610	90,003	394	0.4%	90,003	103,383	13,379	14.9%
ACA Adults	412,711	418,929	6,218	1.5%	418,929	512,537	93,609	22.3%
Total OHP	**1,066,271**	**1,079,157**	**12,886**	**1.2%**	**1,079,157**	**1,222,984**	**143,827**	**13.3%**
Other Medical Assistance Total	70,171	70,341	171	0.2%	70,341	77,860	7,518	10.7%
Cover All Kids	6,497	6,418	-79	-1.2%	6,418	6,889	470	7.3%
Total Medical Assistance	**1,142,939**	**1,155,916**	**12,977**	**1.1%**	**1,155,916**	**1,307,732**	**151,816**	**13.1%**
Mental Health [1]								
Under Commitment								
Total Forensic Care	937	932	-5	-0.5%	932	947	15	1.6%
Civilly Committed	955	997	42	4.4%	997	928	-69	-6.9%
Previously Committed	2,949	3,035	86	2.9%	3,035	3,026	-9	-0.3%
Never Committed	51,425	54,645	3,220	6.3%	54,645	58,935	4,290	7.9%
Total Served	56,266	59,609	3,343	5.9%	59,609	63,836	4,227	7.1%

1. Numbers reported represent adults only.

Health Systems Medicaid (HSM)

The current Public Health Emergency has obviously caused many changes to the Medicaid caseload and disrupted the normal pattern of entries, exits and transfers. We will first provide a brief history of the Medicaid caseload before directly addressing the impact of the COVID-19 pandemic.

General Summary of Health Systems Medicaid

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 Federal Marketplace open enrollment period. 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.

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.

Automated Renewals has reduced the number of exits that have occurred historically in the 12th and 24th month of a case history, particularly in the Parent, Caretaker, Other Relative (PCR) caseload. We also saw decreases in the exits for the ACA Adult caseload and smaller impacts to CAWEM – Adult and Children's Medicaid.

Lastly, Cover All Kids is a program that started in January 2018 that extended eligibility for OHP level benefits to children who were otherwise eligible for Children's Medicaid or CHIP except for reason of citizenship.

The COVID-19 Public Health Emergency

The Public Health Emergency is discussed in general in the Introduction and other portions of this document, but for Medicaid in particular it has had some very specific impacts.

As a result of the Families First Coronavirus Response Act (FFCRA, H.R. 6021), during the Public Health Emergency (PHE) as defined by the U.S. Department of Health and Human Services, 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 have left the state. In addition, their level of benefits cannot be reduced under the same rules. This part in particular changes transfer patterns between certain non-OHP programs that have lesser benefits, such as Qualified Medicare Beneficiary (QMB) and also CAWEM. This will continue until the last day of the month in which the state of emergency is lifted. This policy has led to a large reduction in the number of cases exiting the program, resulting in a large caseload increase.

New intakes will still be processed as normal, and denials will occur if clients fail to provide appropriate information or if they are over the income limit; however, self-attestation will be accepted for some elements of eligibility including verification of income.

In a memorandum of understanding from the Secretary of Health and Human Services, dated January 22, 2021, a commitment was made to all the States' Governors to continue the Public Health Emergency through 2021. The specific assumptions built into the current forecast due to the FFCRA will be discussed below.

In addition to the FFRCA, many other changes have taken place that will impact the Medicaid caseload. The shutdown of a large number of business and the resulting recession associated with the pandemic has either caused many Oregonians to lose employer-related health insurance immediately, or will cause them to lose insurance in 2021, after furloughed employees miss their insurer's open enrollment period. Layoffs and furloughs have also reduced the household incomes of hundreds of thousands of Oregonians. Most people lost their jobs or had their hours reduced in March and April. Since then many have regained work, possibly at reduced hours. Schools have switched to distance learning, making it more difficult for parents to return to work, even if called back from furlough. Perhaps counterintuitively, the pandemic has resulted in fewer emergency room and doctor's visits as people appear to be avoiding or putting off medical services if possible. Overall, the pandemic has appeared to reduce all social and economic activity, possibly reducing opportunities to connect potential Medicaid clients with OHA, reducing new enrollments.

Assumptions In This Medicaid Forecast

A large and complex model like that used for estimating the Medicaid caseload is always dependent on assumptions. However, the current situation is unprecedented and an unusually large number of assumptions about factors outside of Medicaid had to be made. The following sections layout those assumptions in some detail. All of the following assumptions were derived in consultation with the Integrated Eligibility/ONE system business leads.

Timing

The current emergency declaration on COVID-19 was effective on January 27, 2020 and renewed a number times. We assume it will end in January 2022. Under the Families First Coronavirus Response Act (FFRCA), CMS provided blanket waivers to current policy, changing many rules regarding Medicaid eligibility during the emergency. When the emergency ends many of those changes to Medicaid eligibility will have to be reverted. CMS has provided only limited guidance to the Oregon Health Authority on how those changes should be carried out. Currently, OHA expects that reverting the changes to the eligibility system may take up to 4 months. In addition, after the changes are made to the eligibility system, OHA expects that it will be a further 2 months to address those clients who have had an adverse action recorded, but not acted on due to the Emergency Continuing Eligibility rules, and 3 months to review cases for those determined eligible based on self-attestation. That leads to the following timeline.

	Emergency Declaration Scheduled to End	Eligibility System Changes Assumed to be Completed	First New Exits Assumed to Occur
Medicaid Eligibility Timing	January, 2022	May, 2022	July 31, 2022

The important date for modeling purposes is when the new exits start to be processed. If the new exits occur later than assumed, then the peak in the Medicaid caseload will occur later and be higher. The opposite would occur if they are sooner.

We assume that cases whose eligibility was determined under the emergency rules will be reviewed over a period of 4 months, with 20% in the first month, 30% in months 2 and 3 and the final 20% in month 4. In practice, the length of time required to review these cases will be dependent on CMS directives, as well as the number of eligibility workers available to do the reviews and any technical limitations related to the eligibility system.

Exits During Review Period

The assumed 4-month review period will lead to a large number of exits, both due to the resumption of closures and the quantity of renewals. We specifically assume 45 percent of the backlogged cases will exit during the 4-month review period. This is broadly consistent with the behavior observed during other periods in the history of Oregon Medicaid when the normal renewal process did not take place, but was then followed up with a systematic review of deferred cases or a clean-up. After the 4-month review period, we expect a resumption of exit rates in line with the pre-COVID patterns.

Economic Assumptions

We know many Oregonians lost their jobs either to furlough or to traditional layoffs due to restrictions put in place in March and April 2020 at the start of the Public Health Emergency. This resulted in a noticeable increase in the number of New Enters into the Medicaid caseload, particularly in April and May. After that however, New Enters fell off sharply. They remained lower until November and December 2020, when New Enters again climbed up to very high levels during the open enrollment period on the federal marketplace. There has been a seasonal increase in New Enters associated with the end of the year and open enrollment since the ACA started, but 2020 showed a spike in New Enters that was noticeably larger than the previous year.

The previous Fall 2020 forecast made use of some models to estimate how many newly unemployed Oregonian may sign up for Medicaid. Now that we have a year of data, we can use those patterns to estimate future impacts. For this forecast, we assume there will be a relatively small number of additional New Enters, above the normal levels, signing up each month going forward. We would expect this to continue until Oregon unemployment rates return to pre-COVID levels. We also assume there will also be some additional New Enters during the newly extended Open Enrollment period, initially out to May 15, and now extended out to at least August 15, 2021. New Enters are also forecast to increase during the usual year-end open enrollment period in late 2021. Overall, this stream of New Enters is expected to taper off over time as the economy recovers.

Constructing New Enters Estimates

The starting point for this estimation is the New Enters estimates prepared for the Spring 2020 forecast. Those estimates were on track until the COVID-19 emergency. Using those estimates as a baseline, we add the extra new enters based on the scenario outlined above. That boosts the levels of ACA Adults, PCR, Children's Medicaid, CAWEM-Adult, and CHIP overall.

Next, we make some adjustments for the reduction in churn on and off the caseload. Specifically, a pattern we observe under normal conditions in the Medicaid caseload is that a significant number of clients who exit each month come back onto the caseload over the next few months. If there is a large reduction in exits, then those clients will not need to come back as new enters. We estimate this impact by multiplying the reduction in exits by the fraction that normally come back each of the following months. The impact of this adds to the caseload so long as the policy reducing exits continues.

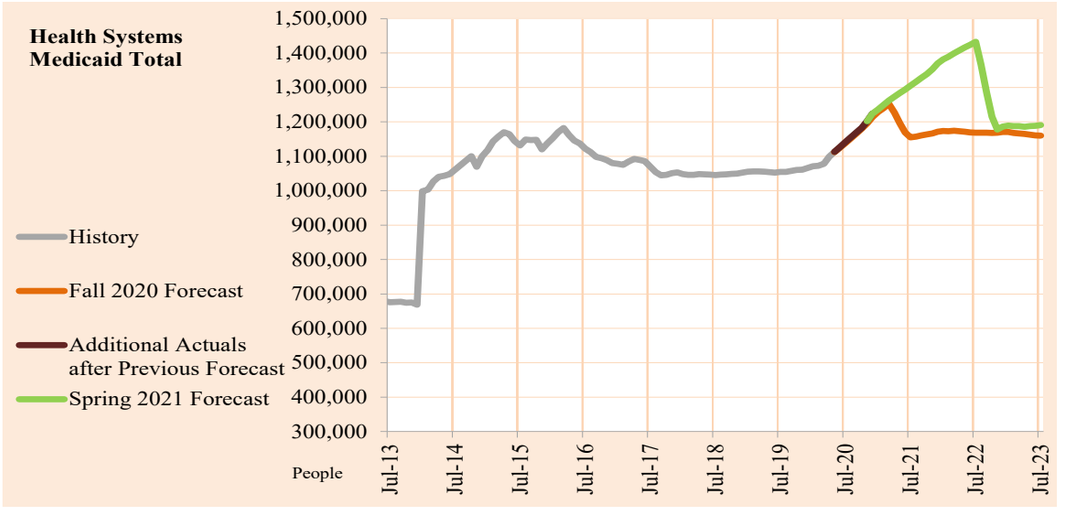
Once the emergency period ends, we expect to see a large number of exits. This will lead to a re-establishment of the churn phenomenon, with large numbers of clients who had their cases closed during the cleanup returning, adding to the count of new enters. We estimate the impact by multiplying the increase in exits by the fraction of exits that normally come back each of the following months.

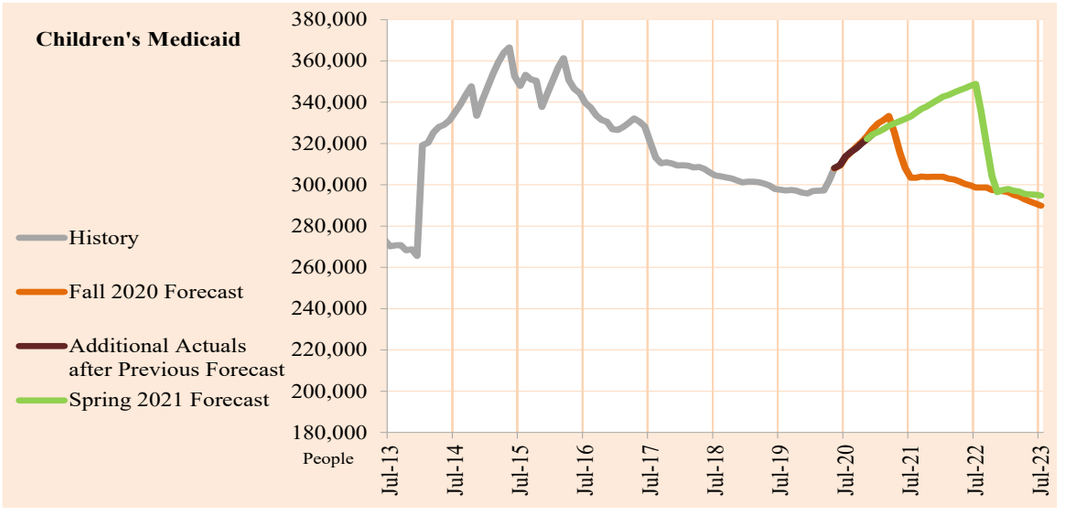
Caseload Actuals and Trends

As of October 2020, the Medicaid caseload was 1,183,120 and the preliminary estimate for January 2021 is 1,235,949. In this forecast, caseloads are expected to grow quickly until the end of the Public Health Emergency and the resumption of the previous eligibility process, after which it can be expected to fall sharply for a few months before leveling out a new higher level.

