FALL 2014 DHS|OHA CASELOAD FORECAST

Budget Planning and Analysis
Office of Forecasting, Research and Analysis

DHS oregon department of human services

Oregon Health Authority

FALL 2014 DHS OHA CASELOAD FORECAST

OCTOBER 2014

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EXECUTIVE SUMMARY

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

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

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

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

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

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

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

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

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

Introduction

This document summarizes the Fall 2014 forecasts of client caseloads for the Oregon Department of Human Services (DHS) and Oregon Health Authority (OHA). The Office of Forecasting, Research and Analysis (OFRA) issues these forecasts semiannually in the spring and fall. DHS caseload forecasts cover the major program areas administered by the department: Self Sufficiency, Child Welfare, Vocational Rehabilitation, Aging and People with Disabilities, and Developmental Disabilities. OHA caseload forecasts cover the major program areas of Medical Assistance Programs and Addictions and Mental Health. Forecasts are used for budgeting and planning and usually extend through the end of the next biennium. Forecasts are developed using a combination of time-series techniques, input-output deterministic models and expert consensus. Forecast accuracy is tracked via monthly reports that compare actual caseload counts to the forecasted caseload. An annual forecast quality report which compares forecast accuracy across programs and over time is also available.[1]

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

Forecast environment and risks

Oregon's economy is still recovering from the Great Recession of 2008-2009. Oregon lost nearly 150,000 jobs between December 2007 and December 2009, more than half of which disappeared during the six months ending in March 2009. The large and sudden loss of jobs resulted in large and sudden increases in many DHS and OHA caseloads. This period is easily identified in many of the caseload graphs that follow.

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

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

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

The Office of Economic Analysis (OEA) identifies major risks to Oregon's economy in its quarterly forecasts. The second quarter 2014 edition lists the major risks as federal fiscal policies, strength of the housing market recovery, European debt problems and potential financial instability, commodity price inflation, and uncertainty surrounding federal timber payments.[2]

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

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

Oregon Health Authority

Total Oregon Health Authority Biennial Average Forecast Comparison

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

1. Parent/Caretaker Relative is a new caseload group for adults under 42% FPL. This caseload used to be part of the TANF Medical caseload.
2. Pregnant Woman Program is a new name for Poverty Level Medical - Women.
3. Children's Medicaid Program is a new group for children previously in TANF Medical, Poverty Level Medical - Children, and CHIP under 133% FPL.
4. OHP Standard program closed on Dec 31, 2013.

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

5. In prior forecasts some clients were counted more than once. With the new definitions, each client is counted only once for any given month.
6. The old Civil Commitment caseload included everyone receiving service who had been civilly committed at some point in time. The new definition counts only clients who are currently under commitment (although a proxy rule is being used to estimate the end date for clients' mandated service).
7. Prior forecasts did not include these two caseload categories.

Medical Assistance Programs

The primary drivers of caseload growth for MAP since 2008 were: the most recent recession (December 2007 through an official ending date of June 2009), implementation of the Oregon Healthy Kids Initiative in July 2009, and implementation of the Patient Protection and Affordable Care Act of 2010 (ACA) in January 2014. Taken together, these three factors drove the total MAP caseloads from about 408,000 clients prior to the recession to about 1,000,000 clients by January 2014, for a net increase of 592,000 clients (145 percent). The impact of ACA reform was by far the largest ever experienced.

The most significant impact of ACA is the expansion of Medicaid coverage to Oregon adults (aged 18-64) with incomes up to 138 percent Federal Poverty Level (FPL). Despite the growing economy with its downwards pressure on MAP caseloads, implementation of ACA added more than 315,000 adults to the OHP Plus caseload (including 60,000 who were transferred from the discontinued program called OHP Standard) and about 12,000 adults to the CAWEM group. Other impacts of ACA reform include:

1. "Welcome Mat" effect – Not everyone who is eligible for public programs, participates in them. When public programs are expanded, new enrollment often occurs not only among the newly eligible, but also among the previously eligible populations. Parent/Caretaker Relative, Pregnant Woman, CHIP, and Children's Medicaid Program caseloads all experienced a welcome mat effect due to ACA reform. However, the exact magnitude is hard to estimate due to other impacts of the reform, such as deferred redetermination and new coverage alternatives (see below).

2. Deferred redeterminations – ACA reform created workload management challenges. To prepare for the influx of new applications and enrollments due to expansion, OHA asked CMS for approval to defer scheduled redeterminations for a six month period. As a result of these deferred redeterminations, fewer people exited than normal, resulting in higher total caseloads. Almost all caseloads were impacted to some degree by the deferred redeterminations. The caseloads most impacted include: Parent/Caretaker Relative, Pregnant Woman Program, Children's Medicaid Program, CHIP, and CAWEM.

3. 3. Availability of alternative coverage – Some caseloads declined due to the availability of regular OHP coverage for more low income adults than in the past. This effect was observed in BCCP and ABAD.

Risks and Assumptions

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

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

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

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

ACA severely impacted all three of these components:

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

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

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

Pregnant Woman Program, previously known as Poverty Level Medical – Women (PLMW), is expected to be 14,400 by March 2015, accounting for 1.6 percent of the OHP Plus caseload. Without ACA expansion, this group was expected to continue the historical pattern of slow, steady increases with some seasonal variability. As with the Parent/Caretaker Relative caseload, this group is also impacted by the welcome mat effect and deferred redeterminations. This caseload will continue growing, reaching 23,000 by Oct 2014, after which it is expected to drop rapidly.

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

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

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

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

Old Age Assistance (OAA) is expected to be 38,600 by March 2015 and will account for 4.2 percent of OHP Plus caseload. The group has grown at a fairly rapid rate since January of 2009 and has only recently shown any indication that the growth rate might slow. The current forecast is for this caseload to continue growing into the foreseeable future. This group is driven by population dynamics as well as economic conditions.

Other Medical Assistance Programs

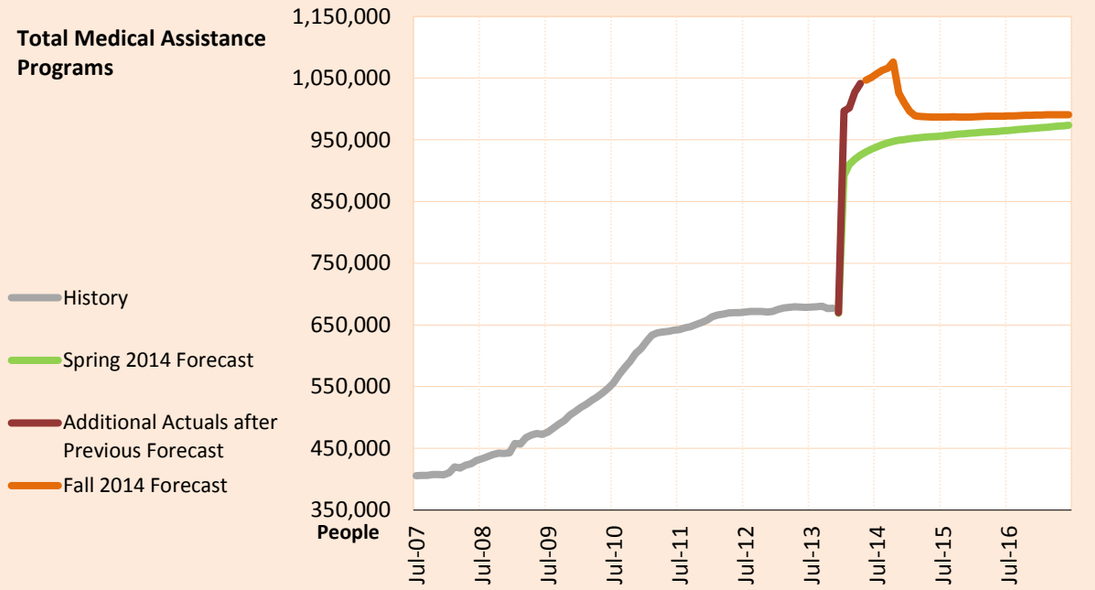
Citizen-Alien Waived Emergent Medical (CAWEM) is expected to be 36,100 by March 2015 and will account for 59 percent of the Other MAP caseload. This caseload has two subcomponents: 1) the regular program, which covers only emergency medical services, and 2) the prenatal program, which also covers prenatal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

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

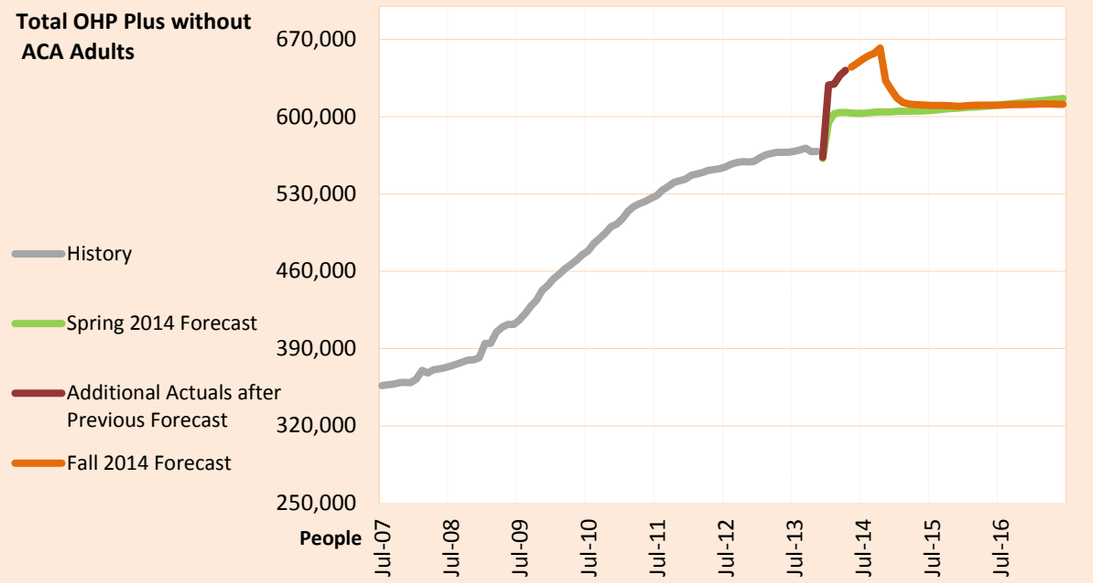
Qualified Medicare Beneficiary (QMB) is expected to be 24,000 by March 2015 and will account for 39.9 percent of Other MAP caseload. This caseload has grown at a consistent rate since January of 2009 and is expected to continue this growth pattern through the forecast horizon.

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

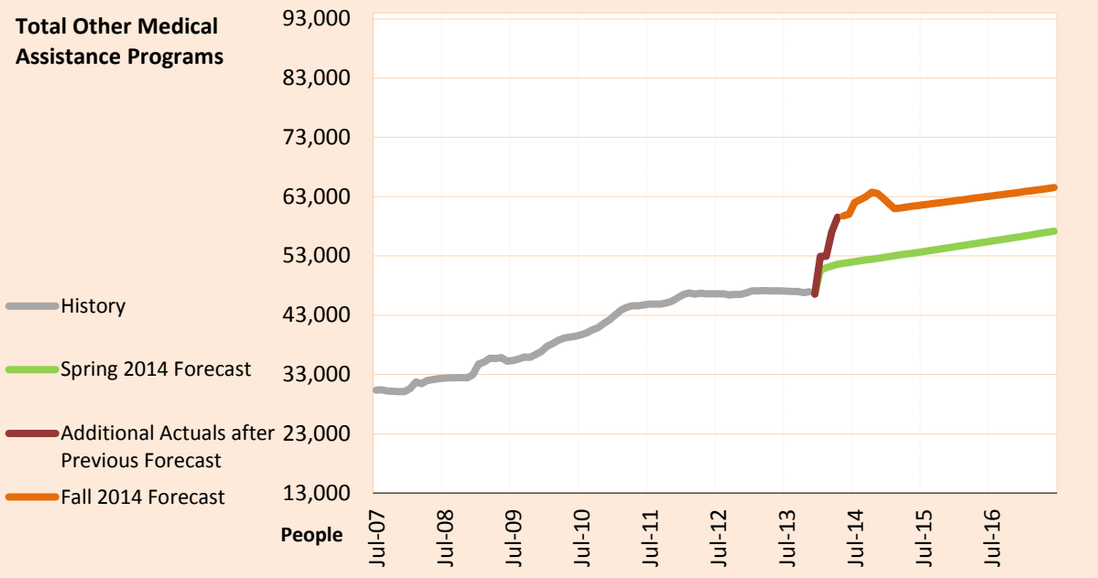
Total Medical Assistance Programs



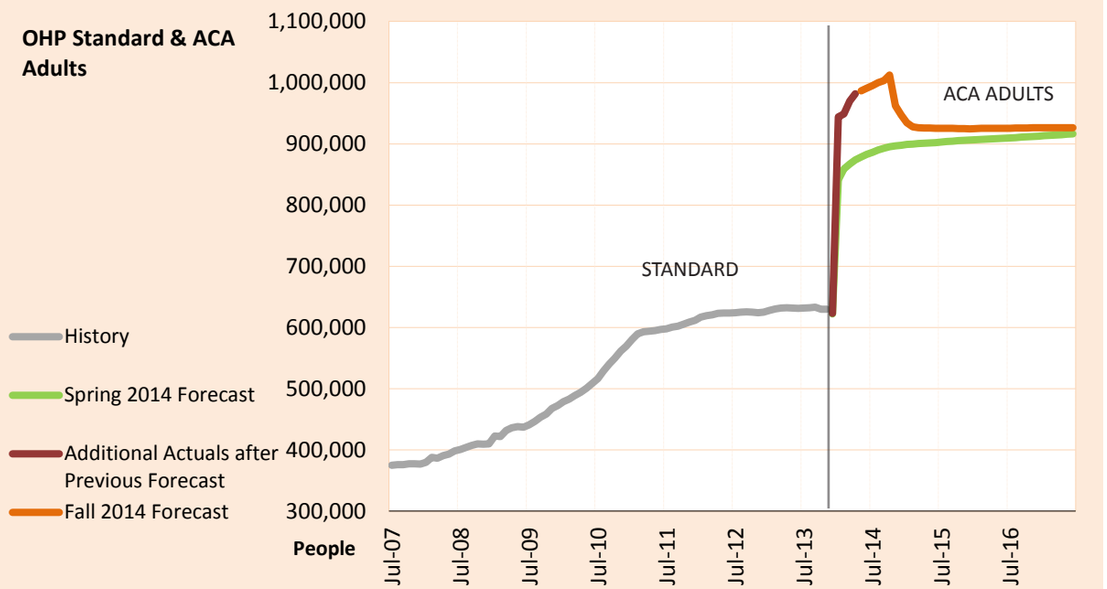
Total OHP Plus without ACA Adults



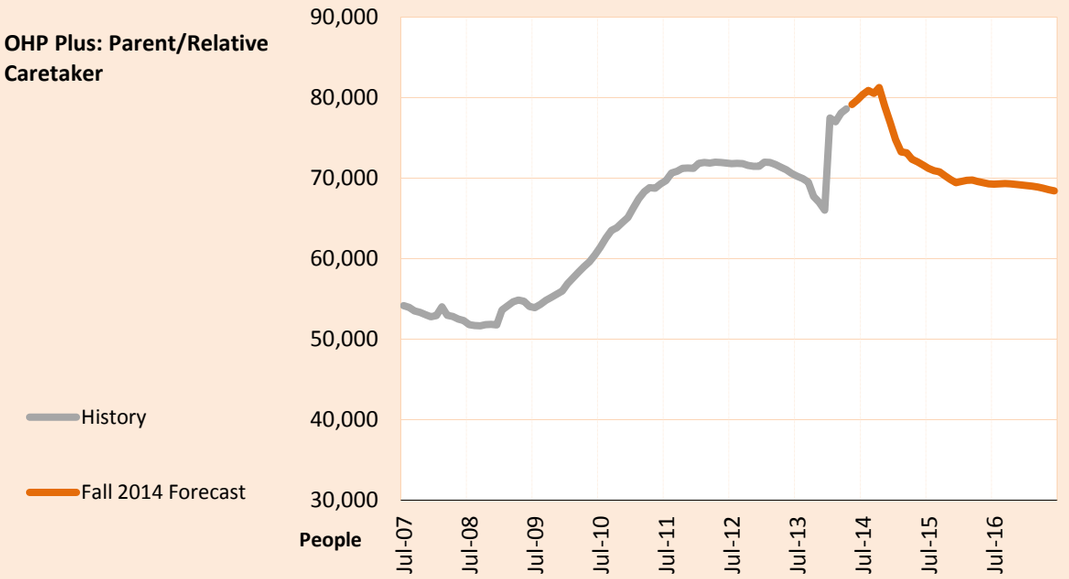
Total Other Medical Assistance Programs



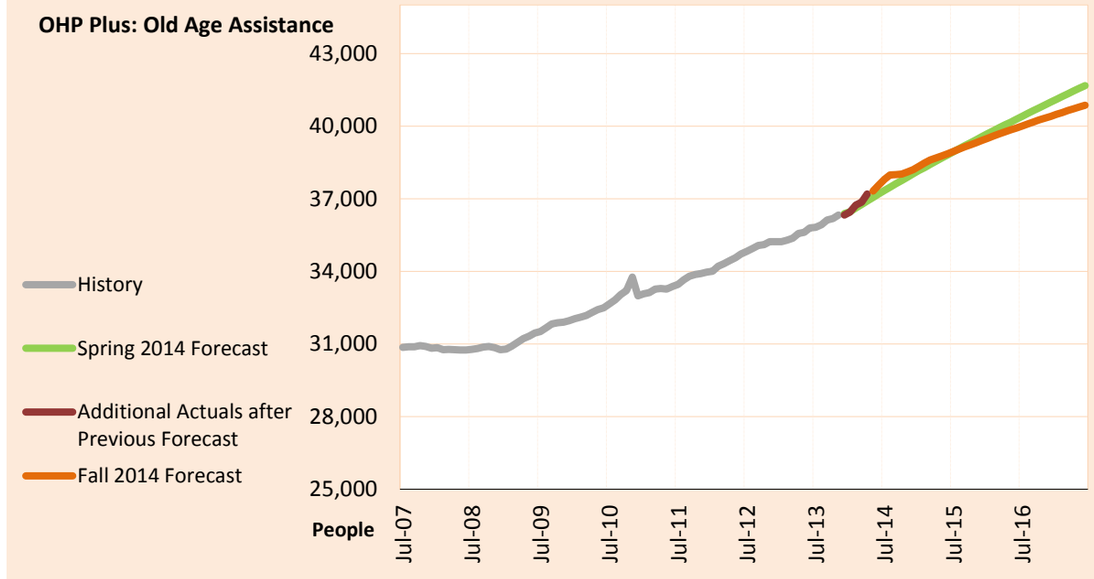
OHP Standard & ACA Adults



OHP Plus: Parent/Relative Caretaker

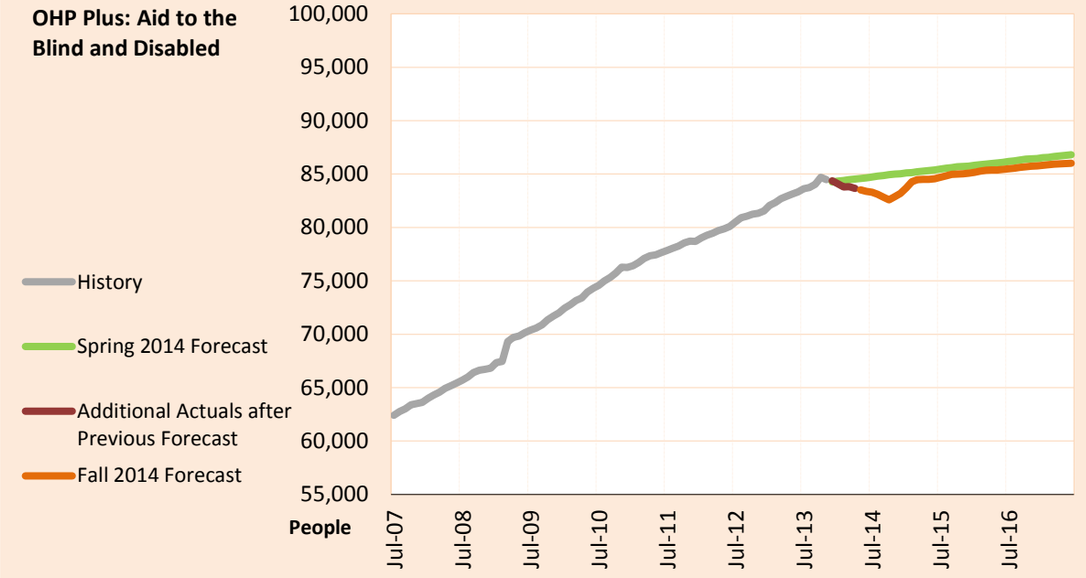


OHP Plus: Old Age Assistance

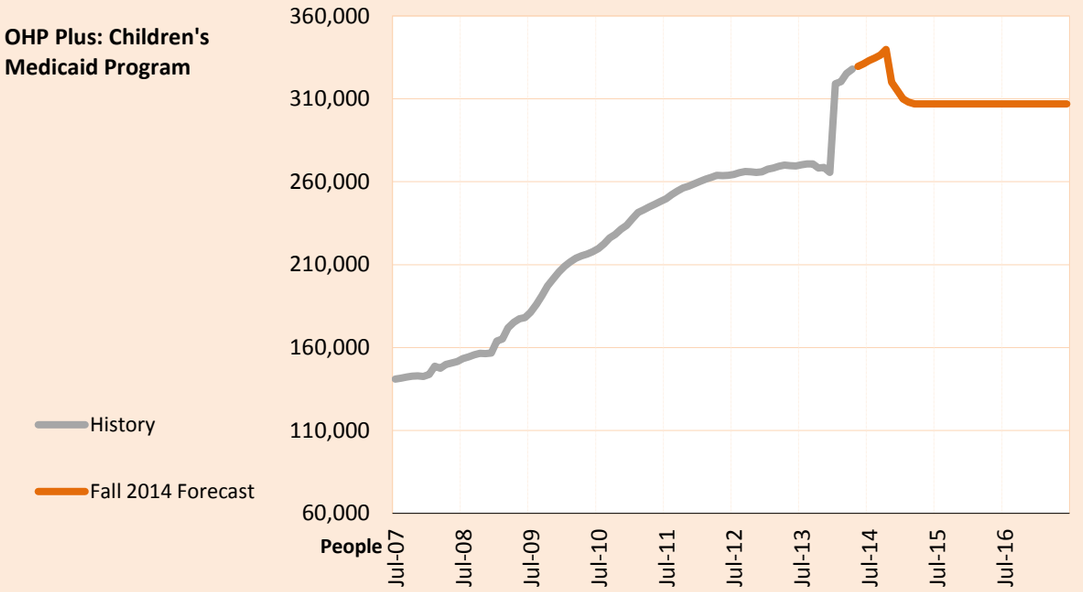


OHP Plus: Pregnant Woman Program

OHP Plus: Aid to the Blind and Disabled

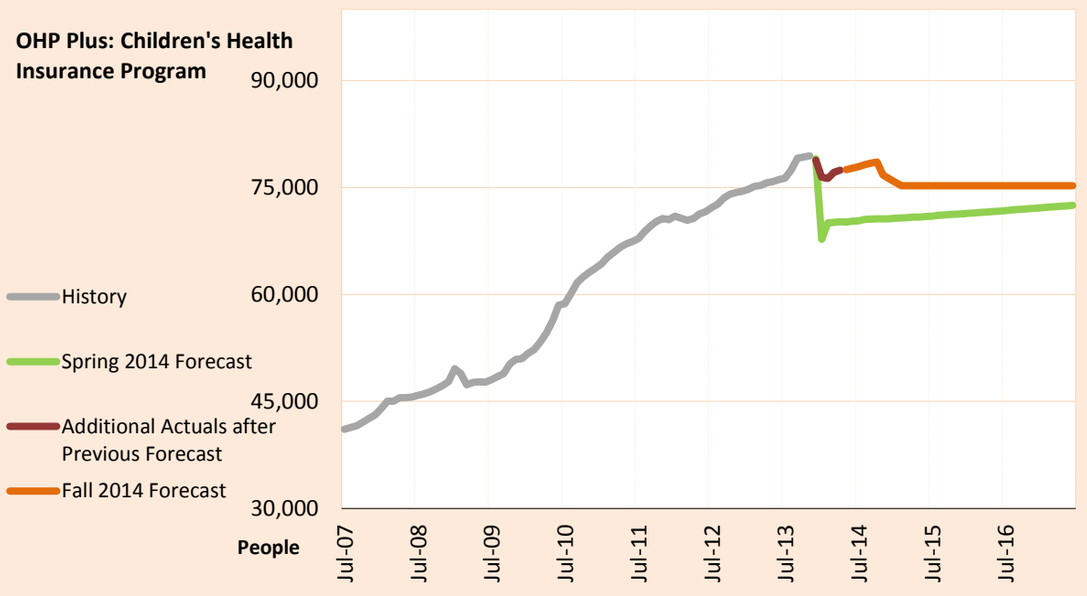


OHP Plus: Children's Medicaid Program

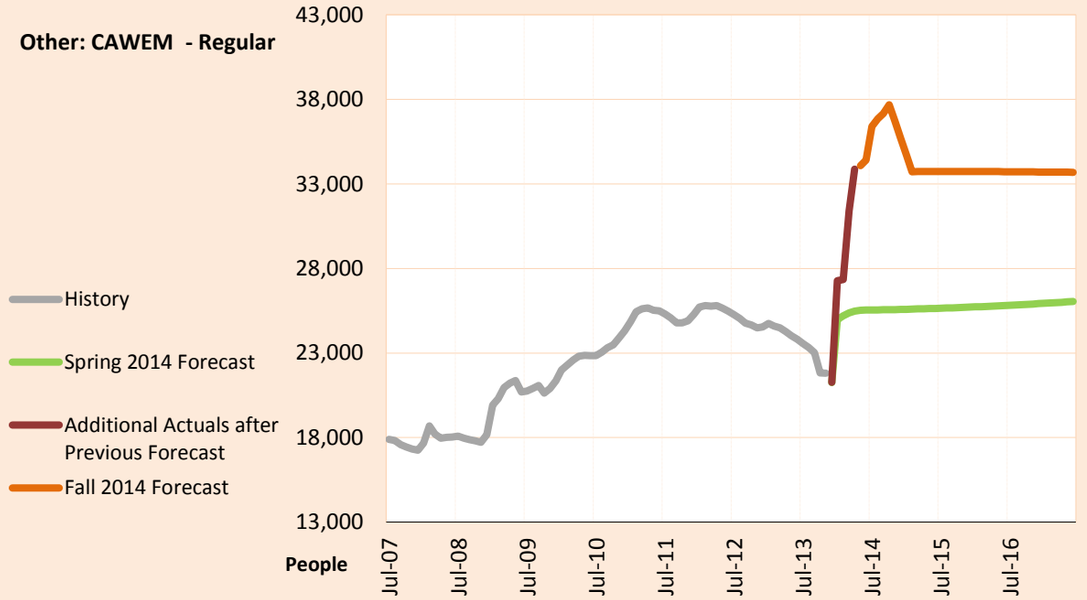


OHP Plus: Foster, Substitute and Adoption Care

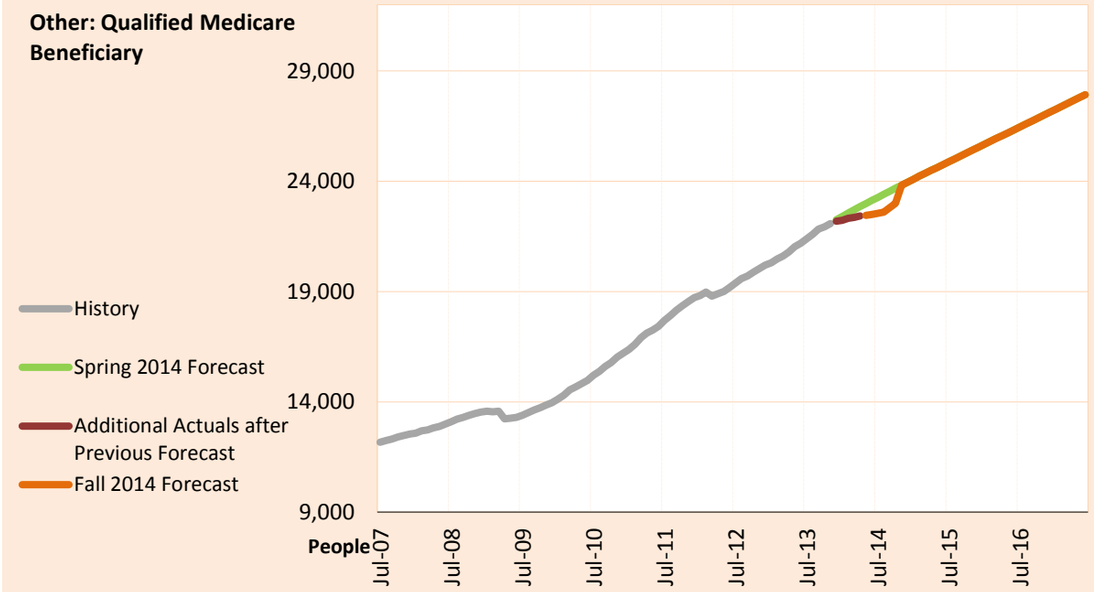
OHP Plus: Children's Health Insurance Program



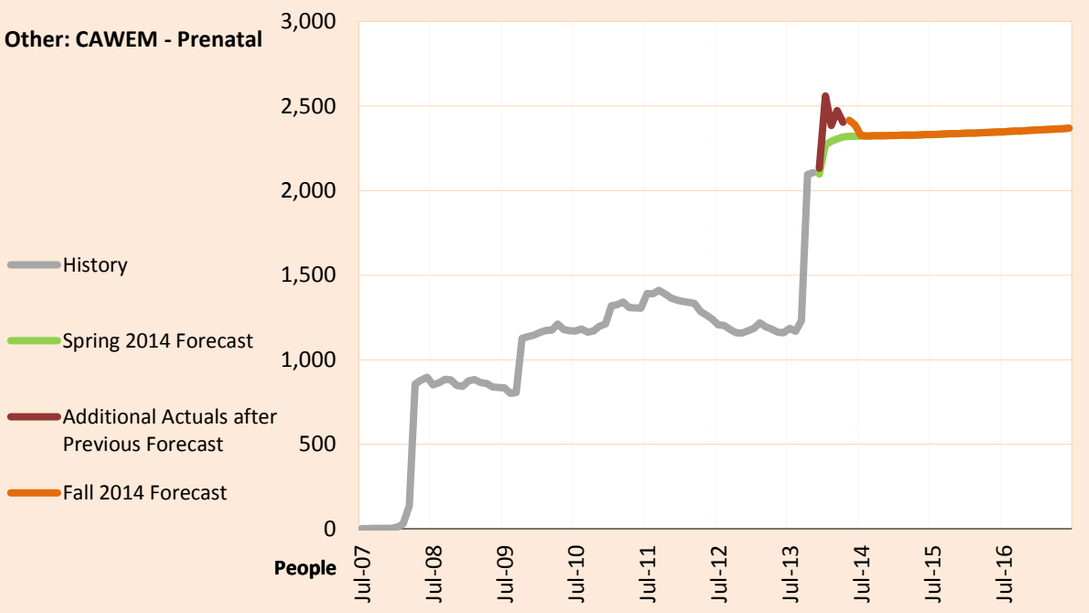
Other: CAWEM - Regular



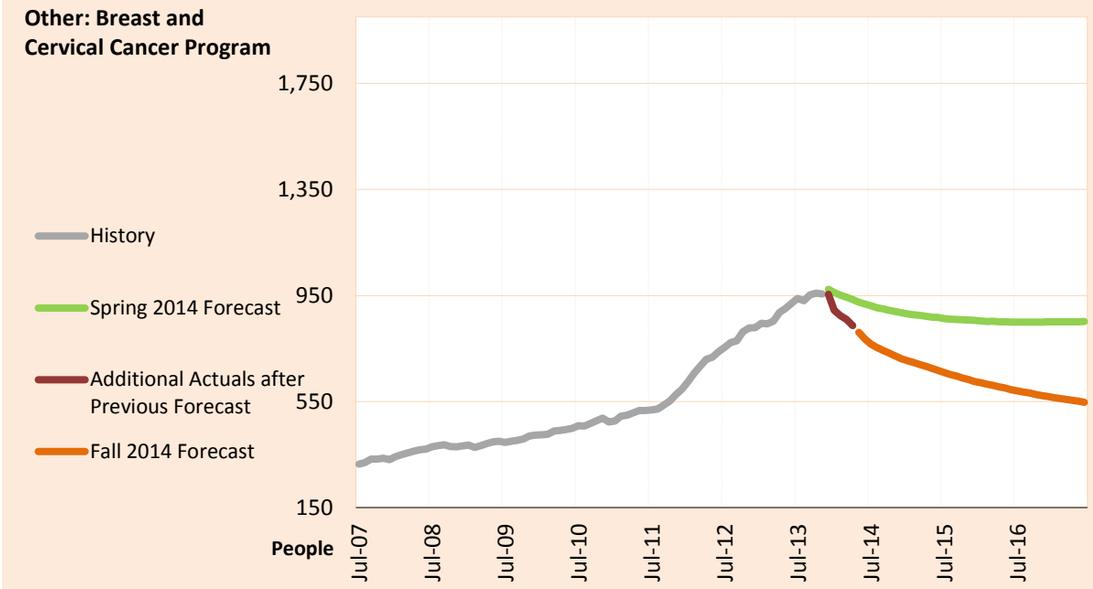
Other: Qualified Medicare Beneficiary



Other: CAWEM - Prenatal



Other: Breast and Cervical Cancer Program



Medical Assistance and KidsConnect Biennial Average Forecast comparison

OHP Plus	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
ACA Adults with children	71,085	64,033	-9.9%	64,033	81,433	27.2%
ACA Adults without children	141,411	182,642	29.2%	182,642	233,567	27.9%
Total ACA Adults	**212,496**	**246,675**	**16.1%**	**246,675**	**315,000**	**27.7%**
Parent/Caretaker Relative[1]	NA	74,859	NA	74,859	69,512	-7.1%
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Poverty Level Medical - Children[3]	179,103	NA	NA	NA	NA	NA
Total OHP Plus	807,237	863,316	6.9%	863,316	925,690	7.2%
Other Medical Assistance Programs						
Citizen-Alien Waived Emergent Medical - Regular	24,747	31,127	25.8%	31,127	33,719	8.3%
Citizen-Alien Waived Emergent Medical - Prenatal	2,150	2,186	1.7%	2,186	2,349	7.5%
Qualified Medicare Beneficiary	23,166	22,942	-1.0%	22,942	26,402	15.1%
Breast & Cervical Cancer program	915	804	-12.1%	804	597	-25.7%
Other Subtotal	**50,978**	**57,059**	**11.9%**	**57,059**	**63,067**	**10.5%**
OHP Standard[4]	**15,444**	**15,444**	**0.0%**	**15,444**	**NA**	**NA**
Total Medical Assistance Programs	**873,659**	**935,819**	**7.1%**	**935,819**	**988,757**	**5.7%**

1. Parent/Caretaker Relative is a new caseload group for adults under 42% FPL. This caseload used to be part of the TANF Medical caseload.
2. Pregnant Woman Program is a new name for Poverty Level Medical - Women.
3. Children's Medicaid Program is a new caseload group for children who were previously in TANF Medical, Poverty Level Medical - Children, and CHIP under 133% FPL.
4. OHP Standard program closed on Dec 31, 2013 and participants were moved into the ACA Adults caseload.

Addictions and Mental Health

This forecast covers clients receiving mental health services from the Oregon Health Authority. For budgeting purposes, the Mental Health caseload is divided between Mandated and Non-Mandated populations. Oregon law requires Mandated populations, including clients who have been criminally or civilly committed, to receive mental health services. This forecast captures three distinct groups: (1) clients who are currently committed; (2) clients who were previously committed but no longer are; and (3) clients who have never been committed. Within the committed group, there are three populations: (1) Aid and Assist, served at the Oregon State Hospital; (2) Guilty Except for Insanity (GEI), served at the Oregon State Hospital and in the community; and (3) Civilly Committed individuals, also served at both the Oregon State Hospital and in the community.