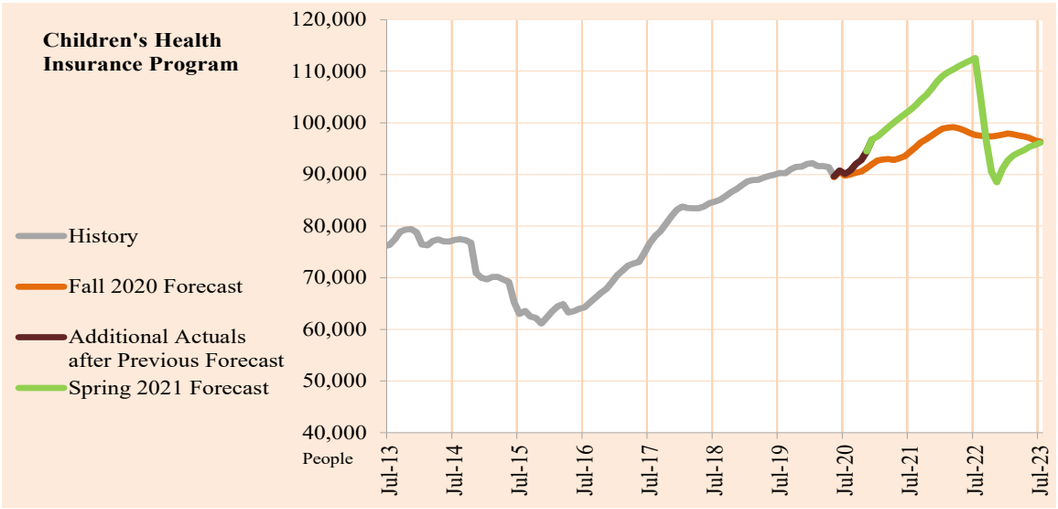
Health Systems Medicaid (HSM) - The 2019-21 biennial average forecast for Total Medicaid (which does not include the non-Medicaid Cover All Kids group) is 1,149,498 clients, which is 1.1% higher than the Fall 2020 Forecast. The 2021-23 biennial average forecast is 1,300,844 clients.

Children's Medicaid – This caseload had shown a slow decline over the two years prior to the Public Health Emergency. The most recent preliminary estimate for January 2021 shows 325,545 clients on this caseload. By the end of 2019-2021 biennium (in June 2021) there will be a projected 331,940 clients on this caseload, and it will account for about 25.7 percent of the total Medicaid caseload. The average monthly caseload forecast for the 2021-23 biennium is expected to be 3.9 percent higher than 2019-21.

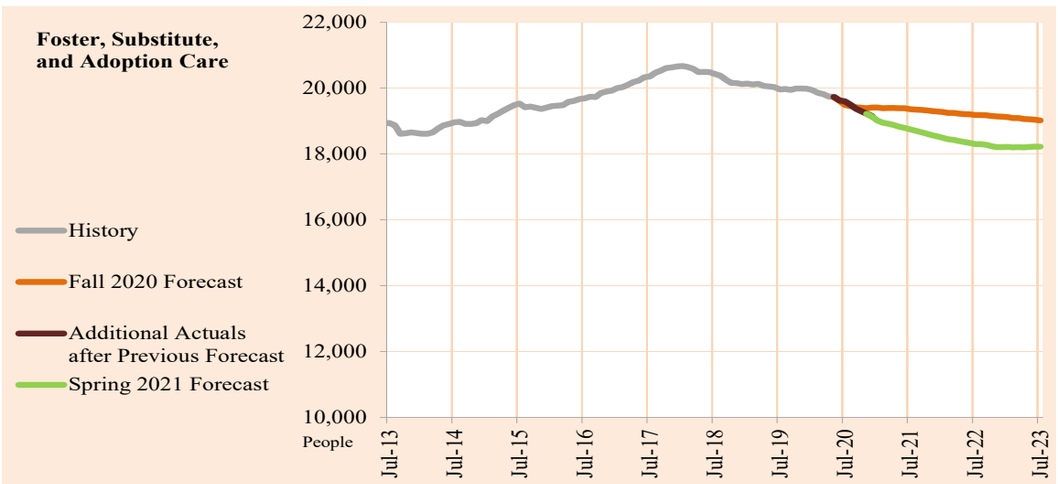




Children's Health Insurance Program (CHIP) – The most recent preliminary estimate for January 2021 shows 97,375 children on this caseload. The largest part of growth in this program continues to come from transfers from Children's Medicaid, which shows a lot of recent variance, increasing the risk to forecast accuracy. The caseload is expected to continue to grow going forward, with 101,655 clients on this caseload by the end of the 2019-2021 biennium in June 2021.. The average monthly caseload forecast for the 2021-23 biennium is expected to be 8.7 percent higher than 2019-21.

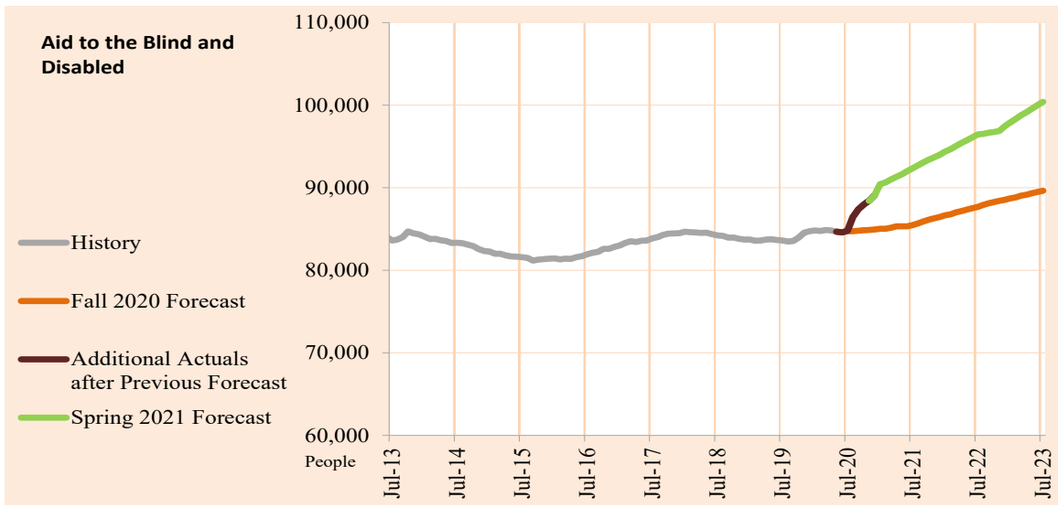


Foster, Substitute and Adoption Care – The most recent preliminary estimate for January 2021 shows 19,013 children on this caseload. This caseload has been declining for the last two years. This decline is linked to the number of children placed in foster care and will be driven by current and future policy changes in that area. There also appears to be a short-term decrease, most likely related to the lack of in-person schooling and other activities that bring abused and neglected children to the attention of mandatory reporters. By the end of 2019-2021 biennium there is projected to be 18,789 clients on this caseload. This caseload is expected to very slowly decline through the 2021-23 biennium.

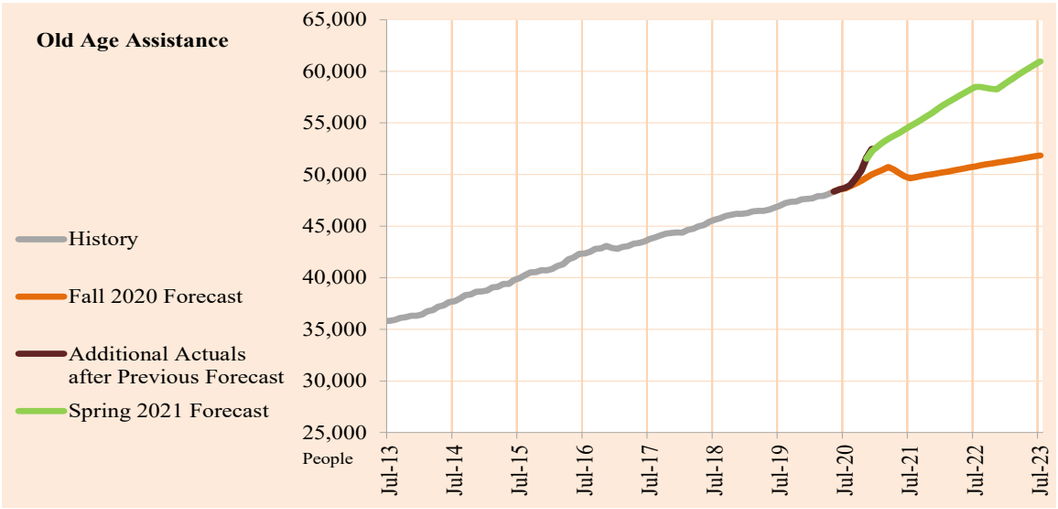


Aid to the Blind and Disabled (ABAD) – The most recent preliminary estimate for January 2021 shows 90,425 clients on this caseload. Historically, this caseload grew steadily; however, the ACA reform caused a temporary lull by making health insurance available to low-income adults without having to prove disability (via the ACA Adults caseload) . New enters started increasing again after the ACA expansion in 2014, but from a new, lower baseline.

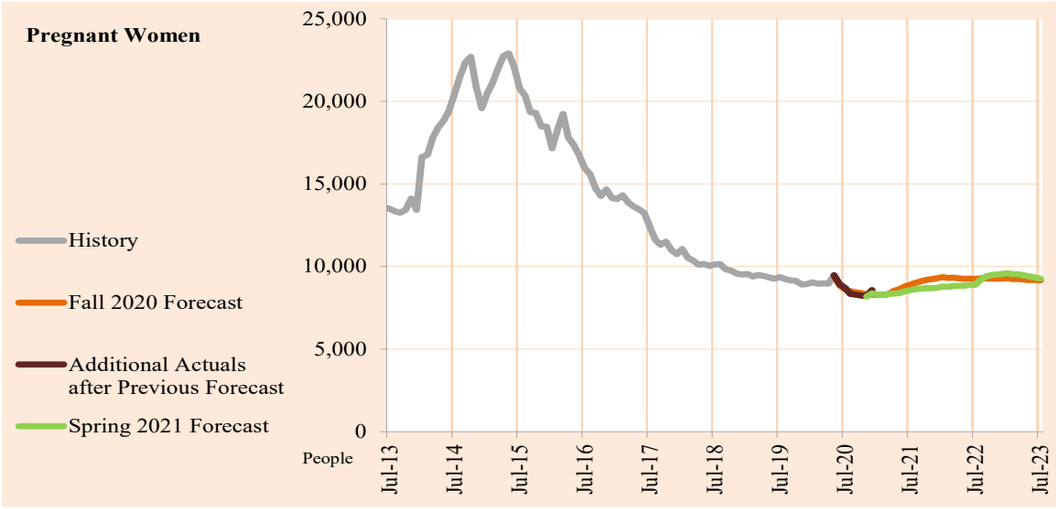
This shift in new enters caused the caseload to dip at first and then in 2016 it started growing again. However, the slow, steady growth in new enters appears to have leveled off and started to decline around January 2018. This is most likely linked to a tightening of Social Security disability determinations by federal administrative law judges, coupled with changes to eligibility rules for In-Home disability care. It reached a minimum in mid-2019, then started to grow again. More recently it has shown increased growth as well as some level shifts up related to the switch to the Integrated Eligibility system. This caseload is expected to increase through the remainder of the 2019-2021 biennium to 92,010 cases at the end of the biennium, in June 2021. The caseload will continue to increase through the 2021-2023 biennium.



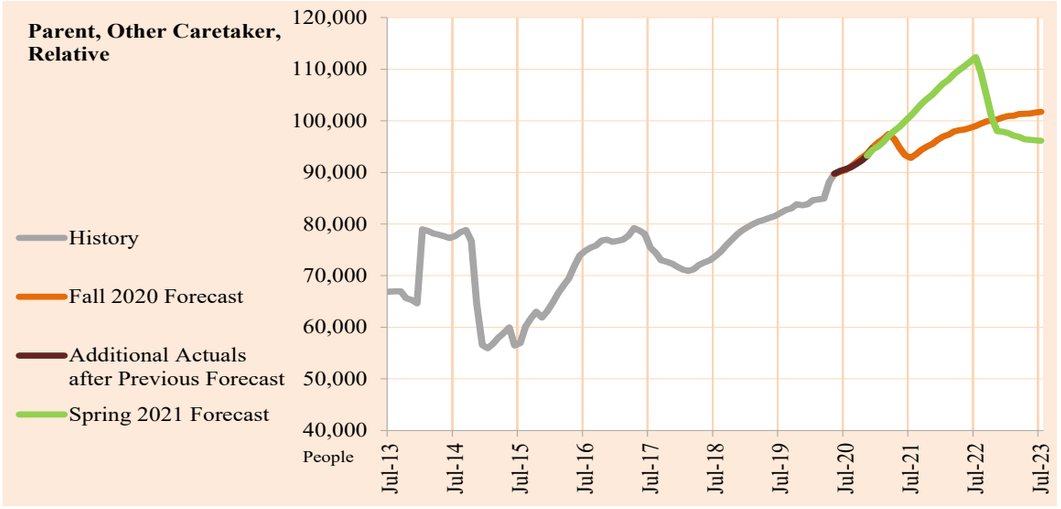
Old Age Assistance (OAA) – The most recent preliminary estimate for January 2021 shows 52,710 clients on this caseload. This caseload has shown increased growth and some upward shifts related to the switch to the Integrated Eligibility system. As cases were rolled into the new system, client eligibility was reexamined, improving the accuracy of the determination. The caseload is expected to be 54,349 by the end of the 2019-2021 biennium in June 2021. This caseload is expected to continue to increase through the 2021-2023 biennium to reach 60,650 cases by June 2023.