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

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

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

Mandated

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

Non Mandated

4. Previously Committed
5. Never Committed

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

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

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

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

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

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

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

Risks and Assumptions

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

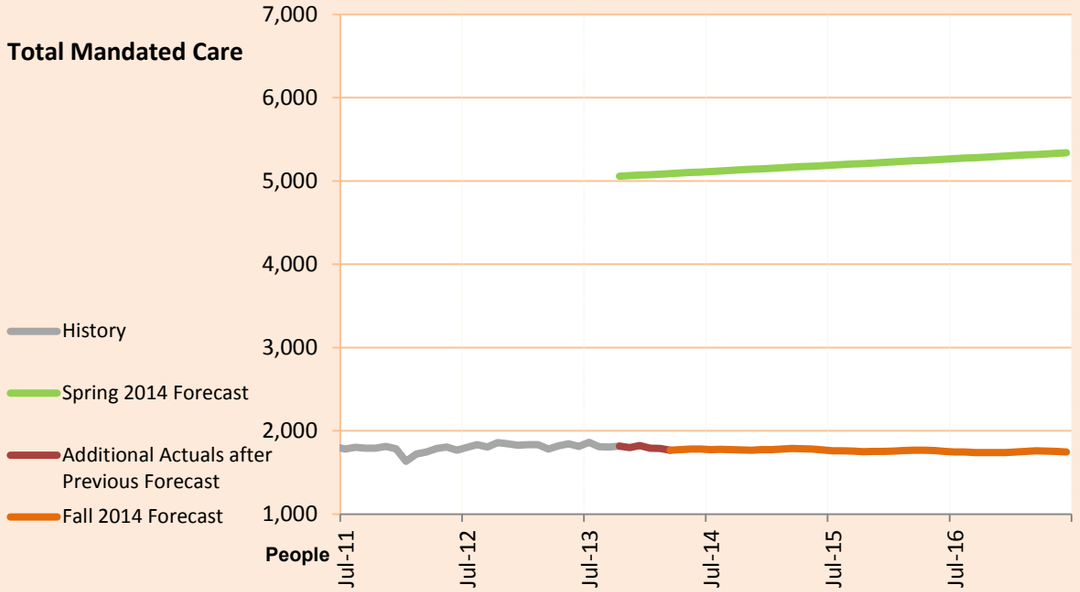
External factors, such as population growth or program policies did not influence the forecast except to the degree they influence historical trends. Therefore, the base forecast assumption is that current trends will continue unchanged through the forecast horizon of June 2017.

Implementation of the Patient Protection and Affordable Care Act of 2010 (ACA) will significantly impact delivery of mental health services in Oregon. In January 2014, Medicaid enrollment was extended to adults 18-64 with incomes up to 138 percent of FPL. This change alone is expected to provide medical coverage, including men-tal health services, to more than 300,000 previously uninsured adults. With better access to both physical and mental health services, the need for mandated mental health services may be reduced, possibly even within the time horizon of this fore-cast. In addition, integration of mental health services under the new coordinated care organizations (CCOs) is expected to improve the overall effectiveness of medi-cal care, including mental health services.

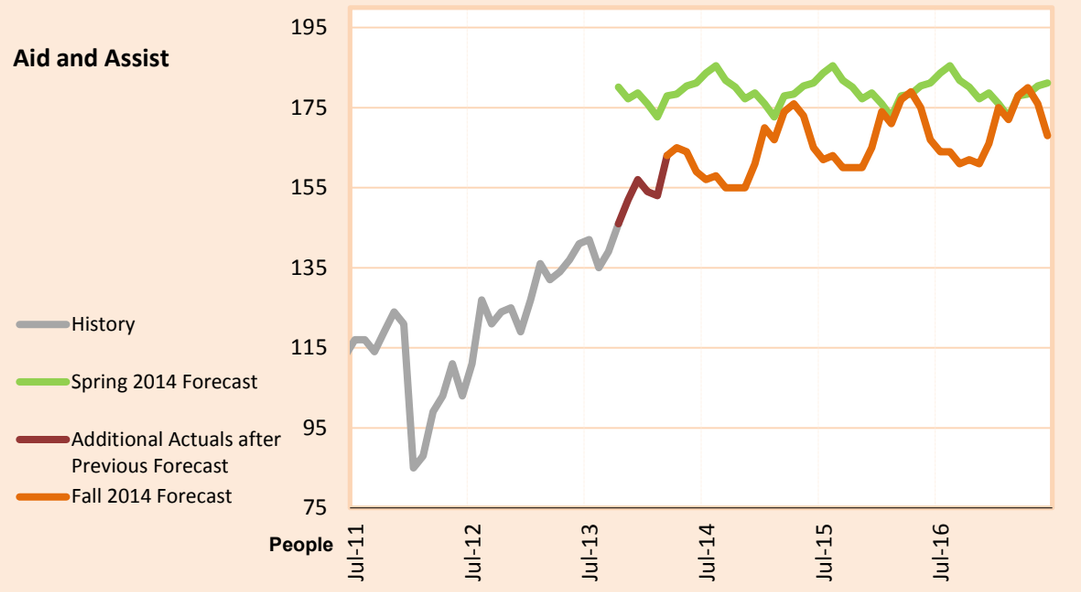
Capacity issues, such as the availability of beds in hospitals and community settings, can influence Court decisions concerning civil commitment. The avail¬ability of beds in various mental health settings can also influence client placement and the result-ing caseloads. The Blue Mountain Recovery Center, a 60-bed campus of the Oregon State Hospital closed in March 2014. Oregon State Hospital will open the 174-bed facility in Junction City in March 2015, at which time it will close the 72-bed campus in Portland. At the main Oregon State Hospital campus in Salem, additional units were opened during the 2013-15 biennium. It's possible that these changes will reduce pressure on the civil commit waiting list and acute care settings.

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

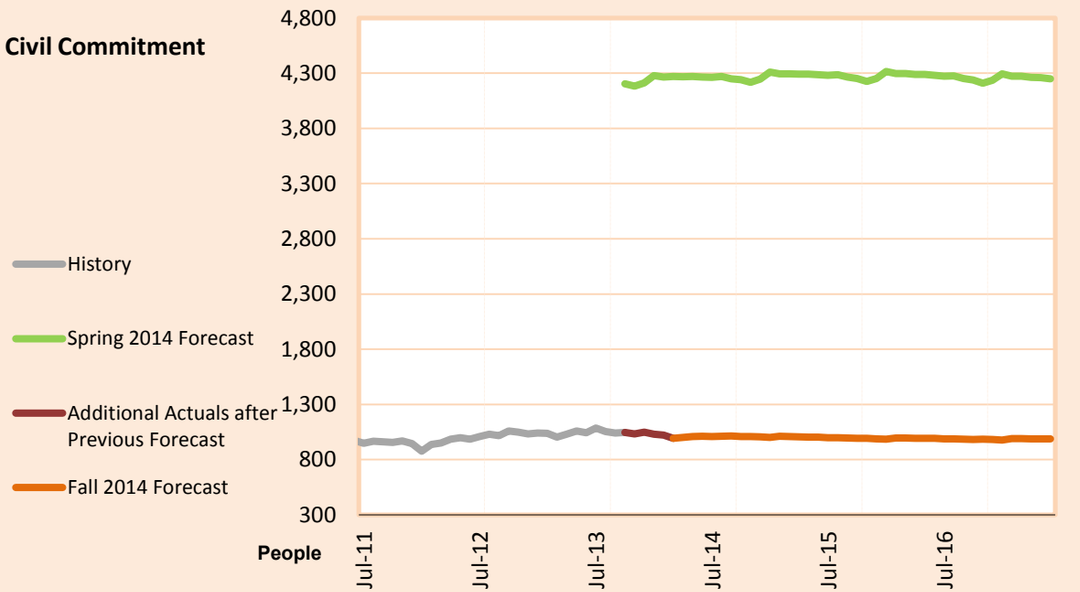
Total Mandated Care



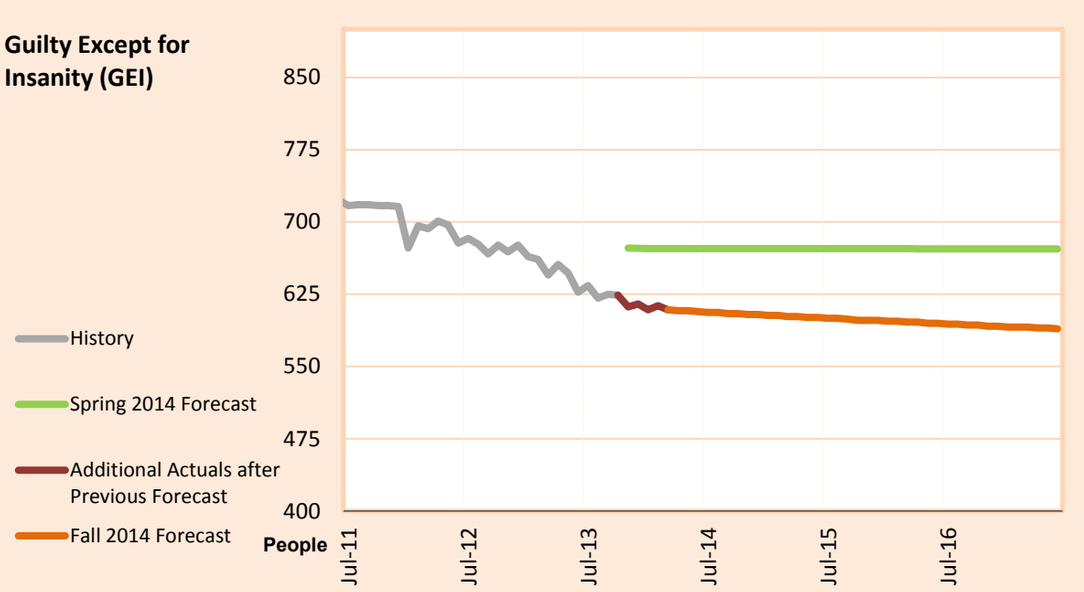
Aid and Assist

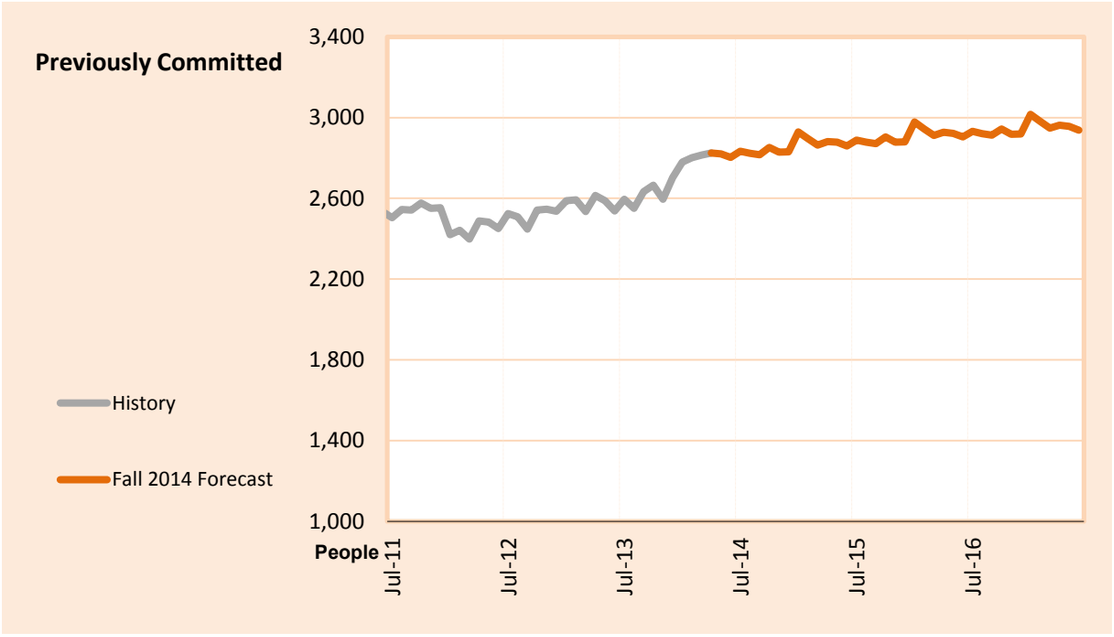


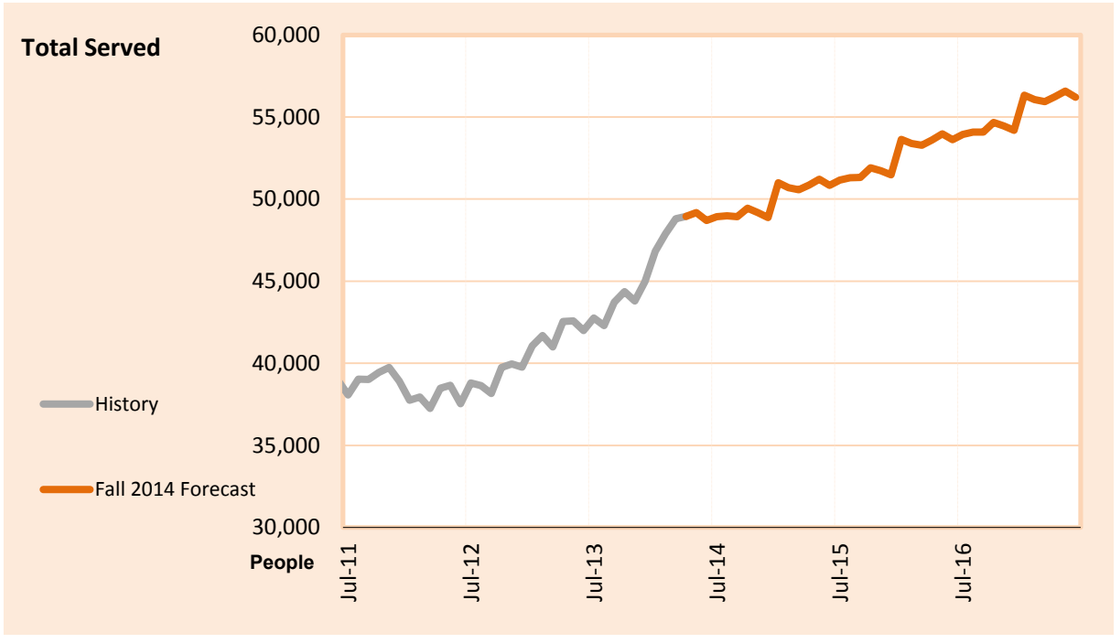
Civil Commitment

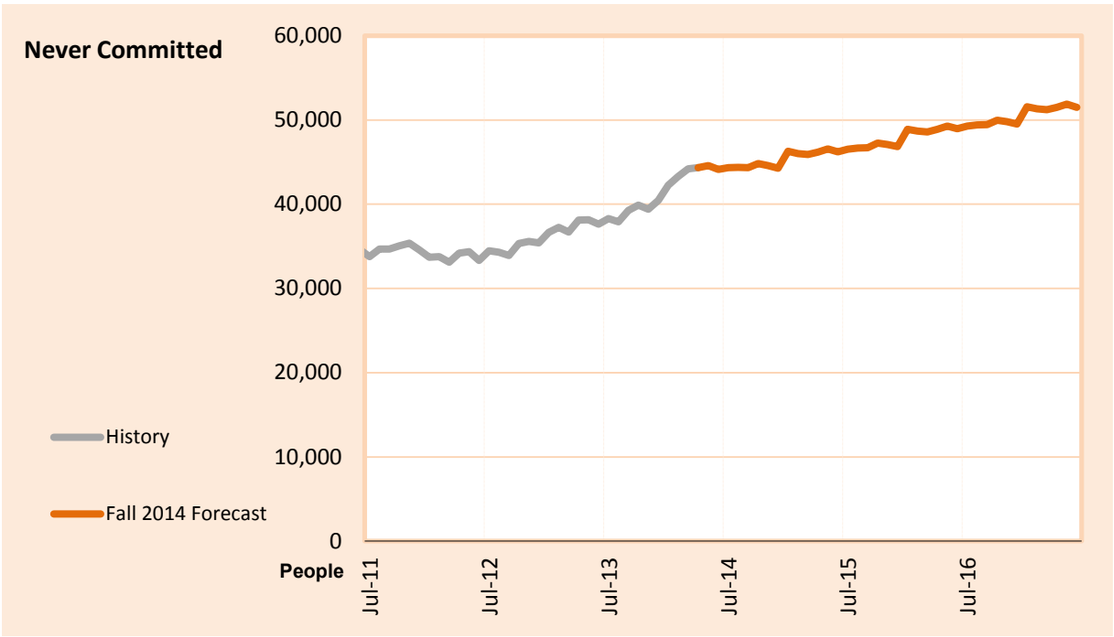


Guilty Except for Insanity (GEI)




Previously Committed
3,400
3,000
2,600
2,200
1,800
1,400
1,000
People
History
Fall 2014 Forecast
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16


Total Served
60,000
55,000
50,000
45,000
40,000
35,000
30,000
People
History
Fall 2014 Forecast
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16


Never Committed
60,000
50,000
40,000
30,000
20,000
10,000
0
People
History
Fall 2014 Forecast
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16

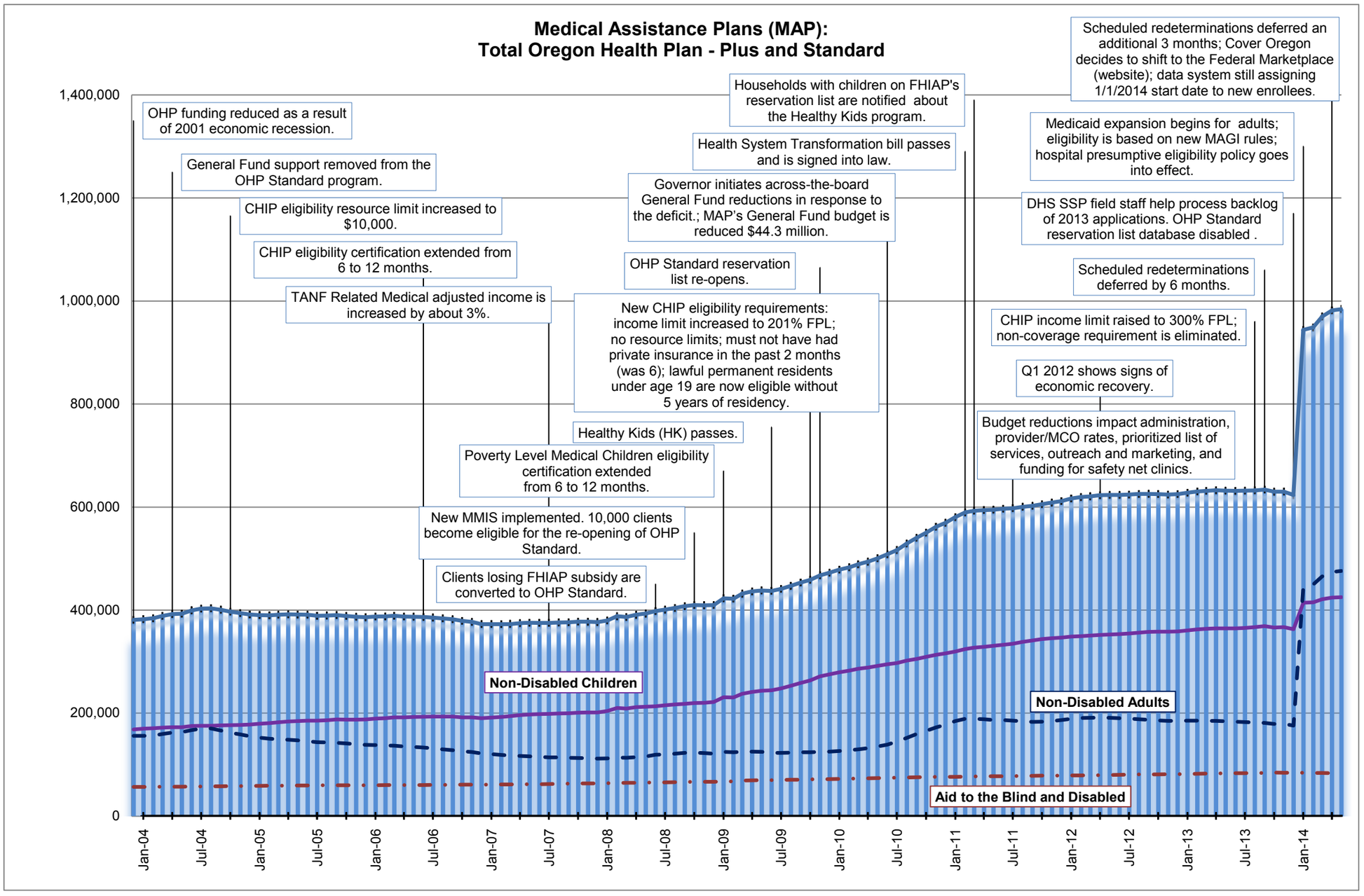
Addictions and Mental Health Biennial Average Forecast comparison

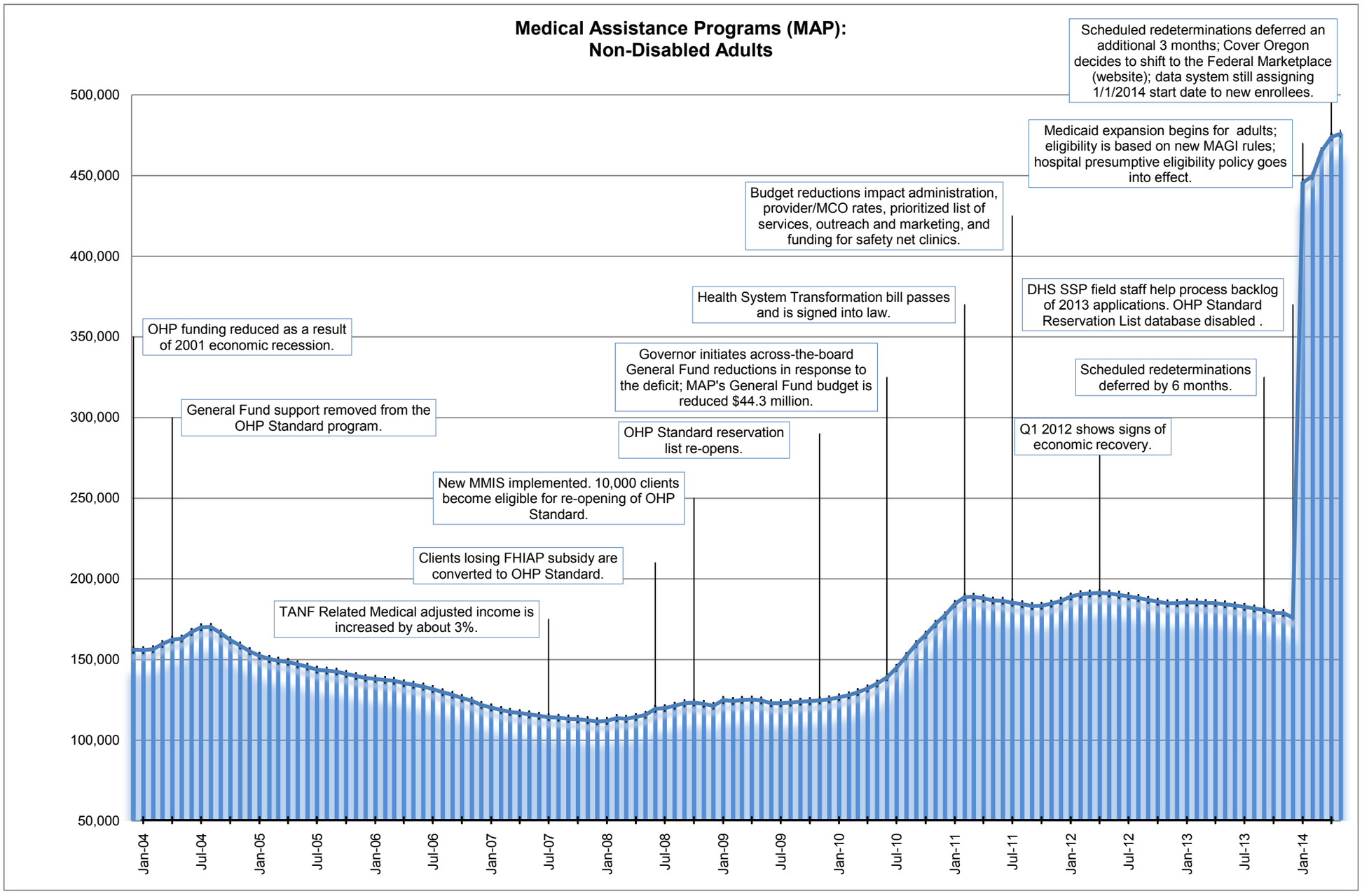
	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Under Commitment						
Aid and Assist[1]	178	158	NA	158	168	6.3%
Guilty Except for Insanity (GEI)[1]	673	610	NA	610	595	-2.5%
Civil Commitment[1, 2]	3,289	1,020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

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

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

Appendix II
OHA Caseload History & Definitions


Medical Assistance Plans (MAP):
Total Oregon Health Plan - Plus and Standard
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
0
OHP funding reduced as a result of 2001 economic recession.
General Fund support removed from the OHP Standard program.
CHIP eligibility resource limit increased to $10,000.
CHIP eligibility certification extended from 6 to 12 months.
TANF Related Medical adjusted income is increased by about 3%.
Households with children on FHIAP's reservation list are notified about the Healthy Kids program.
Health System Transformation bill passes and is signed into law.
Governor initiates across-the-board General Fund reductions in response to the deficit.; MAP's General Fund budget is reduced $44.3 million.
OHP Standard reservation list re-opens.
New CHIP eligibility requirements: income limit increased to 201% FPL; no resource limits; must not have had private insurance in the past 2 months (was 6); lawful permanent residents under age 19 are now eligible without 5 years of residency.
Healthy Kids (HK) passes.
Poverty Level Medical Children eligibility certification extended from 6 to 12 months.
New MMIS implemented. 10,000 clients become eligible for the re-opening of OHP Standard.
Clients losing FHIAP subsidy are converted to OHP Standard.
Scheduled redeterminations deferred an additional 3 months; Cover Oregon decides to shift to the Federal Marketplace (website); data system still assigning 1/1/2014 start date to new enrollees.
Medicaid expansion begins for adults; eligibility is based on new MAGI rules; hospital presumptive eligibility policy goes into effect.
DHS SSP field staff help process backlog of 2013 applications. OHP Standard reservation list database disabled .
Scheduled redeterminations deferred by 6 months.
CHIP income limit raised to 300% FPL; non-coverage requirement is eliminated.
Q1 2012 shows signs of economic recovery.
Budget reductions impact administration, provider/MCO rates, prioritized list of services, outreach and marketing, and funding for safety net clinics.
Non-Disabled Children
Non-Disabled Adults
Aid to the Blind and Disabled
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11
Jul-11
Jan-12
Jul-12
Jan-13
Jul-13
Jan-14


Medical Assistance Programs (MAP):
Non-Disabled Adults
Scheduled redeterminations deferred an additional 3 months; Cover Oregon decides to shift to the Federal Marketplace (website); data system still assigning 1/1/2014 start date to new enrollees.
Medicaid expansion begins for adults; eligibility is based on new MAGI rules; hospital presumptive eligibility policy goes into effect.
Budget reductions impact administration, provider/MCO rates, prioritized list of services, outreach and marketing, and funding for safety net clinics.
Health System Transformation bill passes and is signed into law.
DHS SSP field staff help process backlog of 2013 applications. OHP Standard Reservation List database disabled .
OHP funding reduced as a result of 2001 economic recession.
Governor initiates across-the-board General Fund reductions in response to the deficit; MAP's General Fund budget is reduced $44.3 million.
Scheduled redeterminations deferred by 6 months.
General Fund support removed from the OHP Standard program.
OHP Standard reservation list re-opens.
Q1 2012 shows signs of economic recovery.
New MMIS implemented. 10,000 clients become eligible for re-opening of OHP Standard.
Clients losing FHIAP subsidy are converted to OHP Standard.
TANF Related Medical adjusted income is increased by about 3%.
500,000
450,000
400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
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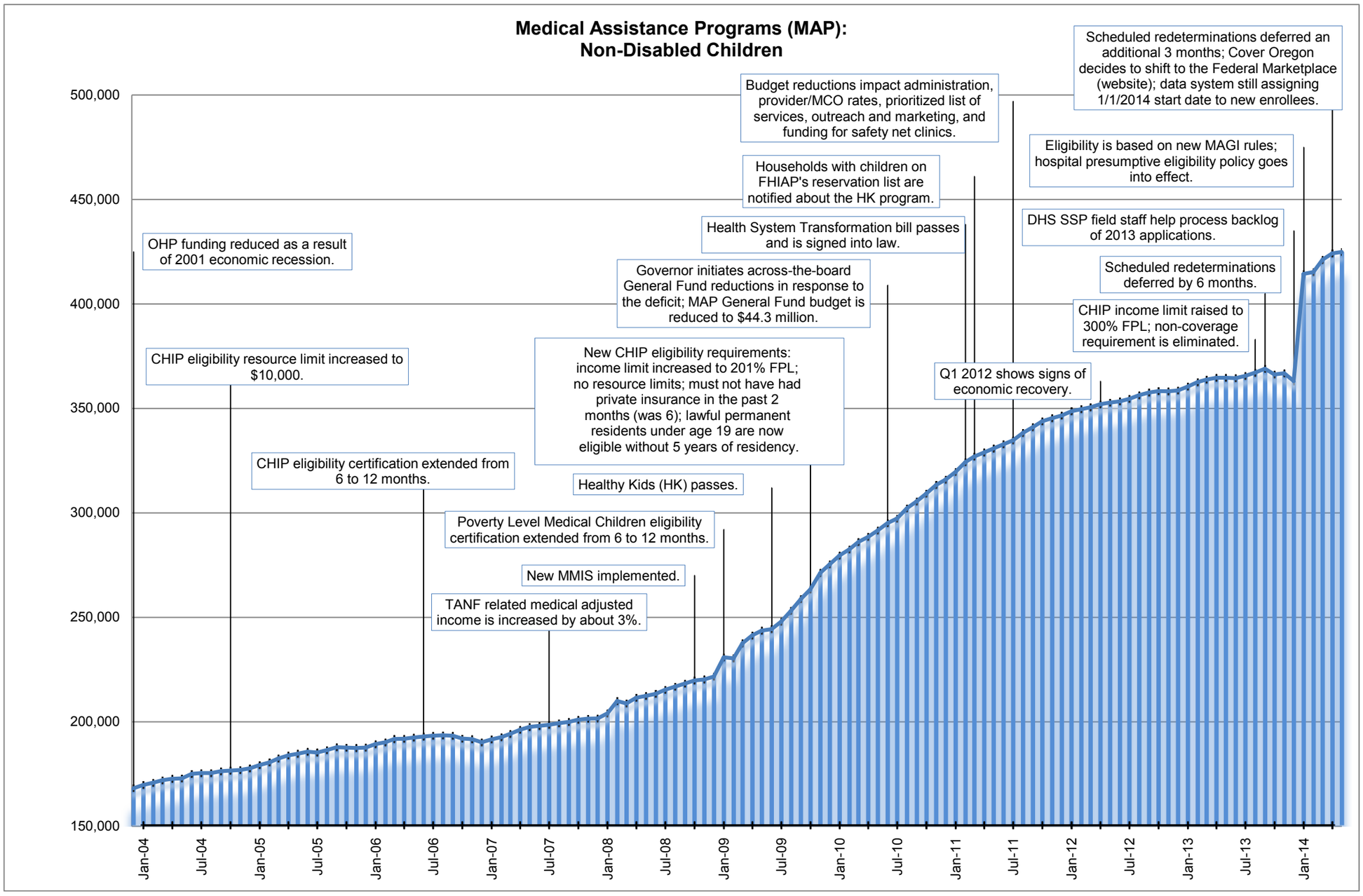
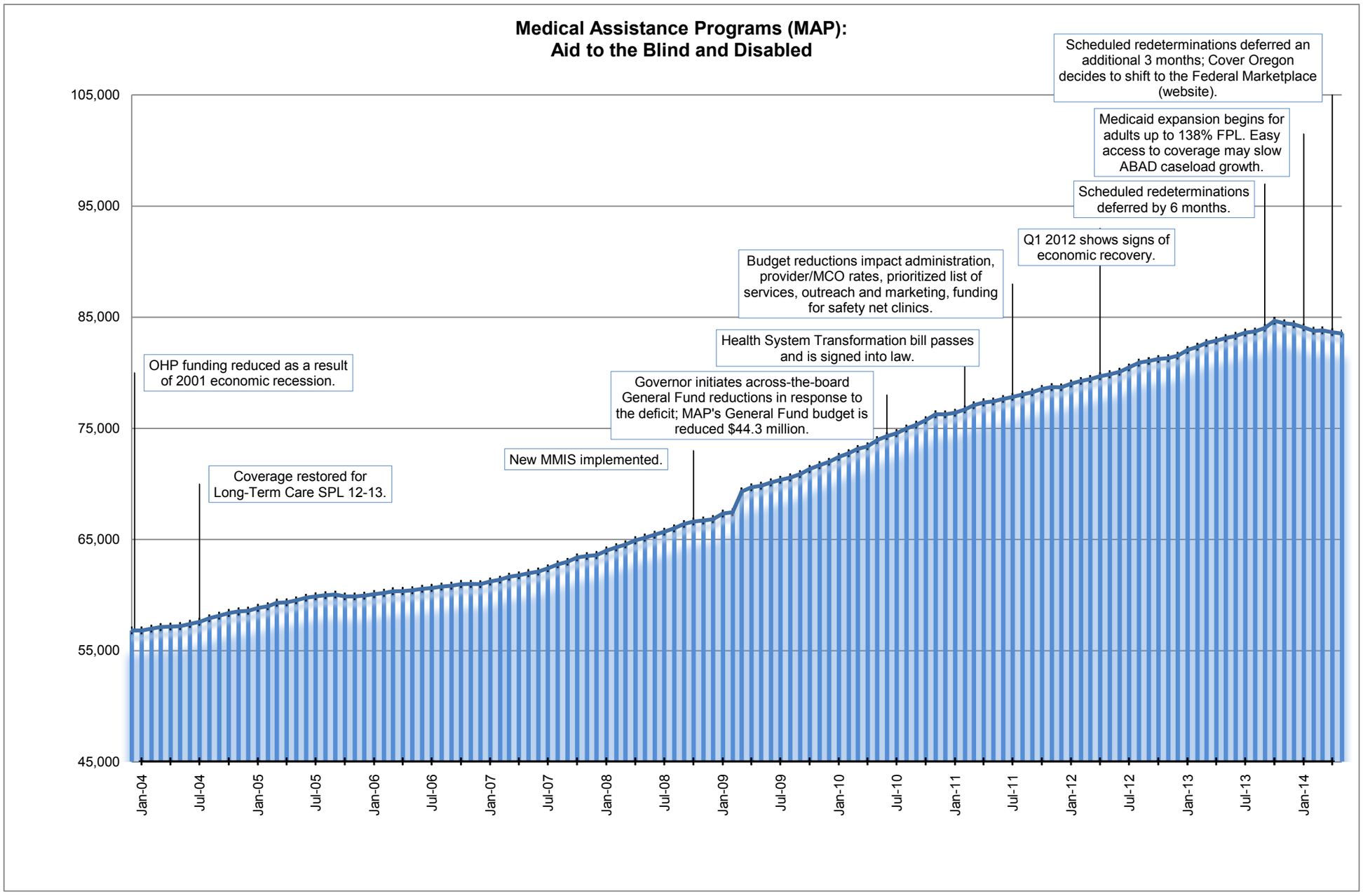
Jan-10
Jul-10
Jan-11
Jul-11
Jan-12
Jul-12
Jan-13
Jul-13
Jan-14


Medical Assistance Programs (MAP):
Non-Disabled Children
500,000
450,000
400,000
350,000
300,000
250,000
200,000
150,000
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11
Jul-11
Jan-12
Jul-12
Jan-13
Jul-13
Jan-14
OHP funding reduced as a result of 2001 economic recession.
CHIP eligibility resource limit increased to $10,000.
CHIP eligibility certification extended from 6 to 12 months.
TANF related medical adjusted income is increased by about 3%.
New MMIS implemented.
Poverty Level Medical Children eligibility certification extended from 6 to 12 months.
Healthy Kids (HK) passes.
New CHIP eligibility requirements: income limit increased to 201% FPL; no resource limits; must not have had private insurance in the past 2 months (was 6); lawful permanent residents under age 19 are now eligible without 5 years of residency.
Governor initiates across-the-board General Fund reductions in response to the deficit; MAP General Fund budget is reduced to $44.3 million.
Health System Transformation bill passes and is signed into law.
Households with children on FHIAP's reservation list are notified about the HK program.
Budget reductions impact administration, provider/MCO rates, prioritized list of services, outreach and marketing, and funding for safety net clinics.
Q1 2012 shows signs of economic recovery.
Eligibility is based on new MAGI rules; hospital presumptive eligibility policy goes into effect.
Scheduled redeterminations deferred an additional 3 months; Cover Oregon decides to shift to the Federal Marketplace (website); data system still assigning 1/1/2014 start date to new enrollees.
DHS SSP field staff help process backlog of 2013 applications.
Scheduled redeterminations deferred by 6 months.
CHIP income limit raised to 300% FPL; non-coverage requirement is eliminated.


Medical Assistance Programs (MAP):
Aid to the Blind and Disabled
Scheduled redeterminations deferred an additional 3 months; Cover Oregon decides to shift to the Federal Marketplace (website).
Medicaid expansion begins for adults up to 138% FPL. Easy access to coverage may slow ABAD caseload growth.
Scheduled redeterminations deferred by 6 months.
Q1 2012 shows signs of economic recovery.
Budget reductions impact administration, provider/MCO rates, prioritized list of services, outreach and marketing, funding for safety net clinics.
Health System Transformation bill passes and is signed into law.
Governor initiates across-the-board General Fund reductions in response to the deficit; MAP's General Fund budget is reduced $44.3 million.
New MMIS implemented.
Coverage restored for Long-Term Care SPL 12-13.
OHP funding reduced as a result of 2001 economic recession.
105,000
95,000
85,000
75,000
65,000
55,000
45,000
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
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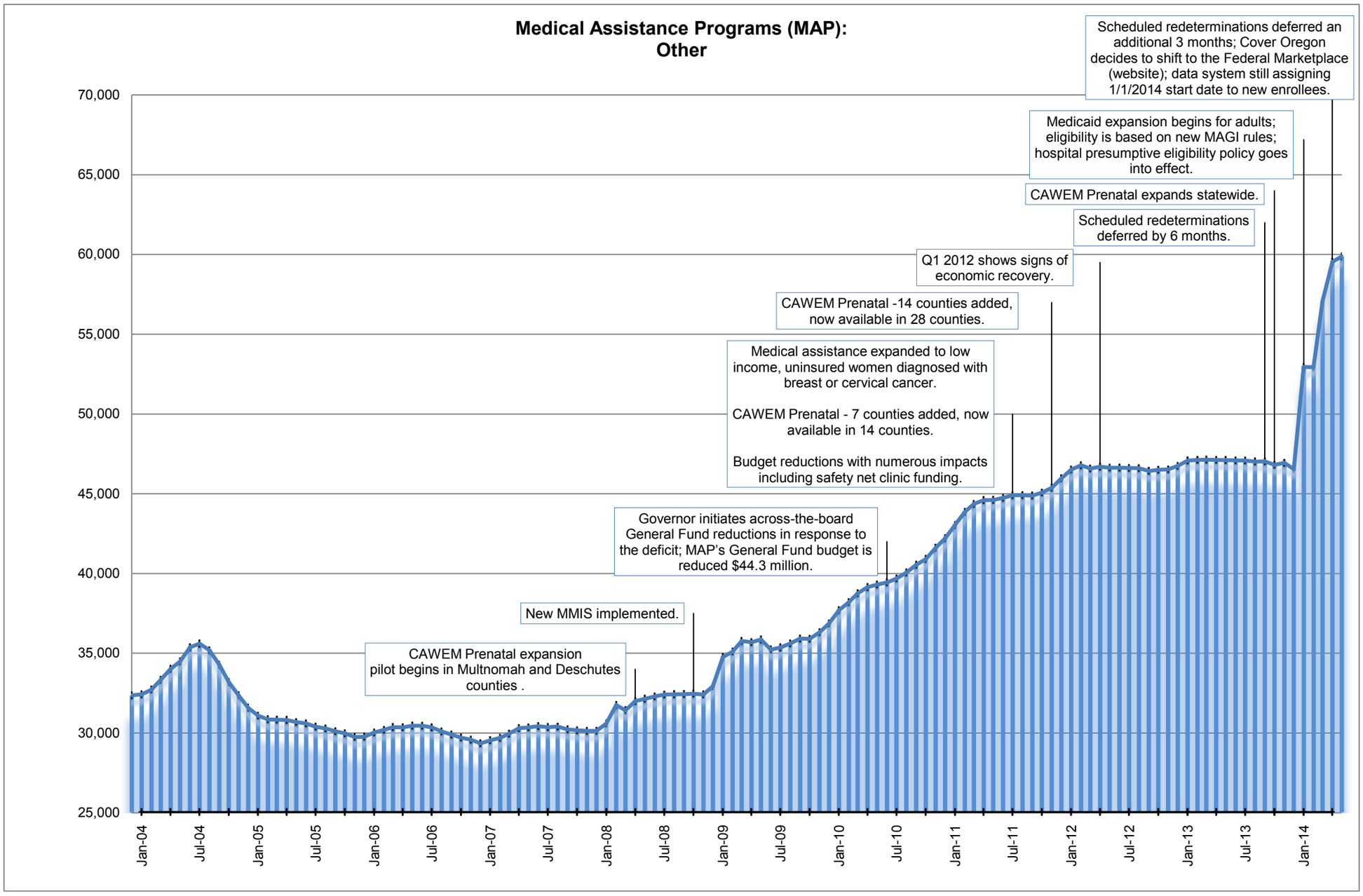
Jan-13
Jul-13
Jan-14


Medical Assistance Programs (MAP):
Other
Scheduled redeterminations deferred an additional 3 months; Cover Oregon decides to shift to the Federal Marketplace (website); data system still assigning 1/1/2014 start date to new enrollees.
Medicaid expansion begins for adults; eligibility is based on new MAGI rules; hospital presumptive eligibility policy goes into effect.
CAWEM Prenatal expands statewide.
Scheduled redeterminations deferred by 6 months.
Q1 2012 shows signs of economic recovery.
CAWEM Prenatal -14 counties added, now available in 28 counties.
Medical assistance expanded to low income, uninsured women diagnosed with breast or cervical cancer.
CAWEM Prenatal - 7 counties added, now available in 14 counties.
Budget reductions with numerous impacts including safety net clinic funding.
Governor initiates across-the-board General Fund reductions in response to the deficit; MAP's General Fund budget is reduced $44.3 million.
New MMIS implemented.
CAWEM Prenatal expansion pilot begins in Multnomah and Deschutes counties .
70,000
65,000
60,000
55,000
50,000
45,000
40,000
35,000
30,000
25,000
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
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Jul-10
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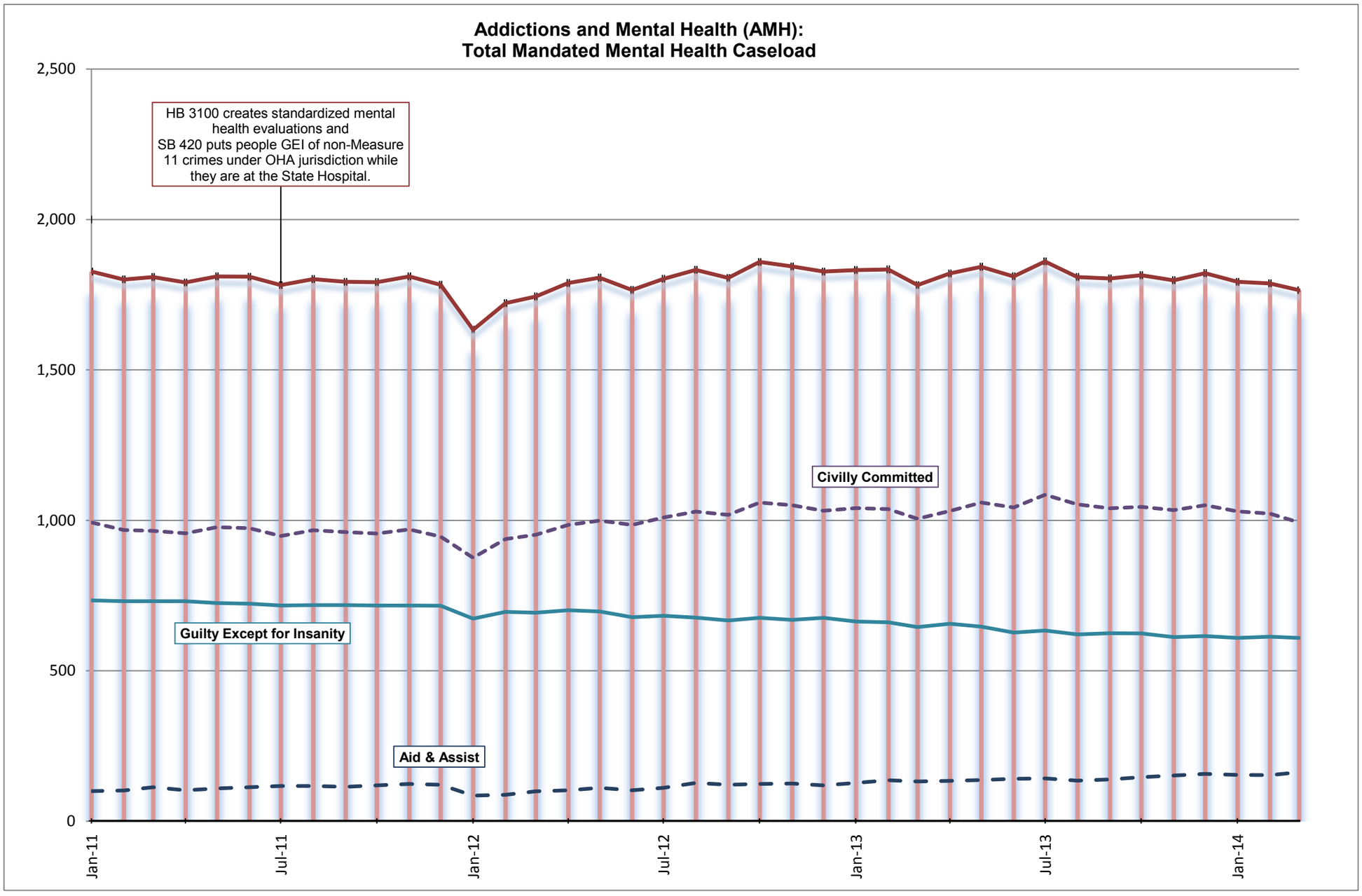
Jul-12
Jan-13
Jul-13
Jan-14


Addictions and Mental Health (AMH):
Total Mandated Mental Health Caseload
2,500
2,000
1,500
1,000
500
0
HB 3100 creates standardized mental health evaluations and SB 420 puts people GEI of non-Measure 11 crimes under OHA jurisdiction while they are at the State Hospital.
Civilly Committed
Guilty Except for Insanity
Aid & Assist
Jan-11
Jul-11
Jan-12
Jul-12
Jan-13
Jul-13
Jan-14

Federal Poverty Level (FPL)

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

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

MEDICAL ASSISTANCE PROGRAMS (MAP)

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

Historically, MAP programs were divided into three major categories based on benefit packages:

- Oregon Health Plan Plus (OHP Plus) – a basic benefit package.
- Oregon Health Plan Standard (OHP Standard) – a reduced set of benefits with additional premiums and co-payments for coverage.
- Other Medical Assistance Programs – programs that provide medical benefits but are not considered part of OHP.

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

OHP Plus Benefit Package

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

ACA Adults

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

Pregnant Woman Program

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

Poverty Level Medical Women (PLMW)

This caseload has been renamed Pregnant Woman Program.

Parent/Caretaker Relative

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

Temporary Assistance for Needy Families (TANF)

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

Children's Medicaid Program

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

Poverty Level Medical Children (PLMC)

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

Children's Health Insurance Program (CHIP)

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

Foster, Substitute, and Adoption Care

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

Aid to the Blind and Disabled Program (ABAD)

Aid to the Blind and Disabled provides medical coverage through Medicaid to individuals who are blind or disabled and eligible for federal Supplemental Security Income (SSI). The income limit is 100 percent of the SSI level (roughly 74 percent of FPL), unless the client also meets long-term care criteria, in which case the income limit rises to 300 percent of SSI (roughly 225 percent of FPL).

Old Age Assistance (OAA)

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

OHP Standard Benefit Package (discontinued December 31, 2013)

This program has ended, with clients transferred to the new ACA Adults caseload. Prior to ACA, clients in OHP Standard were not eligible for traditional Medicaid programs. OHP Standard provided a reduced package of services compared to the OHP Plus program. OHP Standard also required participants to share some of the cost of their medical care through premiums and co-payments.

Other Medical Assistance Programs (Non-OHP Benefit Packages)

Citizen/Alien Waived Emergent Medical (CAWEM)

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

- Regular (CAWEM CW) which provides only emergency medical care.
- Prenatal (CAWEM CX) which also covers all pre-natal medical services (plus up to 2 months postpartum).

Qualified Medicare Beneficiary (QMB)

Qualified Medicare Beneficiary clients meet the criteria for both Medicare and Medicaid participation. Clients in this caseload have incomes from 100 percent of SSI (roughly 74 percent of FPL) to 100 percent of FPL, and do not meet the criteria for medical covered long-term care services. DHS pays for any Medicare Part A and Part B premiums as well as any applicable Medicare coinsurance and/or deductible not exceeding the Department's fee schedule.

Breast and Cervical Cancer Program (BCCP)

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

KidsConnect (discontinued December 31, 2013)

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

ADDICTIONS AND MENTAL HEALTH (AMH)

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

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

Total Mandated Population

Mandated caseloads include both criminal commitment and civil commitment caseloads. Mandated populations are required to receive mental health services by Oregon law through community settings and State Hospitals. The State Hospitals provide 24-hour supervised care to people with the most severe mental health disorders, many of whom have been committed because they are a danger to themselves or others, including people who have been found guilty except for insanity.

Aid and Assist — State Hospital

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

Guilty Except for Insanity (GEI)

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

Civil Commitment

This caseload has been redefined to include only individuals currently under commitment (although a proxy rule is currently being used to estimate the end date for clients’ mandated service). The Civilly Committed caseload includes people who are found through a civil court process to be dangerous to themselves and/or others or are unable to care for themselves as a result of mental illness, with the court mandating treatment for the individual. They may be served at the State Hospital or in the community.

Previously Committed

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

Never Committed

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

This document can be provided upon request in alternate formats for individuals with disabilities or in a language other than English for people with limited English skills. To request this form in another format or language, contact Office of Forecasting Research and Analysis at 503-947-5185 or 503-378-2897 for TTY.

FALL 2014 DHS|OHA REGIONAL FORECASTS BY DISTRICT

Budget, Planning and Analysis
Office of Forecasting, Research and Analysis

DHS oregon department of human services

Oregon Health Authority

FALL 2014 DHS OHA
REGIONAL FORECAST BY DISTRICT

OCTOBER 2014

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Fall 2014 DHS|OHA Regional Caseload Forecast

The Regional Forecast is designed to increase the Statewide Caseload Forecast's use as a tool for regional and local policy decisions by breaking down the Statewide Caseload Forecast into smaller geographic units. By developing a regional focus on caseloads and causal factors, we hope to support a wide range of local and community partners as they, in turn, support the diverse needs of Oregonians.

This forecast presents county biennial averages for each DHS service district, as well as district totals. The result is a forecast for all 36 Oregon counties for 15 different programs within the Oregon Department of Human Services and the Oregon Health Authority.

The results of the DHS and OHA statewide biennial forecasts are also included in this document in order to provide a contrast to the county and district forecast values. For more information, see the Fall 2014 DHS/OHA Caseload Forecast.

Care must be taken in interpreting some of this forecast's results. Because county-by-county values are presented, small numerical values are forecast and published. As the number of cases in a caseload shrinks, the possibility of forecasting error grows. In general, the forecasts presented here are designed to illustrate the general magnitude of caseloads and trends for each county. They are not presented to conform to a highly specific numerical target for caseloads through June 2017. This is especially true for counties with small populations where a modest increase in caseload represents a major percentage increase.

Changes to Forecasted Caseloads

Starting in January 2014, the Oregon Health Authority implemented several significant changes in how Medicaid is delivered due to the federal Patient Protection and Affordable Care Act of 2010 (ACA). The ACA allows eligibility for Medicaid caseloads to be extended to higher income levels. As a result of this expansion, several programmatic changes occurred in Oregon Health Plan (OHP) Plus:

1. Adult citizens, 19-64 years old, are now eligible for OHP Plus coverage up to 138% of the Federal Poverty Level (FPL);
2. OHP Standard was phased out, with existing clients folded into OHP Plus;
3. A new category, "ACA Adult" was created which includes the newly eligible adults (as indicated in #1 above), former Standard clients, and transfers out of TANF-Related Medical who would have previously been considered over-income;
4. Children of families with income up to 138% of FPL now qualify for Medicaid, therefore some children who previously qualified for OHP Plus through the Children's Health Insurance Program (CHIP) were transferred to Medicaid; and
5. CHIP eligibility was extended to 300% of FPL. The Healthy Kids Connect program has been closed, and existing caseloads transferred to CHIP.

Eligibility changes have necessitated changes in how programs are organized. This reorganization is reflected in new caseload categories that appear for the first time in this forecast cycle:

1. The category of "TANF-Related Medical" has been discontinued. Adults from this category will now be a stand-alone category called "Parent/Caretaker Relative."
2. A new category called "Children's Medicaid Program" was created. This category is made up of children from "TANF-Related Medical," all clients from "Poverty Level Medical-Children," and those children who previously qualified for CHIP who were transferred to Medicaid (see #4 above).
3. The "Poverty-Level Medical Women" category has been renamed "Pregnant Women Program."
4. The ACA Adults program has been split into two groups, one representing ACA Adults who have children in the household: "ACA Adults with Children," and a category of ACA Adults who have no children in the household: "ACA Adults without Children."

There are multiple unknowns at play when estimating participation in a new program and reformulating existing ones. Chief among them is the rate at which new clients will choose to take advantage of the expanded eligibility. The initial modeling for the uptake of expanded Medicaid was prepared by the State Health Access Data Assistance Center (SHADAC) in concert with the Oregon Health Authority (OHA). However, this estimate was quickly abandoned as pre-enrollment in the fall of 2013 exceeded the expectations of the model. The most recent forecast assumes that 78% of the total expected population of adult ACA clients (including transfers from other programs) entered the caseload on January 1, 2014. Furthermore, the forecast assumes that 99% of total expansion will occur by mid-2015, eventually topping out at about 299,500 cases by mid-2017.

Although current data is generally in agreement with this estimate, the creation of any new program will, by definition, be a venture into the unknown. Without a caseload his¬tory to draw from, the forecasting process is based on best-evidence estimations without the foundation usually available for the forecasts. The likelihood of forecast error, there¬fore, is larger than for established programs. Under these circumstances, error at the county level is magnified.

In addition to the difficulty with forecasting a new program, the publicity surrounding healthcare expansion also opens the door for a possible "welcome mat effect," where enrollment often occurs not only among the newly eligible, but also among the previously eligible populations who would not have otherwise applied for services. Although growth in non ACA-related caseloads indicates there has been some welcome mat effect, the exact magnitude of that effect cannot be determined due to an array of other changes occurring at the same time. Nevertheless, the welcome mat effect remains one of many risks to the accuracy of this forecast.

The ACA expansion also influenced forecasting accuracy due to pressures put on the OHA system overall. In order to adequately deal with the high volume of new enrollments, redetermination of eligibility for some existing cases was suspended in the fall of 2013, and was only recently re-initiated. The current redetermination plan includes both the normally occurring redeterminations as well as an aggressive schedule for working through the redetermination backlog. This sudden review of large numbers of cases will necessarily create a downward pressure on caseloads equal to the previous upward pressure related to suspending redeterminations. This downturn in caseload is modeled in the current forecast, but the specific details are difficult to estimate, both in timing (when the caseloads will go down related to the backlog being addressed) and magnitude (how many cases will be closed or transferred to a new program as a result of the redeterminations).

Changes in the economy are a persistent risk to the accuracy of all forecasted caseloads. Although patterns of economic improvement and caseload reductions in human services have been documented in previous recessions, the only reference point for the extraordinary events of the Great Recession is the "double-dip" recession of 1981. That recession and recovery predate the existing programs in DHS and OHA, making it difficult to reconcile those patterns to the current situation found in Oregon. Patterns of recovery are especially difficult to forecast at the county level, given that different parts of the state have different economic and employment resources to draw on.

Special Sections

Two special sections are presented in this document.

The first shows Oregon counties through the lens of a "hardship score" developed by the New York Times Magazine. The Times created this particular scoring system in an article about Clay County, Kentucky. The county was portrayed as the "hardest place in America to live" based on its performance on several "livability measures" – educational attainment, household income, unemployment rate, disability rate, live expectancy, and obesity. This section presents Oregon counties in the same manner. Although the measures used by the New York Times might be controversial in terms of what determines "livability" or "hardship," these measures are nevertheless useful for understanding how the economy and the residents of the counties are doing, and how they're likely to do in the future.

The second special section illustrates areas of the state with the highest poverty density – that is, spots with the highest percentage of poor residents within a relatively small area. These poverty density measures are at the level of census tracts, and represent the first time the regional forecast has presented data at a smaller-than-county level.

Regional Forecast Methodology

Each forecast was developed using time series models; however, different methods were used for different programs based on goodness-of-fit. For the current forecast, several programs used the Statewide Forecast as an independent variable. This controlled for the inability of local time series models to detect the variation caused by the recession and recovery. However, it also means that, in the future, counties that do not follow the statewide trend could be distorted to match the expected statewide pattern. As patterns at the county level are better understood, forecasts will become more accurate.

Goodness-of-fit was determined for each program's forecast by summing the total county values and comparing the result to the official Statewide Forecast. Generally, if the Regional Forecast was within 5 percent of the Statewide Forecast, it was accepted as valid. There will be some inherent error because regional values used for the analysis will never total the exact amount of the statewide historic values. In addition, statewide forecasts use different forecast methods not available to the regional forecasts.

To avoid internal discrepancies, each forecast is apportioned to the official Statewide Forecast. Thus, the critical information from the regional forecast becomes the forecast direction of caseload change and the magnitude of change in comparison to the state as a whole.

Data from multiple sources were used in order to interpret the forecast for each county and provide basic demographic and economic information. Information was included from:

- The U.S. Census Bureau, "American Community Survey" 1 year (2012) estimates, 3 year (2010-2012) estimates, and 5 year (2008-2012) estimates.
- The Oregon Employment Department's "Oregon Labor Market Information System," "Current Employment Statistics" and "Labor Force and Unemployment by Area" data, August, 2014;
- The Portland State University Population Research Center, "Estimates of Population Age Groups for Oregon and Its Counties," July 1, 2013;
- Oregon Economic and Revenue Forecast, June, 2014, Volume XXXIV, No.2.

Counties of Oregon and the "Livability Index"

This section focuses on the “livability” of counties across the state using a method created by the New York Times Magazine in a story about Clay County, Kentucky[1]. The Times’ scoring method examined county performance based on two groups of indicators: one economic, and the other health-based. Economic indicators of livability include educational attainment (number of residents with a college education), household income, and unemployment rate. The measures of health include disability rate, live expectancy, and obesity.

This section presents Oregon counties in the same manner. Scores on the six measures of livability were developed. An overall index was created based on the ranking of each county compared to the other counties in the state, and averaged to create a single livability score. The results appear on the following pages. Each table shows how the county scored on the six measures, as well as the index score each achieved. In the far right column is a rank of that county compared to every county in the United States (all 3,135 of them) as scored by the New York Times.

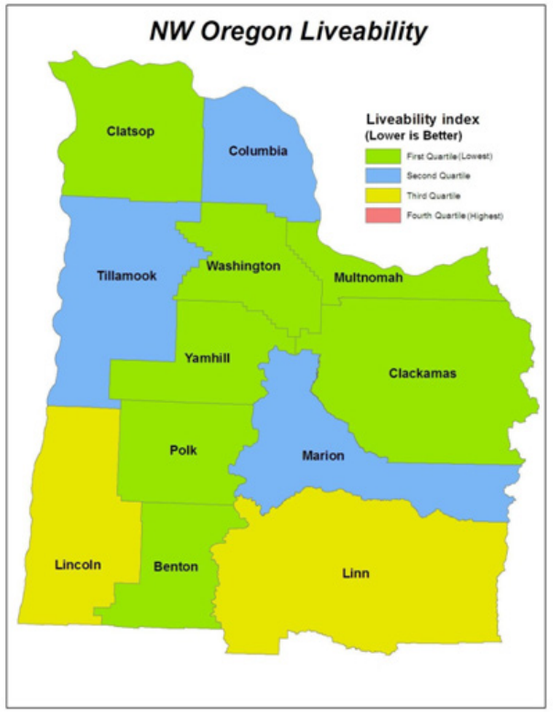
Index values are displayed in maps with colors representing where the county scored in quartiles – the lower the score, then better the county’s performance. Best scores are displayed in green, second best in blue, third quartile in yellow, and bottom quartile in red.

Although the measures used by the New York Times might be controversial in terms of what determines “livability” or “hardship,” these measures are nevertheless useful for understanding how the economy and the residents of the counties are doing, and how they’re likely to do in the future.

1. See: http://www.nytimes.com/2014/06/29/magazine/whats-the-matter-with-eastern-kentucky.html

Livability Index: Northwest Oregon

County	Median Hhold Income	% with College Education	% Unemployed	% Disabled	Life Expectancy	% Obese	Index Score	Rank (of 3,135 Counties)
Clatsop	$45,691	21.1%	6.1%	1.1%	78.3	35%	12.5	1,097
Columbia	$52,739	17.4%	7.6%	1.3%	78.2	38%	18.7	1,481
Tillamook	$42,957	20.3%	6.5%	1.1%	78.8	36%	14.5	1,368
Multnomah	$54,024	39.2%	6.2%	1.4%	78.9	30%	7.3	597
Clackamas	$66,758	31.8%	6.2%	0.7%	80.1	33%	4.0	271
Washington	$63,238	39.5%	5.8%	0.6%	81.4	32%	2.2	103
Marion	$46,873	20.8%	7.4%	1.4%	78.4	38%	18.0	1,546
Polk	$49,781	28.5%	6.7%	1.0%	79.6	39%	11.8	989
Yamhill	$58,612	22.5%	6.6%	0.8%	79.8	37%	9.3	786
Benton	$47,808	48.6%	5.5%	0.7%	81.2	32%	3.7	159
Lincoln	$42,342	24.0%	7.7%	1.5%	77.4	37%	22.0	1,664
Linn	$45,130	16.1%	8.5%	1.7%	77.7	37%	23.8	1,828



As a region, the counties of the Northwest part of the state score best on the "livability Index." This isn't surprising, given the resources available in the urban center of the Portland Metro area. Clatsop County score is aided by its relatively low unemployment. Columbia County has a very high income rank, yet a low number of college educated people, especially in contrast to the rest of the region. Tillamook County is a bit low in income and the number of college educated in the county, but scores well on the other measures.

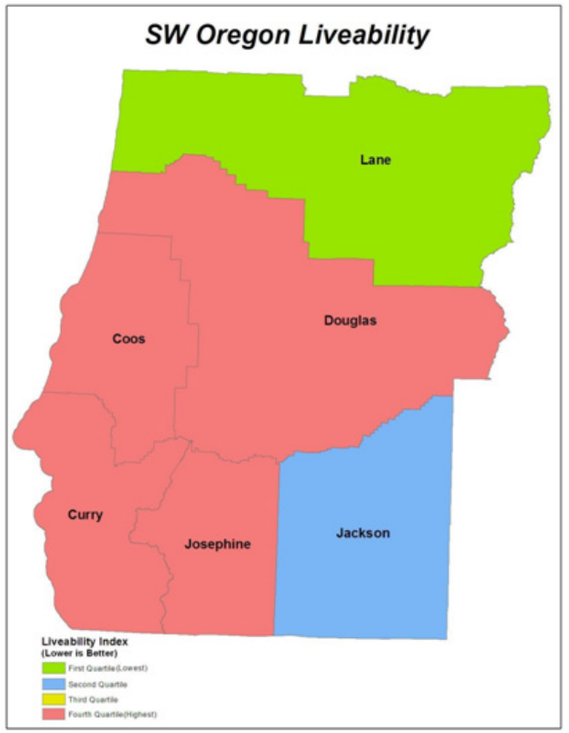
Multnomah, Clackamas, and Washington all score very high on all measures with one exception – Multnomah County has a high number of disabled persons. This may be due to the number of disabled people moving to the Portland Metro area in search of services that they would not otherwise find in other parts of the state.

The mid-valley area is a mixed bag in terms of livability scores. Marion County is solidly in the middle of the pack compared to other counties in the state, but has high obesity and disability ranks, a bad sign when thinking about the overall health of a region. Polk County scores in the top ten in some measures, but has a very high obesity ranking, as does Yamhill. Benton County has the highest proportion of college educated residents in the state, and scores in the top five in all other livability measures except income, which is a bit low. The income measure may be weighed down a bit by the large number of college students in Corvallis.

Lincoln and Linn counties don't fare as well as their neighbors in livability scores, Lincoln does well in numbers of college educated residents, but is near the bottom in life expectancy and percent of the population with disabilities. Linn also ranks near worst in disabilities, and has a very low percent of the population with a college education.

Livability Index: Southwest Oregon

County	Median Hhold Income	% with College Education	% Unemployed	% Disabled	Life Expectancy	% Obese	Index Score	Rank (of 3,135 Counties)
Lane	$43,459	27.5%	6.9%	1.4%	79.3	33%	12.7	1,087
Douglas	$40,605	15.2%	9.8%	1.6%	77.4	38%	29.5	2,228
Coos	$37,345	17.8%	8.9%	2.1%	76.5	39%	30.5	2,379
Curry	$38,017	20.4%	10.7%	1.3%	77.5	37%	25.7	1,881
Jackson	$43,363	24.4%	8.6%	1.1%	78.6	32%	14.0	1,215
Josephine	$38,298	16.4%	9.8%	1.8%	77.3	36%	28.5	2,198



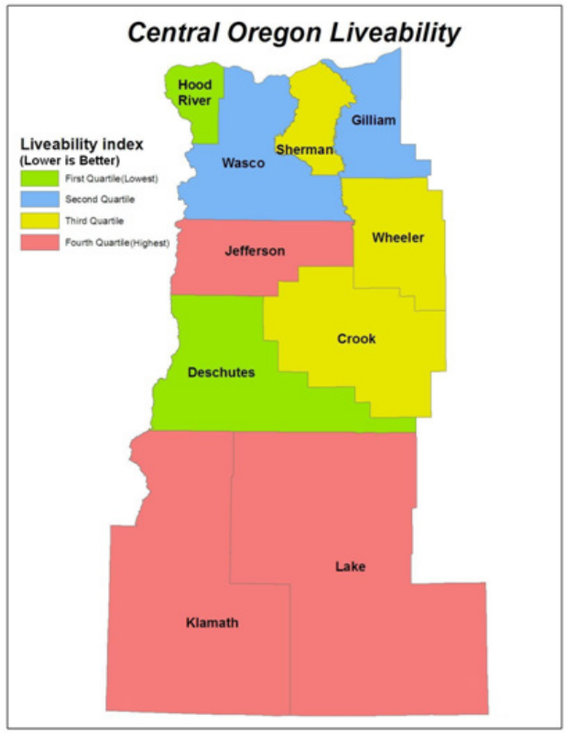
The southwest region of the state has some of the poorest performers in the "livability Index," with especially poor health indicators (such as disability and life expectancy). The one outlier is Lane County, which scores in the top ten in number of college educated, life expectancy, and low rates of obesity. Douglas County fares poorly in all ranking, near bottom in every livability measure except income, which is closer to the middle of the pack. Douglas County has been dealing with high unemployment for a long time, and has a greying population, more inclined to disability and obesity.

Coos and Curry counties have been dealing with high unemployment and low income since before the Great Recession, which pulls their rankling down. Curry has one of the highest unemployment rates in the state, and Coos County has the poorest scores in the state in disability and life expectancy. Josephine County also fares poorly in measures of healthy population, with scores near the bottom in disability and life expectancy (but fares better than some of its neighbors in obesity).

Jackson County, with the economic engine of Medford, fares better than any of its immediate neighbors, with top-five scores on college education and low obesity. Disability and life expectancy are fairly good, as is income. Medford has been struggling with high unemployment, which keeps its overall livability score down a bit, but it is improving. Given the advantages the Medford area has in education and health, it's likely that it is poised for better times, especially if California immigrants start to arrive in the numbers they did before the Great Recession.

Livability Index: Central Oregon

County	Median Hhold Income	% with College Education	% Unemployed	% Disabled	Life Expectancy	% Obese	Index Score	Rank (of 3,135 Counties)
Gilliam	$45,833	16.1%	6.3%	1.4%	78.0	38%	19.3	1,599
Hood River	$58,344	26.4%	5.1%	0.5%	79.4	35%	5.2	311
Sherman	$44,583	14.8%	6.3%	1.5%	78.0	38%	22.7	1,842
Wasco	$42,080	20.6%	6.4%	1.4%	78.0	40%	20.8	1,674
Wheeler	$36,357	14.8%	7.0%	1.2%	77.5	36%	23.3	1,760
Crook	$35,052	14.4%	10.2%	1.2%	78.7	35%	24.0	1,844
Deschutes	$46,791	30.5%	8.2%	0.8%	80.1	28%	8.2	552
Jefferson	$45,069	15.5%	9.5%	1.6%	77.9	39%	26.7	2,056
Klamath	$36,885	19.5%	9.9%	1.7%	76.6	34%	27.2	1,945
Lake	$40,049	19.8%	9.5%	1.7%	76.6	34%	25.0	1,959



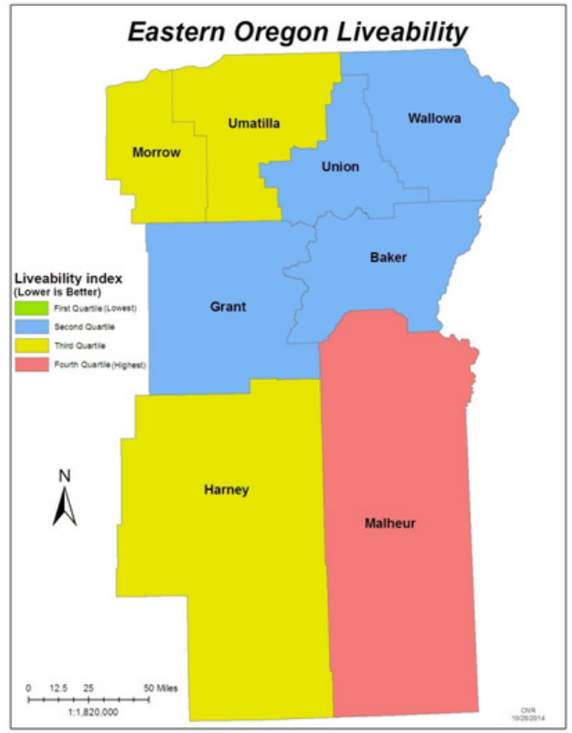
The central part of Oregon is most definitely a mixed bag, with some of the best and worst performers on "livability." Among the counties in the gorge area, Hood River scores best, ranking in the top ten in every measure of livability, even rates of the college educated – a pattern not generally seen in counties with agricultural roots. It's a sign that Hood River is pivoting away from agriculture/tourism and toward new industries, as well as becoming an "xburb" of Portland.

Other areas of the gorge fare well in livability, with relatively low unemployment and good to middle scores on other indicators. There are some wrinkles, though – Wasco is near the bottom in measures of obesity. Sherman is near the bottom in college education. Wheeler is near the bottom in income.

The middle section of the state – Crook, Deschutes, and Jefferson counties – took a big economic hit during the Great Recession, and it has carried over. Crook is near bottom in income, number of college educated residents, and unemployment, yet scores well on measures of health. Jefferson scores near the bottom on almost every measure except income, which is moderately good. Deschutes, though, is where the best news resides. After a deep slide due to the housing crisis, the Bend area is roaring back, with good scores in income and an improved unemployment picture. Added to that top-ten scores on all health measures and relatively high income, and it looks like the Bend area is poised for much better days going forward.