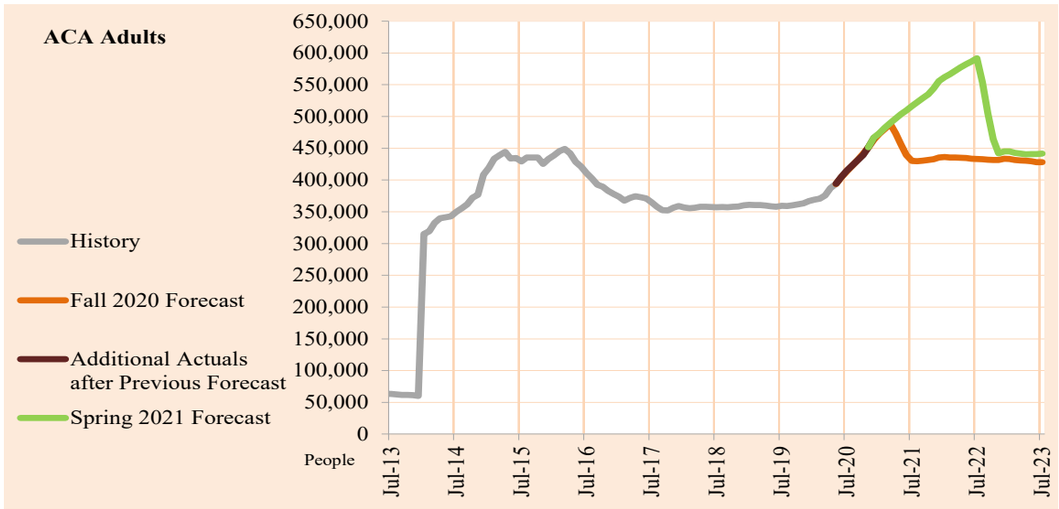
Pregnant Women – The most recent preliminary estimate for January 2021 shows 8,308 women on this caseload. The decline in the number of live births in the state of Oregon over the past two years has put downward pressure on this caseload, and it is possible that the COVID-19 pandemic has decreased births further. The caseload is expected to be 8,496 at the end of the 2019-2021 biennium in June 2021.



Parent, Other Caretaker, Relative (PCR) – This caseload showed the largest impact from the change to automated renewals back in January 2018. In the absence of automated renewals, the caseload would have been expected to decline, but instead it has shown 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. However, in the year before the Public Health Emergency the total volume of people enrolled in the PCR group (that is, all people enrolled for at least one month in the PCR caseload over the course of a year) actually went down, even as the average monthly caseload went up. This is due to people staying on the caseload longer and not as many clients exiting only to come back later. The initial shutdown of businesses in March and April 2020 related to the COVID-19 pandemic caused a large spike in new enters and transfers to the PCR caseload. Since then patterns have been more stable. The most recent preliminary estimate for January 2021 shows 95,033 clients on this caseload. The caseload is expected to grow to 99,926 by the end of the 2019-2021 biennium in June 2021. By June of 2023 the caseload is expected to fall back to 96,251 clients.



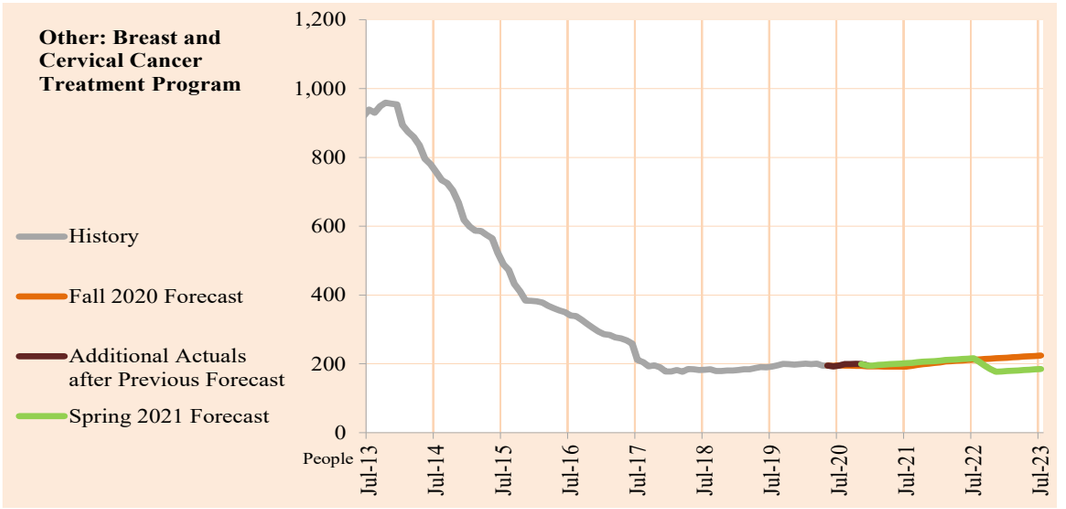
ACA Adults – This caseload also showed a large spike in new enters in March and April 2020 related to the start of the Public Health Emergency and again in December related to the open enrollment period. The most recent preliminary estimate for January 2021 shows 473,662 clients on this caseload. The caseload is expected to rise slightly to 509,464 by the end of the 2019-2021 biennium in June 2021, and will account for about 39.4 percent of the total Medicaid caseload. The average monthly caseload for ACA Adults is expected to increase by 22.3 percent from the 2019-2021 biennium to 2021-2023.

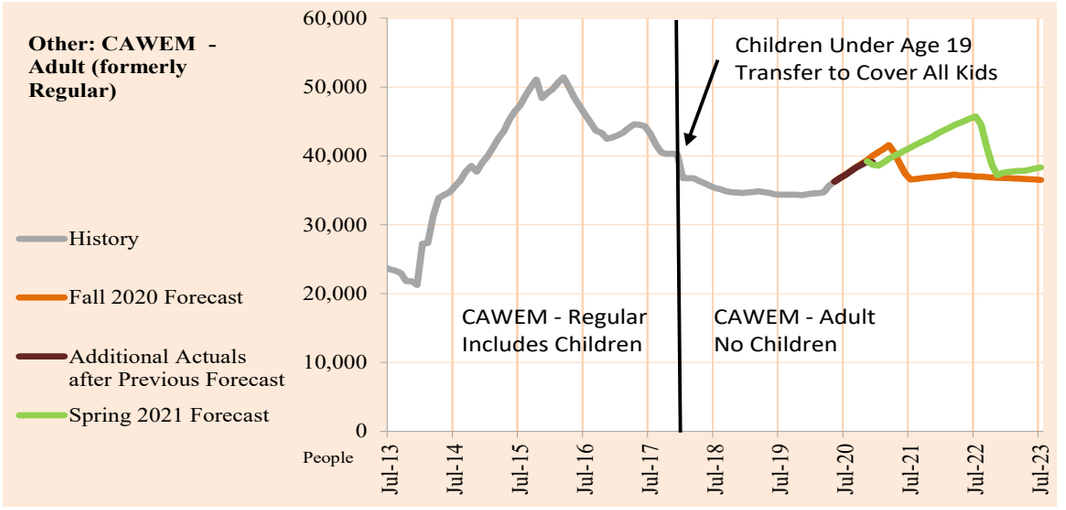


Breast and Cervical Cancer Treatment Program (BCCTP) – The most recent preliminary estimate for January 2021 shows 195 clients on this caseload. The caseload dropped during the redetermination and clean-up period in the ONE system in 2016 and 2017, but it appears to have leveled off at a new floor during 2018. This caseload is expected to be 201 by the end of the 2019-2021 biennium in June 2021, and drop very slightly through June 2023.

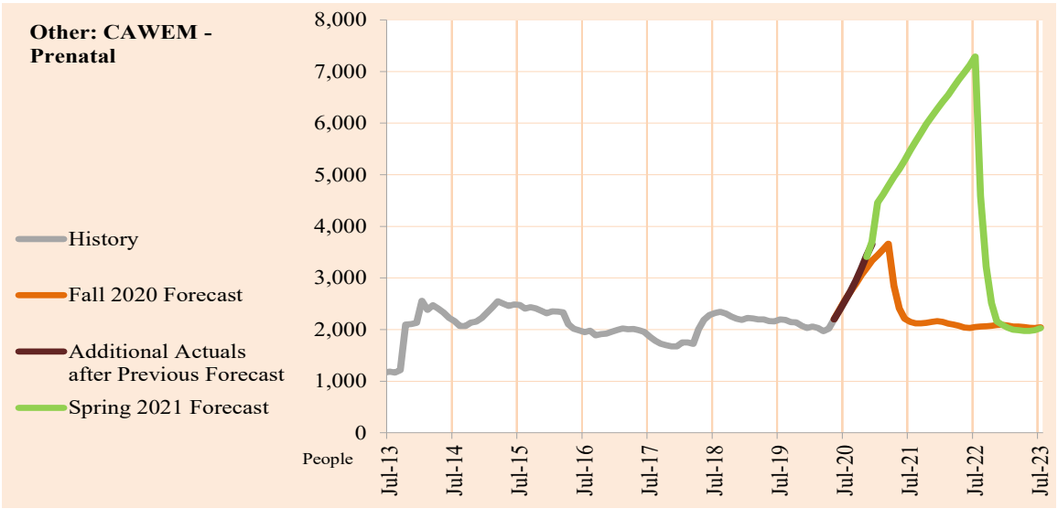
Other Medical Assistance Programs

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 January 2021 shows 38,587 clients on this caseload. The caseload is expected to reach 40,828 at the end of 2019-2021 biennium in June 2021. It will continue to grow during the Public Health Emergency before falling back to 38,200 by June 2023.





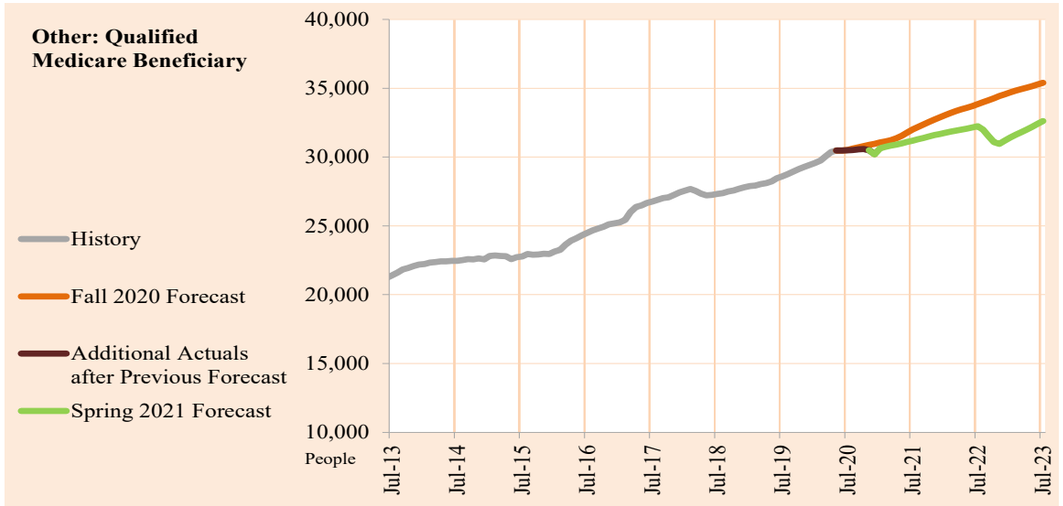
Citizen-Alien Waived Emergent Medical - Prenatal (CAWEMP) – This caseload experienced a level shift up with the inclusion of an additional 2 months of post-partum care starting in April 2018. The number of clients being served did not change significantly, but the additional length of care caused a 35% growth in the caseload. Since the start of the Public Health Emergency, this caseload has grown dramatically, showing the largest relative growth of all the caseloads. This is because the suspension of closures and reductions in benefits means almost everyone entering this caseload will stay on until the end of the emergency. The most recent preliminary estimate for January 2021 shows 4,460 clients on this caseload. The caseload is expected to be 5,278 by the end of the 2019-2021 biennium In June 2021. It is expected to hit a peak of over 7,000 before falling back down to Pre-COVID levels by June 2023.