Livability Index: Eastern Oregon

County	Median Hhold Income	% with College Education	% Unemployed	% Disabled	Life Expectancy	% Obese	Index Score	Rank (of 3,135 Counties)
Morrow	$48,457	11.1%	7.8%	1.0%	77.5	40%	22.7	1,941
Umatilla	$48,514	14.8%	7.6%	1.2%	77.5	41%	22.7	1,887
Baker	$40,348	20.5%	8.7%	1.4%	78.6	36%	20.7	1,584
Union	$41,462	21.5%	7.5%	1.3%	78.3	36%	17.7	1,432
Wallowa	$40,204	22.3%	9.0%	0.9%	78.6	36%	17.0	1,346
Grant	$34,337	17.5%	11.2%	0.9%	78.8	35%	20.7	1,679
Harney	$39,674	15.7%	10.5%	1.4%	78.8	35%	23.3	1,823
Malheur	$36,318	13.7%	8.9%	1.5%	77.1	37%	30.3	2,233



The eastern side of the state is the only region that has no counties in the first (that is, best) quartile in “livability score.” Still, the east has some strengths, although they are somewhat undermined by a poor job market that has kept unemployment high for years.

Morrow and Umatilla score in the top ten in income level, but share the very bottom two scores in obesity rate. Both counties are also lagging behind other parts of the state in number of college educated residents, and life expectancy.

Baker and Union counties manage to score in the middle of the pack on all measures of livability. Wallowa is essentially the same as the other two, but with a relatively low score on income.

Grant County has favorable ranking in health measures – numbers of disabled residents, life expectancy, and obesity. But Grant is dead last in unemployment and income level. The local economy in Grant County has been a long-term problem. Harney and Malheur counties also score near the bottom in income and unemployment. These two counties also score poorly on numbers of college educated and rates of disability. Malheur has a poor score on rates of obesity compared to other counties in the state.

Areas of High Poverty Density

The US Census Bureau organizes the county into census tracts in order to conduct the decennial census. Each tract is required to be within the same county, and be contiguous. Because census tracts were designed to facilitate the census count, some tracts can be very large in rural areas where few people live, or quite small in urban areas with a dense population.

Tracts are useful for analysis of social and demographic issues, and a good deal of data is collected by the Census Bureau at the census tract level. This analysis looks as poverty in census tracts in Oregon.

The Census Bureau defines census tracts of "high poverty density" as any tract that has 20 percent or more residents living in poverty. Oregon has quite a few of these areas – more than can be described in this publication. To highlight the very highest poverty areas. This report focuses on areas where one in three residents (33%) are in poverty. For a more detailed analysis of all the high poverty density areas, see http://www.oregon.gov/dhs/ofra/Pages/index.aspx and click High Poverty Hotspots - 2014.

At right is a map showing all of the state's highest poverty areas. The graphics are organized so that color represents the percent of the population in poverty, while the size of the circle represents the total number of people in poverty. The most intensive poverty areas would therefore have a high percent in poverty, and a large number of people in poverty.

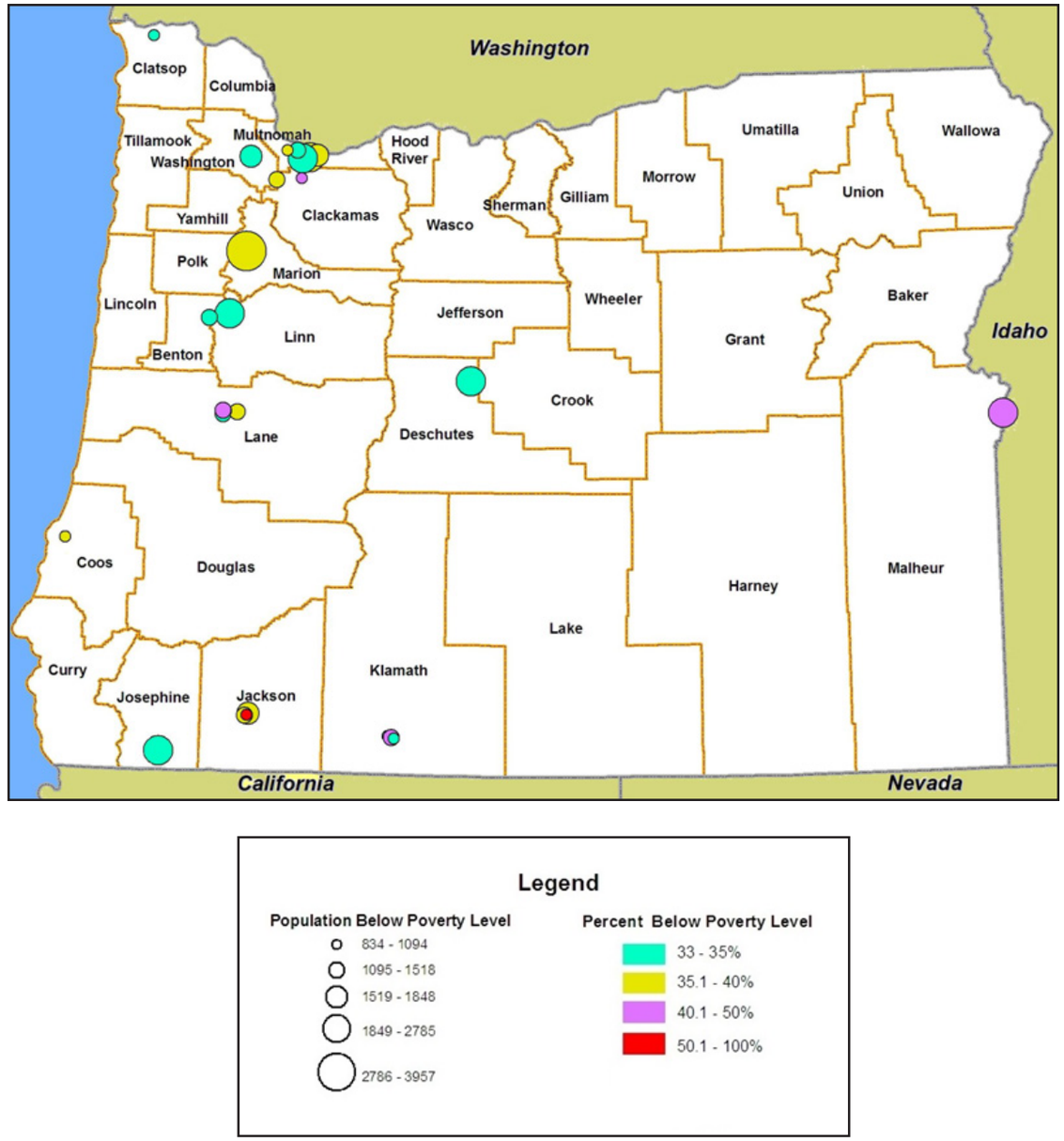
As can be seen on the map, poverty density is not an urban phenomenon. One of the highest poverty counts is in rural Josephine County, in the Cave Junction area. Another is located in Redmond, in Deschutes County.

High Poverty areas can happen in any part of the state, regardless of overall economic conditions. Clackamas and Washington counties are generally considered high-wealth areas when measuring median household income, yet both contain high-poverty neighborhoods.

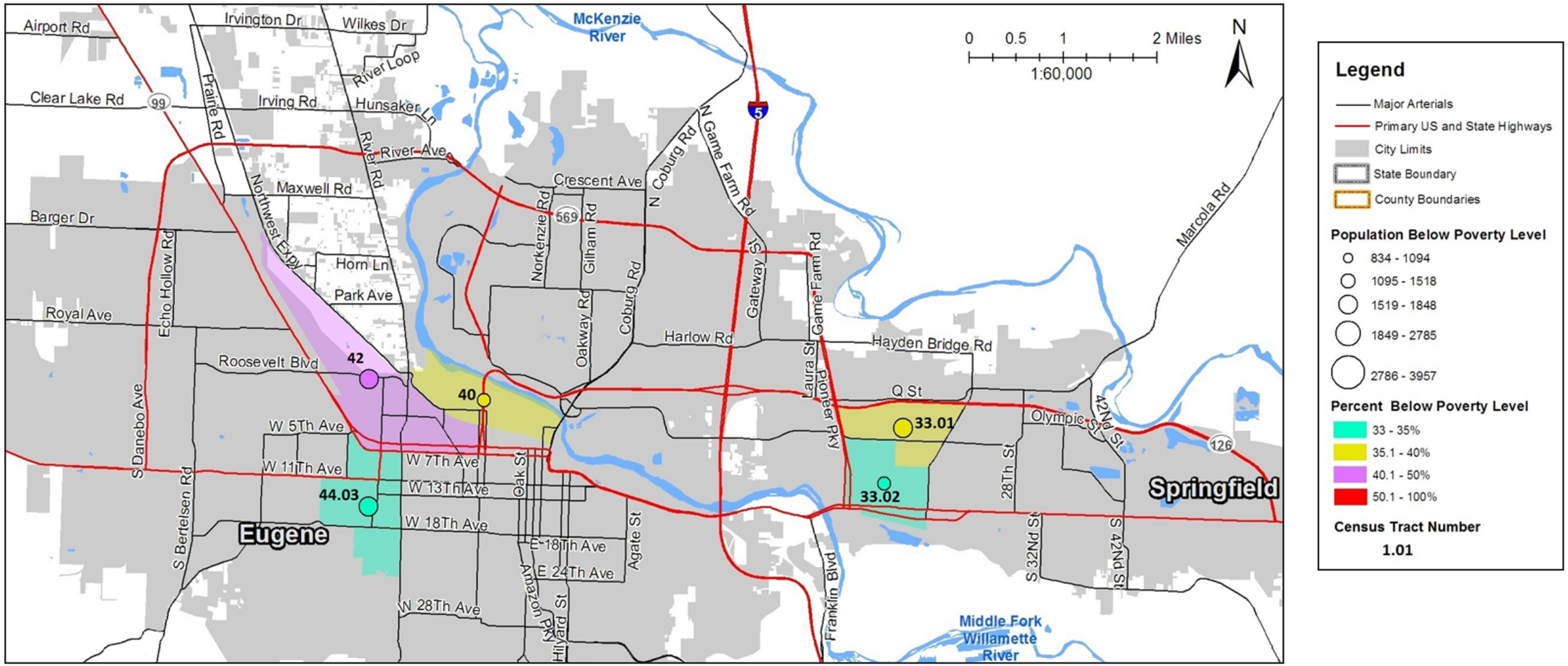
Detailed maps of the high-poverty areas can be found on the following pages, along with information about the demographics of the census tracts being examined. Almost all the census tracts displayed in this publication are different than the state overall in several ways:

1. A higher percentage of people on public assistance (TANF, SNAP),
2. A higher percentage of single parents (especially in urban tracts),
3. A higher percentage of disabled persons (especially in rural tracts),
4. A larger number of racial and ethnic minorities (true of all urban and some rural tracts),
5. A much smaller number of high school graduates, and
6. A larger number of persons employed in service sector jobs. Service sector jobs are often found to be low-paying, and provide only part time or part year employment.

Some census tracts that met the criteria for inclusion in this analysis were eliminated because they contained a very large number of people living in group quarters, such as is common with college dormitories and prisons. Other tracts were eliminated due to the overwhelmingly large number of college students living in the tract (the cutoff was 75 percent or greater enrolled in college). Although it is true that some college students meet the traditional definition of poverty, others who have little or no income are actually supported by other means, and including them could distort this analysis.

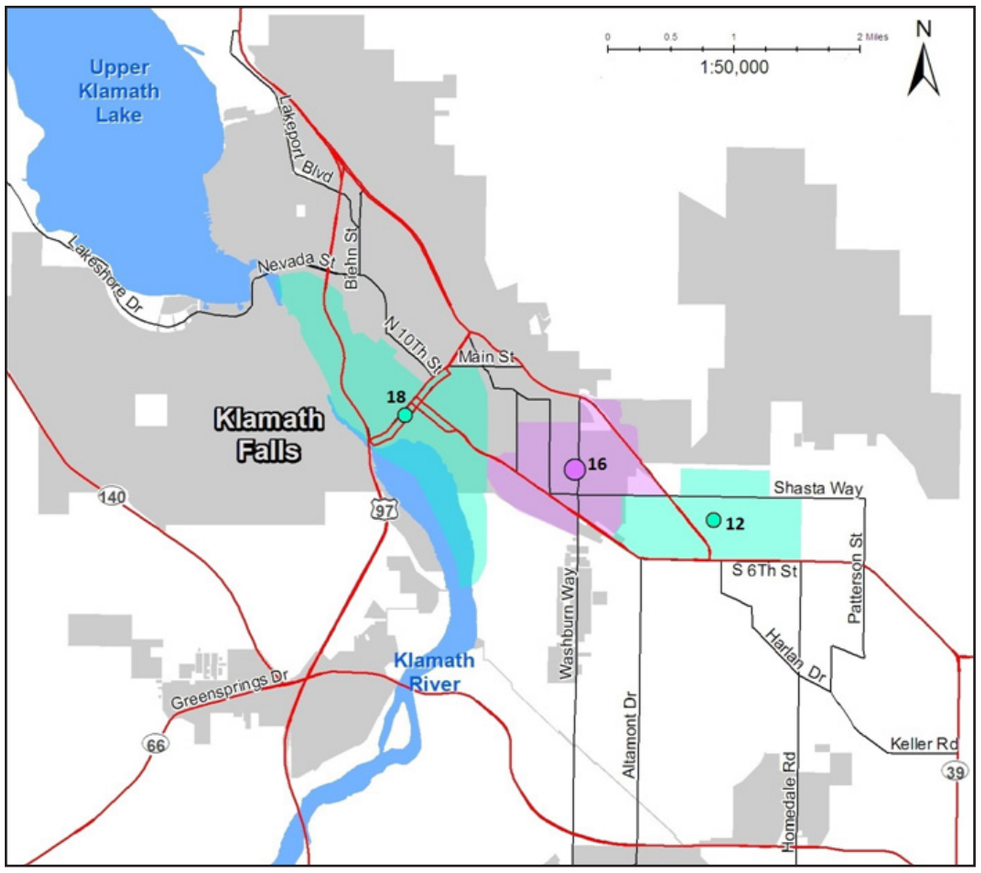


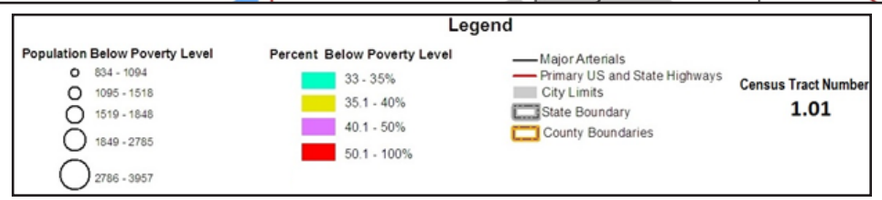
Areas of High Poverty Density: Eugene/Springfield



Eugene/Springfield - This metro area contains several areas of high-density poverty. All four census tracts illustrated here have a large percentage of disabled people in the census tract and a large percentage of people living on $10,000 or less per year. It should be noted that other census tracts which also show high-poverty density in the Eugene area have been eliminated from this analysis, given that they contain a large preponderance (over 75%) of residents enrolled in college.

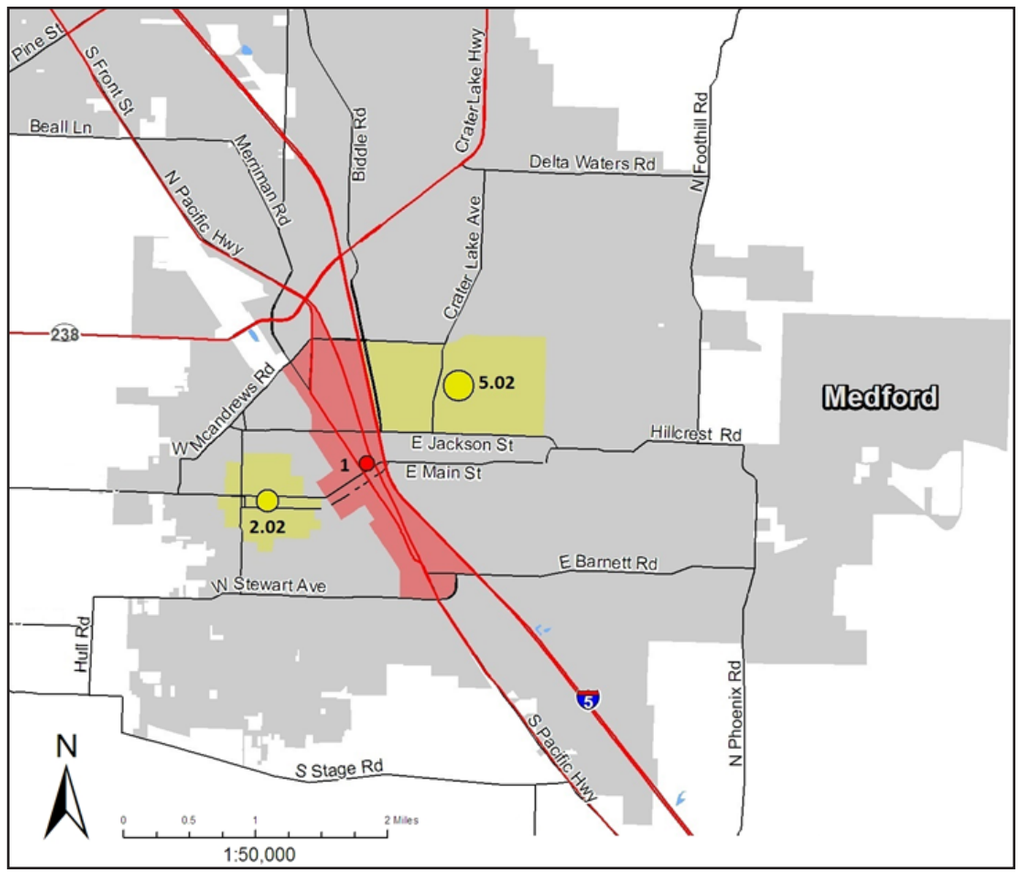
Areas of High Poverty Density: Klamath Falls and Medford





Klamath Falls - Census tracts 9712, 9716, and 9718 (referred to as 12, 16, and 18 on the map above) follow state Highway 39 and Business 97 through the northern part of the city of Klamath Falls. Tracts 9712 and 9716 have high concentrations of Hispanics, especially census tract 9716, where over a third of residents are Hispanic. Tract 9716 is also notable in the number of residents with a college education – only 5.7 percent, the lowest of all high-poverty tracts under consideration in this document. Statewide, 30 percent of the population is college educated.

Census tract 9718 has a very high American Indian population (12.5 percent, versus less than 2 percent statewide) and a high percent of disabled residents (22 percent).



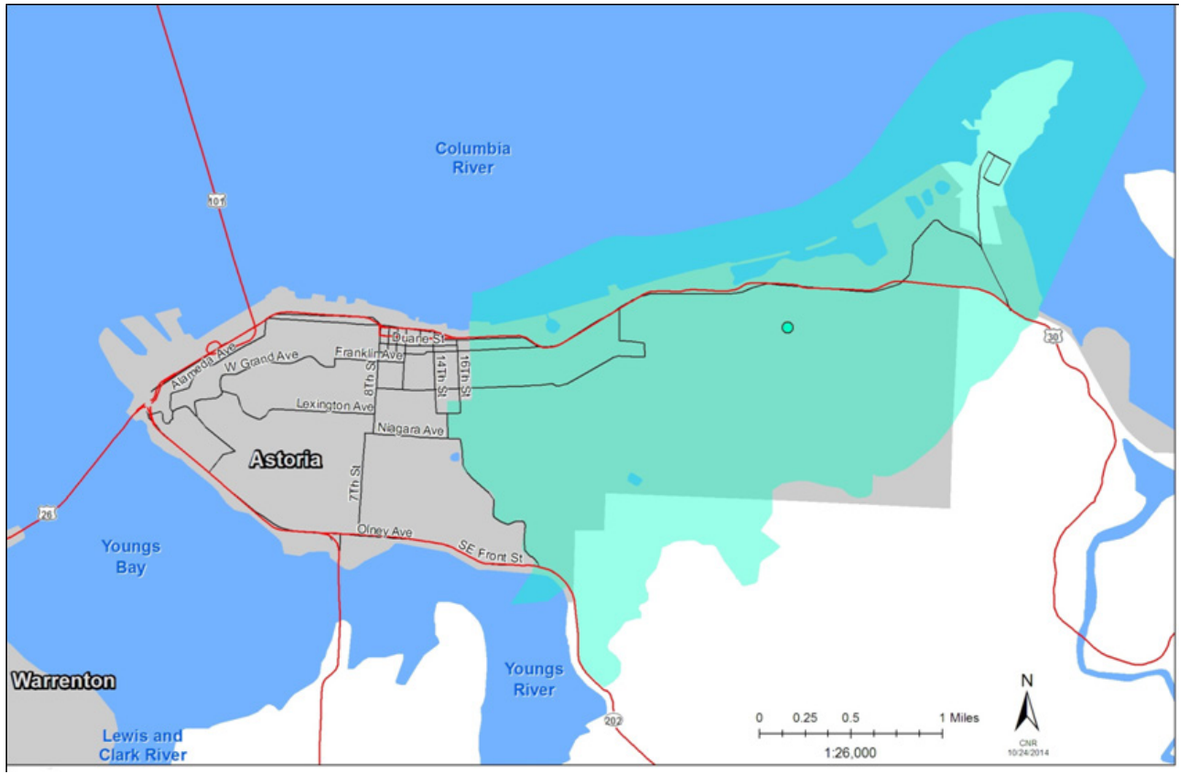
Medford - Jackson County's census tract 1 is sandwiched between highway 99 and interstate 5 in central Medford. It contains the highest concentration of poverty of any tract in the state. Over 50 percent of the residents of the area are living in poverty. Almost a third of all households are getting by on less than $10,000 a year. It has the highest percentage of residents in service sector jobs (42 percent) of any high-poverty tract in the state, is very high in numbers of disabled people (28.5 percent, essentially double the statewide value), and is very high in percentage Hispanic (one third of all residents). Probably as a result of the large Hispanic population, the number of households where English is not spoken in the home is very high (28 percent of the area, compared to 15 percent statewide).

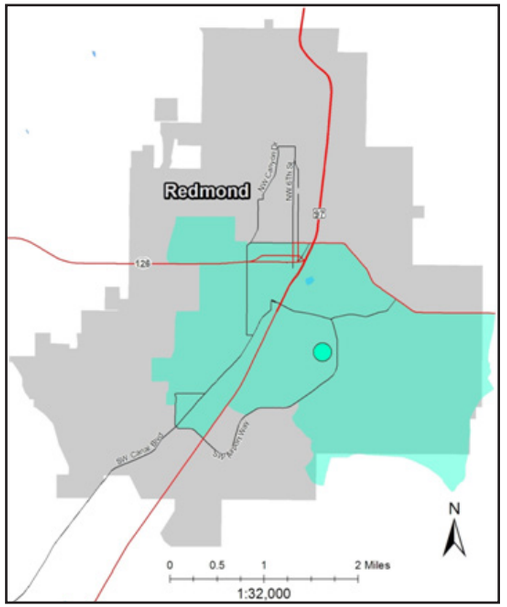
Only 64 percent of the residents of census tract 1 completed high school.

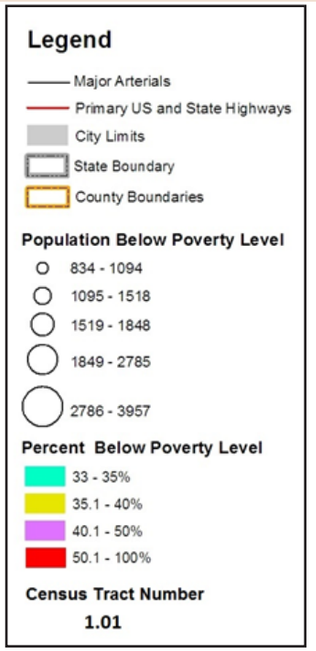
Census tract 2.02 is adjacent to tract 1, to the west along west Main St. like census tract 1, about a third of the residents are Hispanic. It also has a high number of residents who live on less than $10,000 a year.

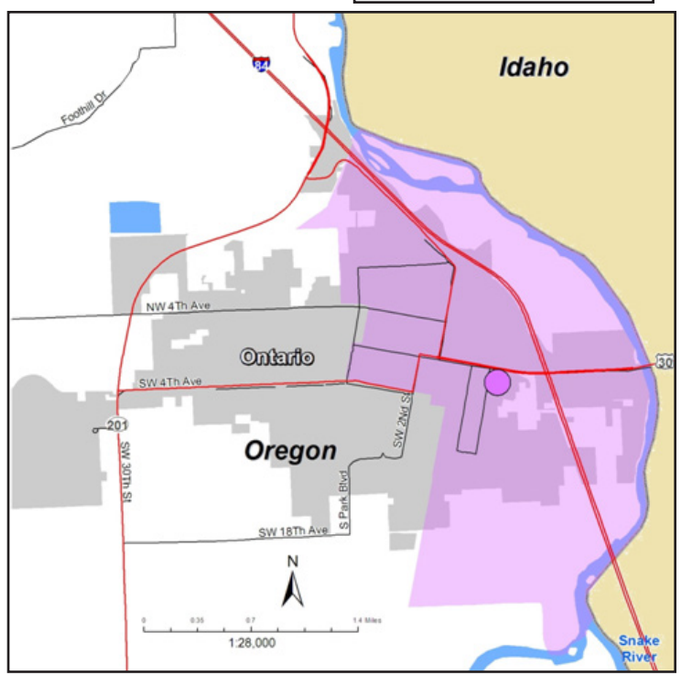
Tract 5.02 is east of interstate 5, south of East McAndrews Road. It is high in the number of households getting by on less than $10,000 a year.

Areas of High Poverty Density: Astoria, Redmond, and Ontario







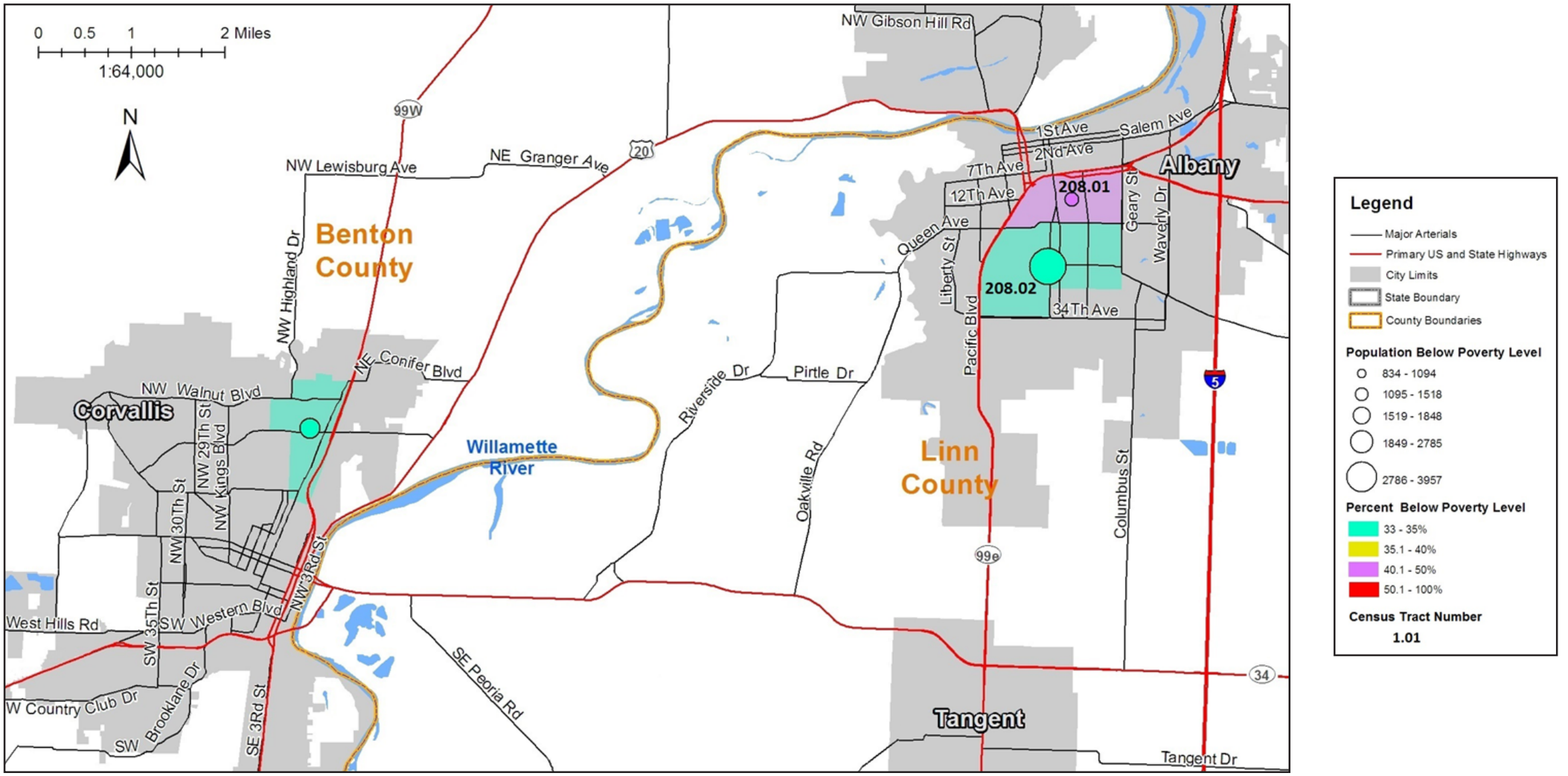


Astoria - Census tract 9503 in Clatsop County (above) comprises the eastern half of Astoria. It contains a large concentration of Hispanic residents (17 percent, compared to 12 percent of the state as a whole), and a large percentage of households where a language other than English is spoken in the home (20 percent, versus 15 percent statewide). Despite the fact that the eastern Astoria area has high-density poverty, it is somewhat economically diverse, with a higher median household income than most areas fitting the high-density definition.

Redmond - Census tract 9 in Deschutes (upper right) represents the southeastern area of the town of Redmond, Oregon. Its northern boundary is essentially highway 126 as it snakes through town. It has a high concentration of Hispanic residents (15 percent in the tract, compared to 12 percent statewide) and a higher concentration of households with children (thirty-seven percent in the area, compared to 29 percent statewide).

Ontario - Malheur County's census tract 9704 (bottom right) comprises the eastern half of the city of Ontario. It is the smallest, most densely populated census tract in an otherwise rural county. It is very high in number of households getting by on less than $10,000 a year (21 percent), very high in number of Hispanic residents (54 percent, the highest ratio of all tracts measured here) and is very high in residents who speak a language other than English in the home (45 percent). Only 65 percent of the residents of the eastern part of Ontario completed high school.

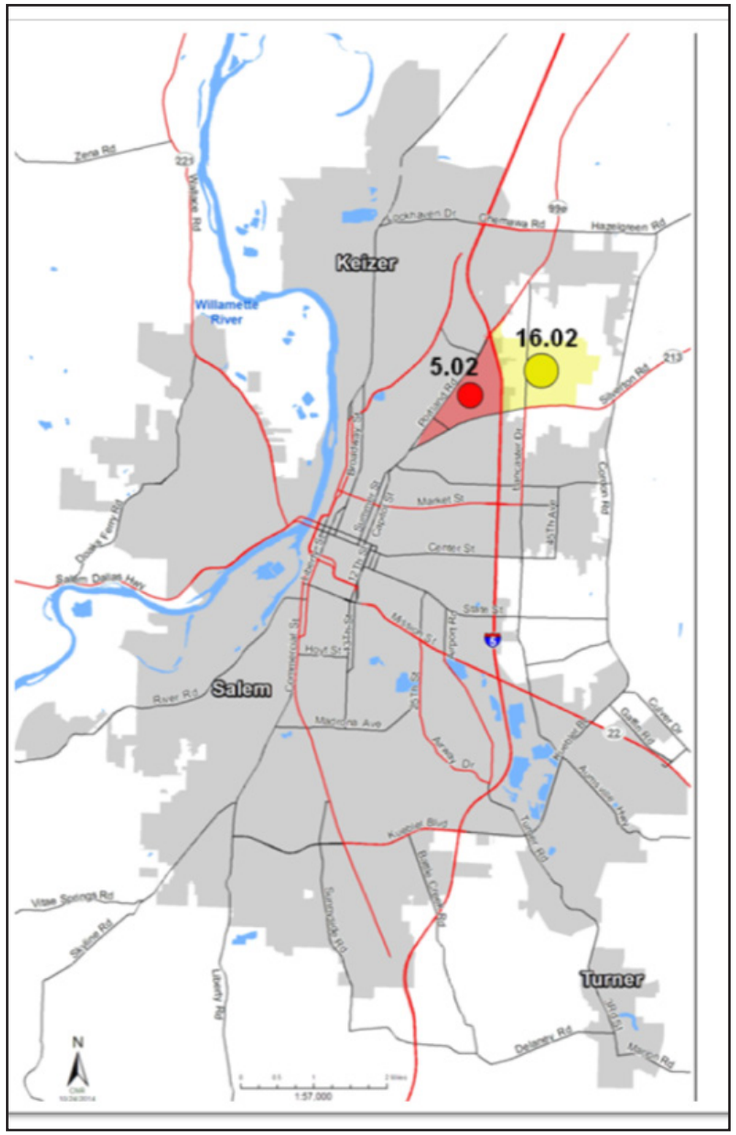
Areas of High Poverty Density: Corvallis and Albany



Corvallis - Census tract 10.01 hugs the western side of highway 99 as it enters the city limits of Corvallis. It is higher in racial/ethnic minorities compared to statewide (larger numbers of African American, Asian, and Hispanics than can be found statewide), and has a high number of families reporting speaking a language other than English around the house (27 percent in the tract, compared to 15 percent statewide). It should be noted that other census tracts which also show high-poverty density in the Corvallis area have been eliminated from this analysis, given that they contain a large preponderance (over 75%) of residents enrolled in college.

Albany - Neighboring Linn County has two census tracts that are high in poverty: 208.01 and 208.02. These tracts represent the central part of the city of Albany. These two tracts contain a large number of households that get by on less than $10,000 a year. Tract 208.01 has a higher percentage of American Indian residents (5.8 percent) than is found statewide. Tract 208.02 contains a very high concentration of disabled persons (28.5 percent of residents).

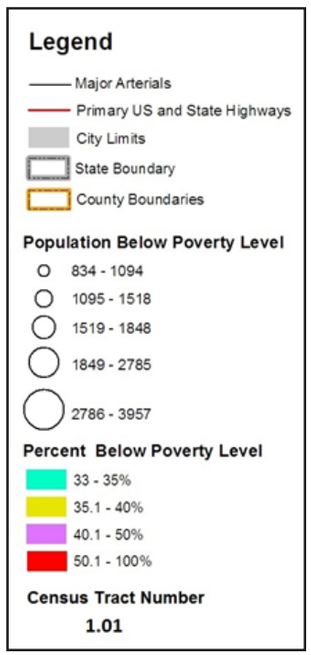
Areas of High Poverty Density: Salem, Rural Josephine County and Coos Bay

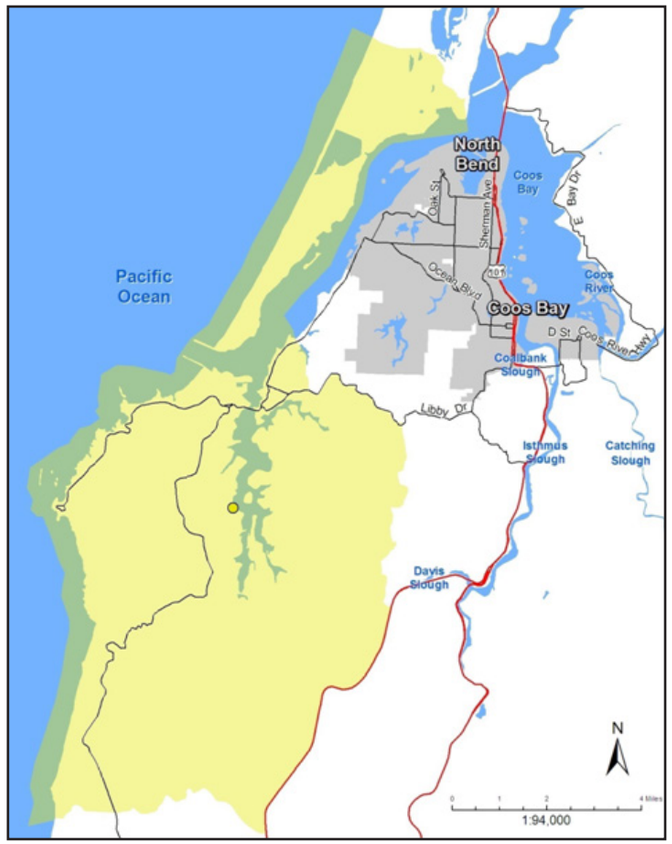


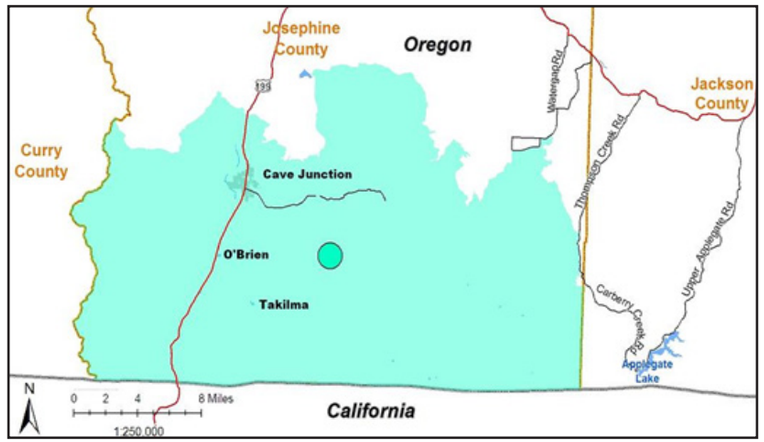
Salem/Keizer - The area of Northeast Salem (left) containing census tracts 5.02 and 16.02 are among the most densely populated and highest poverty in the state. Both tracts have a large number of residents earning $10,000 or less (19 percent and 21 percent respectively). They are both high in single-parent households – over 25 percent of all households in both tracts. Almost half of all households in tract 5.02 contain children –the second highest ratio among the high-poverty tracts. About fifty percent of the residents of both of these tracts speak a language other than English in the household.

Coos Bay - Census tract 5.02 in Coos County (right) is in the Coos Bay area of the county. It contains a high percentage of disabled people (27 percent). In other ways, this area does not have the usual indicators of poverty, and has a very low percentage of households on public assistance compared to other tracts in this analysis.

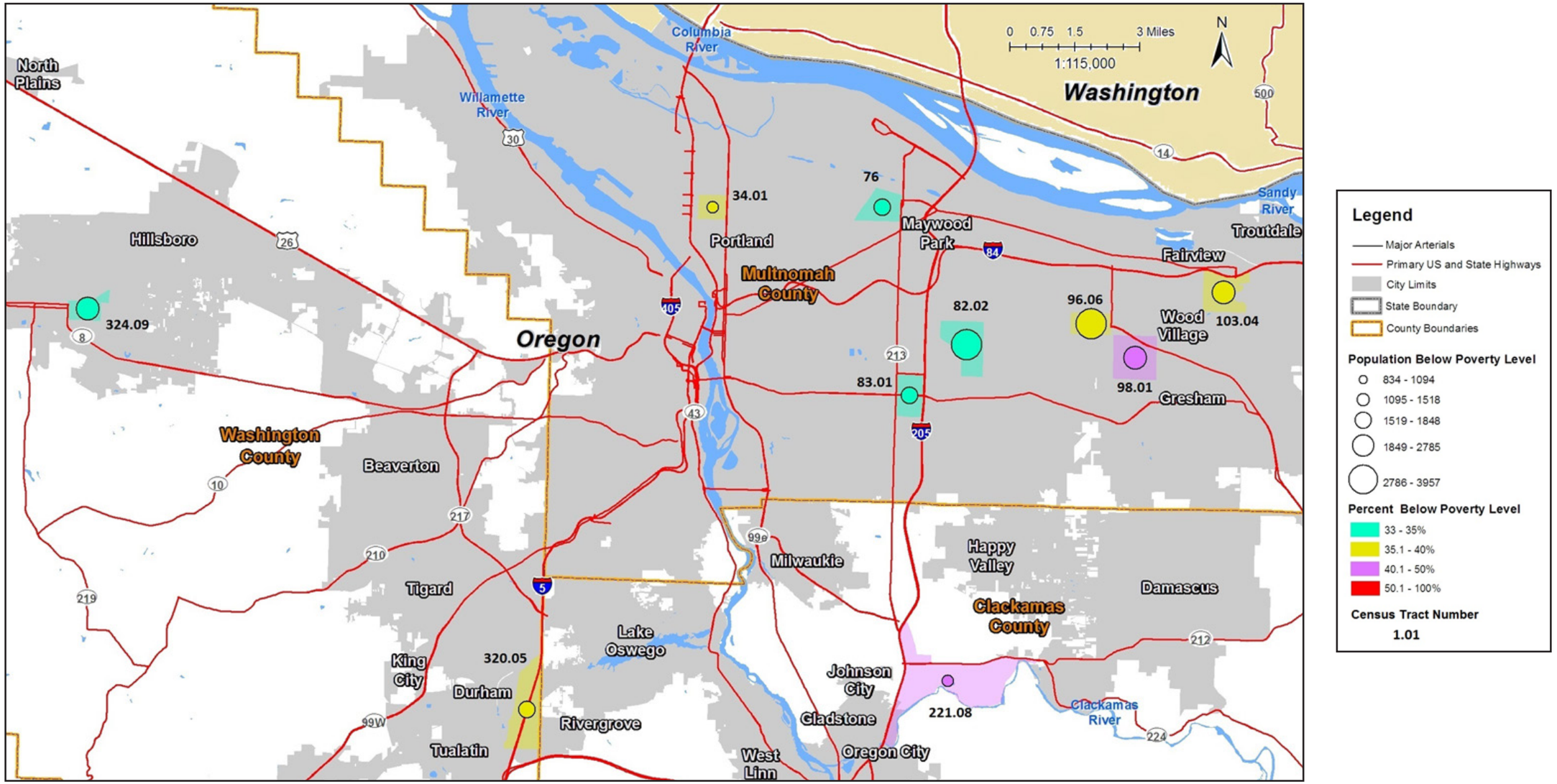
Rural Josephine County - Census tract 3616 (lower right) comprises a large section of southern Josephine County along the California border. It includes the towns of Cave Junction, O'Brien, Kerby, and Takilma. It is the most rural of the census tracts with high poverty concentrations, and has a high population of people over the age of 65.







Areas of High Poverty Density: Portland Metro



For more information about the poverty density in Portland Metro area, please see the following page.

Multnomah County has a large number of census tracts that conform to the statistics of a very-high-density poverty area (over 33 percent in poverty).

Census tract 34.01 includes portions of the Humboldt and King neighborhoods. It contains a large number of single parent households (24 percent of all households, compared to 8.5 percent statewide). This census tract contains the largest concentration of African Americans of any high-poverty area. Thirty-five percent of the residents of this tract are Black, while statewide African Americans make up less than two percent of the population.

Census tract 76 is the Cully neighborhood. It is high in Hispanic households, who make up 28 percent of the population. Forty-one percent of the population speaks a language other than English in the home, suggesting a large immigrant population.

Census tract 82.02 is the Mill Park area. It is the most economically diverse area that is included in this analysis – it contains more people with high income and lower levels of public assistance than any other census tract in this analysis. However, it does contain a large number of people in poverty. This area has a high concentration of African Americans, Asians, and Hispanics. Forty-one percent of the residents of this tract speak a language other than English in the home.

Tract 83.01 is a portion of the Foster Powell neighborhood. It contains a high concentration of people living on $10,000 or less (19 percent, compared to 7.6 percent statewide). It is very high in the proportion of residents over 65 (35 percent) and the number of residents who speak a language other than English in the home (52 percent). This census tract contains a large number of African Americans (11 percent) and an especially high concentration of Asian Americans (29 percent in a state that has an Asian minority of 3.9 percent).

Census tract 96.06 is part of Gresham. It has a very high concentration of households who get by on $10,000 or less a year (22.5 percent). It is also very high in the number of households with children (45 percent). Thirty-six percent of the census tract is Hispanic (compared to 12.5 percent statewide).

Census tract 98.01 is in Gresham, near Venice Park. It has a high concentration of single parents (22 percent, compared to a statewide value of 8.5 percent), and a high concentration of households containing children in general (42 percent). It contains a large number of non-white residents, with high concentrations of African Americans, American Indians, and Pacific Islanders/Native Hawaiians. Language other than English is spoken in 39.5 percent of the households. This census tract is also more economically diverse than most in this analysis, and has more relatively high income residents than most high-poverty areas.

Census tract 103.04 is in the Wood Village neighborhood. It contains a high percentage of households with children (42 percent, compared to a statewide value of 29 percent). It also has more non-whites than the state overall, with higher concentrations of African Americans, American Indians, and Pacific Islanders/Native Hawaiians.

Washington County has two high density poverty areas. Census tract 320.05 is in the Durham area of Washington County. It has one of the highest ratios of households with children (over 40 percent) of any high-poverty tract in this analysis. Over 40 percent of the residents are Hispanic. Thirty-eight percent of residents speak a language other than English in the home. Tract 320.05 contains a larger percentage of African Americans, Pacific Islander/Native Hawaiian, and American Indians than can be found statewide.

Census tract 324.09 in Washington County is one of the most densely packed areas of Hillsboro. It runs east from SE 10th Ave to SE 24th Ave. It is very high in single parent households (24 percent, compared to 8.5 percent statewide) and has the highest ratio of households with children present (56.5 percent) of any tract in this analysis. It also has a higher percentage of Hispanics (75 percent) than any other high-poverty tract.

Clackamas County is one of the most affluent and highly populated counties in the state. It has only one tract with high poverty density. Tract 221.08 is bounded by Carver Road to the north and the Clackamas River to the south. Most of the area is industrial, but has some residential interspersed in the area, including a large mobile home park. Very few residents of tract 221.08 have a college education (8.6 percent of the residents of the area, compared to 30 percent statewide). A large number of residents (23 percent) get by on $10,000 or less per year.

Total Department of Human Services Biennial Average Forecast comparison

	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Self Sufficiency						
Supplemental Nutrition Assistance Program (households)	429,661	437,386	1.8%	437,386	421,679	-3.6%
Temporary Assistance for Needy Families - Basic and UN (families: cash assistance)	33,336	32,953	-1.1%	32,953	29,048	-11.9%
Child Welfare (children served)						
Adoption Assistance	11,190	11,101	-0.8%	11,101	11,182	0.7%
Guardianship Assistance	1,365	1,382	1.2%	1,382	1,557	12.7%
Out of Home Care	7,477	7,319	-2.1%	7,319	7,285	-0.5%
Child In-Home	1,717	1,543	-10.1%	1,543	1,441	-6.6%
Vocational Rehabilitation Services	8,836	8,936	1.1%	8,936	9,963	11.5%
Aging and People with Disabilities						
Long-Term Care: In-Home	13,863	14,438	4.1%	14,438	15,486	7.3%
Long-Term Care: Community-Based	11,656	11,526	-1.1%	11,526	11,915	3.4%
Long-Term Care: Nursing Facilities	4,320	4,219	-2.3%	4,219	4,023	-4.6%
Intellectual and Developmental Disabilities						
Total I/DD Services	16,251	16,067	-1.1%	16,067	17,868	11.2%
Total Case Management Enrollment	22,139	22,203	0.7%	22,303	24,223	8.6%

Total Oregon Health Authority Biennial Average Forecast Comparison

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

1. Parent/Caretaker Relative is a new caseload group for adults under 42% FPL. This caseload used to be part of the TANF Medical caseload.
2. Pregnant Women Program is a new name for Poverty Level Medical - Women.
3. Children's Medicaid Program is a new caseload group for children who were previously in TANF Medical, Poverty Level Medical - Children, and CHIP under 133% FPL.
4. OHP Standard program closed on Dec 31, 2013.

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

5. In prior forecasts, some clients were counted more than once. With the new definitions, each client is counted only once for any given month.
6. The old Civil Commitment caseload included everyone receiving service who had been civilly committed at some point in time. The new definition counts only clients who are currently under commitment (although a proxy rule is being used to estimate the end date for clients' mandated service).

Forecasted Biennial Average Totals by County

SNAP Total		
Counties	Fall 14 Forecast 2013-15	Fall 14 Forecast 2015-17
Baker	2,156	2,262
Benton	6,059	5,786
Clackamas	27,993	27,305
Clatsop	4,696	4,565
Columbia	5,508	5,629
Coos	10,094	9,795
Crook	2,545	2,431
Curry	2,721	2,689
Deschutes	16,922	14,450
Douglas	15,614	14,984
Gilliam	132	128
Grant	647	636
Harney	821	828
Hood River	1,645	1,444
Jackson	28,621	27,692
Jefferson	3,649	3,609
Josephine	14,437	14,442
Klamath	9,987	9,858
Lake	845	864
Lane	47,105	45,815
Lincoln	6,768	6,698
Linn	16,119	16,790
Malheur	4,000	4,102
Marion	38,965	36,714

TANF		
Counties	Fall 14 Forecast 2013-15	Fall 14 Forecast 2015-17
Baker	173	151
Benton	304	261
Clackamas	1,725	1,297
Clatsop	116	107
Columbia	372	323
Coos	713	643
Crook	200	192
Curry	125	127
Deschutes	1,156	959
Douglas	1,338	1,195
Gilliam	12	11
Grant	36	40
Harney	43	34
Hood River	59	43
Jackson	2,233	1,927
Jefferson	435	389
Josephine	1,215	1,067
Klamath	627	540
Lake	27	36
Lane	2,758	2,571
Lincoln	393	363
Linn	1,223	1,086
Malheur	356	316
Marion	3,823	3,348

Long Term Care Total		
Counties	Fall 14 Forecast 2013-15	Fall 14 Forecast 2015-17
Baker	140	144
Benton	289	291
Clackamas	2,481	2,585
Clatsop	292	296
Columbia	322	354
Coos	931	963
Crook	191	217
Curry	266	287
Deschutes	867	919
Douglas	1,065	1,132
Gilliam	11	12
Grant	60	66
Harney	65	65
Hood River	88	81
Jackson	1,733	1,795
Jefferson	172	187
Josephine	939	940
Klamath	511	527
Lake	41	41
Lane	2,965	3,125
Lincoln	485	492
Linn	1,247	1,334
Malheur	303	310
Marion	2,325	2,414

Oregon Health Plan Total		
Counties	Fall 14 Forecast 2013-15	Fall 14 Forecast 2015-17
Baker	4,312	4,249
Benton	13,000	12,648
Clackamas	66,176	65,505
Clatsop	9,629	9,345
Columbia	10,858	10,442
Coos	18,896	18,614
Crook	5,709	5,478
Curry	5,600	5,722
Deschutes	40,559	39,176
Douglas	30,667	30,304
Gilliam	346	346
Grant	1,422	1,441
Harney	1,788	1,789
Hood River	6,010	5,931
Jackson	60,225	57,730
Jefferson	7,929	7,776
Josephine	27,775	27,300
Klamath	20,049	19,668
Lake	1,832	1,782
Lane	91,335	89,901
Lincoln	13,236	12,892
Linn	33,421	32,922
Malheur	9,649	9,507
Marion	92,986	91,326

Forecasted Biennial Average Totals by County (Cont'd)

SNAP Total		
Counties	Fall 14 Forecast 2013-15	Fall 14 Forecast 2015-17
Morrow	1,125	1,153
Multnomah	96,196	94,299
Polk	7,961	7,024
Sherman	145	149
Tillamook	2,791	2,778
Umatilla	8,311	7,313
Union	2,766	2,675
Wallowa	615	635
Wasco	3,127	3,050
Washington	35,769	33,253
Wheeler	139	139
Yamhill	10,393	9,697

TANF		
Counties	Fall 14 Forecast 2013-15	Fall 14 Forecast 2015-17
Morrow	97	83
Multnomah	7,990	7,207
Polk	780	679
Sherman	3	5
Tillamook	103	105
Umatilla	700	576
Union	285	249
Wallowa	44	37
Wasco	153	144
Washington	2,614	2,327
Wheeler	10	9
Yamhill	710	603

Long Term Care Total		
Counties	Fall 14 Forecast 2013-15	Fall 14 Forecast 2015-17
Morrow	51	53
Multnomah	7,049	7,357
Polk	613	635
Sherman	11	13
Tillamook	179	181
Umatilla	643	658
Union	226	224
Wallowa	64	63
Wasco	300	284
Washington	2,458	2,546
Wheeler	11	13
Yamhill	787	823

Oregon Health Plan Total		
Counties	Fall 14 Forecast 2013-15	Fall 14 Forecast 2015-17
Morrow	2,969	2,857
Multnomah	191,230	187,242
Polk	17,741	17,534
Sherman	300	312
Tillamook	6,123	6,024
Umatilla	20,376	19,783
Union	6,511	6,463
Wallowa	1,667	1,720
Wasco	7,459	7,464
Washington	94,020	91,276
Wheeler	306	334
Yamhill	23,425	22,885

Regional Forecasts by District

District 1 Regional Forecast

Slow steady improvement in the job market continued in District 1. This led the unemployment rate to rise in the early months of 2014 as more people entered the job market than could find employment. Some of the new entrants were new arrivals to the area, while others were people who had abandoned the job market but reentered to take advantage of improvements in the economy.

At the end of the summer of 2014, total employment was at pre-recession levels in Clatsop and Tillamook counties, although Columbia still has ground to make up. In Columbia County manufacturing jobs have still not recovered, nor has retail trade; but construction employment is up from 2013 and exceeds pre-recession levels.

In contrast to the statewide pattern, TANF caseload is expected to rise slightly through 2017 in Clatsop and Tillamook counties; while Columbia County is expected to decline. The SNAP Self-Sufficiency caseload will fall for all counties in the district.

DISTRICT 1	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	Aug-13	Aug-14
Oregon	3,919,020	22.1%	15.4%	$50,251	11.3%	8.1%	7.2%
Clatsop	37,270	20.3%	18.7%	$45,691	12.4%	7.0%	6.1%
Columbia	49,850	22.6%	15.8%	$52,739	10.2%	8.2%	7.6%
Tillamook	25,375	19.9%	22.8%	$42,957	9.9%	7.5%	6.5%

District 1 Regional Forecast, Oregon Department of Human Services

Counties served: **Clatsop, Columbia and Tillamook** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Clatsop	3,013	3,103	3.0%	3,103	2,787	-10.2%
Columbia	3,705	3,812	2.9%	3,812	3,554	-6.8%
Tillamook	1,899	1,952	2.8%	1,952	1,810	-7.3%
District 1 total	8,617	**8,867**	2.9%	**8,867**	**8,151**	**-8.1%**
SNAP - Aid to People with Disabilities						
Clatsop	1,590	1,593	0.2%	1,593	1,778	12%
Columbia	1,693	1,696	0.2%	1,696	2,075	22%
Tillamook	838	839	0.1%	839	968	15%
District 1 total	**4,121**	**4,128**	**0.2%**	**4,128**	**4,821**	**16.8%**
TANF						
Clatsop	118	116	-1.7%	116	107	-7.76%
Columbia	377	372	-1.3%	372	323	-13.17%
Tillamook	104	103	-1.0%	103	105	1.94%
District 1 total	**599**	**591**	**-1.3%**	**591**	**535**	**-9.5%**

District 1 Regional Forecast, Oregon Department of Human Services (continued)

Counties served: **Clatsop, Columbia and Tillamook** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Clatsop	98	112	14.3%	112	114	1.8%
Columbia	120	130	8.3%	130	153	17.7%
Tillamook	77	77	0.0%	77	81	5.2%
District 1 total	**295**	**319**	8.1%	**319**	**348**	**9.1%**
Community-Based Care						
Clatsop	133	133	0.0%	133	135	1.5%
Columbia	140	132	-5.7%	132	143	8.3%
Tillamook	73	75	2.7%	75	77	2.7%
District 1 total	**346**	**340**	-1.7%	**340**	**355**	**4.4%**
Nursing Care						
Clatsop	50	47	-6.0%	47	47	0.0%
Columbia	61	60	-1.6%	60	58	-3.3%
Tillamook	33	27	-18.2%	27	23	-14.8%
District 1 total	**144**	**134**	**-6.9%**	**134**	**128**	**-4.5%**

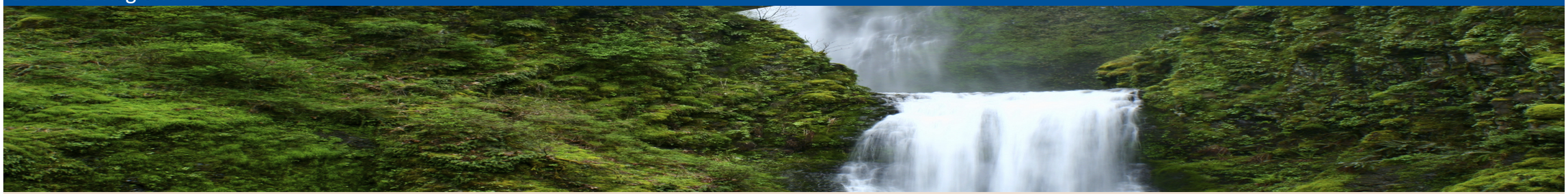
District 1 Regional Forecast, Oregon Health Authority (clients)

Counties served: **Clatsop, Columbia and Tillamook** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Parents/Caretaker Relative						
Clatsop	NA	518	-	518	471	-9.1%
Columbia	NA	1,016	-	1,016	818	-19.5%
Tillamook	NA	447	-	447	437	-2.2%
District 1 Total	**NA**	**1,981**	**-**	**1,981**	**1,726**	**-12.9%**
Children's Medicaid Program						
Clatsop	NA	2,794	-	2,794	2,777	-0.6%
Columbia	NA	3,271	-	3,271	3,206	-2.0%
Tillamook	NA	1,935	-	1,935	1,965	1.6%
District 1 Total	**NA**	**8,000**	-	**8,000**	**7,948**	**-0.7%**
Children's Health Insurance Program (CHIP)						
Clatsop	790	815	3.2%	815	761	-6.6%
Columbia	697	788	13.1%	788	751	-4.7%
Tillamook	512	477	-6.8%	477	431	-9.6%
District 1 Total	**1,999**	**2,080**	4.1%	**2,080**	**1,943**	**-6.6%**
Pregnant Women Program						
Clatsop	173	196	13.3%	196	184	-6.1%
Columbia	151	177	17.2%	177	159	-10.2%
Tillamook	84	96	14.3%	96	86	-10.4%
District 1 Total	**408**	**469**	**15.0%**	**469**	**429**	**-8.5%**
Foster Care & Adoption Services						
Clatsop	237	239	0.8%	239	239	0.0%
Columbia	329	325	-1.2%	325	322	-0.9%
Tillamook	111	113	1.8%	113	111	-1.8%
District 1 Total	**677**	**677**	**0.0%**	**677**	**672**	**-0.7%**

District 1 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: **Clatsop, Columbia and Tillamook** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Aid to Blind/Disabled						
Clatsop	904	861	-4.8%	861	867	0.7%
Columbia	1,138	1,106	-2.8%	1,106	1,129	2.1%
Tillamook	578	587	1.6%	587	622	6.0%
District 1 total	**2,620**	**2,554**	**-2.5%**	**2,554**	**2,618**	**2.5%**
Old Age Assistance						
Clatsop	336	329	-2.1%	329	328	-0.3%
Columbia	375	377	0.5%	377	420	11.4%
Tillamook	183	195	6.6%	195	200	2.6%
District 1 total	**894**	**901**	**0.8%**	**901**	**948**	**5.2%**
ACA Adults with Children						
Clatsop	NA	1,006	-	1,006	961	-4.5%
Columbia	NA	986	-	986	940	-4.6%
Tillamook	NA	590	-	590	561	-4.8%
District 1 Total	**NA**	**2,582**	**-**	**2,582**	**2,463**	**-4.6%**
ACA Adults without Children						
Clatsop	NA	2,871	-	2,871	2,757	-4.0%
Columbia	NA	2,812	-	2,812	2,697	-4.1%
Tillamook	NA	1,683	-	1,683	1,611	-4.3%
District 1 Total	NA	**7,366**	-	**7,366**	**7,064**	**-4.1%**

District 2 Regional Forecast



Employment in Multnomah is at an all-time high, exceeding pre-recession levels. Job growth in the private sector easily topped 3 percent (annualized) earlier in the year but moderated as a surge in the professional and business services industry tapered off. Public sector employment, especially at the local/county level is up, but federal and state employment remains flat. Federal employment remains lower now than before the Great Recession in Multnomah County.

Like other areas of the state, the unemployment rate went up a little in the spring of 2014, not because of a contraction in the job market, but because of an increase in the number of people looking for work. Some of that increase was due to new arrivals to the area, while others were people who had abandoned the job market but returned to take advantage of an improving economy. As of August 2014, unemployment in District 2 is lower than statewide.

Self-Sufficiency caseloads are expected to fall in District 2 in line with statewide expectations.

DISTRICT 2	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	Aug-13	Aug-14
Oregon	3,919,020	22.1%	15.4%	$50,251	11.3%	8.1%	7.2%
Multnomah	756,530	20.0%	11.5%	$54,024	11.9%	7.0%	6.2%

District 2 Regional Forecast, Oregon Department of Human Services

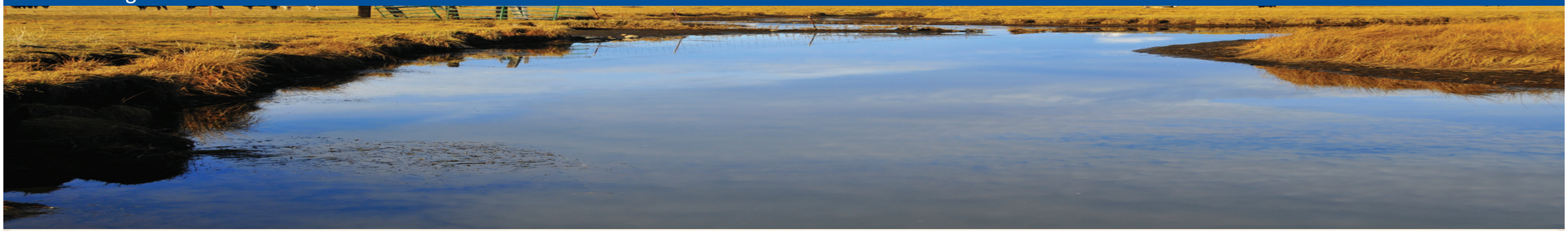
Counties served: **Multnomah** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Multnomah	66,838	69,530	4.0%	69,530	65,642	-5.6%
District 2 total	66,838	**69,530**	4.0%	**69,530**	**65,642**	**-5.6%**
SNAP - Aid to People with Disabilities Multnomah	26,619	26,666	0.2%	26,666	28,657	7.5%
District 2 total	**26,619**	**26,666**	**0.2%**	**26,666**	**28,657**	**7.5%**
TANF						
Multnomah	8,083	7,990	-1.2%	7,990	7,207	-9.8%
District 2 total	**8,083**	**7,990**	**-1.2%**	**7,990**	**7,207**	**-9.8%**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Multnomah	3,247	3,369	3.8%	3,369	3,591	6.6%
District 2 total	**3,247**	**3,369**	3.8%	**3,369**	**3,591**	**6.6%**
Community-Based Care						
Multnomah	2,533	2,504	-1.1%	2,504	2,638	5.4%
District 2 total	**2,533**	**2,504**	-1.1%	**2,504**	**2,638**	**5.4%**
Nursing Care						
Multnomah	1,223	1,176	-3.8%	1,176	1,128	-4.1%
District 2 total	**1,223**	**1,176**	**-3.8%**	**1,176**	**1,128**	**-4.1%**

District 2 Regional Forecast, Oregon Health Authority (clients)

Counties served: **Multnomah**

	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Parents/Caretaker Relative						
Multnomah	NA	14,820	-	14,820	14,208	-4.1%
District 2 Total	**NA**	**14,820**	**-**	**14,820**	**14,208**	**-4.1%**
Children's Medicaid Program						
Multnomah	NA	57,568	-	57,568	57,462	-0.2%
District 2 Total	**NA**	**57,568**	**-**	**57,568**	**57,462**	**-0.2%**
Children's Health Insurance Program (CHIP)						
Multnomah	11,747	12,280	4.5%	12,280	11,354	-7.5%
District 2 Total	**11,747**	**12,280**	**4.5%**	**12,280**	**11,354**	**-7.5%**
Pregnant Women Program						
Multnomah	2,475	2,954	19.4%	2,954	2,670	-9.6%
District 2 Total	**2,475**	**2,954**	**19.4%**	**2,954**	**2,670**	**-9.6%**
Foster/Substitute Care						
Multnomah	3,299	3,221	-2.4%	3,221	3,179	-1.3%
District 2 total	**3,299**	**3,221**	**-2.4%**	**3,221**	**3,179**	**-1.3%**
Aid to Blind/Disabled						
Multnomah	18,616	18,404	-1.1%	18,404	18,673	1.5%
District 2 total	**18,616**	**18,404**	**-1.1%**	**18,404**	**18,673**	**1.5%**
Old Age Assistance						
Multnomah	9,727	9,781	0.6%	9,781	10,522	7.6%
District 2 total	**9,727**	**9,781**	**0.6%**	**9,781**	**10,522**	**7.6%**
ACA Adults with Children						
Multnomah	NA	18,731	-	18,731	17,885	-4.5%
District 2 Total	NA	**18,731**	-	**18,731**	**17,885**	**-4.5%**
ACA Adults without Children						
Multnomah	NA	53,427	-	53,427	51,299	-4.0%
District 2 Total	NA	**53,427**	-	**53,427**	**51,299**	**-4.0%**

District 3 Regional Forecast

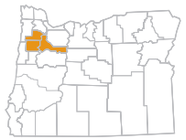


Almost all employment sectors are up from the previous year in District 3, including construction. Still, construction employment remains a shadow of its former self compared to the building boom of the 2000's. Yamhill County, which was spared some of the worst effects of the Great Recession, has seen growth taper off while Marion and Polk counties show a more vigorous recovery pattern.

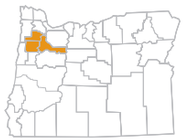
Self-Sufficiency caseloads are expected to fall through 2017. Reductions will be fastest in Polk County.

DISTRICT 3	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	Aug-13	Aug-14
Oregon	3,919,020	22.1%	15.4%	$50,251	11.3%	8.1%	7.2%
Marion	322,880	26.1%	14.0%	$46,873	14.1%	8.6%	7.4%
Polk	77,065	24.3%	16.1%	$49,781	13.3%	7.8%	6.7%
Yamhill	101,400	24.4%	14.9%	$58,612	10.0%	7.5%	6.6%

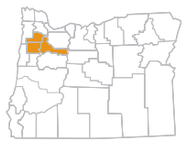
District 3 Regional Forecast, Oregon Department of Human Services

Counties served: **Marion, Polk and Yamhill** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Marion	29,044	29,740	2.4%	29,740	26,760	-10.0%
Polk	5,901	5,922	0.4%	5,922	4,763	-19.6%
Yamhill	7,602	7,810	2.7%	7,810	6,850	-12.3%
District 3 total	42,547	**43,472**	2.2%	**43,472**	**38,373**	**-11.7%**
SNAP - Aid to People with Disabilities						
Marion	9,208	9,225	0.2%	9,225	9,954	7.9%
Polk	2,036	2,039	0.1%	2,039	2,261	10.9%
Yamhill	2,579	2,583	0.2%	2,583	2,847	10.2%
District 3 total	13,823	**13,847**	0.2%	**13,847**	**15,062**	**8.8%**
TANF						
Marion	3,868	3,823	-1.2%	3,823	3,348	-12.4%
Polk	789	780	-1.1%	780	679	-12.9%
Yamhill	718	710	-1.1%	710	603	-15.1%
District 3 total	**5,375**	**5,313**	**-1.2%**	**5,313**	**4,630**	**-12.9%**

District 3 Regional Forecast, Oregon Department of Human Services (continued)

Counties served: **Marion, Polk and Yamhill** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Marion	1,028	1,088	5.8%	1,088	1,169	7.4%
Polk	275	280	1.8%	280	303	8.2%
Yamhill	246	273	11.0%	273	299	9.5%
District 3 total	**1,549**	**1,641**	5.9%	**1,641**	**1,771**	**7.9%**
Community-Based Care						
Marion	946	929	-1.8%	929	950	2.3%
Polk	249	241	-3.2%	241	244	1.2%
Yamhill	383	379	-1.0%	379	394	4.0%
District 3 total	**1,578**	**1,549**	-1.8%	**1,549**	**1,588**	**2.5%**
Nursing Care						
Marion	302	308	2.0%	308	295	-4.2%
Polk	99	92	-7.1%	92	88	-4.3%
Yamhill	130	135	3.8%	135	130	-3.7%
District 3 total	**531**	**535**	**0.8%**	**535**	**513**	**-4.1%**

District 3 Regional Forecast, Oregon Health Authority (clients)

Counties served: **Marion, Polk and Yamhill** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Parents/Caretaker Relative						
Marion	NA	7,293	-	7,293	6,705	-8.1%
Polk	NA	1,600	-	1,600	1,689	5.6%
Yamhill	NA	1,862	-	1,862	1,826	-1.9%
District 3 Total	**NA**	**10,755**	**-**	**10,755**	**10,220**	**-5.0%**
Children's Medicaid Program						
Marion	NA	36,967	-	36,967	36,489	-1.3%
Polk	NA	6,203	-	6,203	6,200	0.0%
Yamhill	NA	8,388	-	8,388	8,370	-0.2%
District 3 Total	**NA**	**51,558**	**-**	**51,558**	**51,059**	**-1.0%**
Children's Health Insurance Program (CHIP)						
Marion	8,417	8,406	-0.1%	8,406	8,603	2.3%
Polk	1,391	1,498	7.7%	1,498	1,395	-6.9%
Yamhill	2,074	2,239	8.0%	2,239	2,052	-8.4%
District 3 Total	**11,882**	**12,143**	**2.2%**	**12,143**	**12,050**	**-0.8%**
Pregnant Women Program						
Marion	1,323	1,578	19.3%	1,578	1,473	-6.7%
Polk	278	301	8.3%	301	309	2.7%
Yamhill	356	414	16.3%	414	378	-8.7%
District 3 Total	**1,957**	**2,293**	**17.2%**	**2,293**	**2,160**	**-5.8%**
Foster Care & Adoption Services						
Marion	1,775	1,779	0.2%	1,779	1,777	-0.1%
Polk	415	401	-3.4%	401	409	2.0%
Yamhill	430	421	-2.1%	421	407	-3.3%
District 3 Total	**2,620**	**2,601**	**-0.7%**	**2,601**	**2,593**	**-0.3%**

District 3 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: **Marion, Polk and Yamhill** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Aid to the Blind/Disabled						
Marion	7,361	7,302	-0.8%	7,302	7,441	1.9%
Polk	1,577	1,537	-2.5%	1,537	1,558	1.4%
Yamhill	1,749	1,744	-0.3%	1,744	1,777	1.9%
District 3 Total	**10,687**	**10,583**	**-1.0%**	**10,583**	**10,776**	**1.8%**
Old Age Assistance						
Marion	3,110	3,093	-0.5%	3,093	3,336	7.9%
Polk	636	644	1.3%	644	666	3.4%
Yamhill	870	851	-2.2%	851	898	5.5%
District 3 Total	**4,616**	**4,588**	**-0.6%**	**4,588**	**4,900**	**6.8%**
ACA Adults with Children						
Marion	NA	6,897	-	6,897	6,593	-4.4%
Polk	NA	1,443	-	1,443	1,372	-4.9%
Yamhill	NA	1,948	-	1,948	1,855	-4.8%
District 3 Total	NA	**10,288**	-	**10,288**	**9,820**	**-4.5%**
ACA Adults without Children						
Marion	NA	19,671	-	19,671	18,909	-3.9%
Polk	NA	4,114	-	4,114	3,936	-4.3%
Yamhill	NA	5,558	-	5,558	5,322	-4.2%
District 3 Total	NA	**29,343**	-	**29,343**	**28,167**	**-4.0%**

District 4 Regional Forecast

District 4 is the most economically diverse region in this report with coastal tourism dominating Lincoln County, agriculture and manufacturing dominating Linn County, and university employment dominating Benton County.