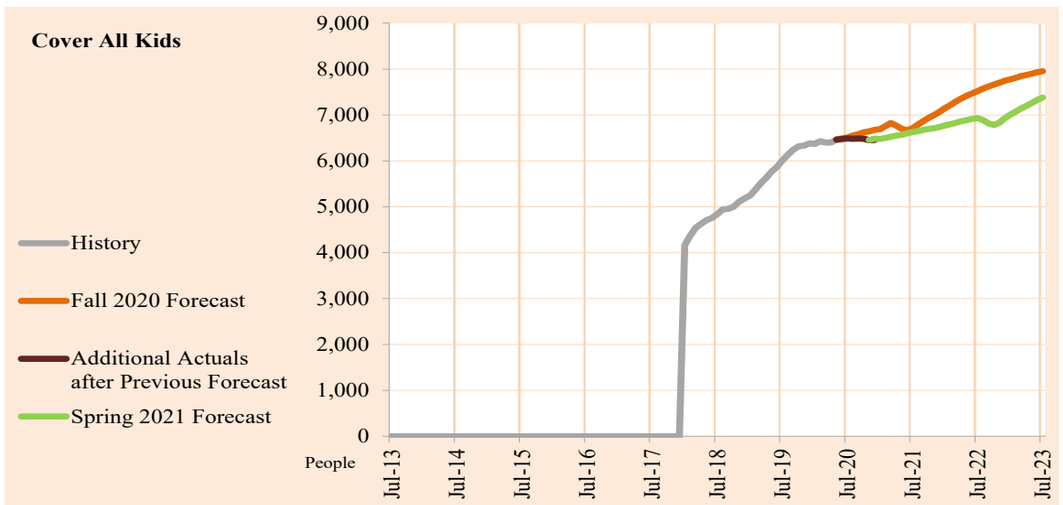


Qualified Medicare Beneficiary (QMB) – The most recent preliminary estimate for January 2021 shows 30,636 clients on this caseload. This caseload is expected to be 31,091 by the end of the 2019-2021 biennium in June 2021. This caseload has grown consistently since January of 2009 and is expected to grow slowly 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 January 2021 shows 6,478 clients on this caseload. This caseload is expected to grow to 6,599 by the end of 2019-2021 biennium in June 2021, and is expected to continue to grow through the 2021-23 biennium.

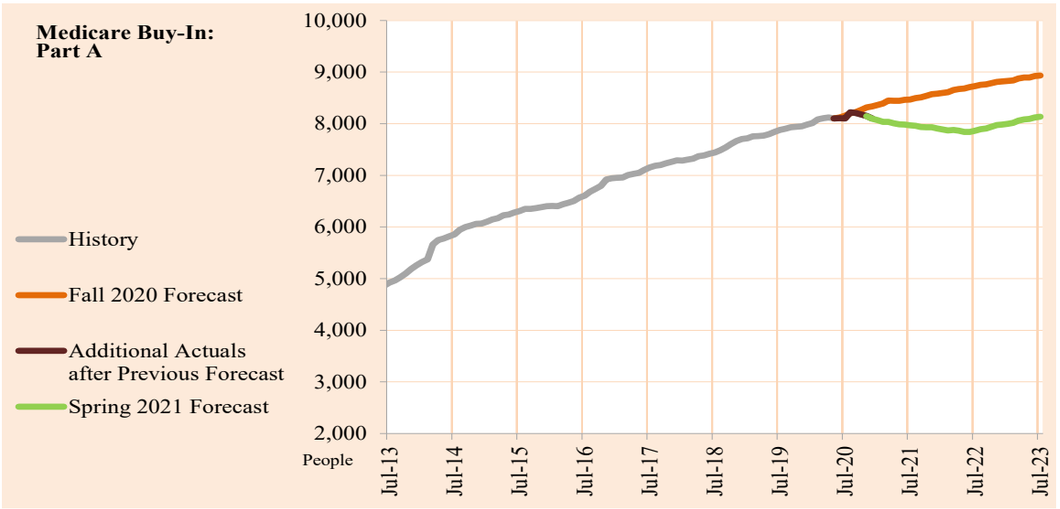


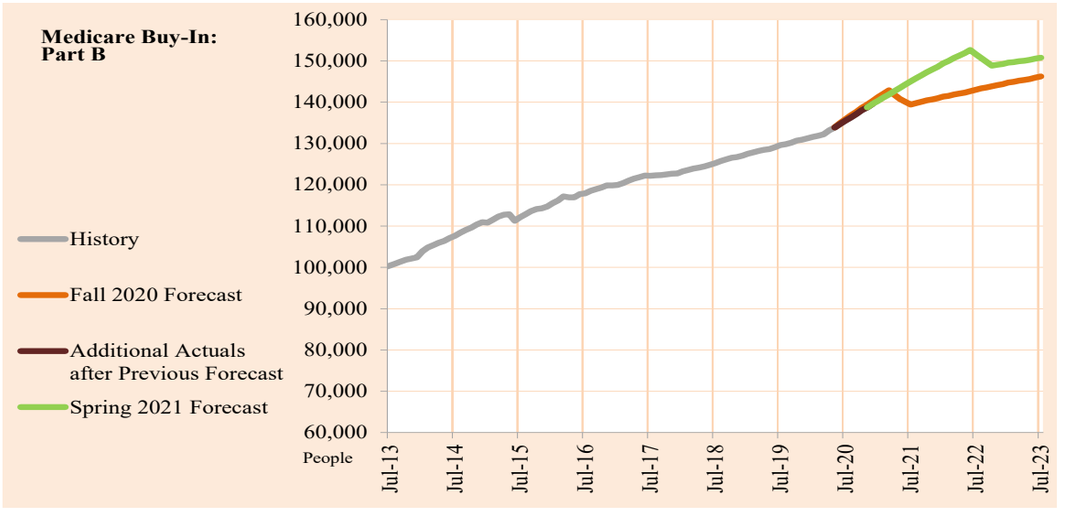


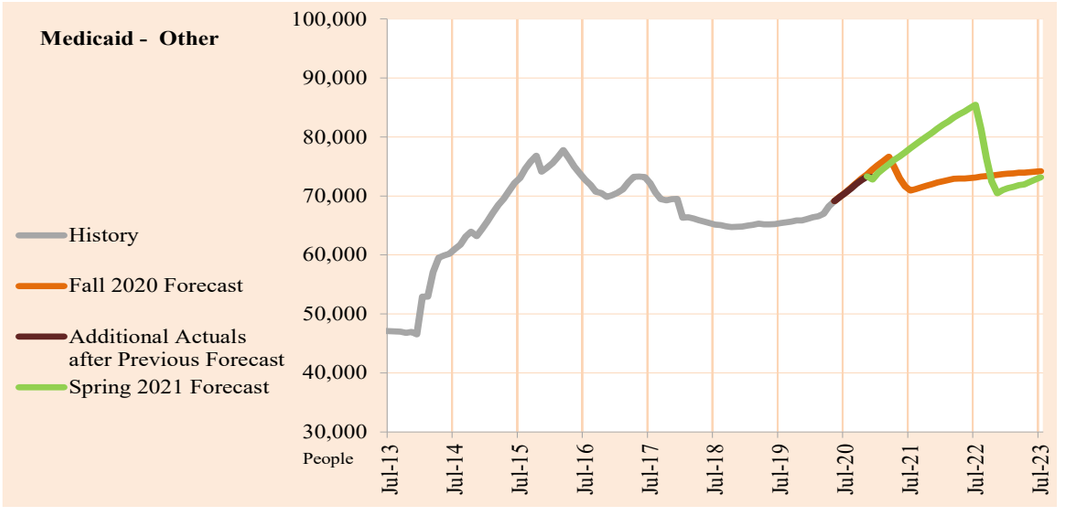
Medicare Part A/B Premium Assistance Programs

Medicare Part-A Premium Assistance – The most recent preliminary estimate for January 2021 shows 8,066 clients on this caseload. This caseload has ceased growing. It is expected to be 7,985 by the end of the 2019-2021 biennium in June 2021, and reach 8,135 clients by the end of the 2021-23 biennium in June 2023.

Medicare Part B Premium Assistance – The most recent preliminary estimate for January 2021 shows 140,346 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 144,255 by the end of the 2019-2021 biennium in June 2021 and grow to 150,539 by the end of the 2021-23 biennium. Twenty-nine percent of those receiving Medicare Part-B assistance are in the OAA caseload; 23% are in the ABAD caseload; and 22% are in QMB. Most of the remaining 26% are in the Partial Dual eligible caseloads.







Risks to the Forecast Related to COVID-19

There are unusually large risks associated with this forecast. Obviously, any of the assumptions described previously could prove to be incorrect. The final length of the official Public Health Emergency is an open question. We reasonably expect it will extend until at least January 2022, but it could be extended longer. The length of time (4 months) to revert changes to the Eligibility System at the end of the emergency could be longer or shorter. The length of time to complete review of all the cases renewed during the emergency (another 4 months) could be shorter or longer. The fraction of cases closed during the review process could be higher or lower, impacting the new level of the caseload after the Public Health Emergency. The length and rate of economic recovery could cause variation in the forecast. The rate at which newly eligible people sign up for Medicaid is a large risk. It may be impacted by the extension of the open enrollment period on the federal marketplace. They could enter Medicaid in larger or smaller numbers than anticipated, or the timing of their entry could be miscalculated.

Other Risks to the Forecast

The establishment of the Integrated Eligibility (I.E.) system is a general risk to almost all ODHS and OHA caseload forecasts, but it has some particular impacts on the Medicaid forecast. The movement of clients from the ONE system to Integrated Eligibility has caused some spikes in the transfers from other programs into ABAD. It also appears to have increased the regular monthly transfers into both ABAD and Old Age Assistance causing those caseloads to grow slightly faster. We have very little history of the transfer patterns under the Integrated Eligibility system and the data we do have was captured during the transition period (from November 2020 to February 2021). There is some risk that long term transfer patterns have changed or that the recent transfer patterns we have seen during the transition period are not typical. It would be surprising if there were no unexpected problems associated with switching to a new eligibility system. There is a risk that something unforeseen may be uncovered that materially impacts the caseload forecast. Currently, we are not aware of any outstanding issues that would significantly impact the forecast.

The Cover All Kids caseload was revised down slightly pre-COVID based on the decrease of new enters; post-COVID those numbers decreased further. We don't know if that decrease is temporary or permanent. We assume it is temporary, but if not, it is a risk to the forecast.

Health Systems Medicaid Biennial Average Forecast Comparison

	2019-21 Biennium			*% Change Between Forecasts*	Spring 2021 Forecast			*% Change Between Biennia*
	Fall 20 Forecast	**Spring 21 Forecast**	**Change**		**2019-21**	**2021-23**	**Change**	
HEALTH SYSTEMS - MEDICAID								
OHP								
Children's Medicaid	310,609	311,688	1,079	0.3%	311,688	323,917	12,229	3.9%
Children's Health Insurance Program	91,474	93,674	2,200	2.4%	93,674	101,867	8,193	8.7%
Foster, Substitute and Adoption Care	19,642	19,499	-143	-0.7%	19,499	18,377	-1,122	-5.8%
Aid to the Blind and Disabled	84,700	86,823	2,124	2.5%	86,823	96,046	9,223	10.6%
Old Age Assistance	48,762	49,818	1,056	2.2%	49,818	57,786	7,968	16.0%
Pregnant Women	8,764	8,723	-41	-0.5%	8,723	9,071	348	4.0%
Parent, Caretaker Relative	89,610	90,003	394	0.4%	90,003	103,383	13,379	14.9%
ACA Adults	412,711	418,929	6,218	1.5%	418,929	512,537	93,609	22.3%
Total OHP	**1,066,271**	**1,079,157**	**12,886**	**1.2%**	**1,079,157**	**1,222,984**	**143,827**	**13.3%**
Other Medical Assistance								
Breast and Cervical Cancer Treatment Program	195	198	2	1.2%	198	198	0	0.1%
Citizen-Alien Waived Emergent Medical - Adult	37,111	36,976	-135	-0.4%	36,976	41,394	4,418	11.9%
Citizen-Alien Waived Emergent Medical - Prenatal	2,556	3,049	493	19.3%	3,049	4,572	1,523	50.0%
Qualified Medicare Beneficiary	30,309	30,119	-190	-0.6%	30,119	31,695	1,576	5.2%
Other Subtotal	**70,171**	**70,341**	**171**	**0.2%**	**70,341**	**77,860**	**7,518**	**10.7%**
Total Medicaid	**1,136,442**	**1,149,498**	**13,056**	**1.1%**	**1,149,498**	**1,300,844**	**151,346**	**13.2%**
Cover All Kids	6,497	6,418	-79	-1.2%	6,418	6,889	470	7.3%
TOTAL MEDICAL ASSISTANCE	**1,142,939**	**1,155,916**	**12,977**	**1.1%**	**1,155,916**	**1,307,732**	**151,816**	**13.1%**
Medicare Part A	8,173	8,048	-125	-1.5%	8,048	7,947	-102	-1.3%
Medicare Part B	135,746	135,797	51	0.0%	135,797	149,441	13,644	10.0%

Mental Health (MH)

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) Psychiatric Security Review Board (PSRB); 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.

General Assumptions for the Mental Health Forecast

The COVID-19 emergency has led to disruptions in how ODHS and OHA services are being provided (see the Introduction for more information). The primary influence of COVID-19 on mental health services has been to increase the Aid and Assist capacity at the State Hospital and in the community. In addition, the State Hospital has had to set aside ward space to accommodate the possible quarantining of COVID-positive patients. These two modifications to service delivery have reduced capacity for Civil Commit cases.

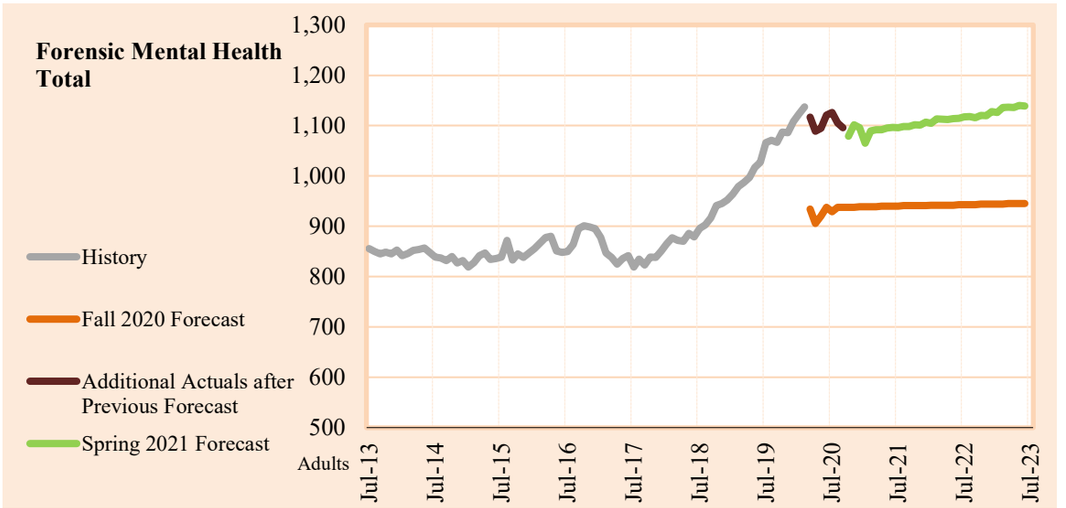
The effects of the COVID pandemic on the Mental Health caseload is considered primarily to be a unique risk to forecast accuracy.

Total Mandated Mental Health Services

The mandated caseload encompasses the committed caseload (Aid and Assist, PSRB, and Civilly Committed clients). The 2019-21 biennial average forecast is 1,929 clients per month. The 2021-23 biennial monthly average is expected to be 1,875 clients, 2.8 percent lower than the 2019-21 biennial average. As with all MH categories forecasted in this report, the Mandated population includes only adults.

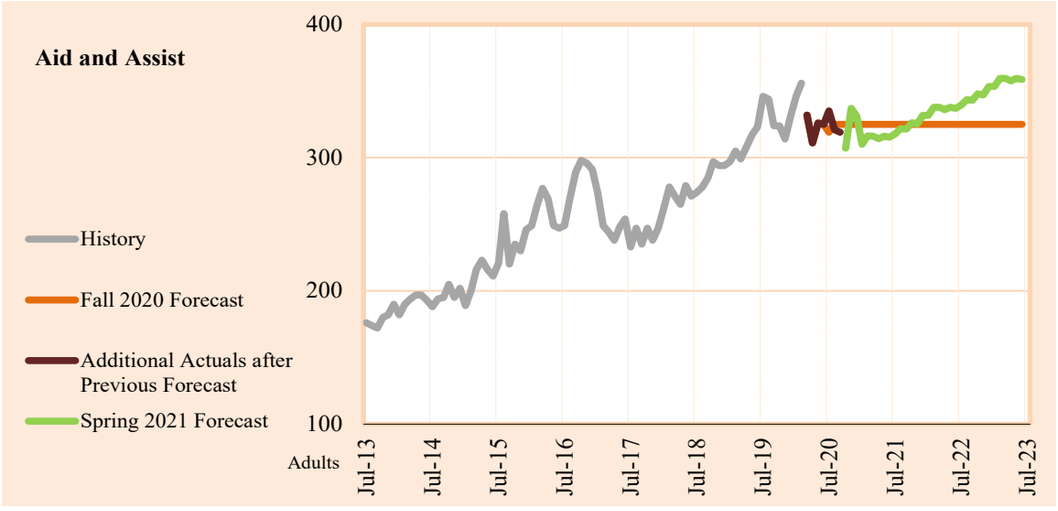
Total Forensic Mental Health Services

The forensic caseload encompasses the Aid and Assist and PSRB clients. The 2019-21 biennial average forecast is 932 clients per month. The 2021-23 biennial monthly average is expected to be 947 clients, 1.6 percent higher than the 2019-21 biennial average.

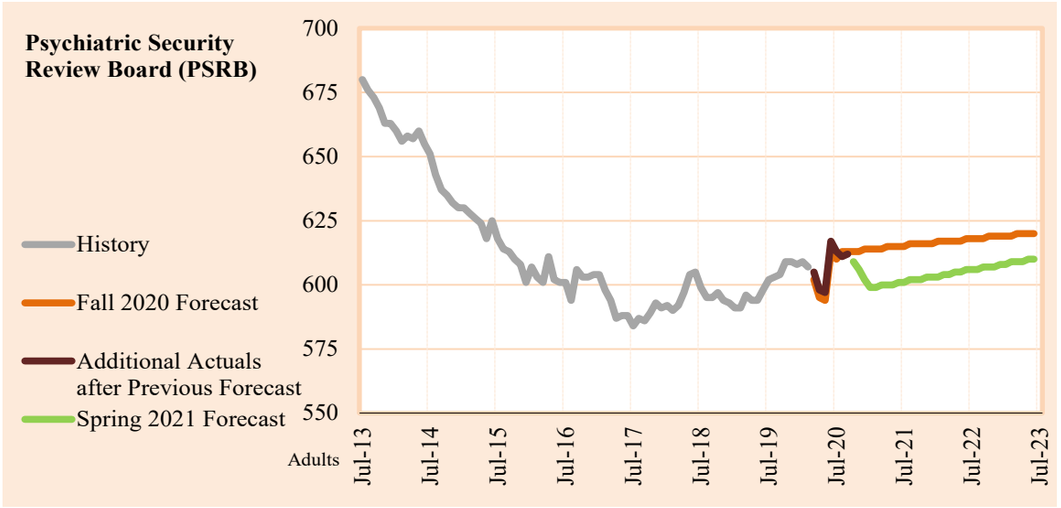


Aid and Assist – This caseload has been growing since 2013. In 2017, there was a 22 percent decrease in the caseload from a high of about 300 clients in October 2016, down to around 235 cases per month during the second half of 2017. Throughout 2019 and 2020, the caseload fluctuated between 300 and 350 clients per month. The 2019-21 biennial average forecast is 326 clients per month. The 2021-23 biennial average is 341 clients per month, 4.6 percent higher than the 2019-21 biennial average forecast. These numbers reflect clients served at the State Hospital.

Data on the community restoration Aid and Assist clients are now being collected, and there is a complete data set for 2019 from the counties. Due to the pandemic, there was a suspension of reporting requirements in 2020 that ended in December 2020, and the expectation is that data will continue to be improved upon throughout 2021. Because of the suspension of data reporting requirements in 2020, these data must be considered preliminary. The 2019-21 biennial average forecast is 181 clients per month. The 2021-23 biennial average is expected to be 170 clients per month, which is 6.1 percent lower than the 2019-21 biennial average.

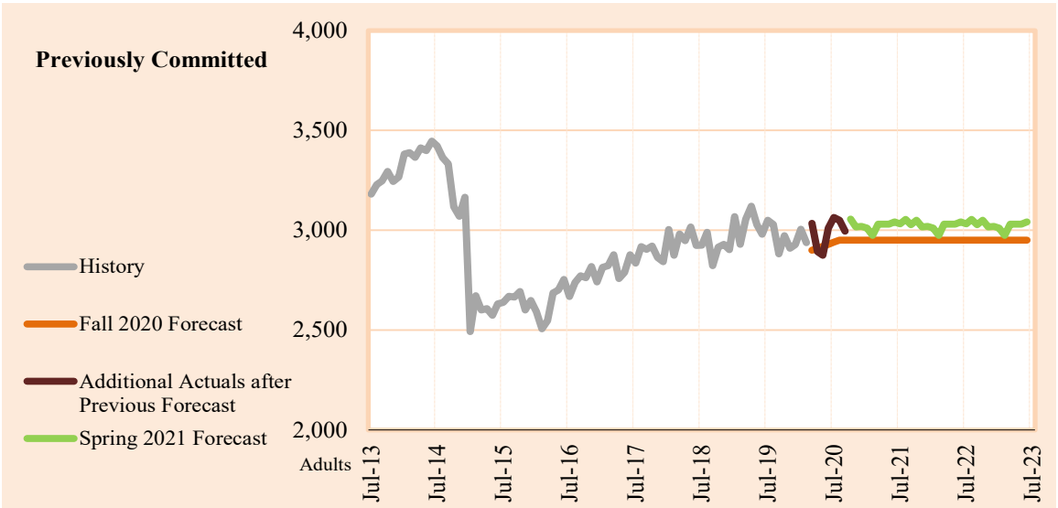


Psychiatric Security Review Panel (PSRB) – These clients are under the jurisdiction of the Psychiatric Security Review Board. This caseload began to drop about 10 years ago, and since 2016 the caseload has hovered around 600 clients per month. The 2019-21 biennial average forecast is 606 cases per month. The 2021-23 biennial average is the same as the 2019-21 biennial average forecast.

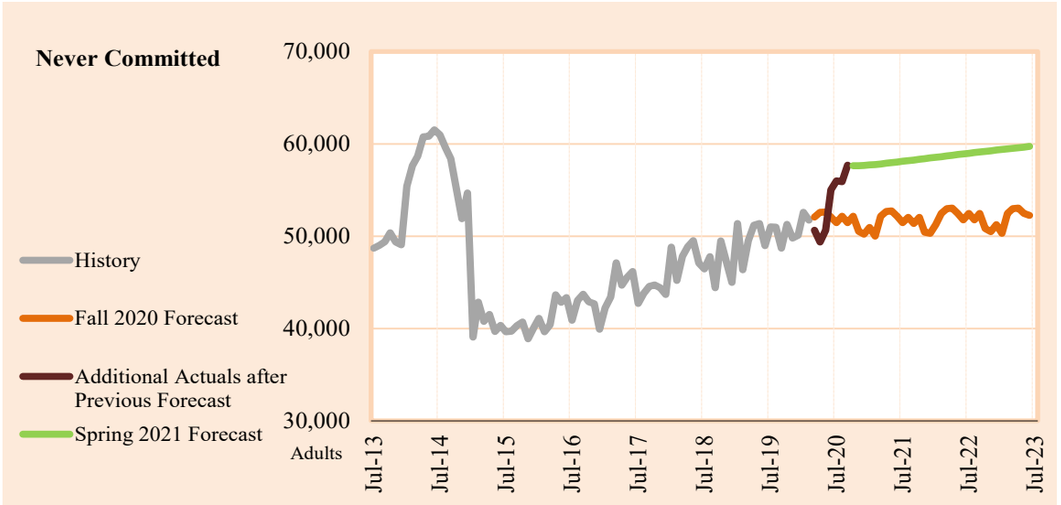


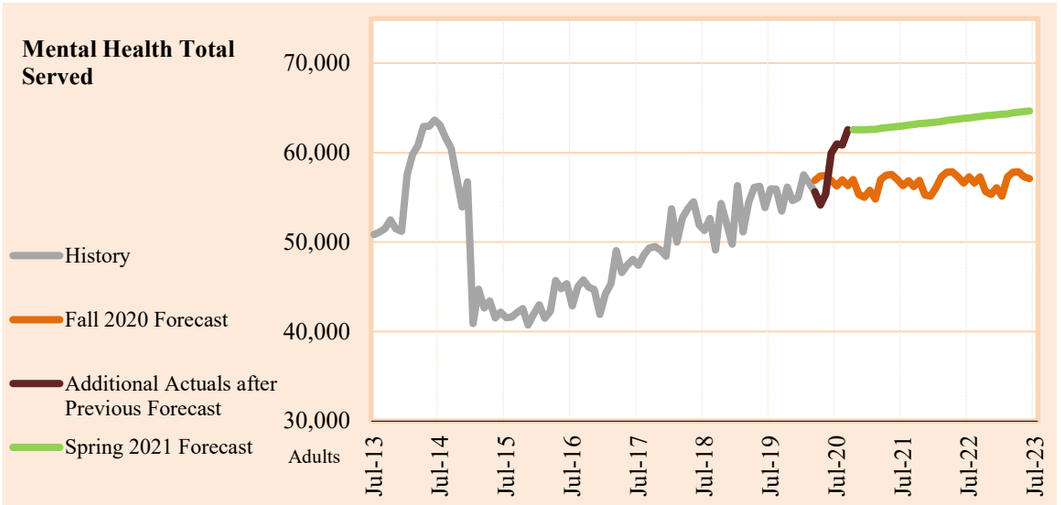
Civil Commitments – The data for this caseload are subject to the interaction of reporting practices, data system changes, and data warehouse activities. There has been ongoing work to improve data accuracy. Coincident with the expansion of Medicaid, such that more people were eligible for health insurance, 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 997 clients per month. The 2021-23 biennial monthly average is 928 clients, 6.9 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 3,035 clients. The 2021-23 biennial monthly average is 3,026 clients, 0.3 percent lower 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 54,645 clients. The 2021-23 biennial monthly average is 58,935 clients, 7.9 percent higher than the 2019-21 biennial average.





Forecast Environment and Risks

The community restoration Aid and Assist caseload 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 Psychiatric Security Review Board caseload is subject to review by the 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. This population, at the State Hospital, has been most affected by the pandemic. The State Hospital is legally required to prioritize Aid and Assist and PSRB clients; only 4 to 5 Civilly Committed patients were admitted between March 2020 and August 2020.