Of the three counties, Linn suffered worst during the Great Recession and unemployment remains higher than statewide. Still, things are improving from the previous year with unemployment finally under 10 percent. Benton County has recovered all the jobs lost during the economic downturn, although higher-paying manufacturing jobs have not returned. Instead, other sectors such as healthcare and social assistance are booming. Local education jobs are coming back to District 4 as rounds of cost-cutting due to budget shortfalls have stopped and schools are refilling lost positions.

Benton and Lincoln counties are expected to see declining SNAP caseloads through 2017, although Linn County will likely see the current high caseloads level off, but not fall. TANF caseloads will likely fall in all three counties.

DISTRICT 4	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	Aug-13	Aug-14
Oregon	3,919,020	22.1%	15.4%	$50,251	11.3%	8.1%	7.2%
Benton	87,725	17.3%	14.0%	$47,808	9.7%	6.1%	5.5%
Lincoln	46,560	17.0%	24.4%	$42,342	11.0%	8.4%	7.7%
Linn	118,665	23.7%	16.8%	$45,130	13.0%	10.1%	8.5%

District 4 Regional Forecast, Oregon Department of Human Services

Counties served: **Benton, Lincoln and Linn** 	**Current Biennium**		**% Change Between Forecasts**	**Fall 14 Forecast**		**% Change Between Biennia**
	Spring 14 Forecast	**Fall 14 Forecast**		**2013-15**	**2015-17**	
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Benton	4,661	4,779	2.5%	4,779	4,419	-7.5%
Lincoln	4,277	4,412	3.2%	4,412	4,139	-6.2%
Linn	11,286	11,578	2.6%	11,578	11,457	-1.0%
District 4 Total	20,224	20,769	2.7%	20,769	20,015	-3.6%
SNAP - Aid to People with Disabilities						
Benton	1,278	1,280	0.2%	1,280	1,367	6.8%
Lincoln	2,351	2,356	0.2%	2,356	2,559	8.6%
Linn	4,532	4,541	0.2%	4,541	5,333	17.4%
District 4 Total	**8,161**	**8,177**	**0.2%**	**8,177**	**9,259**	**13.2%**
TANF						
Benton	308	304	-1.3%	304	261	-14.1%
Lincoln	398	393	-1.3%	393	363	-7.6%
Linn	1,237	1,223	-1.1%	1,223	1,086	-11.2%
District 4 Total	**1,943**	**1,920**	**-1.2%**	**1,920**	**1,710**	**-10.9%**

District 4 Regional Forecast, Oregon Department of Human Services (continued)

Counties served: **Benton, Lincoln and Linn** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Benton	167	149	-10.8%	149	147	-1.3%
Lincoln	292	307	5.1%	307	316	2.9%
Linn	690	699	1.3%	699	758	8.4%
District 4 total	**1,149**	**1,155**	0.5%	**1,155**	**1,221**	**5.7%**
Community-Based Care						
Benton	104	104	0.0%	104	112	7.7%
Lincoln	140	141	0.7%	141	142	0.7%
Linn	396	393	-0.8%	393	424	7.9%
District 4 total	**640**	**638**	-0.3%	**638**	**678**	**6.3%**
Nursing Care						
Benton	42	36	-14.3%	36	32	-11.1%
Lincoln	40	37	-7.5%	37	34	-8.1%
Linn	162	155	-4.3%	155	152	-1.9%
District 4 total	**244**	**228**	**-6.6%**	**228**	**218**	**-4.4%**

District 4 Regional Forecast, Oregon Health Authority (clients)

Counties served: **Benton, Lincoln and Linn** 	**Current Biennium**		**% Change Between Forecasts**	**Fall 14 Forecast**		**% Change Between Biennia**
	Spring 14 Forecast	**Fall 14 Forecast**		**2013-15**	**2015-17**	
Parents/Caretaker Relative						
Benton	NA	911	-	911	818	-10.2%
Lincoln	NA	1,042	-	1,042	998	-4.2%
Linn	NA	3,140	-	3,140	3,337	6.3%
District 4 Total	**NA**	**5,093**	**-**	**5,093**	**5,153**	**1.2%**
Children's Medicaid Program						
Benton	NA	3,761	-	3,761	3,785	0.6%
Lincoln	NA	3,864	-	3,864	3,833	-0.8%
Linn	NA	11,137	-	11,137	11,023	-1.0%
District 4 Total	**NA**	**18,762**	-	**18,762**	**18,641**	**-0.6%**
Children's Health Insurance Program (CHIP)						
Benton	938	1,044	11.3%	1,044	997	-4.5%
Lincoln	916	966	5.5%	966	895	-7.3%
Linn	2,503	2,587	3.4%	2,587	2,389	-7.7%
District 4 Total	**4,357**	**4,597**	5.5%	**4,597**	**4,281**	**-6.9%**
Pregnant Women Program						
Benton	171	189	10.5%	189	155	-18.0%
Lincoln	161	201	24.8%	201	178	-11.4%
Linn	501	581	16.0%	581	536	-7.7%
District 4 Total	**833**	**971**	**16.6%**	**971**	**869**	**-10.5%**
Foster Care & Adoption Services						
Benton	219	210	-4.1%	210	216	2.9%
Lincoln	306	299	-2.3%	299	296	-1.0%
Linn	715	707	-1.1%	707	700	-1.0%
District 4 Total	**1,240**	**1,216**	**-1.9%**	**1,216**	**1,212**	**-0.3%**

District 4 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: **Benton, Lincoln and Linn** 	**Current Biennium**		**% Change Between Forecasts**	**Fall 14 Forecast**		**% Change Between Biennia**
	Spring 14 Forecast	**Fall 14 Forecast**		**2013-15**	**2015-17**	
Aid to the Blind/Disabled						
Benton	1,160	1,148	-1.0%	1,148	1,160	1.0%
Lincoln	1,363	1,346	-1.2%	1,346	1,364	1.3%
Linn	3,410	3,374	-1.1%	3,374	3,442	2.0%
District 4 Total	**5,933**	**5,868**	**-1.1%**	**5,868**	**5,966**	**1.7%**
Old Age Assistance						
Benton	338	336	-0.6%	336	338	0.6%
Lincoln	511	523	2.3%	523	534	2.1%
Linn	1,136	1,148	1.1%	1,148	1,200	4.5%
District 4 Total	**1,985**	**2,007**	**1.1%**	**2,007**	**2,072**	**3.2%**
ACA Adults with Children						
Benton	NA	1,402	-	1,402	1,339	-4.5%
Lincoln	NA	1,297	-	1,297	1,239	-4.4%
Linn	NA	2,790	-	2,790	2,661	-4.6%
District 4 Total	NA	**5,488**	-	**5,488**	**5,240**	**-4.5%**
ACA Adults without Children						
Benton	NA	3,999	-	3,999	3,840	-4.0%
Lincoln	NA	3,698	-	3,698	3,555	-3.9%
Linn	NA	7,957	-	7,957	7,634	-4.1%
District 4 Total	**NA**	**15,655**	**-**	**15,655**	**15,028**	**-4.0%**

District 5 Regional Forecast

Lane County is a microcosm of the state overall – some tourism employment, some agriculture, some manufacturing, and a white-collar workforce centered in Eugene. Unemployment in Lane County has followed the state trend, showing a consistent pattern of slow growth. Most employment sectors are adding jobs, especially natural resource extraction (mining and logging). Federal government employment however, continues to contract as the federal government pivots toward austerity rather than expansion.

Lane County will see reductions in Self-Sufficiency caseloads, but at a slightly slower pace than statewide, especially where TANF is concerned.

DISTRICT 5	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	Aug-13	Aug-14
Oregon	3,919,020	22.1%	15.4%	$50,251	11.3%	8.1%	7.2%
Lane	356,125	19.2%	16.9%	$43,459	12.8%	8.0%	6.9%

District 5 Regional Forecast, Oregon Department of Human Services

County served: **Lane** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Lane	33,076	33,786	2.1%	33,786	31,397	-7.1%
District 5 total	33,076	**33,786**	2.1%	**33,786**	**31,397**	**-7.1%**
SNAP - Aid to People with Disabilities						
Lane	13,295	13,319	0.2%	13,319	14,418	8.3%
District 5 total	13,295	**13,319**	0.2%	**13,319**	**14,418**	**8.3%**
TANF						
Lane	2,791	2,758	-1.2%	2,758	2,571	-6.8%
District 5 total	**2,791**	**2,758**	-1.2%	**2,758**	**2,571**	**-6.8%**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Lane	1,359	1,482	9.1%	1,482	1,657	11.8%
District 5 total	**1,359**	**1,482**	9.1%	**1,482**	**1,657**	**11.8%**
Community-Based Care						
Lane	1,076	1,051	-2.3%	1,051	1,075	2.3%
District 5 total	**1,076**	**1,051**	-2.3%	**1,051**	**1,075**	**2.3%**
Nursing Care						
Lane	443	432	-2.5%	432	393	-9.0%
District 5 total	**443**	**432**	**-2.5%**	**432**	**393**	**-9.0%**

District 5 Regional Forecast, Oregon Health Authority (clients)

County served: **Lane** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Parents/Caretaker Relative						
Lane	NA	6,795	-	6,795	5,646	-16.9%
District 5 Total	**NA**	**6,795**	**-**	**6,795**	**5,646**	**-16.9%**
Children's Medicaid Program						
Lane	NA	25,557	-	25,557	25,578	0.1%
District 5 Total	**NA**	**25,557**	**-**	**25,557**	**25,578**	**0.1%**
Children's Health Insurance Program (CHIP)						
Lane	6,080	6,756	11.1%	6,756	7,423	9.9%
District 5 Total	**6,080**	**6,756**	**11.1%**	**6,756**	**7,423**	**9.9%**
Pregnant Women Program						
Lane	1,553	1,852	19.3%	1,852	1,784	-3.7%
District 5 Total	**1,553**	**1,852**	**19.3%**	**1,852**	**1,784**	**-3.7%**
Foster Care & Adoption Services						
Lane	2,361	2,372	0.5%	2,372	2,381	0.4%
District 5 Total	**2,361**	**2,372**	**0.5%**	**2,372**	**2,381**	**0.4%**
Aid to the Blind/Disabled						
Lane	9,995	9,943	-0.5%	9,943	10,140	2.0%
District 5 Total	**9,995**	**9,943**	**-0.5%**	**9,943**	**10,140**	**2.0%**
Old Age Assistance						
Lane	3,363	3,353	-0.3%	3,353	3,701	10.4%
District 5 Total	**3,363**	**3,353**	**-0.3%**	**3,353**	**3,701**	**10.4%**
ACA Adults with Children						
Lane	NA	9,009	-	9,009	8,595	-4.6%
District 5 Total	NA	**9,009**	-	**9,009**	**8,595**	**-4.6%**
ACA Adults without Children						
Lane	NA	25,698	-	25,698	24,653	-4.1%
District 5 Total	**NA**	**25,698**	**-**	**25,698**	**24,653**	**-4.1%**

District 6 Regional Forecast

Douglas County had a significant employment contraction during the Great Recession and has been slow to recover. However, things are improving and unemployment is finally under 10 percent for the first time since 2008. Douglas County unemployment rates have been consistently higher than the state overall for the last 20 years.

Many employment sectors have been expanding in Douglas County, but manufacturing and retail trade remain weak. Construction employment began to contract before the start of the Great Recession and has yet to fully recover.

Douglas County has a high percentage of retirement-age adults and will likely continue to feel the strain of a population in need of age-related services, while the number of working-age adults continues to decline.

Douglas County is expected to see reductions in the Self-Sufficiency caseload in line with the statewide trend.

DISTRICT 6	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median House-hold Income	Percent in poverty	Aug-13	Aug-14
Oregon	3,919,020	22.1%	15.4%	$50,251	11.3%	8.1%	7.2%
Douglas	108,850	19.9%	23.2%	$40,605	14.5%	11.0%	9.8%

District 6 Regional Forecast, Oregon Department of Human Services

County served: **Douglas** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Douglas	10,128	10,376	2.4%	10,376	9,389	-9.5%
District 6 total	10,128	**10,376**	2.4%	**10,376**	**9,389**	**-9.5%**
SNAP - Aid to People with Disabilities						
Douglas	5,228	5,238	0.2%	5,238	5,595	6.8%
District 6 total	5,228	**5,238**	0.2%	**5,238**	**5,595**	**6.8%**
TANF						
Douglas	1,353	1,338	-1.1%	1,338	1,195	-10.7%
District 6 total	**1,353**	**1,338**	**-1.1%**	**1,338**	**1,195**	**-10.7%**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Douglas	537	571	6.3%	571	620	8.6%
District 6 total	**537**	**571**	6.3%	**571**	**620**	**8.6%**
Community-Based Care						
Douglas	387	379	-2.1%	379	394	4.0%
District 6 total	**387**	**379**	-2.1%	**379**	**394**	**4.0%**
Nursing Care						
Douglas	107	115	7.5%	115	118	2.6%
District 6 total	**107**	**115**	**7.5%**	**115**	**118**	**2.6%**

District 6 Regional Forecast, Oregon Health Authority (clients)

County served: **Douglas** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Parents/Caretaker Relative						
Douglas	NA	3,004	-	3,004	3,177	5.8%
District 6 Total	**NA**	**3,004**	**-**	**3,004**	**3,177**	**5.8%**
Children's Medicaid Program						
Douglas	NA	9,291	-	9,291	9,265	-0.3%
District 6 Total	**NA**	**9,291**	**-**	**9,291**	**9,265**	**-0.3%**
Children's Health Insurance Program (CHIP)						
Douglas	1,800	1,745	-3.1%	1,745	1,590	-8.9%
District 6 Total	**1,800**	**1,745**	-3.1%	**1,745**	**1,590**	**-8.9%**
Pregnant Women Program						
Douglas	463	545	17.7%	545	478	-12.3%
District 6 Total	**463**	**545**	17.7%	**545**	**478**	**-12.3%**
Foster Care & Adoption Services						
Douglas	719	745	3.6%	745	807	8.3%
District 6 Total	**719**	**745**	**3.6%**	**745**	**807**	**8.3%**
Aid to the Blind/Disabled						
Douglas	3,206	3,189	-0.5%	3,189	3,248	1.9%
District 6 Total	**3,206**	**3,189**	**-0.5%**	**3,189**	**3,248**	**1.9%**
Old Age Assistance						
Douglas	1,049	1,068	1.8%	1,068	1,107	3.7%
District 6 Total	**1,049**	**1,068**	**1.8%**	**1,068**	**1,107**	**3.7%**
ACA Adults with Children						
Douglas	NA	2,876	-	2,876	2,749	-4.4%
District 6 Total	**NA**	**2,876**	**-**	**2,876**	**2,749**	**-4.4%**
ACA Adults with Children						
Douglas	NA	8,204	-	8,204	7,883	-3.9%
District 6 Total	**NA**	**8,204**	**-**	**8,204**	**7,883**	**-3.9%**

District 7 Regional Forecast

Overall recovery from the Great Recession is still spotty in this corner of Oregon. The unemployment rate in Coos County has been steadily declining, although less from new job creation than from fewer people in the county actively seeking employment. Curry County continues to suffer double-digit unemployment, which increased in 2014, probably due to more people looking for work than before.

Improvement in the demand for wood products has increased employment in logging and related manufacturing above recession lows. Rising tourism spending is creating gains in leisure and hospitality employment. Local government jobs in Coos County continue to contract as the public sector reduces spending in response to budget shortfalls.

The economies of Coos and Curry counties are fighting uphill against a demographic tide. The region has lost population over the last 10 years, especially young working-age adults. This hampers the region's ability to grow economically. Coos and Curry counties have a high percentage of retirement-age adults and will likely continue to feel the strain of a population in need of age-related services. At the same time, the district has a smaller base of employment-age adults to provide those services.

Self-Sufficiency caseloads in Coos County are expected to decline at a slower rate than statewide. Curry County will show a slight increase in TANF through 2017.

DISTRICT 7	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	Aug-13	Aug-14
Oregon	3,919,020	22.1%	15.4%	$50,251	11.3%	8.1%	7.2%
Coos	62,860	19.0%	23.4%	$37,345	11.6%	10.4%	8.9%
Curry	22,300	15.0%	30.4%	$38,017	8.4%	10.7%	10.7%

District 7 Regional Forecast, Oregon Department of Human Services (clients)

Counties served: **Coos and Curry** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Coos	6,373	6,432	0.9%	6,432	5,864	-8.8%
Curry	1,508	1,545	2.5%	1,545	1,427	-7.6%
District 7 total	7,881	**7,977**	1.2%	**7,977**	**7,291**	**-8.6%**
SNAP - Aid to People with Disabilities						
Coos	3,656	3,662	0.2%	3,662	3,931	7.3%
Curry	1,174	1,176	0.2%	1,176	1,262	7.3%
District 7 total	4,830	**4,838**	0.2%	**4,838**	**5,193**	**7.3%**
TANF						
Coos	722	713	-1.2%	713	643	-9.8%
Curry	126	125	-0.8%	125	127	1.6%
District 7 total	**848**	**838**	**-1.2%**	**838**	**770**	**-8.1%**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Coos	546	572	4.8%	572	612	7.0%
Curry	80	91	13.8%	91	98	7.7%
District 7 total	**626**	**663**	5.9%	**663**	**710**	**7.1%**
Community-Based Care						
Coos	278	276	-0.7%	276	276	0.0%
Curry	148	143	-3.4%	143	157	9.8%
District 7 total	**426**	**419**	-1.6%	**419**	**433**	**3.3%**
Nursing Care						
Coos	82	83	1.2%	83	75	-9.6%
Curry	30	32	6.7%	32	32	0.0%
District 7 total	**112**	**115**	**2.7%**	**115**	**107**	**-7.0%**

District 7 Regional Forecast, Oregon Health Authority (clients)

Counties served: **Coos and Curry** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Parents/Caretaker Relative						
Coos	NA	1,528	-	1,528	1,539	0.7%
Curry	NA	391	-	391	473	21.0%
District 7 Total	**NA**	**1,919**	**-**	**1,919**	**2,012**	**4.8%**
Children's Medicaid Program						
Coos	NA	5,274	-	5,274	5,282	0.2%
Curry	NA	1,503	-	1,503	1,557	3.6%
District 7 Total	**NA**	**6,777**	-	**6,777**	**6,839**	**0.9%**
Children's Health Insurance Program (CHIP)						
Coos	1,174	1,145	-2.5%	1,145	1,032	-9.9%
Curry	309	352	13.9%	352	384	9.1%
District 7 Total	**1,483**	**1,497**	0.9%	**1,497**	**1,416**	**-5.4%**
Pregnant Women Program						
Coos	328	357	8.8%	357	349	-2.2%
Curry	85	92	8.2%	92	88	-4.3%
District 7 Total	**413**	**449**	**8.7%**	**449**	**437**	**-2.7%**
Foster Care & Adoption Services						
Coos	494	501	1.4%	501	507	1.2%
Curry	78	81	3.8%	81	83	2.5%
District 7 Total	**572**	**582**	**1.7%**	**582**	**590**	**1.4%**

District 7 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: **Coos and Curry** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Aid to the Blind/Disabled						
Coos	2,307	2,273	-1.5%	2,273	2,314	1.8%
Curry	613	592	-3.4%	592	590	-0.3%
District 7 Total	**2,920**	**2,865**	**-1.9%**	**2,865**	**2,904**	**1.4%**
Old Age Assistance						
Coos	916	947	3.4%	947	1,016	7.3%
Curry	340	340	0.0%	340	388	14.1%
District 7 Total	**1,256**	**1,287**	**2.5%**	**1,287**	**1,404**	**9.1%**
ACA Adults with Children						
Coos	NA	1,784	-	1,784	1,700	-4.7%
Curry	NA	584	-	584	558	-4.4%
District 7 Total	NA	**2,367**	-	**2,367**	**2,258**	**-4.6%**
ACA Adults without Children						
Coos	NA	5,087	-	5,087	4,875	-4.2%
Curry	NA	1,665	-	1,665	1,601	-3.9%
District 7 Total	**NA**	**6,753**	**-**	**6,753**	**6,476**	**-4.1%**

District 8 Regional Forecast

Slow but steady, the Rogue Valley economy is improving and producing new jobs. Manufacturing and retail trade have seen solid increases in 2014, especially in Jackson County. Construction employment is improving, but is lagging behind other parts of the state.

Buoyed by greater demand for wood products, logging and related manufacturing is up in Josephine County. Leisure and hospitality jobs in the Rogue Valley are nearly back to pre-recession levels.

The region may begin to see a boost from households moving to the Rogue Valley from California – a trend that slowed during the Great Recession but is overdue to resume.

Self-Sufficiency caseloads are expected to drop in District 8, but at a slower pace than statewide.

DISTRICT 8	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	Aug-13	Aug-14
OREGON	3,919,020	22.1%	15.4%	$50,251	11.3%	8.1%	7.2%
JACKSON	206,310	21.3%	19.5%	$43,363	13.9%	9.8%	8.6%
Josephine	82,815	19.8%	24.3%	$38,298	14.3%	11.2%	9.8%

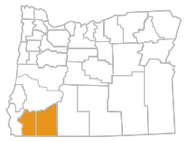
District 8 Regional Forecast, Oregon Department of Human Services

Counties served: **Jackson and Josephine** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Jackson	20,204	20,641	2.2%	20,641	19,030	-7.8%
Josephine	9,956	10,050	0.9%	10,050	9,702	-3.5%
District 8 total	30,160	**30,691**	1.8%	**30,691**	**28,732**	**-6.4%**
SNAP - Aid to People with Disabilities						
Jackson	7,966	7,980	0.2%	7,980	8,662	8.5%
Josephine	4,379	4,387	0.2%	4,387	4,740	8.0%
District 8 total	12,345	**12,367**	0.2%	**12,367**	**13,402**	**8.4%**
TANF						
Jackson	2,259	2,233	-1.2%	2,233	1,927	-13.7%
Josephine	1,229	1,215	-1.1%	1,215	1,067	-12.2%
District 8 total	**3,488**	**3,448**	**-1.1%**	**3,448**	**2,994**	**-13.2%**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Jackson	867	846	-2.4%	846	916	8.3%
Josephine	451	453	0.4%	453	469	3.5%
District 8 total	**1,318**	**1,299**	-1.4%	**1,299**	**1,385**	**6.6%**
Community-Based Care						
Jackson	762	742	-2.6%	742	747	0.7%
Josephine	341	336	-1.5%	336	336	0.0%
District 8 total	**1,103**	**1,078**	-2.3%	**1,078**	**1,083**	**0.5%**
Nursing Care						
Jackson	140	145	3.6%	145	132	-9.0%
Josephine	153	150	-2.0%	150	135	-10.0%
District 8 total	**293**	**295**	**0.7%**	**295**	**267**	**-9.5%**

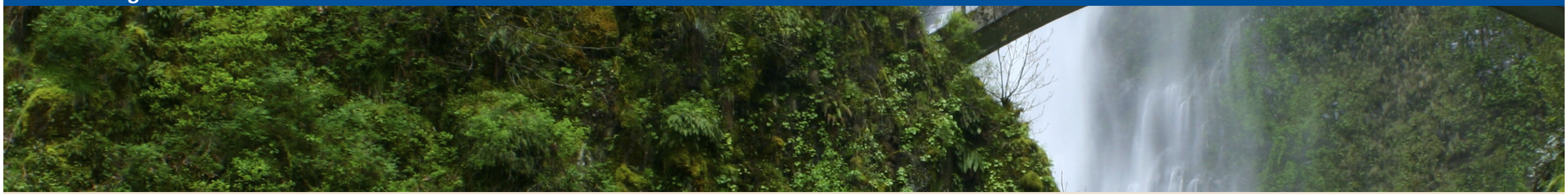
District 8 Regional Forecast, Oregon Health Authority (clients)

Counties served: **Jackson and Josephine** 	**Current Biennium**		**% Change Between Forecasts**	**Fall 14 Forecast**		**% Change Between Biennia**
	Spring 14 Forecast	**Fall 14 Forecast**		**2013-15**	**2015-17**	
Parents/Caretaker Relative						
Jackson	NA	5,035	-	5,035	3,844	-23.7%
Josephine	NA	2,688	-	2,688	2,707	0.7%
District 8 Total	**NA**	**7,723**	**-**	**7,723**	**6,551**	**-15.2%**
Children's Medicaid Program						
Jackson	NA	18,955	-	18,955	18,750	-1.1%
Josephine	NA	8,098	-	8,098	8,090	-0.1%
District 8 Total	**NA**	**27,053**	-	**27,053**	**26,840**	**-0.8%**
Children's Health Insurance Program (CHIP)						
Jackson	4,580	4,948	8.0%	4,948	4,627	-6.5%
Josephine	1,596	1,657	3.8%	1,657	1,538	-7.2%
District 8 Total	**6,176**	**6,605**	6.9%	**6,605**	**6,165**	**-6.7%**
Pregnant Women Program						
Jackson	1,040	1,213	16.6%	1,213	1,110	-8.5%
Josephine	412	513	24.5%	513	476	-7.2%
District 8 Total	**1,452**	**1,726**	**18.9%**	**1,726**	**1,586**	**-8.1%**
Foster Care & Adoption Services						
Jackson	1,144	1,189	3.9%	1,189	1,232	3.6%
Josephine	485	499	2.9%	499	512	2.6%
District 8 Total	**1,629**	**1,688**	**3.6%**	**1,688**	**1,744**	**3.3%**

District 8 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: **Jackson and Josephine** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Aid to the Blind/Disabled						
Jackson	4,933	4,887	-0.9%	4,887	4,990	2.1%
Josephine	2,800	2,743	-2.0%	2,743	2,788	1.6%
District 8 Total	**7,733**	**7,630**	**-1.3%**	**7,630**	**7,778**	**1.9%**
Old Age Assistance						
Jackson	2,037	2,047	0.5%	2,047	2,232	9.0%
Josephine	1,067	1,069	0.2%	1,069	1,114	4.2%
District 8 Total	**3,104**	**3,116**	**0.4%**	**3,116**	**3,346**	**7.4%**
ACA Adults with Children						
Jackson	NA	5,698	-	5,698	5,415	-5.0%
Josephine	NA	2,728	-	2,728	2,605	-4.5%
District 8 Total	NA	**8,426**	-	**8,426**	**8,019**	**-4.8%**
ACA Adults without Children						
Jackson	NA	16,253	-	16,253	15,530	-4.4%
Josephine	NA	7,780	-	7,780	7,470	-4.0%
District 8 Total	**NA**	**24,033**	**-**	**24,033**	**23,001**	**-4.3%**

District 9 Regional Forecast



District 9 has the lowest population of any region of the state. Agriculture is the primary source of income in the area, which limits the opportunity for economic growth but also provided a buffer from the worst aspects of the Great Recession.

More people are working now in District 9 than before the Great Recession, primarily in Wasco and Hood River counties. All five counties in the region have unemployment lower than Oregon overall. Hood River County is expanding in many sectors, while Wasco shows some recent job market weakness. Wasco County is one of the few counties in the state to show contraction in the labor force from August 2013 to August 2014.

District 9 SNAP caseloads are expected to continue to decline through 2017, and Hood River County will see large drops in SNAP Self-Sufficiency. District 9 TANF caseloads are not expected to change much from current levels.

DISTRICT 9	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	Aug-13	Aug-14
Oregon	3,919,020	22.1%	15.4%	$50,251	11.3%	8.1%	7.2%
Gilliam	1,945	18.3%	24.9%	$45,833	7.6%	7.7%	6.3%
Hood River	23,295	25.2%	13.7%	$58,344	7.4%	6.1%	5.1%
Sherman	1,780	19.6%	23.8%	$44,583	14.9%	7.5%	6.3%
Wasco	25,810	23.0%	19.2%	$42,080	9.8%	7.5%	6.4%
Wheeler	1,430	18.1%	30.9%	$36,357	9.8%	6.9%	7.0%

District 9 Regional Forecast, Oregon Department of Human Services

Counties served: **Gilliam, Hood River, Sherman, Wasco and Wheeler** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Gilliam	77	75	-2.6%	75	71	-5.3%
Hood River	1,297	1,275	-1.7%	1,275	1,013	-20.5%
Sherman	85	83	-2.4%	83	83	0.0%
Wasco	2,117	2,092	-1.2%	2,092	1,910	-8.7%
Wheeler	79	81	2.5%	81	73	-9.9%
District 9 total	3,655	**3,606**	-1.3%	**3,606**	**3,150**	**-12.6%**
SNAP - Aid to People with Disabilities						
Gilliam	57	57	0.0%	57	57	0.0%
Hood River	369	370	0.3%	370	431	16.5%
Sherman	62	62	0.0%	62	66	6.5%
Wasco	1,033	1,035	0.2%	1,035	1,140	10.1%
Wheeler	58	58	0.0%	58	66	13.8%
District 9 total	1,579	**1,582**	0.2%	**1,582**	**1,760**	**11.3%**
TANF						
Gilliam	12	12	0.0%	12	11	-8.3%
Hood River	60	59	-1.7%	59	43	-27.1%
Sherman	3	3	0.0%	3	5	66.7%
Wasco	155	153	-1.3%	153	144	-5.9%
Wheeler	10	10	0.0%	10	9	-10.0%
District 9 total	**240**	**237**	**-1.3%**	**237**	**212**	**-10.5%**

District 9 Regional Forecast, Oregon Department of Human Services (continued)

Counties served: **Gilliam, Hood River, Sherman, Wasco and Wheeler** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Gilliam	3	4	33.3%	4	4	0.0%
Hood River	27	27	0.0%	27	27	0.0%
Sherman	8	7	-12.5%	7	7	0.0%
Wasco	108	105	-2.8%	105	102	-2.9%
Wheeler	4	2	-50.0%	2	2	0.0%
District 9 total	**150**	**145**	-3.3%	**145**	**142**	**-2.1%**
Community-Based Care						
Gilliam	7	7	0.0%	7	8	14.3%
Hood River	26	26	0.0%	26	22	-15.4%
Sherman	3	3	0.0%	3	5	0.0%
Wasco	86	81	-5.8%	81	79	-2.5%
Wheeler	6	9	50.0%	9	11	22.2%
District 9 total	**128**	**126**	-1.6%	**126**	**125**	**-0.8%**
Nursing Care						
Gilliam	1	0	-100.0%	0	0	0.0%
Hood River	38	35	-7.9%	35	32	-8.6%
Sherman	1	1	0.0%	1	1	0.0%
Wasco	129	114	-11.6%	114	103	-9.6%
Wheeler	1	0	-100.0%	0	0	0.0%
District 9 total	**170**	**150**	**-11.8%**	**150**	**136**	**-9.3%**

District 9 Regional Forecast, Oregon Health Authority (clients)

Counties served: **Gilliam, Hood River, Sherman, Wasco and Wheeler** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Parents/Caretaker Relative						
Gilliam	NA	36	-	36	37	2.8%
Hood River	NA	268	-	268	257	-4.1%
Sherman	NA	26	-	26	36	38.5%
Wasco	NA	478	-	478	436	-8.8%
Wheeler	NA	26	-	26	31	19.2%
District 9 Total	**NA**	**834**	**-**	**834**	**797**	**-4.4%**
Children's Medicaid Program						
Gilliam	NA	114	-	114	115	0.9%
Hood River	NA	2,177	-	2,177	2,257	3.7%
Sherman	NA	79	-	79	85	7.6%
Wasco	NA	2,530	-	2,530	2,519	-0.4%
Wheeler	NA	93	-	93	109	17.2%
District 9 Total	**NA**	**4,993**	-	**4,993**	**5,085**	**1.8%**
Children's Health Insurance Program (CHIP)						
Gilliam	21	31	47.6%	31	36	16.1%
Hood River	908	885	-2.5%	885	802	-9.4%
Sherman	24	23	-4.2%	23	21	-8.7%
Wasco	696	718	3.2%	718	803	11.8%
Wheeler	14	15	7.1%	15	21	40.0%
District 9 Total	**1,663**	**1,672**	0.5%	**1,672**	**1,683**	**0.7%**
Pregnant Women Program						
Gilliam	3	3	0.0%	3	3	0.0%
Hood River	97	113	16.5%	113	106	-6.2%
Sherman	4	3	-25.0%	3	3	0.0%
Wasco	145	162	11.7%	162	155	-4.3%
Wheeler	4	3	-25.0%	3	4	33.3%
District 9 Total	**253**	**284**	**12.3%**	**284**	**271**	**-4.6%**

District 9 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: **Gilliam, Hood River, Sherman, Wasco and Wheeler** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Foster Care & Adoption Services						
Gilliam	11	14	27.3%	14	12	-14.3%
Hood River	80	80	0.0%	80	82	2.5%
Sherman	15	14	-6.7%	14	14	0.0%
Wasco	154	158	2.6%	158	162	2.5%
Wheeler	8	10	25.0%	10	13	30.0%
District 9 Total	**268**	**276**	**3.0%**	**276**	**283**	**2.5%**
Aid to Blind/Disabled						
Gilliam	28	29	3.6%	29	28	-3.4%
Hood River	262	261	-0.4%	261	271	3.8%
Sherman	33	32	-3.0%	32	33	3.1%
Wasco	703	708	0.7%	708	752	6.2%
Wheeler	22	21	-4.5%	21	21	0.0%
District 9 total	**1,048**	**1,051**	**0.3%**	**1,051**	**1,105**	**5.1%**
Old Age Assistance						
Gilliam	18	19	5.6%	19	20	5.3%
Hood River	130	132	1.5%	132	135	2.3%
Sherman	9	10	11.1%	10	11	10.0%
Wasco	357	357	0.0%	357	387	8.4%
Wheeler	13	14	7.7%	14	14	0.0%
District 9 total	**527**	**532**	**0.9%**	**532**	**567**	**6.6%**
ACA Adults with Children						
Gilliam	NA	26	-	26	25	-5.4%
Hood River	NA	544	-	544	522	-3.9%
Sherman	NA	29	-	29	28	-3.9%
Wasco	NA	610	-	610	582	-4.6%
Wheeler	NA	32	-	32	31	-2.8%
District 9 Total	NA	**1,241**	-	**1,241**	**1,188**	**-4.2%**

District 9 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: **Gilliam, Hood River, Sherman, Wasco and Wheeler** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
ACA Adults without Children						
Gilliam	NA	74	-	74	70	-4.9%
Hood River	NA	1,550	-	1,550	1,499	-3.3%
Sherman	NA	84	-	84	81	-3.4%
Wasco	NA	1,738	-	1,738	1,668	-4.0%
Wheeler	NA	92	-	92	90	-2.3%
District 9 Total	NA	**3,538**	-	**3,538**	**3,408**	**-3.7%**

District 10 Regional Forecast

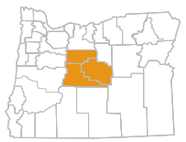
Central Oregon is growing again. Jobs are coming back to the region at a faster pace than anywhere else in the state. An area that looked moribund from 2009 through 2012 is now the fastest recovering region, with employment up 4.3 percent compared to last year. Still, District 10 was one of the hardest hit areas of the state during the Great Recession. Even with the recent job recovery, the area is still 14 percent below the 2008 employment peak. Unemployment remains high in the area, especially in Crook County which lost jobs in both construction and wood products manufacturing as a result of the housing bust.

According to the U.S. Census Bureau, Deschutes County is the fastest growing county in the state, adding 4,000 residents between 2012 and 2013. Unfortunately this growth has resulted in a tightening of the housing and rental markets, particularly low-income housing options. The growing population is likely leading to a surge in construction employment as new homes, apartments, and commercial buildings are needed to meet the increased demand for housing. The employment sector that includes construction has grown 16.4 percent since 2013. The summer tourism season will likely also benefit, with a higher number of visitors using overnight accommodations.

Self-Sufficiency caseloads are expected to fall quickly in Deschutes County. Crook County will also see reduced caseloads as the economy improves. Jefferson County, however, will see only modest reductions in SNAP, and increases in TANF through 2017.