As stated in the introductory portion of this section, COVID-19 has required the State Hospital and community providers to increase the Aid and Assist capacity at the expense of Civil Commit cases. The timing of the end of the state of emergency, and the pivot back to normal operations is unknown, although it is assumed to occur some time in 2021. This represents a unique risk to forecast accuracy for both the Civil Commit and Aid and Assist caseloads.

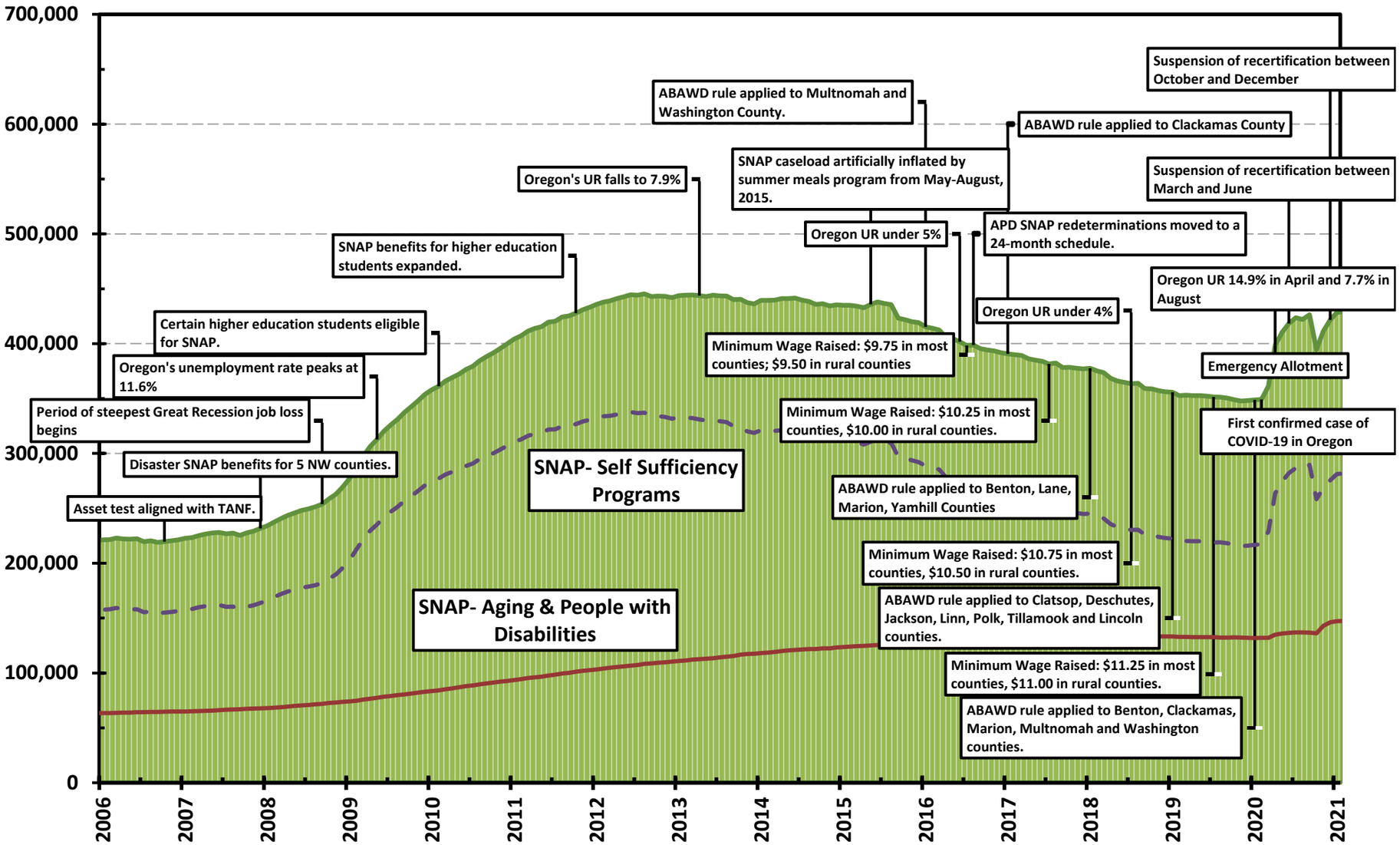
Mental Health Biennial Average Forecast Comparison

	2019-21 Biennium			*% Change Between Forecasts*	Spring 2021 Forecast			*% Change Between Biennia*
	Fall 20 Forecast	**Spring 21 Forecast**	**Change**		**2019-21**	**2021-23**	**Change**	
MENTAL HEALTH [1]								
Under Commitment								
Aid and Assist[2]	328	326	-2	-0.6%	326	341	15	4.6%
Psychiatric Security Review Board	609	606	-3	-0.5%	606	606	0	0.0%
Total Forensic Care	**937**	**932**	**-5**	**-0.5%**	**932**	**947**	**15**	**1.6%**
Civilly Committed	955	997	42	4.4%	997	928	-69	-6.9%
Total Mandated Mental Health Services	**1,892**	**1,929**	**37**	2.0%	**1,929**	**1,875**	**-54**	**-2.8%**
Previously Committed	2,949	3,035	86	2.9%	3,035	3,026	-9	-0.3%
Never Committed	51,425	54,645	3,220	6.3%	54,645	58,935	4,290	7.9%
Total Served	**56,266**	**59,609**	**3,343**	**5.9%**	**59,609**	**63,836**	**4,227**	**7.1%**
Community Restoration Aid and Assist[3]	N/A	181	N/A	N/A	181	170	-11	-6.1%
Total Aid and Assist (State Hospital and Community Restoration)	N/A	491	N/A	N/A	491	511	20	4.1%

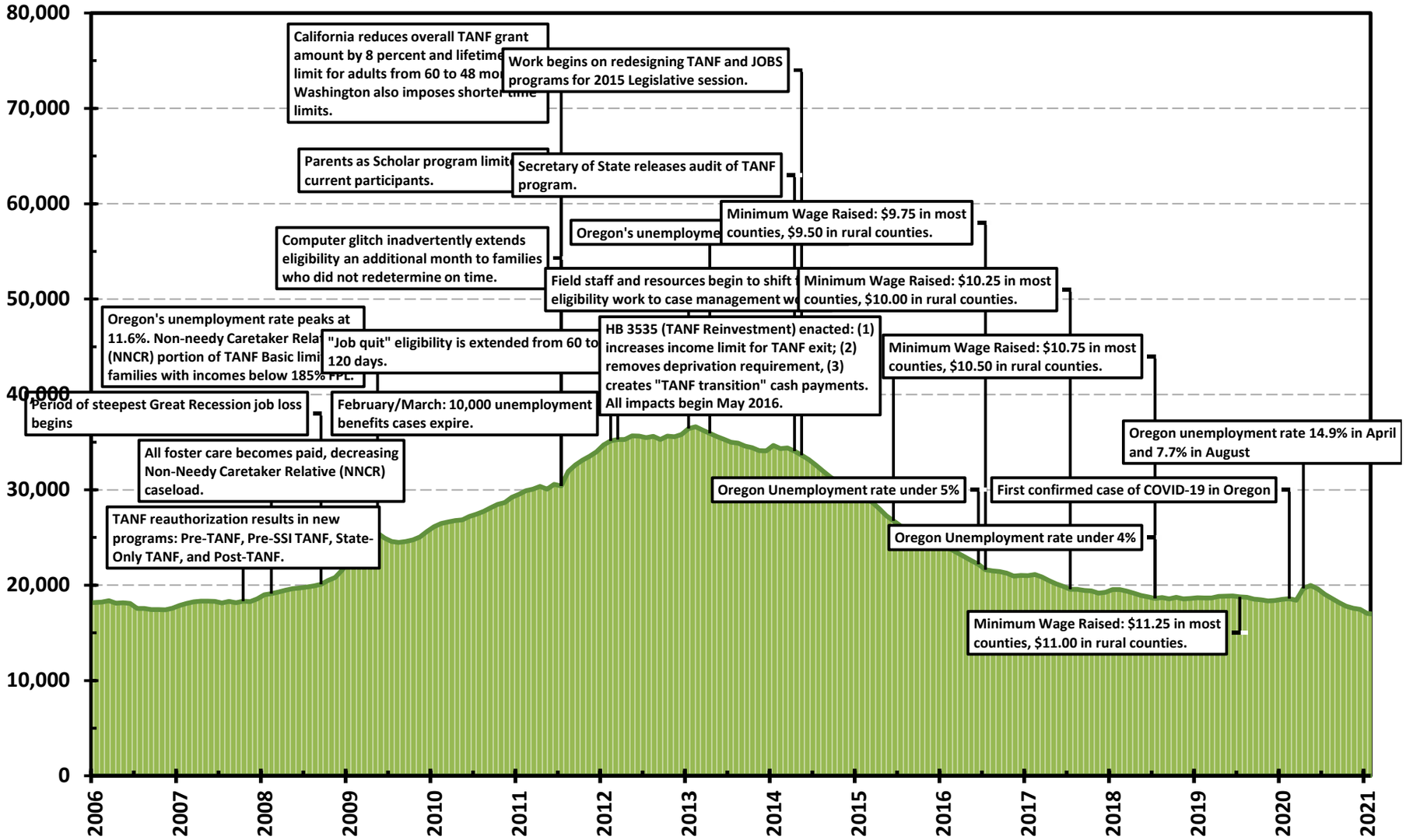
1. Numbers reported represent adults only.
2. State Hospital only.
3. This is the first time Community Restoration data is forecast. These data are preliminary, and subject to change as county reporting requirements are modified.

Appendix I
ODHS Caseload History & Definitions

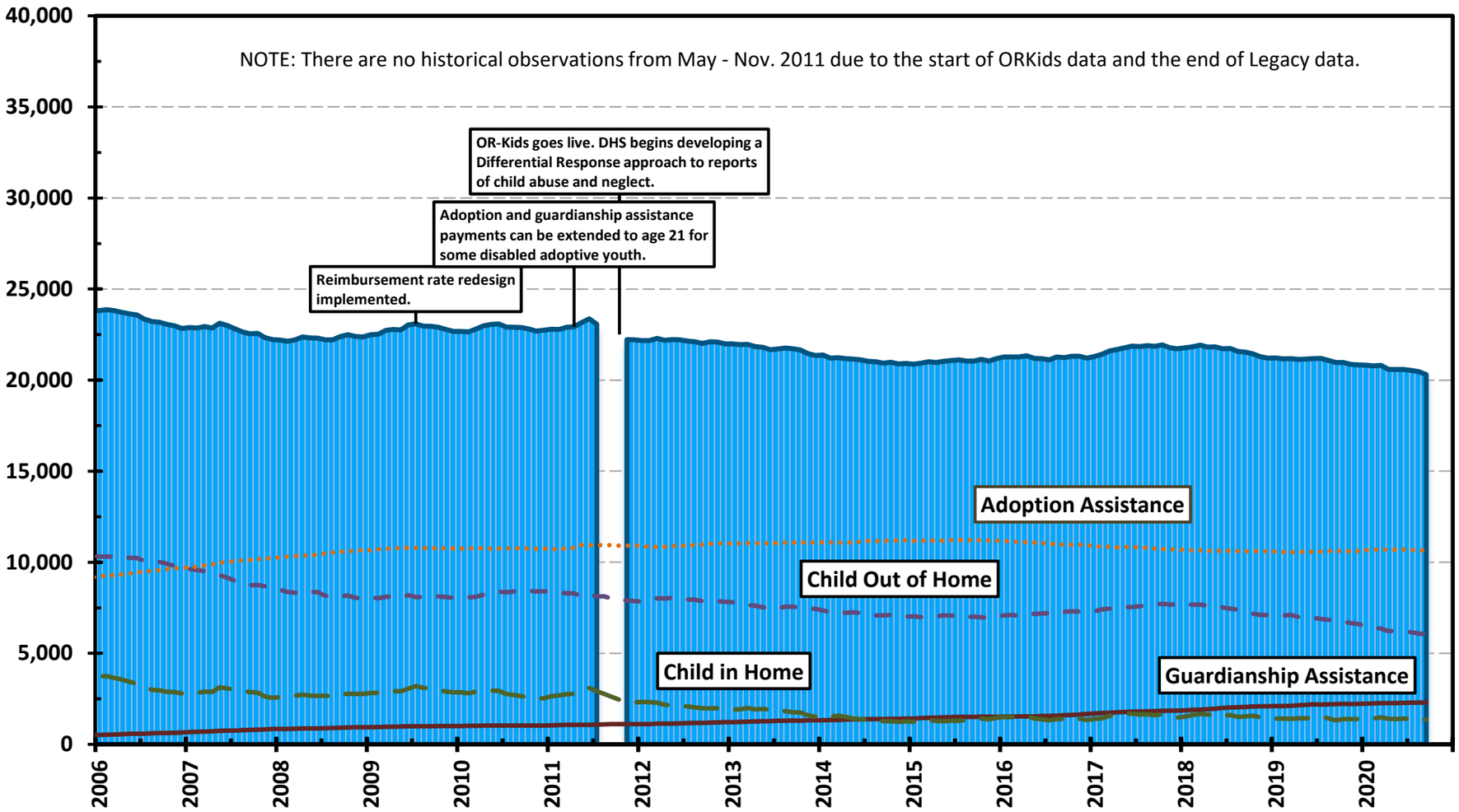
Self Sufficiency Programs (SSP):
Supplemental Nutrition Assistance Program (SNAP) Caseload



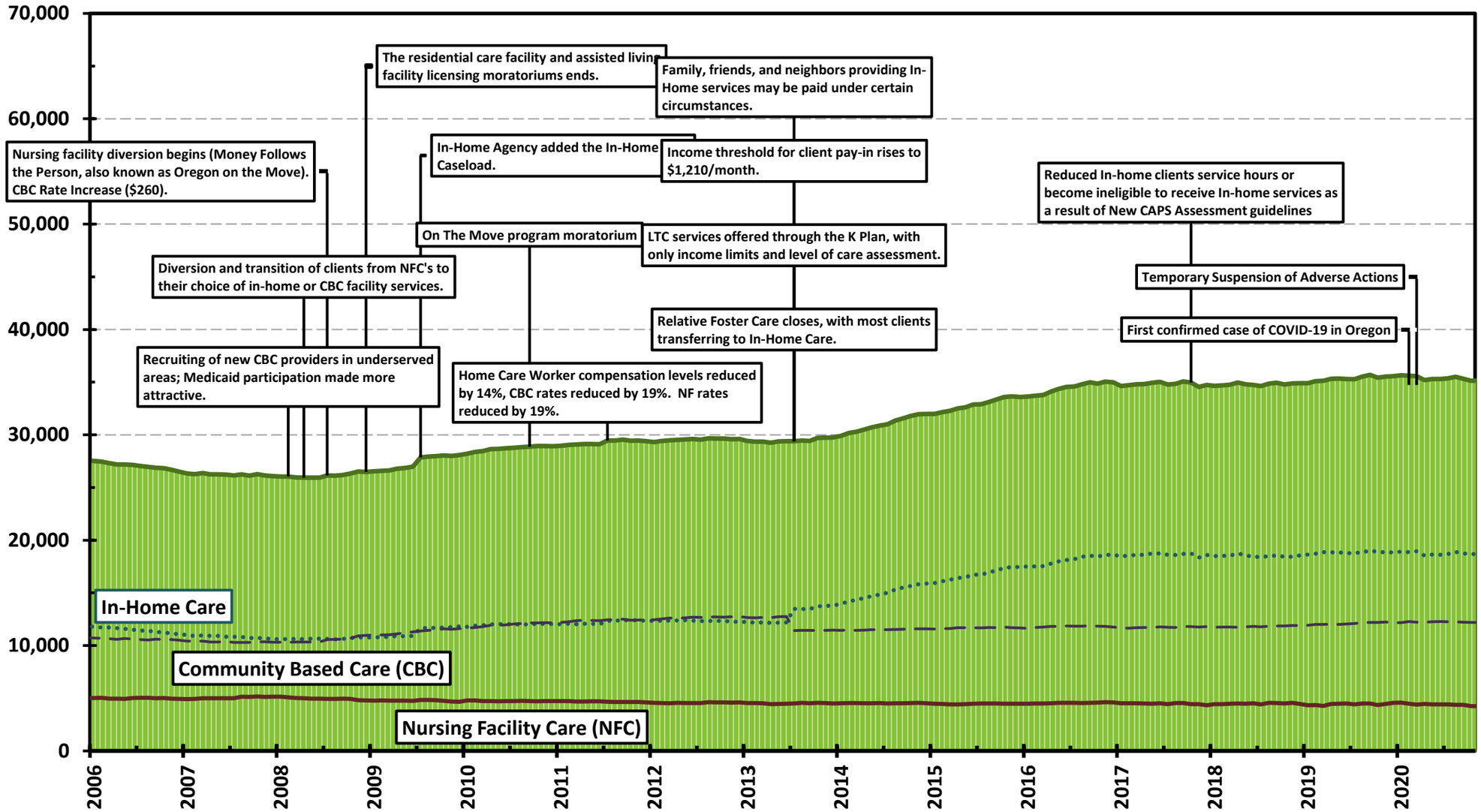
Self Sufficiency Programs:
Temporary Assistance for Needy Families (TANF) Caseload



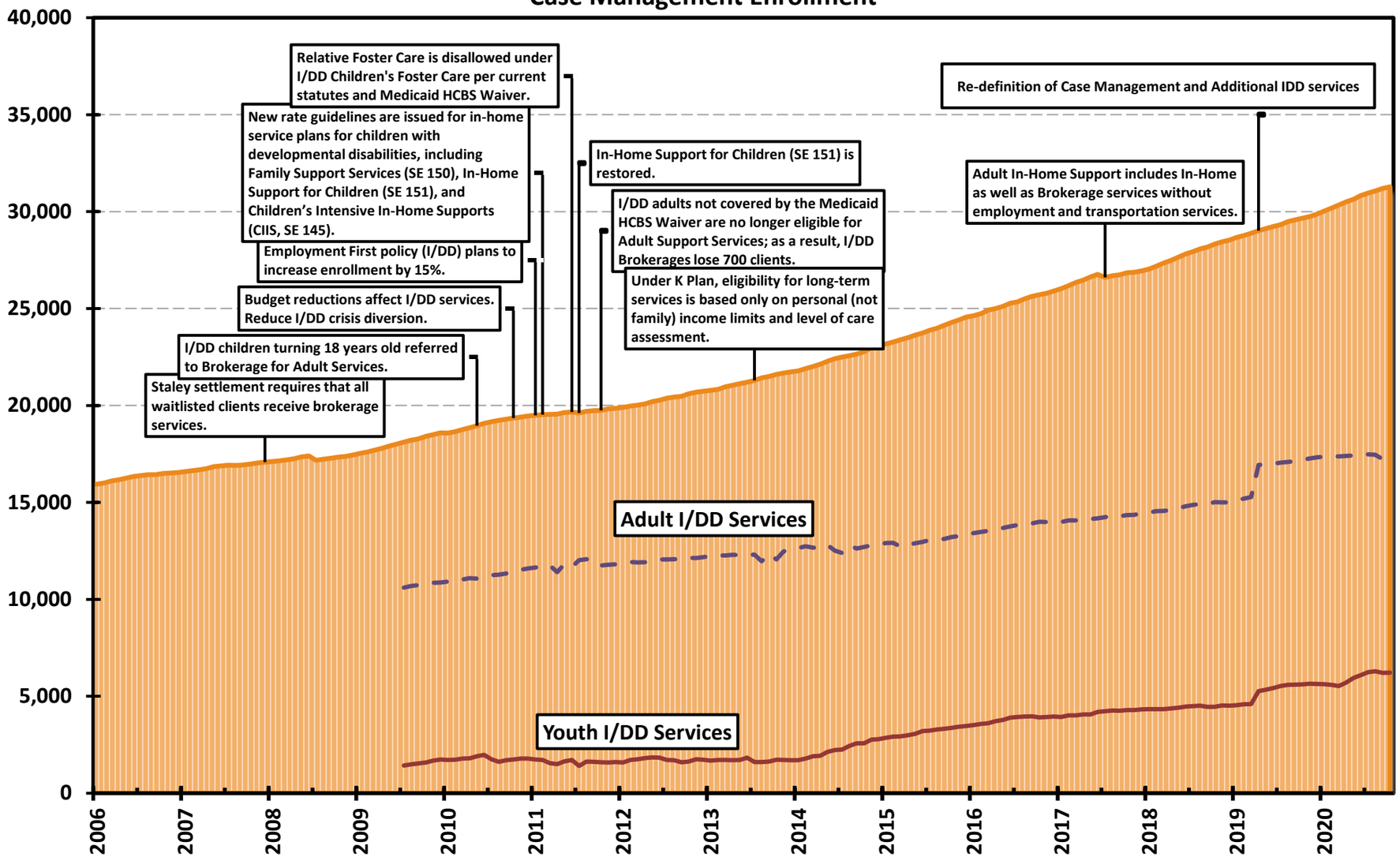
Child Welfare (CW) Caseload



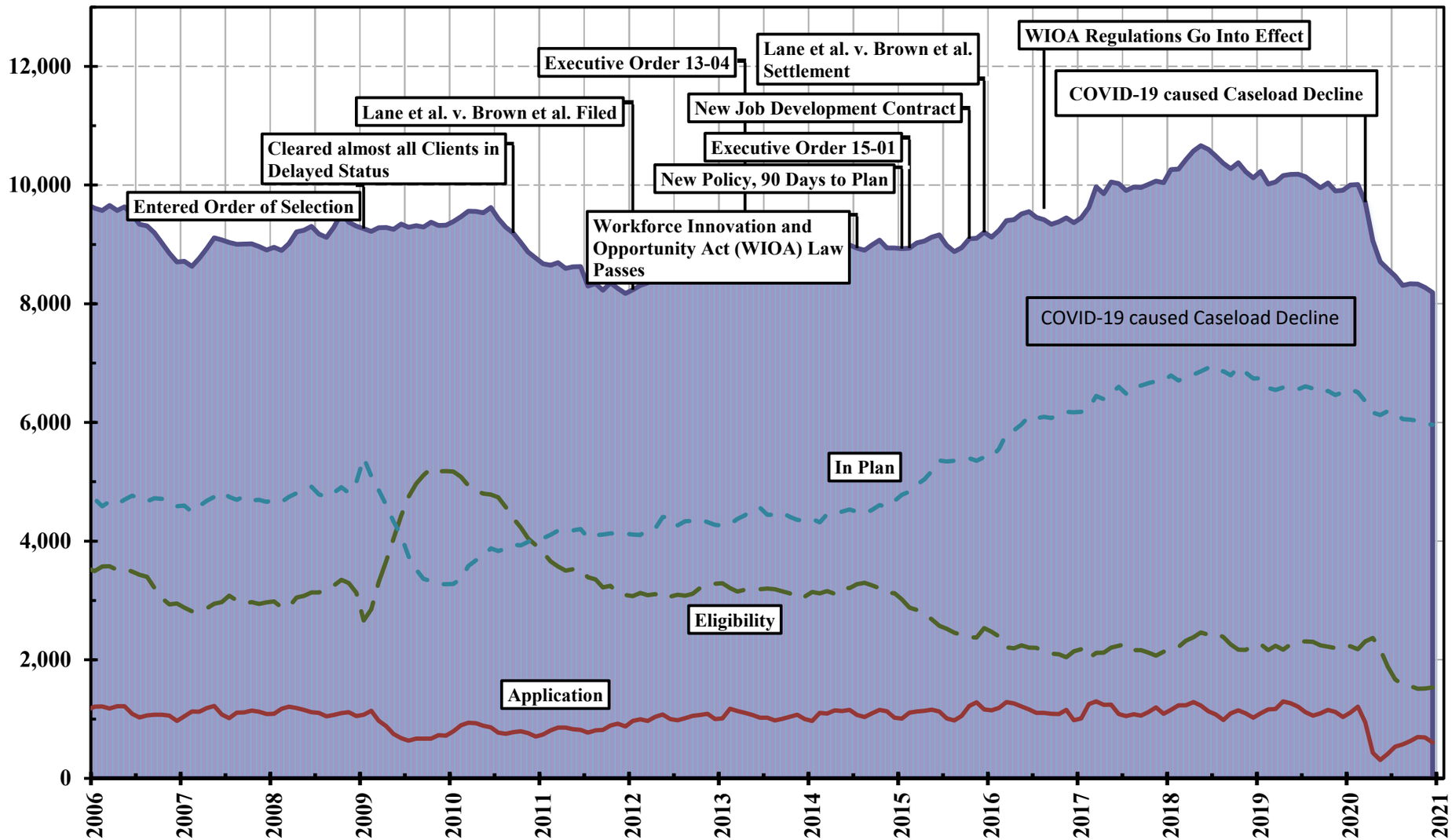
Aging and People with Disabilities (APD) Caseload



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



Vocational Rehabilitation



ODHS 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[3]."

Persons in Household	2021 Poverty Guidelines (Annual Income)						
	100%	133%	138%	150%	200%	300%	400%
1	$12,880	$17,130	$17,774	$19,320	$25,760	$38,640	$51,520
2	$17,420	$23,169	$24,040	$26,130	$34,840	$52,260	$69,680
3	$21,960	$29,207	$30,305	$32,940	$43,920	$65,880	$87,840
4	$26,500	$35,245	$36,570	$39,750	$5,300	$79,500	$106,000
5	$31,040	$41,283	$42,835	$46,560	$62,080	$93,120	$124,160
6	$35,580	$47,321	$49,100	$53,370	$71,160	$106,740	$142,320
7	$40,120	$53,360	$55,366	$60,180	$80,240	$120,360	$160,480
8	$44,660	$59,398	$61,631	$66,990	$89,320	$133,980	$178,640
Add $4,540 for each person over 8							

3. Source: https://www.medicaidplanningassistance.org/federal-poverty-guidelines/

Self-Sufficiency Programs (SSP)

Self-Sufficiency Programs (SSP) aids with low-income families to help them become healthy, safe, and economically independent. Except for SNAP, SSP 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 gross income limit is 130 percent of Federal Poverty (FPL). The Broad-Based Categorical Eligibility (BBCE) enables states to raise income and asset limits to quality certain low-income households such as households/families receiving TANF, SSI, or other general assistance. Also, BBCE permits states to adopt less restrictive asset tests for households including elderly (60+) or disabled persons. By applying the policy, households less below 185 percent of FPL qualify for SNAP.