DISTRICT 10	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	Aug-13	Aug-14
Oregon	3,919,020	22.1%	15.4%	$50,251	11.3%	8.1%	7.2%
Crook	20,690	20.7%	22.9%	$35,052	16.5%	12.5%	10.2%
Deschutes	162,525	22.7%	16.4%	$46,791	11.6%	9.9%	8.2%
Jefferson	22,040	24.2%	17.0%	$45,069	14.8%	10.9%	9.5%

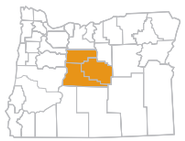
District 10 Regional Forecast, Oregon Department of Human Services

Counties served: **Crook, Deschutes and Jefferson** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Crook	1,614	1,637	1.4%	1,637	1,447	-11.6%
Deschutes	12,618	12,800	1.4%	12,800	9,813	-23.3%
Jefferson	2,769	2,833	2.3%	2,833	2,686	-5.2%
District 10 total	17,001	**17,270**	1.6%	**17,270**	**13,946**	**-19.2%**
SNAP - Aid to People with Disabilities						
Crook	906	908	0.2%	908	984	8.4%
Deschutes	4,115	4,122	0.2%	4,122	4,637	12.5%
Jefferson	814	816	0.2%	816	923	13.1%
District 10 total	5,835	**5,846**	0.2%	**5,846**	**6,544**	**11.9%**
TANF						
Crook	202	200	-1.0%	200	192	-4.0%
Deschutes	1,170	1,156	-1.2%	1,156	959	-17.0%
Jefferson	440	435	-1.1%	435	389	-10.6%
District 10 total	**1,812**	**1,791**	**-1.2%**	**1,791**	**1,540**	**-14.0%**

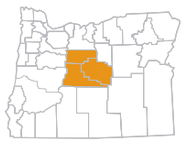
District 10 Regional Forecast, Oregon Department of Human Services (continued)

Counties served: **Crook, Deschutes and Jefferson** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Crook	97	117	20.6%	117	142	21.4%
Deschutes	364	392	7.7%	392	425	8.4%
Jefferson	75	83	10.7%	83	90	8.4%
District 10 total	**536**	**592**	10.4%	**592**	**657**	**11.0%**
Community-Based Care						
Crook	60	59	-1.7%	59	59	0.0%
Deschutes	408	407	-0.2%	407	428	5.2%
Jefferson	75	73	-2.7%	73	82	12.3%
District 10 total	**543**	**539**	-0.7%	**539**	**569**	**5.6%**
Nursing Care						
Crook	17	15	-11.8%	15	16	6.7%
Deschutes	77	68	-11.7%	68	66	-2.9%
Jefferson	16	16	0.0%	16	15	-6.3%
District 10 total	**110**	**99**	**-10.0%**	**99**	**97**	**-2.0%**

District 10 Regional Forecast, Oregon Health Authority (clients)

Counties served: **Crook, Deschutes and Jefferson** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Parents/Caretaker Relative						
Crook	NA	470	-	470	425	-9.6%
Deschutes	NA	3,339	-	3,339	2,828	-15.3%
Jefferson	NA	792	-	792	755	-4.7%
District 10 Total	**NA**	**4,601**	**-**	**4,601**	**4,008**	**-12.9%**
Children's Medicaid Program						
Crook	NA	1,738	-	1,738	1,633	-6.0%
Deschutes	NA	12,789	-	12,789	12,669	-0.9%
Jefferson	NA	3,063	-	3,063	3,064	0.0%
District 10 Total	**NA**	**17,590**	-	**17,590**	**17,366**	**-1.3%**
Children's Health Insurance Program (CHIP)						
Crook	534	571	6.9%	571	535	-6.3%
Deschutes	3,424	4,141	20.9%	4,141	3,994	-3.5%
Jefferson	569	575	1.1%	575	520	-9.6%
District 10 Total	**4,527**	**5,287**	16.8%	**5,287**	**5,049**	**-4.5%**
Pregnant Women Program						
Crook	88	107	21.6%	107	102	-4.7%
Deschutes	654	756	15.6%	756	708	-6.3%
Jefferson	97	118	21.6%	118	103	-12.7%
District 10 Total	**839**	**981**	**16.9%**	**981**	**913**	**-6.9%**
Foster Care & Adoption Services						
Crook	91	90	-1.1%	90	91	1.1%
Deschutes	508	510	0.4%	510	510	0.0%
Jefferson	204	200	-2.0%	200	200	0.0%
District 10 Total	**803**	**800**	**-0.4%**	**800**	**801**	**0.1%**

District 10 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: **Crook, Deschutes and Jefferson** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Aid to the Blind/Disabled						
Crook	465	465	0.0%	465	509	9.5%
Deschutes	2,544	2,507	-1.5%	2,507	2,563	2.2%
Jefferson	549	554	0.9%	554	572	3.2%
District 10 Total	**3,558**	**3,526**	**-0.9%**	**3,526**	**3,644**	**3.3%**
Old Age Assistance						
Crook	190	192	1.1%	192	193	0.5%
Deschutes	904	920	1.8%	920	991	7.7%
Jefferson	200	211	5.5%	211	241	14.2%
District 10 Total	**1,294**	**1,323**	**2.2%**	**1,323**	**1,425**	**7.7%**
ACA Adults with Children						
Crook	NA	539	-	539	514	-4.5%
Deschutes	NA	4,049	-	4,049	3,855	-4.8%
Jefferson	NA	627	-	627	600	-4.3%
District 10 Total	NA	**5,215**	-	**5,215**	**4,970**	**-4.7%**
ACA Adults without Children						
Crook	NA	1,537	-	1,537	1,476	-4.0%
Deschutes	NA	11,548	-	11,548	11,058	-4.2%
Jefferson	NA	1,789	-	1,789	1,721	-3.8%
District 10 Total	NA	**14,874**	-	**14,874**	**14,254**	**-4.2%**

District 11 Regional Forecast

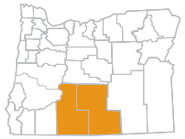
The Klamath basin has experienced another summer of extreme drought, with negative direct effects to farmers and ranchers, as well as businesses that provide goods and services to those farmers and ranchers.

Klamath County is one of the few places to see overall employment shrink from 2013 to 2014. Almost all employment sectors are down with the exception of construction. Lake County is adding jobs, erasing losses experienced in 2012 and 2013. The unemployment rate is down in both Klamath and Lake counties, but that is probably due to fewer unemployed people actively looking for work rather than an upswing in available jobs.

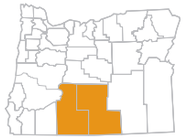
The SNAP self-sufficiency caseload is expected to fall in District 11, though at a slower pace than statewide. TANF is expected to fall in Klamath County, but not in Lake County.

DISTRICT 11	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	Aug-13	Aug-14
Oregon	3,919,020	22.1%	15.4%	$50,251	11.3%	8.1%	7.2%
Klamath	66,810	21.6%	19.1%	$36,885	11.7%	10.9%	9.9%
Lake	7,940	18.2%	22.6%	$40,049	12.6%	12.0%	9.5%

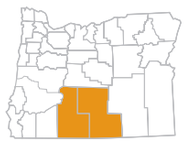
District 11 Regional Forecast, Oregon Department of Human Services

Counties served: **Klamath and Lake** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Klamath	7,019	7,057	0.5%	7,057	6,538	-7.4%
Lake	498	492	-1.2%	492	451	-8.3%
District 11 total	7,517	**7,549**	0.4%	**7,549**	**6,989**	**-7.4%**
SNAP - Aid to People with Disabilities						
Klamath	2,925	2,930	0.2%	2,930	3,320	13.3%
Lake	352	353	0.3%	353	413	17.0%
District 11 total	3,277	**3,283**	0.2%	**3,283**	**3,733**	**13.7%**
TANF						
Klamath	634	627	-1.1%	627	540	-13.9%
Lake	28	27	-3.6%	27	36	33.3%
District 11 total	**662**	**654**	**-1.2%**	**654**	**576**	**-11.9%**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Klamath	273	279	2.2%	279	299	7.2%
Lake	19	20	5.3%	20	19	-5.0%
District 11 total	**292**	**299**	2.4%	**299**	**318**	**6.4%**
Community-Based Care						
Klamath	193	186	-3.6%	186	182	-2.2%
Lake	8	6	-25.0%	6	6	0.0%
District 11 total	**201**	**192**	-4.5%	**192**	**188**	**-2.1%**
Nursing Care						
Klamath	46	46	0.0%	46	46	0.0%
Lake	15	15	0.0%	15	16	6.7%
District 11 total	**61**	**61**	**0.0%**	**61**	**62**	**1.6%**

District 11 Regional Forecast, Oregon Health Authority (clients)

Counties served: **Klamath and Lake** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Parents/Caretaker Relative						
Klamath	NA	1,714	-	1,714	1,654	-3.5%
Lake	NA	143	-	143	128	-10.5%
District 11 Total	**NA**	**1,857**	**-**	**1,857**	**1,782**	**-4.0%**
Children's Medicaid Program						
Klamath	NA	6,546	-	6,546	6,520	-0.4%
Lake	NA	610	-	610	615	0.8%
District 11 Total	**NA**	**7,156**	-	**7,156**	**7,135**	**-0.3%**
Children's Health Insurance Program (CHIP)						
Klamath	1,188	1,190	0.2%	1,190	1,070	-10.1%
Lake	108	97	-10.2%	97	89	-8.2%
District 11 Total	**1,296**	**1,287**	-0.7%	**1,287**	**1,159**	**-9.9%**
Pregnant Women Program						
Klamath	341	406	19.1%	406	374	-7.9%
Lake	29	34	17.2%	34	30	-11.8%
District 11 Total	**370**	**440**	**18.9%**	**440**	**404**	**-8.2%**
Foster Care & Adoption Services						
Klamath	521	517	-0.8%	517	515	-0.4%
Lake	43	48	11.6%	48	50	4.2%
District 11 Total	**564**	**565**	**0.2%**	**565**	**565**	**0.0%**

District 11 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: **Klamath and Lake** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Aid to the Blind/Disabled						
Klamath	2,077	2,070	-0.3%	2,070	2,184	5.5%
Lake	181	181	0.0%	181	180	-0.6%
District 11 Total	**2,258**	**2,251**	**-0.3%**	**2,251**	**2,364**	**5.0%**
Old Age Assistance						
Klamath	631	627	-0.6%	627	657	4.8%
Lake	68	65	-4.4%	65	64	-1.5%
District 11 Total	**699**	**692**	**-1.0%**	**692**	**721**	**4.2%**
ACA Adults with Children						
Klamath	NA	1,812	-	1,812	1,731	-4.5%
Lake	NA	170	-	170	162	-4.7%
District 11 Total	NA	**1,981**	-	**1,981**	**1,892**	**-4.5%**
ACA Adults without Children						
Klamath	NA	5,167	-	5,167	4,963	-3.9%
Lake	NA	484	-	484	464	-4.1%
District 11 Total	NA	**5,652**	-	**5,652**	**5,428**	**-4.0%**

District 12 Regional Forecast

Umatilla County's economy contracted from 2013 to the summer of 2014, losing jobs and shrinking payrolls. Especially hard hit was the professional/business sector, which fell by over 19 percent from 2013 to 2014. Employment in Umatilla County has yet to recover the jobs lost in the Great Recession.

Morrow County, with an economy centered on agriculture, grew throughout the Great Recession. More people in Morrow County were employed in the summer of 2014 than before the start of the economic downturn.

TANF caseloads are expected to fall in District 12 more quickly than statewide. The SNAP Self-Sufficiency caseload is forecast to fall quickly in Umatilla County, but is not expected to change much in Morrow County.

DISTRICT 12	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	Aug-13	Aug-14
Oregon	3,919,020	22.1%	15.4%	$50,251	11.3%	8.1%	7.2%
Morrow	11,425	27.2%	14.3%	$48,457	13.8%	8.0%	7.8%
Umatilla	77,895	26.3%	13.8%	$48,514	14.6%	8.5%	7.6%

District 12 Regional Forecast, Oregon Department of Human Services

Counties served: **Morrow and Umatilla**

	Current Biennium			Fall 14 Forecast		
	Spring 14 Forecast	Fall 14 Forecast	% Change Between Forecasts	2013-15	2015-17	% Change Between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Morrow	849	845	-0.5%	845	842	-0.4%
Umatilla	6,010	6,058	0.8%	6,058	4,903	-19.1%
District 11 total	6,859	**6,903**	0.6%	**6,903**	**5,745**	**-16.8%**
SNAP - Aid to People with Disabilities						
Morrow	280	280	0.0%	280	311	11.1%
Umatilla	2,249	2,253	0.2%	2,253	2,410	7.0%
District 11 total	2,529	**2,533**	0.2%	**2,533**	**2,721**	**7.4%**
TANF						
Morrow	98	97	-1.0%	97	83	-14.4%
Umatilla	708	700	-1.1%	700	576	-17.7%
District 11 total	**806**	**797**	**-1.1%**	**797**	**659**	**-17.3%**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Morrow	43	40	-7.0%	40	43	7.5%
Umatilla	295	322	9.2%	322	339	5.3%
District 11 total	**338**	**362**	7.1%	**362**	**382**	**5.5%**
Community-Based Care						
Morrow	6	7	16.7%	7	7	0.0%
Umatilla	241	236	-2.1%	236	236	0.0%
District 11 total	**247**	**243**	-1.6%	**243**	**243**	**0.0%**
Nursing Care						
Morrow	3	4	33.3%	4	3	-25.0%
Umatilla	81	85	4.9%	85	83	-2.4%
District 11 total	**84**	**89**	**6.0%**	**89**	**86**	**-3.4%**

District 12 Regional Forecast, Oregon Health Authority (clients)

Counties served: **Morrow and Umatilla** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Parents/Caretaker Relative						
Morrow	NA	216	-	216	182	-15.7%
Umatilla	NA	1,704	-	1,704	1,626	-4.6%
District 12 Total	**NA**	**1,920**	**-**	**1,920**	**1,808**	**-5.8%**
Children's Medicaid Program						
Morrow	NA	1,309	-	1,309	1,314	0.4%
Umatilla	NA	8,267	-	8,267	8,258	-0.1%
District 12 Total	**NA**	**9,576**	-	**9,576**	**9,572**	**0.0%**
Children's Health Insurance Program (CHIP)						
Morrow	372	342	-8.1%	342	294	-14.0%
Umatilla	1,954	1,831	-6.3%	1,831	1,712	-6.5%
District 12 Total	**2,326**	**2,173**	-6.6%	**2,173**	**2,006**	**-7.7%**
Pregnant Women Program						
Morrow	36	50	38.9%	50	53	6.0%
Umatilla	344	414	20.3%	414	281	-32.1%
District 12 Total	**380**	**464**	**22.1%**	**464**	**334**	**-28.0%**
Foster Care & Adoption Services						
Morrow	39	41	5.1%	41	43	4.9%
Umatilla	365	370	1.4%	370	368	-0.5%
District 12 Total	**404**	**411**	**1.7%**	**411**	**411**	**0.0%**

District 12 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: **Morrow and Umatilla** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Aid to the Blind/Disabled						
Morrow	200	198	-1.0%	198	195	-1.5%
Umatilla	1,656	1,644	-0.7%	1,644	1,650	0.4%
District 12 Total	**1,856**	**1,842**	**-0.8%**	**1,842**	**1,845**	**0.2%**
Old Age Assistance						
Morrow	69	69	0.0%	69	69	0.0%
Umatilla	791	788	-0.4%	788	809	2.7%
District 12 Total	**860**	**857**	**-0.3%**	**857**	**878**	**2.5%**
ACA Adults with Children						
Morrow	NA	193	-	193	183	-5.4%
Umatilla	NA	1,391	-	1,391	1,313	-5.6%
District 12 Total	NA	**1,584**	-	**1,584**	**1,496**	**-5.6%**
ACA Adults without Children						
Morrow	NA	551	-	551	524	-4.8%
Umatilla	NA	3,967	-	3,967	3,766	-5.1%
District 12 Total	NA	**4,518**	-	**4,518**	**4,290**	**-5.0%**

District 13 Regional Forecast

Northeast Oregon is enjoying steadily lower jobless rates in 2014. As of August, the local unemployment rate had shown a year-over-year improvement for 29 consecutive months in Baker County, 35 months in Union County, and 10 months in Wallowa County.

Union County is poised to make up all the jobs lost due to the Great Recession, if not by the end of 2014, then in 2015. Wallowa employment is also growing, but there are fewer signs of a sustained recovery in Baker County.

Prime working age is generally defined as ages 25 to 54, and there are fewer workers in Eastern Oregon that fall into that category than elsewhere in the state.

Baker County is one of the few places that is expected to see SNAP caseloads continue to rise through 2017. The other counties in District 13 will have reductions, but at a slower pace than statewide. All three counties in the district are expected to see reductions in TANF in line with the statewide pattern.

DISTRICT 13	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	Aug-13	Aug-14
Oregon	3,919,020	22.1%	15.4%	$50,251	11.3%	8.1%	7.2%
Baker	16,280	19.9%	24.2%	$40,348	12.9%	9.6%	8.7%
Union	26,325	22.8%	18.6%	$41,462	10.6%	8.3%	7.5%
Wallowa	7,045	19.4%	26.1%	$40,204	12.0%	10.1%	9.0%

District 13 Regional Forecast, Oregon Department of Human Services

Counties served: **Baker, Union and Wallowa** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Baker	1,373	1,390	1.2%	1,390	1,390	0.0%
Union	1,915	1,941	1.4%	1,941	1,771	-8.8%
Wallowa	341	340	-0.3%	340	331	-2.6%
District 13 total	3,629	**3,671**	1.2%	**3,671**	**3,492**	**-4.9%**
SNAP - Aid to People with Disabilities						
Baker	765	766	0.1%	766	872	13.8%
Union	823	825	0.2%	825	904	9.6%
Wallowa	275	275	0.0%	275	304	10.5%
District 13 total	1,863	**1,866**	0.2%	**1,866**	**2,080**	**11.5%**
TANF						
Baker	175	173	-1.1%	173	151	-12.7%
Union	289	285	-1.4%	285	249	-12.6%
Wallowa	45	44	-2.2%	44	37	-15.9%
District 13 total	**509**	**502**	**-1.4%**	**502**	**437**	**-12.9%**

District 13 Regional Forecast, Oregon Department of Human Services (continued)

Counties served: **Baker, Union and Wallowa** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Baker	39	41	5.1%	41	42	2.4%
Union	82	86	4.9%	86	88	2.3%
Wallowa	31	31	0.0%	31	30	-3.2%
District 13 total	**152**	**158**	3.9%	**158**	**160**	**1.3%**
Community-Based Care						
Baker	80	81	1.3%	81	86	6.2%
Union	105	100	-4.8%	100	95	-5.0%
Wallowa	31	30	-3.2%	30	30	0.0%
District 13 total	**216**	**211**	-2.3%	**211**	**211**	**0.0%**
Nursing Care						
Baker	24	18	-25.0%	18	16	-11.1%
Union	39	40	2.6%	40	41	2.5%
Wallowa	7	3	-57.1%	3	3	0.0%
District 13 total	**70**	**61**	**-12.9%**	**61**	**60**	**-1.6%**

District 13 Regional Forecast, Oregon Health Authority (clients)

Counties served: **Baker, Union and Wallowa** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Parents/Caretaker Relative						
Baker	NA	377	-	377	405	7.4%
Union	NA	671	-	671	651	-3.0%
Wallowa	NA	144	-	144	207	43.8%
District 13 Total	**NA**	**1,192**	**-**	**1,192**	**1,263**	**6.0%**
Children's Medicaid Program						
Baker	NA	1,364	-	1,364	1,367	0.2%
Union	NA	2,271	-	2,271	2,259	-0.5%
Wallowa	NA	470	-	470	511	8.7%
District 13 Total	**NA**	**4,105**	-	**4,105**	**4,137**	**0.8%**
Children's Health Insurance Program (CHIP)						
Baker	302	304	0.7%	304	288	-5.3%
Union	438	518	18.3%	518	616	18.9%
Wallowa	107	160	49.5%	160	122	-23.8%
District 13 Total	**847**	**982**	15.9%	**982**	**1,026**	**4.5%**
Pregnant Women Program						
Baker	76	81	6.6%	81	74	-8.6%
Union	109	122	11.9%	122	114	-6.6%
Wallowa	25	24	-4.0%	24	24	0.0%
District 13 Total	**210**	**227**	**8.1%**	**227**	**212**	**-6.6%**
Foster Care & Adoption Services						
Baker	124	117	-5.6%	117	119	1.7%
Union	125	132	5.6%	132	140	6.1%
Wallowa	22	20	-9.1%	20	19	-5.0%
District 13 Total	**271**	**269**	**-0.7%**	**269**	**278**	**3.3%**

District 13 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: **Baker, Union and Wallowa** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Aid to the Blind/Disabled						
Baker	449	450	0.2%	450	454	0.9%
Union	597	602	0.8%	602	603	0.2%
Wallowa	182	176	-3.3%	176	187	6.3%
District 13 Total	**1,228**	**1,228**	**0.0%**	**1,228**	**1,244**	**1.3%**
Old Age Assistance						
Baker	167	166	-0.6%	166	167	0.6%
Union	245	246	0.4%	246	251	2.0%
Wallowa	64	64	0.0%	64	64	0.0%
District 13 Total	**476**	**476**	**0.0%**	**476**	**482**	**1.3%**
ACA Adults with Children						
Baker	NA	377	-	377	355	-5.8%
Union	NA	506	-	506	473	-6.5%
Wallowa	NA	158	-	158	151	-4.2%
District 13 Total	NA	**1,041**	-	**1,041**	**980**	**-5.9%**
ACA Adults without Children						
Baker	NA	1,076	-	1,076	1,020	-5.2%
Union	NA	1,443	-	1,443	1,356	-6.0%
Wallowa	NA	451	-	451	435	-3.6%
District 13 Total	NA	**2,970**	-	**2,970**	**2,810**	**-5.4%**

District 14 Regional Forecast

District 14 is one of the few regions to experience a reduction in the number people employed comparing 2013 to 2014. Malheur County saw an increase in unemployment as multiple job sectors shed jobs, including financial, professional and business services, and manufacturing. Public sector jobs are also down compared to 2013, although new school-year hiring may erase some of those losses.

Grant County also experienced rising unemployment. On an annualized basis, the number of jobs in Grant County declined every year from 2006 to 2012. Since then, things have stabilized but not necessarily improved.

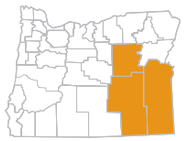
Harney County's unemployment rate has been in double-digits since the middle of 2008. The rate improved in 2014, but remains above 10 percent. Since job creation has improved only marginally, improvements in the unemployment rate are due to fewer people looking for work, not an improved job market.

Prime working age is generally defined as ages 25 to 54, and there are fewer workers in Eastern Oregon that fall into that category than elsewhere in the state.

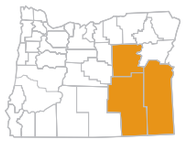
The SNAP Self-Sufficiency caseload is expected to decline in a pattern similar to statewide in Grant and Harney counties, but not in Malheur, which should see very little change in rates of SNAP participation. Malheur will see reductions in TANF in line with the statewide pattern, although the other two counties in the district are expected to see modest increases.

DISTRICT 14	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	Aug-13	Aug-14
Oregon	3,919,020	22.1%	15.4%	$50,251	11.3%	8.1%	7.2%
Grant	7,435	17.8%	27.5%	$34,337	12.5%	12.3%	11.2%
Harney	7,260	21.6%	21.3%	$39,674	16.7%	12.6%	10.5%
Malheur	31,440	25.0%	16.3%	$36,318	16.7%	8.6%	8.9%

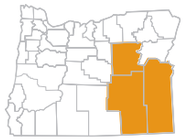
District 14 Regional Forecast, Oregon Department of Human Services

Counties served: **Grant, Harney and Malheur** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Grant	378	370	-2.1%	370	328	-11.4%
Harney	468	477	1.9%	477	437	-8.4%
Malheur	2,798	2,816	0.6%	2,816	2,825	0.3%
District 14 total	3,644	**3,663**	0.5%	**3,663**	**3,590**	**-2.0%**
SNAP - Aid to People with Disabilities						
Grant	277	277	0.0%	277	308	11.2%
Harney	344	344	0.0%	344	391	13.7%
Malheur	1,182	1,184	0.2%	1,184	1,277	7.9%
District 14 total	1,803	**1,805**	0.1%	**1,805**	**1,976**	**9.5%**
TANF						
Grant	37	36	-2.7%	36	40	11.1%
Harney	43	43	0.0%	43	34	-20.9%
Malheur	360	356	-1.1%	356	316	-11.2%
District 14 total	**440**	**435**	**-1.1%**	**435**	**390**	**-10.3%**

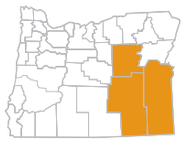
District 14 Regional Forecast, Oregon Department of Human Services (continued)

Counties served: **Grant, Harney and Malheur** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Grant	22	25	13.6%	25	32	28.0%
Harney	30	30	0.0%	30	30	0.0%
Malheur	163	143	-12.3%	143	150	4.9%
District 14 total	**215**	**198**	-7.9%	**198**	**212**	**7.1%**
Community-Based Care						
Grant	25	24	-4.0%	24	25	4.2%
Harney	34	34	0.0%	34	34	0.0%
Malheur	142	133	-6.3%	133	135	1.5%
District 14 total	**201**	**191**	-5.0%	**191**	**194**	**1.6%**
Nursing Care						
Grant	14	11	-21.4%	11	9	-18.2%
Harney	1	1	0.0%	1	1	0.0%
Malheur	28	27	-3.6%	27	25	-7.4%
District 14 total	**43**	**39**	**-9.3%**	**39**	**35**	**-10.3%**

District 14 Regional Forecast, Oregon Health Authority (clients)

Counties served: **Grant, Harney and Malheur** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Parents/Caretaker Relative						
Grant	NA	119	-	119	143	20.2%
Harney	NA	115	-	115	136	18.3%
Malheur	NA	843	-	843	891	5.7%
District 14 Total	**NA**	**1,077**	**-**	**1,077**	**1,170**	**8.6%**
Children's Medicaid Program						
Grant	NA	428	-	428	428	0.0%
Harney	NA	538	-	538	555	3.2%
Malheur	NA	4,071	-	4,071	4,057	-0.3%
District 14 Total	**NA**	**5,037**	-	**5,037**	**5,040**	**0.1%**
Children's Health Insurance Program (CHIP)						
Grant	116	130	12.1%	130	148	13.8%
Harney	141	135	-4.3%	135	126	-6.7%
Malheur	728	666	-8.5%	666	602	-9.6%
District 14 Total	**985**	**931**	-5.5%	**931**	**876**	**-5.9%**
Pregnant Women Program						
Grant	19	19	0.0%	19	20	5.3%
Harney	36	38	5.6%	38	33	-13.2%
Malheur	157	176	12.1%	176	162	-8.0%
District 14 Total	**212**	**233**	**9.9%**	**233**	**215**	**-7.7%**
Foster Care & Adoption Services						
Grant	36	37	2.8%	37	36	-2.7%
Harney	41	47	14.6%	47	49	4.3%
Malheur	246	233	-5.3%	233	233	0.0%
District 14 Total	**323**	**317**	**-1.9%**	**317**	**318**	**0.3%**

District 14 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: **Grant, Harney and Malheur** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Aid to the Blind/Disabled						
Grant	126	131	4.0%	131	134	2.3%
Harney	200	195	-2.5%	195	205	5.1%
Malheur	866	853	-1.5%	853	859	0.7%
District 14 Total	**1,192**	**1,179**	**-1.1%**	**1,179**	**1,198**	**1.6%**
Old Age Assistance						
Grant	82	79	-3.7%	79	80	1.3%
Harney	75	78	4.0%	78	79	1.3%
Malheur	422	420	-0.5%	420	448	6.7%
District 14 Total	**579**	**577**	**-0.3%**	**577**	**607**	**5.2%**
ACA Adults with Children						
Grant	NA	124	-	124	117	-6.0%
Harney	NA	167	-	167	157	-6.0%
Malheur	NA	620	-	620	583	-5.9%
District 14 Total	NA	**911**	-	**911**	**856**	**-5.9%**
ACA Adults without Children						
Grant	NA	355	-	355	335	-5.5%
Harney	NA	475	-	475	449	-5.5%
Malheur	NA	1,767	-	1,767	1,672	-5.4%
District 14 Total	NA	**2,597**	-	**2,597**	**2,457**	**-5.4%**

District 15 Regional Forecast

Clackamas County continues its slow march down the path of recovery. As of the summer of 2014, it had recovered more than half of the jobs lost during the Great Recession. Construction employment leads the charge with more people employed in August of 2014 that at any time since 2009. Even so, construction employment remains far below the highs seen before the housing bust of 2008.

The unemployment rate in Clackamas County is lower than the state overall and among the lowest in the state. Employment in retail sales and leisure and hospitality are poised to reach pre-recession levels. Jobs in healthcare and social assistance increased throughout the Great Recession and are still increasing.

Clackamas County is poised to see large reductions in the SNAP and TANF caseloads at a rate that exceeds the statewide trend.

DISTRICT 15	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	Aug-13	Aug-14
Oregon	3,919,020	22.1%	15.4%	$50,251	11.3%	8.1%	7.2%
Clackamas	386,080	22.9%	15.5%	$66,758	6.7%	6.9%	6.2%

District 15 Regional Forecast, Oregon Department of Human Services

County served: **Clackamas** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Clackamas	19,991	20,350	1.8%	20,350	18,414	-9.5%
District 15 total	19,991	**20,350**	1.8%	**20,350**	**18,414**	**-9.5%**
SNAP - Aid to People with Disabilities						
Clackamas	7,629	7,643	0.2%	7,643	8,891	16.3%
District 15 total	7,629	**7,643**	0.2%	**7,643**	**8,891**	**16.3%**
TANF						
Clackamas	1,744	1,725	-1.1%	1,725	1,297	-24.8%
District 15 total	**1,744**	**1,725**	**-1.1%**	**1,725**	**1,297**	**-24.8%**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Clackamas	1,139	1,167	2.5%	1,167	1,232	5.6%
District 15 total	**1,139**	**1,167**	2.5%	**1,167**	**1,232**	**5.6%**
Community-Based Care						
Clackamas	966	980	1.4%	980	1,024	4.5%
District 15 total	**966**	**980**	1.4%	**980**	**1,024**	**4.5%**
Nursing Care						
Clackamas	343	334	-2.6%	334	329	-1.5%
District 15 total	**343**	**334**	**-2.6%**	**334**	**329**	**-1.5%**

District 15 Regional Forecast, Oregon Health Authority (clients)

County served: **Clackamas** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Parents/Caretaker Relative						
Clackamas	NA	4,954	-	4,954	4,407	-11.0%
District 15 Total	**NA**	**4,954**	**-**	**4,954**	**4,407**	**-11.0%**
Children's Medicaid Program						
Clackamas	NA	20,810	-	20,810	20,807	0.0%
District 15 Total	**NA**	**20,810**	-	**20,810**	**20,807**	**0.0%**
Children's Health Insurance Program (CHIP)						
Clackamas	5,498	6,672	21.4%	6,672	7,588	13.7%
District 15 Total	**5,498**	**6,672**	21.4%	**6,672**	**7,588**	**13.7%**
Pregnant Women Program						
Clackamas	976	1,138	16.6%	1,138	806	-29.2%
District 15 Total	**976**	**1,138**	**16.6%**	**1,138**	**806**	**-29.2%**
Foster Care & Adoption Services						
Clackamas	1,499	1,450	-3.3%	1,450	1,415	-2.4%
District 15 Total	**1,499**	**1,450**	**-3.3%**	**1,450**	**1,415**	**-2.4%**
Aid to the Blind/Disabled						
Clackamas	5,605	5,529	-1.4%	5,529	5,658	2.3%
District 15 Total	**5,605**	**5,529**	**-1.4%**	**5,529**	**5,658**	**2.3%**
Old Age Assistance						
Clackamas	2,825	2,858	1.2%	2,858	2,996	4.8%
District 15 Total	**2,825**	**2,858**	**1.2%**	**2,858**	**2,996**	**4.8%**
ACA Adults with Children						
Clackamas	NA	5,909	-	5,909	5,643	-4.5%
District 15 Total	NA	**5,909**	-	**5,909**	**5,643**	**-4.5%**
ACA Adults without Children						
Clackamas	NA	16,856	-	16,856	16,185	-4.0%
District 15 Total	NA	**16,856**	-	**16,856**	**16,185**	**-4.0%**

District 16 Regional Forecast

Washington County has the second-lowest unemployment rate in the state (after Benton County). Unemployment rose slightly as 2014 progressed, as more people entered the job market. The number of people looking for work in the Portland Metro area has been surging, going up faster than the economic expansion can accommodate. Some of the increase is due to people moving into the area, and some is due to the long-term unemployed moving back into the job market to take advantage of improved prospects.

At an annualized rate, employment in Washington County is at an all-time high, although the rate of expansion is slowing. Most employment sectors are adding jobs, but there is some weakness in the public sector where local government employment is down.

Washington County is poised to see large reductions in the SNAP and TANF caseloads at a rate that exceeds the statewide trend.

DISTRICT 16	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	Aug-13	Aug-14
Oregon	3,919,020	22.1%	15.4%	$50,251	11.3%	8.1%	7.2%
Washington	550,990	24.9%	11.3%	$63,238	7.9%	6.3%	5.8%

District 16 Regional Forecast, Oregon Department of Human Services

County served: **Washington** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Washington	26,913	27,709	3.0%	27,709	24,560	-11.4%
District 16 total	26,913	**27,709**	3.0%	**27,709**	**24,560**	**-11.4%**
SNAP - Aid to People with Disabilities						
Washington	8,045	8,060	0.2%	8,060	8,693	7.9%
District 15 total	8,045	**8,060**	0.2%	**8,060**	**8,693**	**7.9%**
TANF						
Washington	2,645	2,614	-1.2%	2,614	2,327	-11.0%
District 15 total	**2,645**	**2,614**	**-1.2%**	**2,614**	**2,327**	**-11.0%**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Washington	959	1,019	6.3%	1,019	1,080	6.0%
District 15 total	**959**	**1,019**	6.3%	**1,019**	**1,080**	**6.0%**
Community-Based Care						
Washington	1,066	1,084	1.7%	1,084	1,119	3.2%
District 15 total	**1,066**	**1,084**	1.7%	**1,084**	**1,119**	**3.2%**
Nursing Care						
Washington	341	355	4.1%	355	347	-2.3%
District 15 total	**341**	**355**	**4.1%**	**355**	**347**	**-2.3%**

District 16 Regional Forecast, Oregon Health Authority (clients)

County served: **Washington** 	Current Biennium		% Change Between Forecasts	Fall 14 Forecast		% Change Between Biennia
	Spring 14 Forecast	Fall 14 Forecast		2013-15	2015-17	
Parents/Caretaker Relative						
Washington	NA	6,333	-	6,333	5,582	-11.9%
District 16 Total	**NA**	**6,333**	**-**	**6,333**	**5,582**	**-11.9%**
Children's Medicaid Program						
Washington	NA	34,216	-	34,216	34,227	0.0%
District 16 Total	**NA**	**34,216**	-	**34,216**	**34,227**	**0.0%**
Children's Health Insurance Program (CHIP)						
Washington	9,717	10,420	7.2%	10,420	9,636	-7.5%
District 16 Total	**9,717**	**10,420**	7.2%	**10,420**	**9,636**	**-7.5%**
Pregnant Women Program						
Washington	1,304	1,584	21.5%	1,584	1,212	-23.5%
District 16 Total	**1,304**	**1,584**	**21.5%**	**1,584**	**1,212**	**-23.5%**
Foster Care & Adoption Services						
Washington	1,515	1,518	0.2%	1,518	1,512	-0.4%
District 16 Total	**1,515**	**1,518**	**0.2%**	**1,518**	**1,512**	**-0.4%**
Aid to the Blind/Disabled						
Washington	6,205	6,156	-0.8%	6,156	6,293	2.2%
District 16 Total	**6,205**	**6,156**	**-0.8%**	**6,156**	**6,293**	**2.2%**
Old Age Assistance						
Washington	4,025	4,025	0.0%	4,025	4,270	6.1%
District 16 Total	**4,025**	**4,025**	**0.0%**	**4,025**	**4,270**	**6.1%**
ACA Adults with Children						
Washington	NA	7,727	-	7,727	7,379	-4.5%
District 16 Total	NA	**7,727**	-	**7,727**	**7,379**	**-4.5%**
ACA Adults without Children						
Washington	NA	22,041	-	22,041	21,165	-4.0%
District 16 Total	NA	**22,041**	-	**22,041**	**21,165**	**-4.0%**

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OREGON HEALTH AUTHORITY

Annual Performance Progress Report (APPR) for Fiscal Year (2013-2014)

Original Submission Date: 2014

Finalize Date: 9/2/2014

2013-2014 KPM #	2013-2014 Approved Key Performance Measures (KPMs)
1	INITIATION OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received initiation of AOD treatment within 14 days of diagnosis.
2	ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received two or more services within 30 days of initiation visit.
3	FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS - Percentage of enrollees 6 years of age and older who were hospitalized for treatment of mental health disorders and who were seen on an outpatient basis or were in intermediate treatment within seven days of discharge.
4	MENTAL AND PHYSICAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY – Percentage of children in DHS custody who receive a mental and physical health assessment within 60 days of initial custody.
5	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (INITIATION) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed: INITIATION.
6	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (CONTINUATION AND MAINTENANCE) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed: CONTINUATION AND MAINTENANCE
7	30 DAY ILLICIT DRUG USE AMONG 6TH GRADERS - Percentage of 6th graders who have used illicit drugs in the past 30 days.
8	30 DAY ALCOHOL USE AMONG 6TH GRADERS - Percentage of 6th graders who have used alcohol in the past 30 days.
9	30 DAY ILLICIT DRUG USE AMONG 8TH GRADERS - Percentage of 8th graders who have used illicit drugs in the past 30 days.
10	30 DAY ALCOHOL USE AMONG 8TH GRADERS - Percentage of 8th graders who have used alcohol in the past 30 days.
11	30 DAY ILLICIT DRUG USE AMONG 11TH GRADERS - Percentage of 11th graders who have used illicit drugs in the past 30 days.
12	30 DAY ALCOHOL USE AMONG 11TH GRADERS - Percentage of 11th graders who have used alcohol in the past 30 days.