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) 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) is no longer a requirement of TANF enrollment.

TANF One-Parent used to be called TANF Basic, when it 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.

TANF Two-Parent was previously called TANF UN, when it included only two-parent families that did not have at least one parent who was disabled and unable to care for children. 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) 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).

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.

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 ODHS 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 (NFC)

Nursing Facilities provide institutional services for seniors and people with disabilities in facilities licensed and regulated by ODHS. 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.

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 forecasts for 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 89 percent and 11 percent respectively).

Stabilization and Crisis Unit (previously called State Operated Community Programs) offers safety net services and support to the most vulnerable I/DD clients, facing intensive, medical or behavioral challenges, when no other community-based option is available to them. The program serves both adults and children (approximately 84 percent and 16 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 (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).

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

This caseload counts 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.

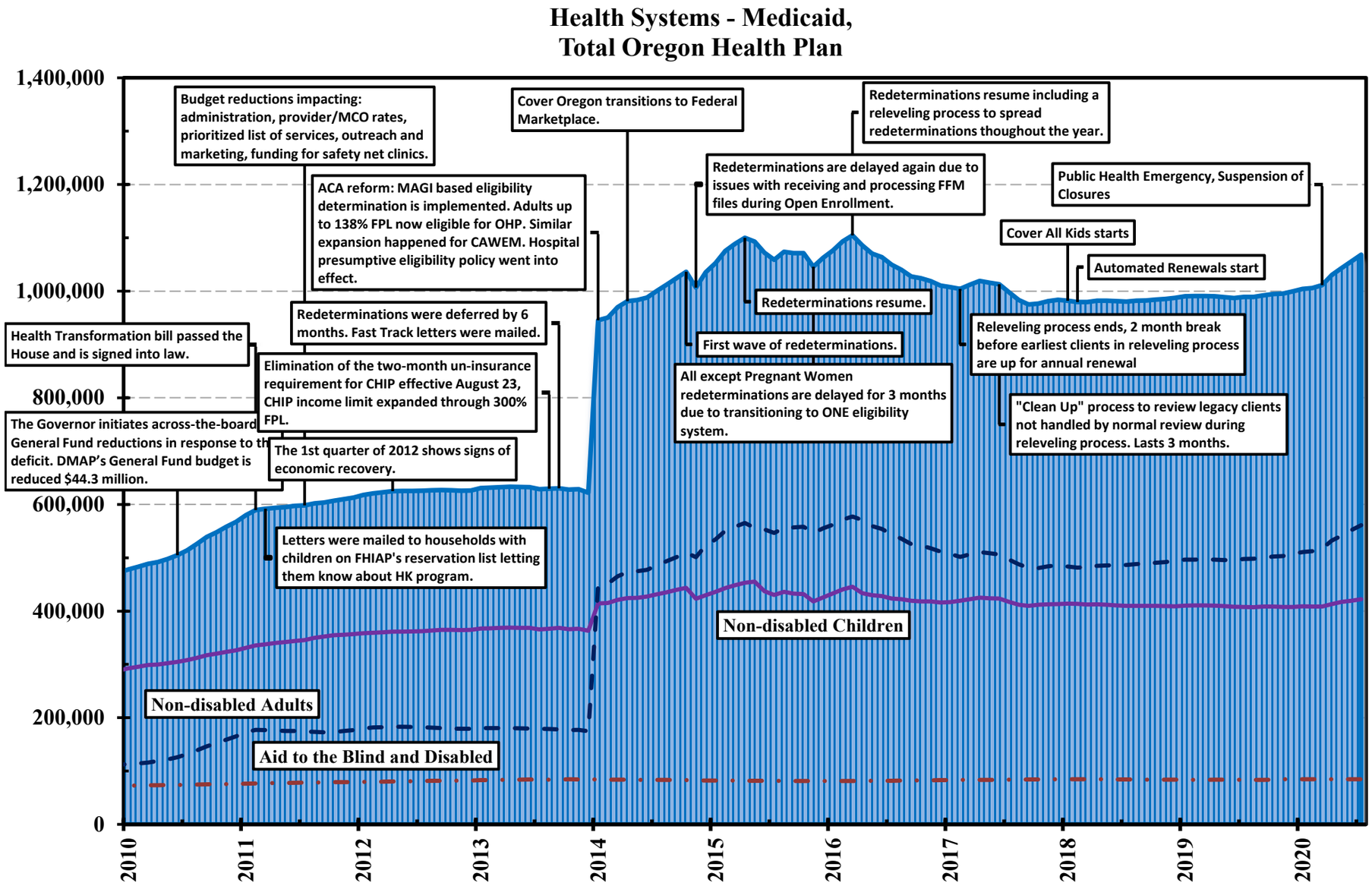
In Application is a count of clients who were in the application stage on the last day of the month or exited VR during the given month without advancing to the next stage. VR case is initiated by the client submitting their application to VR. In this stage, the application is reviewed, and eligibility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

In Eligibility is a 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. Typically, clients in this stage are either waiting for the final eligibility determination or are in the process of plan development.

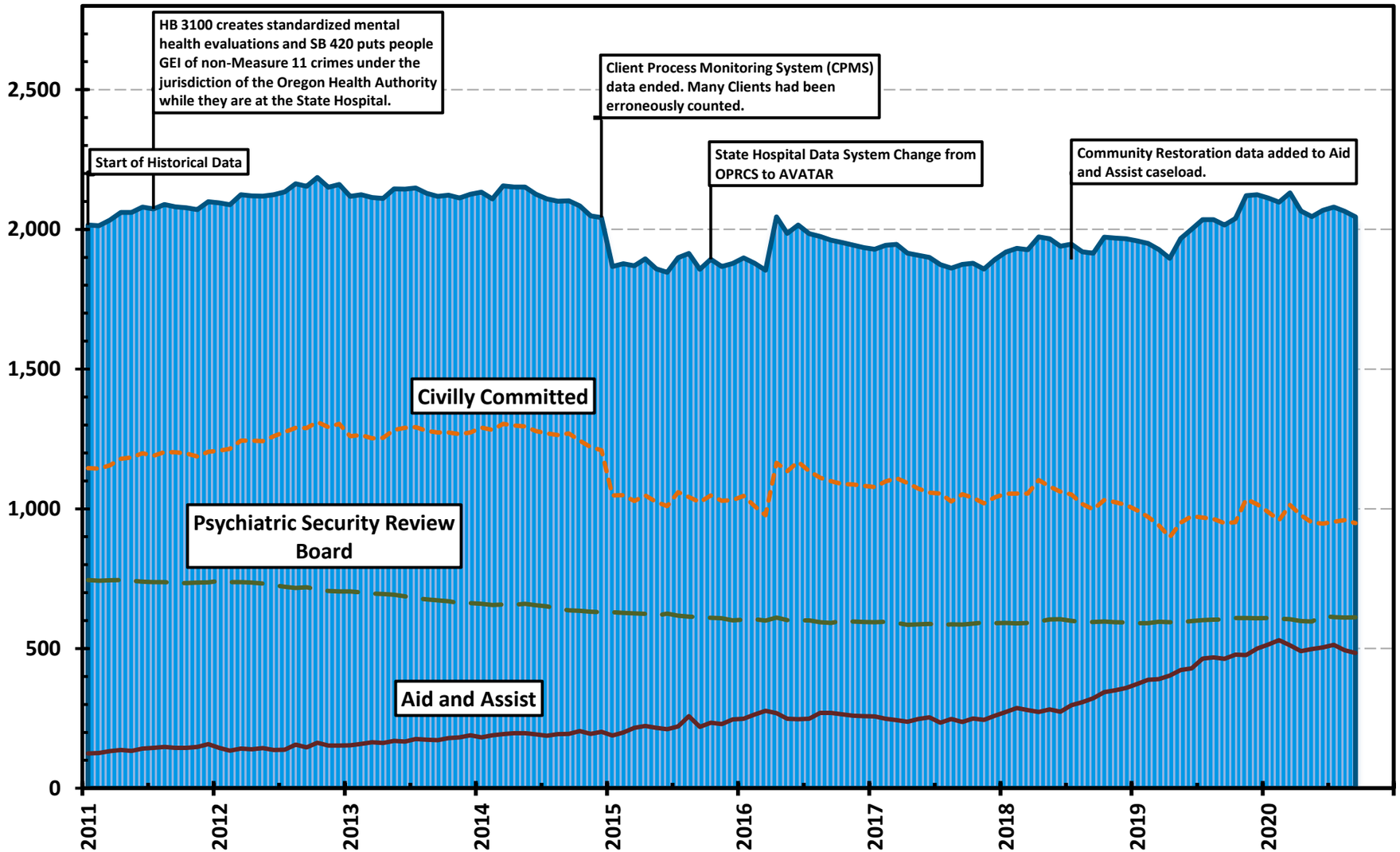
In Plan is a count of clients who had an active plan at any time in a given month. After employment, and if all is going well, a case is normally closed after 90 days.

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 to 3 months.

Appendix II
OHA Caseload History & Definitions


Health Systems - Medicaid,
Total Oregon Health Plan
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
0
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
Budget reductions impacting: administration, provider/MCO rates, prioritized list of services, outreach and marketing, funding for safety net clinics.
Cover Oregon transitions to Federal Marketplace.
Redeterminations resume including a releveling process to spread redeterminations thoughout the year.
Redeterminations are delayed again due to issues with receiving and processing FFM files during Open Enrollment.
Public Health Emergency, Suspension of Closures
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.
Cover All Kids starts
Automated Renewals start
Redeterminations were deferred by 6 months. Fast Track letters were mailed.
Redeterminations resume.
Releveling process ends, 2 month break before earliest clients in releveling process are up for annual renewal
Health Transformation bill passed the House and is signed into law.
First wave of redeterminations.
Elimination of the two-month un-insurance requirement for CHIP effective August 23, CHIP income limit expanded through 300% FPL.
All except Pregnant Women redeterminations are delayed for 3 months due to transitioning to ONE eligibility system.
"Clean Up" process to review legacy clients not handled by normal review during releveling process. Lasts 3 months.
The Governor initiates across-the-board General Fund reductions in response to th deficit. DMAP's General Fund budget is reduced $44.3 million.
The 1st quarter of 2012 shows signs of economic recovery.
Letters were mailed to households with children on FHIAP's reservation list letting them know about HK program.
Non-disabled Children
Non-disabled Adults
Aid to the Blind and Disabled

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



OHA Caseload Definitions

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	100%	133%	138%	150%	200%	300%	400%
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3	$21,960	$29,207	$30,305	$32,940	$43,920	$65,880	$87,840
4	$26,500	$35,245	$36,570	$39,750	$5,300	$79,500	$106,000
5	$31,040	$41,283	$42,835	$46,560	$62,080	$93,120	$124,160
6	$35,580	$47,321	$49,100	$53,370	$71,160	$106,740	$142,320
7	$40,120	$53,360	$55,366	$60,180	$80,240	$120,360	$160,480
8	$44,660	$59,398	$61,631	$66,990	$89,320	$133,980	$178,640
Add $4,540 for each person over 8							

4. Source: https://www.medicaidplanningassistance.org/federal-poverty-guidelines/

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.

Children's Health Insurance Program (CHIP) 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)) 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) 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 represents the expansion of Medicaid under the United States Federal Patient Protection and Affordable Care Act of 2010 (ACA). This caseload includes citizens 18 to 64 years old with incomes up to 138 percent of FPL, who are not pregnant or disabled.

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.

Other Medicaid (Non-OHP Benefit Packages)

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-permute).

Up until January 1, 2018, children under the age of 19 were also enrolled in this program, but after that date all eligible children will transfered to 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 deductible not exceeding the Department's fee schedule.

Cover All Kids (CAK) is a 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.

Medicare Part A/B Premium Assistance Programs[5]

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.

5. Part A and Part B caseloads are not mutually exclusive. For the most part, those who receive Part A premium assistance also receive Part B premium assistance. Likewise, Medicare Part A/Part B caseloads are not grouped under OHP or Other caseloads, because most of the individuals with Part A/Part B premium assistance have already been counted in one of our traditional Medicaid caseloads (OAA, ABAD, and QMB). There is a segment that is not in the traditional Medicaid caseloads. They are in Specified Low Income Medicare Beneficiary (SLMB) or Qualified Individual (QI) groups that we track but do not formally forecast. Lastly, there is a slight discrepancy in counts between people on the Medicaid caseload who have Medicare, and those who receive premium assistance.

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") 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.

Psychiatric Security Review Board (PSRB) includes clients who are under the jurisdiction of the Psychiatric Security Review Board. Clients in PSRB 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 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 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 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.

DHS
Oregon Department of Human Services

Oregon Health Authority

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