2013-2014 KPM #	2013-2014 Approved Key Performance Measures (KPMs)
13	PRENATAL CARE (POPULATION) - Percentage of women who initiated prenatal care in the first 3 months of pregnancy.
14	PRENATAL CARE (MEDICAID) - Percentage of women who initiated prenatal care within 42 days of enrollment.
15	PRIMARY CARE SENSITIVE HOSPITAL ADMISSIONS/INPATIENT STAYS - Rate per 100,000 client years of admissions (for 12 diagnoses) that are more appropriately treated in an outpatient setting.
16	PATIENT CENTERED PRIMARY CARE HOME (PCPCH) ENROLLMENT - Number of members enrolled in patient-centered primary care homes by tier.
17	ACCESS TO CARE - Percentage of members who responded "always" or "usually" too getting care quickly (composite for adult and child).
18	MEMBER EXPERIENCE OF CARE - Composite measurement: how well doctors communicate; health plan information and customer service (Medicaid population).
19	MEMBER HEALTH STATUS - Percentage of CAHPS survey respondents with a positive self-reported rating of overall health (excellent, very good).
20	RATE OF TOBACCO USE (POPULATION) - Rate of tobacco use among adults.
21	RATE OF TOBACCO USE (MEDICAID) - Percentage of CCO enrollees who currently smoke cigarettes or use tobacco every day or some days.
22	RATE OF OBESITY (POPULATION) - Percentage of adults who are obese among Oregonians.
23	RATE OF OBESITY (MEDICAID) - Percentage of Medicaid population who are obese.
24	PLAN ALL CAUSE READMISSIONS - Percentage of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for members 18 years and older.
25	EFFECTIVE CONTRACEPTIVE USE (POPULATION) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
26	EFFECTIVE CONTRACEPTIVE USE (MEDICAID) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.

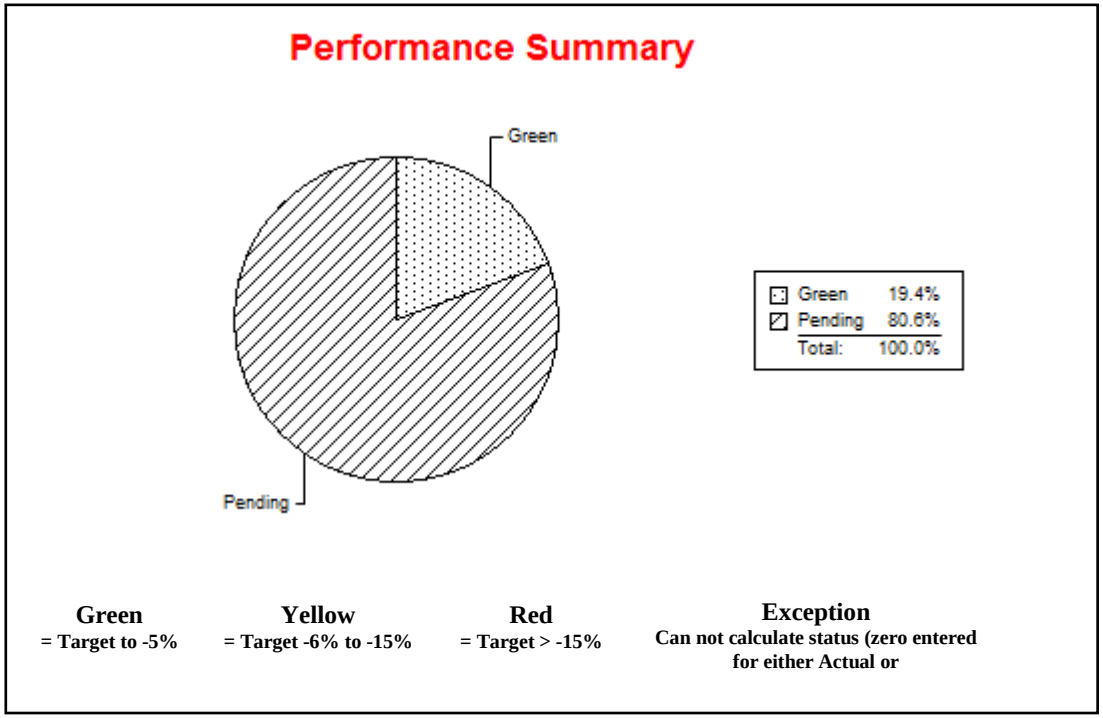
2013-2014 KPM #	2013-2014 Approved Key Performance Measures (KPMs)
27	FLU SHOTS (POPULATION) - Percentage of adults ages 50-64 who receive a flu vaccine.
28	FLU SHOTS (MEDICAID) - Percentage of adults ages 50-64 who receive a flu vaccine.
29	CHILD IMMUNIZATION RATES (POPULATION) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
30	CHILD IMMUNIZATION RATES (MEDICAID) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
31	CUSTOMER SERVICE (OHA) - Percentage of OHA customers rating their satisfaction with the agency's customer service as "good" or "excellent" overall, timeliness, accuracy, helpfulness, expertise, availability of information.

New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2015-2017
	Title: **Rationale:**

OREGON HEALTH AUTHORITY	I. EXECUTIVE SUMMARY

Agency Mission: Helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.

Contact: Cathy Iles, OHA Director's Office	**Contact Phone:** 503-602-1507
Alternate:	**Alternate Phone:**



1. SCOPE OF REPORT

The purpose of this annual performance report is to communicate the results of the work that is done through the Oregon Health Authority (OHA) and its partners. While the primary audience is the Oregon Legislature and other key stakeholders, it is also a communication tool for staff, other governmental agencies and the public.The 2013-15 OHA Key Performance Measures (KPMs) are intended to represent key quality and access metrics for healthcare-related services for individuals across the state. They are framed around the triple aim of better care, better health and lower cost and OHA's Quality Improvement Focus Areas as defined in Oregon's Medicaid 1115 waiver agreement with the Centers for Medicare and Medicaid Services (CMS). The goal is to align KPMs closely with Health System Transformation metrics, both statewide and Coordinated Care Organization (CCO) metrics.

2. THE OREGON CONTEXT

OHA is at the forefront of lowering and containing costs, improving quality and increasing access to health care in order to improve the lifelong health of Oregonians.
The Health Authority will transform the health care system in Oregon by:

- ·Improving the lifelong health of Oregonians
- ·Increasing the quality, reliability, and availability of care for all Oregonians
- ·Lowering or containing the cost of care so it's affordable to everyone

OHA knows what it needs to do to improve health care: focus on health and preventive care, provide care for everyone and reduce waste in the health care system.
OHA includes most of the state's health care programs, including Public Health, the Oregon Health Plan, Healthy Kids, employee benefits and public-private partnerships. This gives the state greater purchasing and market power to begin tackling issues with costs, quality, lack of preventive care and health care access.
The Health Authority is working to fundamentally improve how health care is delivered and paid for, but because poor health is only partially due to lack of medical care, OHA will also be working to reduce health disparities and to broaden the state's focus on prevention.

3. PERFORMANCE SUMMARY

The majority of the 2013-15 OHA KPMs are new. Baseline data are reported for either 2011 or 2012. Targets have been set for 2014 and 2015 for most of them, therefore red, yellow, green status can't be reported yet. However, there are six measures in green status, the rest are pending.

4. CHALLENGES

Oregon faces a $3.5 billion budget crisis and health care is an ever increasing portion of our budget.
Health care spending accounts for 16 percent of the state general fund budget. The need to reform our health care system is more urgent than ever.
Oregon is a national leader in health reform thanks to the groundwork laid by the legislature.
In 2009, the legislature created Oregon Health Policy Board (OHPB) and Oregon Health Authority (OHA) to address the issues of cost, quality and access to health care. While the federal government has made new investments in insurance coverage and access, it will be up to the states to take the next steps to lower cost and improve quality. The Oregon Health Policy Board has created an Action Plan for Health that involves actions by all stakeholders — the legislature, consumers, businesses, health care providers and others — in a staged plan. Coupled with the dollars federal reform will bring into Oregon, this plan meets the legislative mandate to "provide and fund access to affordable, quality care for all Oregonians by 2015." It also meets the spirit of innovation to seek Oregon solutions to address the problems before us.
The plan includes many items that do not require legislative action, but may require changes in how we set budget priorities. For instance, a focus on prevention and treatment of addiction saves lives and dollars as does an early focus on prevention and chronic disease. Finally, the plan emphasizes how we deliver and pay for health care to ensure health equity, promote health and contain costs, beginning with the 850,000 lives for whom the Oregon Health Authority buys health care services.

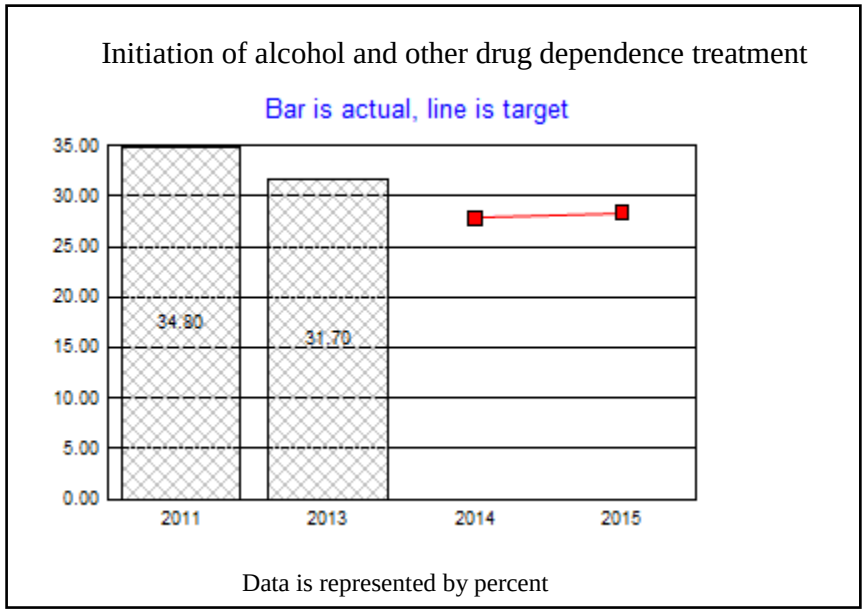
While It continues to be challenging to connect the daily work of the agency to higher level outcomes and goals, doing so will enable us to be accountable for efficient and effective processes and create a culture throughout OHA by which all managers and staff rigorously use performance measures and other metrics for decision-making, managing the daily work

and driving improvements throughout the agency. More effective communication with the public and stakeholders of the value of OHA services is desired as we attempt to educate others about our role as good stewards of public resources.

5. RESOURCES AND EFFICIENCY

2013-15 Total Fund OHA Budget = $12,569,007,723. 4,019 positions.More detail can be found at:http://www.oregon.gov/oha/Pages/budget-legislative.aspx** Source: DHS/OHA Budget, Planning and Analysis

KPM #1	INITIATION OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received initiation of AOD treatment within 14 days of diagnosis.	2013
Goal	Better care/access, lower cost, better health	
Oregon Context	Better care/access, lower cost, better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Areas: Integrating primary care and behavioral health; and improving access to effective and timely care.

2. ABOUT THE TARGETS

These improvement targets were established to result in an increase from the baseline data to the performance target which is the average of the 2011 National Medicaid 75th percentile.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2013, the initiation rate for alcohol and drug treatment was 31.7%. This represents an increase from the preliminary CY2011 data initially provided, but a decrease from the final CY2011. This measure as above the 2014 target; however, targets were set based on preliminary 2011 data.

4. HOW WE COMPARE

Oregon's initiation rate is below the 2012 national Medicaid rate of 39.4%. Additional comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

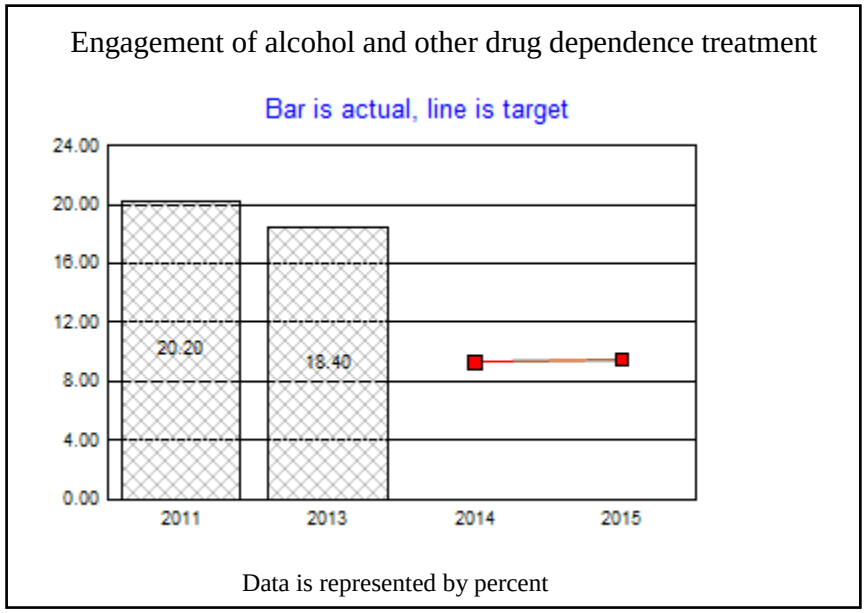
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken. It is possible that the increased statewide emphasis on alcohol and drug use screening (SBIRT) due to the CCO incentive measure will result in an increase in initiation of alcohol and drug treatment, as more individuals with risky or problematic substance use are identified and referred to treatment services.

7. ABOUT THE DATA

CY2011 baseline data have been finalized; CY2013 final data provided.

KPM #2	ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received two or more services within 30 days of initiation visit.	2013
Goal	Better care/access; lower cost; better health	
Oregon Context	Better care/access; lower cost; better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Areas: Integrating primary care and behavioral health; and improving access to effective and timely care.

2. ABOUT THE TARGETS

These improvement targets were established to result in an increase from the baseline data to the performance target which is the average of the 2011 National Medicaid 75th percentile.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2013, the engagement rate for individuals who initiated alcohol and drug treatment was 18.4%. This represents an increase from the preliminary CY2011 data initially provided, but a slight decrease from the final CY2011 rate of 20.2%. This measure is above the 2014 target; however, targets were set based on preliminary 2011 data.

4. HOW WE COMPARE

Oregon's performance is above the 2012 national Medicaid enagement rate of 10.8%. Additional comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

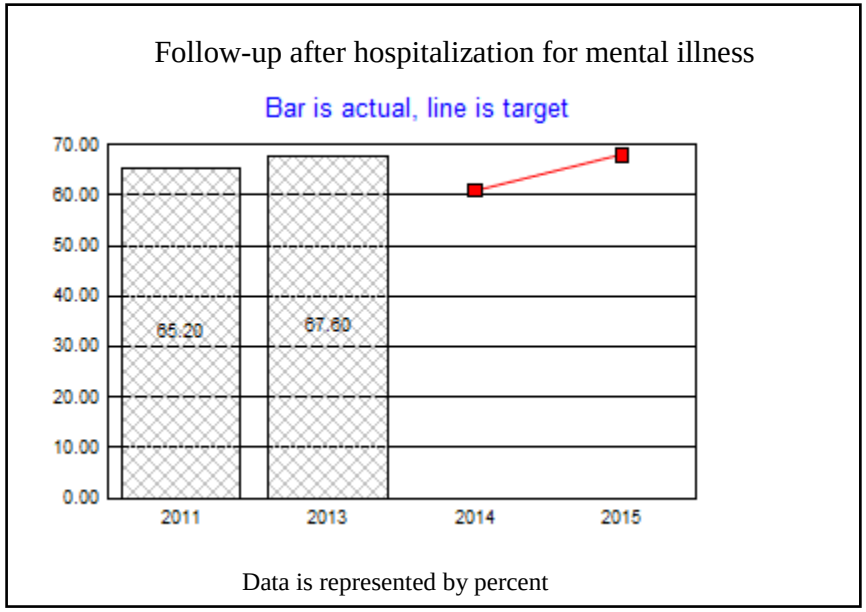
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken. It is possible that the increased statewide emphasis on alcohol and drug use screening (SBIRT) due to the CCO incentive measure will result in increased engagement of alcohol and drug treatment, as more individuals with risky or problematic substance use are identified and referred to treatment services.

7. ABOUT THE DATA

CY2011 baseline data was finalized; CY2013 data provided.

KPM #3	FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS - Percentage of enrollees 6 years of age and older who were hospitalized for treatment of mental health disorders and who were seen on an outpatient basis or were in intermediate treatment within seven days of discharge.	2013
Goal	Lower cost; better health	
Oregon Context	Lower cost; better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Areas: reducing preventable rehospitalizations; integrating primary care and behavioral health.

2. ABOUT THE TARGETS

These improvement targets were established ro result in an increase from the baseline data to the 2015 performance target which is the 2012 National Medicaid 90th percentile.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2013, 67.6% of patients ages 6 and older received a follow-up with a health care provider within 7 days of being discharged from the hospital for mental illness. This is an increase over the final CY 2011 baseline of 65.2%, but still slightly below the 2015 KPM target.

4. HOW WE COMPARE

Oregon is above the national 2012 Medicaid average of 43.7 percent and the 2012 Commercial average of 57.9%. However, Oregon is using a modified version of the measure which is including follow up care provided in community mental health settings, which results in our higher rate. Additional comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

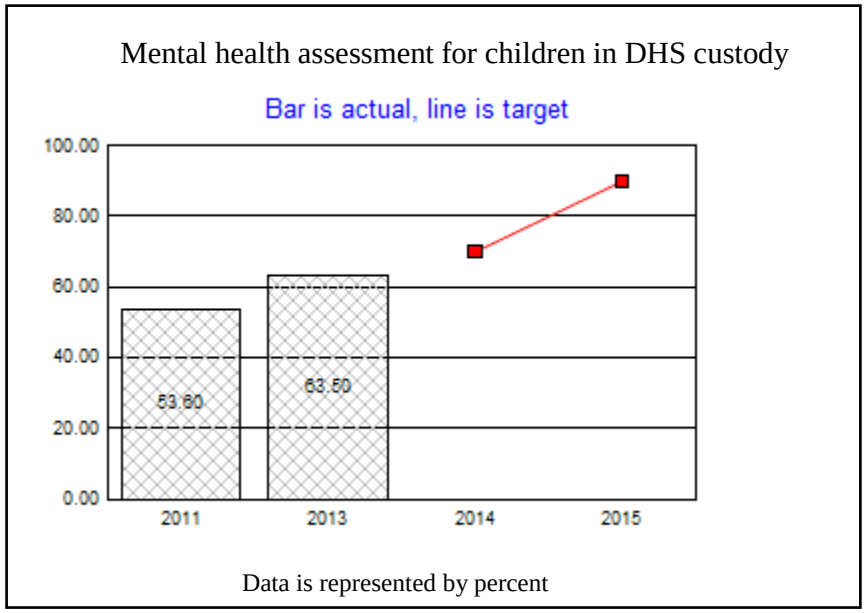
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

CY 2011 and CY 2013.

KPM #4	MENTAL AND PHYSICAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY – Percentage of children in DHS custody who receive a mental and physical health assessment within 60 days of initial custody.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Administrative data and child welfare records	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Areas: Integrating primary care and behavioral health; improving access to effective and timely care.

2. ABOUT THE TARGETS

Targets based on calendar year 2011 baseline data and the 2013 and 2014 benchmark for the CCO incentive measures. Higher is better.

3. HOW WE ARE DOING

In 2011, 53.6% of children entering into foster care received timely mental and physical health assessments. In 2013, the rate increased slightly to 63.5%. Additional comparisons will be made in future reports.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results. One factor driving the improved 2013 rates was increased coordinatation between CCOs and local DHS branch offices.

6. WHAT NEEDS TO BE DONE

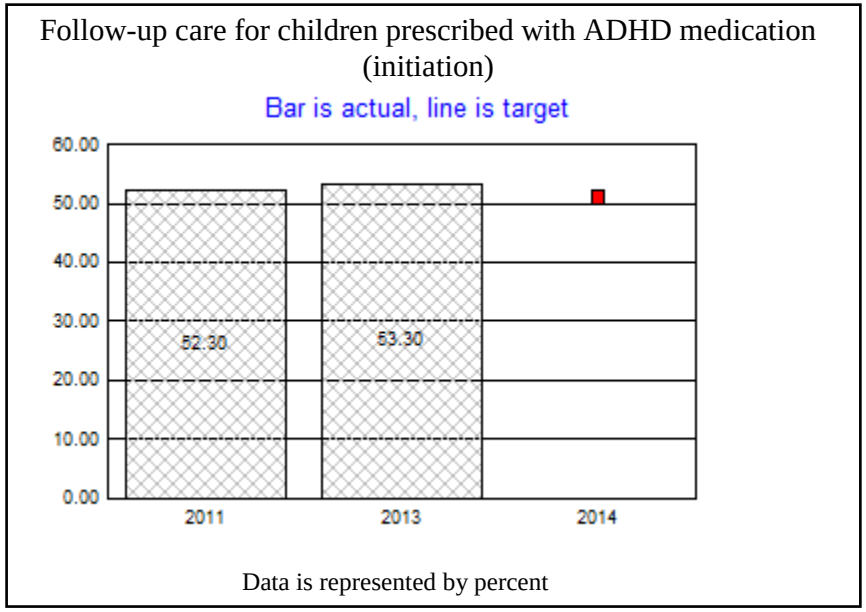
As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year.

KPM #5	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (INITIATION) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed: INITIATION.	2013

Goal	Better health
Oregon Context	Better health
Data Source	Administrative data
Owner	OHA Performance Management Coordinator, 503-602-1507



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Areas: integrating primary care and behavioral health; improving access to effective and timely care.

2. ABOUT THE TARGETS

The 2014 target is the 2012 National Medicaid 90th percentile. These targets will be revisited by the Metrics and Scoring Committee.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2011, 52.3% of children ages 6-12 had at least one follow up visit with a health care provider during the 30 days after receiving a new prescription for Attention Deficit Hyperactivity Disorder (ADHD). In 2013, the rate had increased just slightly to 53.3%, above the KPM target, and above the 90th percentile nationally. Additional comparisons will be made in future reports.

4. HOW WE COMPARE

Oregon is above the national 90th percentile for both Medicaid and Commercial. Additional comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.We have heard from providers that limiting the follow up visit to within the first 30 days is not well aligned with some of the current ADHD medications, which may require a 45 day initial prescription. Children with these longer intial prescriptions would fall outside of the 30 day window for this measure.

6. WHAT NEEDS TO BE DONE

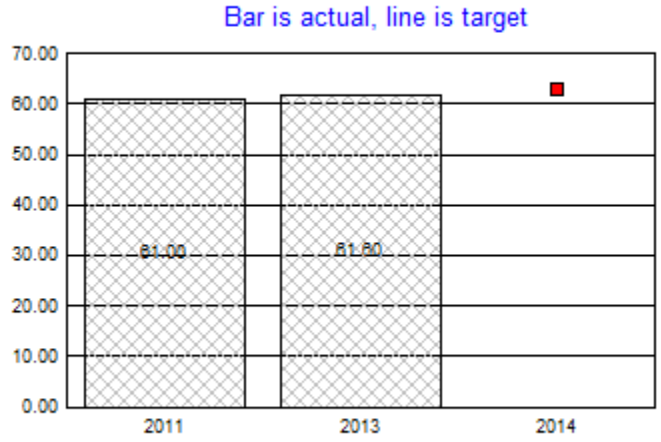
As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year.

KPM #6	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (CONTINUATION AND MAINTENANCE) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed: CONTINUATION AND MAINTENANCE	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	

Follow-up care for children prescribed with ADHD medication (continuation and maintenance)



Data is represented by percent

1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Areas: integrating primary care and behavioral health; improving access to effective and timely care.

2. ABOUT THE TARGETS

The 2014 target is the 2012 National Medicaid 90th percentile. These targets will be revisited by the Metrics and Scoring Committee.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2011, 61.0% of children who remained on ADHD medication for 210 days after receiving a new prescription also had at least two follow up visits with a provider. In 2013, the rate had increased just slightly to 61.6%, still short of the state benchmark and KPM target of 63.0%. Additional comparisons will be made in future reports.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

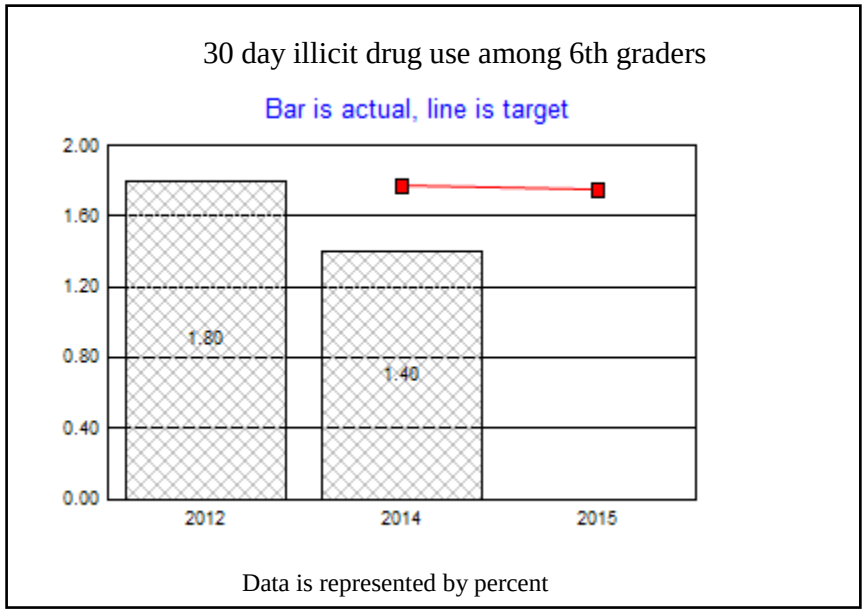
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year.

KPM #7	30 DAY ILLICIT DRUG USE AMONG 6TH GRADERS - Percentage of 6th graders who have used illicit drugs in the past 30 days.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Student wellness survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: integrating primary care and behavioral health.

Addictions and Mental Health Division (AMH) uses a comprehensive approach to addressing illicit drug use issues and intervening when illicit drug use has occurred. This includes

a variety of community and county level programs funded with state and federal dollars.
In the comprehensive planning conducted at the County and Tribal levels all 36 counties and 9 tribes prioritized underage drinking as the number one concern. Closely associated with underage drinking is the use of marijuana. Marijuana is sometimes referred to at the 'turn-key drug' leading to other illicit drug use. Counties and Tribes have implemented programs to directly address underage drinking and illicit drug use. These include strategic media advocacy efforts directed at parents to set clear and specific guidelines for their children's not using alcohol and other drugs. AMH will continue to provide community grants to implement programs to reduce underage drinking and illicit drug use on the local level.

2. ABOUT THE TARGETS

Targets are based on trend data and the annual reduction necessary to meet the Healthy People 2020 goal of a 10% reduction.

3. HOW WE ARE DOING

In 2012, the rate of 6th graders who used any illict drug in the past 30 days was 1.8%; in 2014 this decreased slightly to 1.4%.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

Favorable attitudes on the part of youth about using alcohol and other drugs can be a major predictor of their use. Parental attitudes towards drug use have a tremendous effect on youth use. Youth whose parents feel that drug use is a "rite of passage" or that "kids will be kids" have much higher rates of illicit drug use those whose parents are clear that youth should not use drugs.

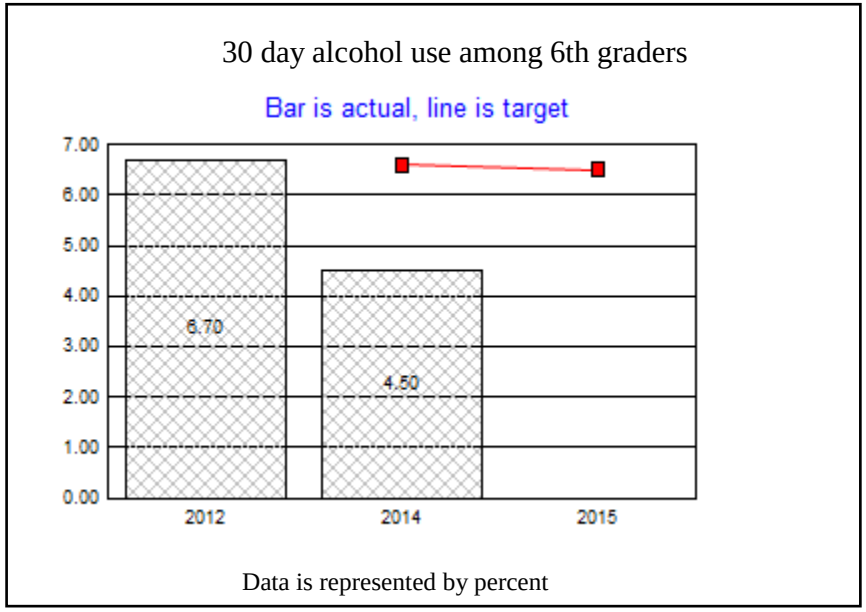
6. WHAT NEEDS TO BE DONE

Oregon needs to continue providing opportunities for youth to engage in positive, safe and healthy alternatives to drug use. Providing communities with adequate prevention funding to implement comprehensive evidence-based programs would give youth those opportunities. Parents who set clear and specific rules for their children continue to be a major prevention strategy to address illicit drug use.

7. ABOUT THE DATA

Data is extracted from the Oregon Student Wellness Survey. The survey is administered annually to 6th, 8th and 11th graders across the state.

KPM #8	30 DAY ALCOHOL USE AMONG 6TH GRADERS - Percentage of 6th graders who have used alcohol in the past 30 days.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Student wellness survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: integrating primary care and behavioral health. There is a comprehensive approach to addressing underage drinking issues and intervening when underage drinking has occurred. This includes a variety of community and county level programs funded with

state and federal dollars. In the comprehensive planning conducted at the County and Tribal levels, all 36 counties and 9 tribes prioritized underage drinking as the number one concern. Accordingly they have implemented programs to directly address underage drinking including minor decoy and controlled party dispersal programs, reward and reminder programs for alcohol retailers, shoulder tap (third party sales) operations, strategic media advocacy efforts directed at social policies related to underage drinking and parent programs that aid the parents in setting clear and specific guidelines concerning alcohol and other drug use.

2. ABOUT THE TARGETS

Targets are based on trend data and the annual reduction necessary to meet the Healthy People 2020 goal of a 10% reduction.

3. HOW WE ARE DOING

In 2012, 6.7% of 6th graders had at least one drink of alcohol within the past 30 days; in 2014, this decreased slightly to 4.5%, meeting the 2014 target.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

Perceptions of youth being caught – either in possession or purchasing alcohol – can be a major determinant in whether or not they use. Parental attitudes towards alcohol use have a tremendous effect on youth use. Youth whose parents feel that alcohol use is a “rite of passage” or that “kids will be kids” have much higher rates of drinking than those whose parents are clear that youth should not drink. Unfortunately, all too many Oregon parents still provide youth with a “safe” place to drink by providing the alcohol, taking away car keys so they don’t drive, or both. These mixed messages give youth the impression that it’s okay to drink, as long as they don’t drive.

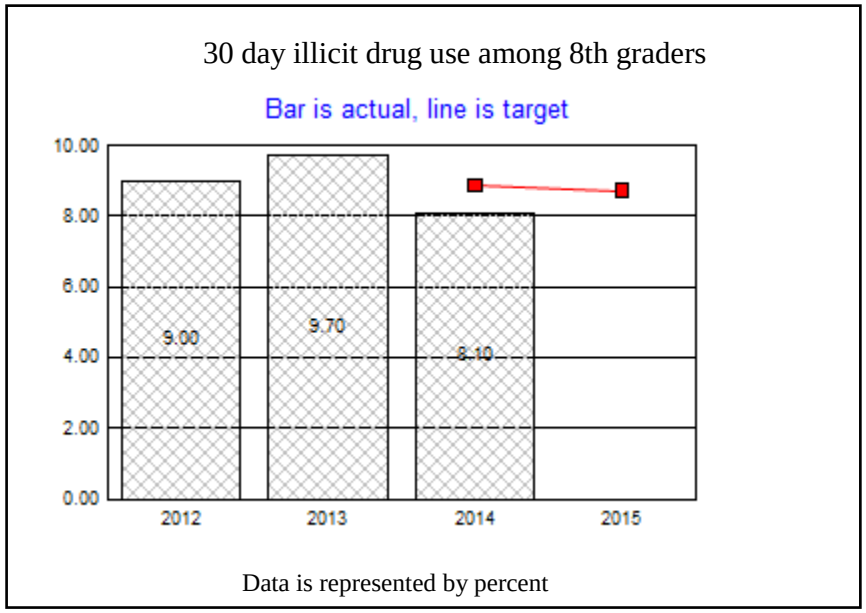
6. WHAT NEEDS TO BE DONE

Oregon needs to continue providing opportunities for youth to engage in positive, safe and healthy alternatives to alcohol use. Providing communities with adequate prevention funding to implement comprehensive evidence-based programs would give youth those opportunities. In addition, continued and consistent enforcement of current laws across the state would provide a constant message that Oregon does not tolerate underage drinking. Statewide media should continue to provide messages to parents that it’s against the law to provide alcohol to minors, as well as the importance of having well-defined expectations of their children regarding alcohol use.

7. ABOUT THE DATA

Data is extracted from the Oregon Healthy Teens Survey / Student Wellness Survey. The survey is administered annually to 6th, 8th and 11th graders across the state.

KPM #9	30 DAY ILLICIT DRUG USE AMONG 8TH GRADERS - Percentage of 8th graders who have used illicit drugs in the past 30 days.	2009
Goal	Better health	
Oregon Context	Better health	
Data Source	Student wellness survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: integrating primary care and behavioral health.
Addictions and Mental Health Division (AMH) uses a comprehensive approach to addressing illicit drug use issues and intervening when illicit drug use has occurred. This includes

a variety of community and county level programs funded with state and federal dollars.
In the comprehensive planning conducted at the County and Tribal levels all 36 counties and 9 tribes prioritized underage drinking as the number one concern. Closely associated with underage drinking is the use of marijuana. Marijuana is sometimes referred to at the 'turn-key drug' leading to other illicit drug use. Counties and Tribes have implemented programs to directly address underage drinking and illicit drug use. These include strategic media advocacy efforts directed at parents to set clear and specific guidelines for their children's not using alcohol and other drugs. AMH will continue to provide community grants to implement programs to reduce underage drinking and illicit drug use on the local level.

2. ABOUT THE TARGETS

Targets are based on trend data and the annual reduction necessary to meet the Healthy People 2020 goal of a 10% reduction.

3. HOW WE ARE DOING

In 2012, 9% of 8th graders had used any ilicit drug in the past 30 days; in 2014, this decreased slightly to 8.1%, just below the 2014 target.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

Favorable attitudes on the part of youth about using alcohol and other drugs can be a major predictor of their use. Parental attitudes towards drug use have a tremendous effect on youth use. Youth whose parents feel that drug use is a "rite of passage" or that "kids will be kids" have much higher rates of illicit drug use those whose parents are clear that youth should not use drugs.

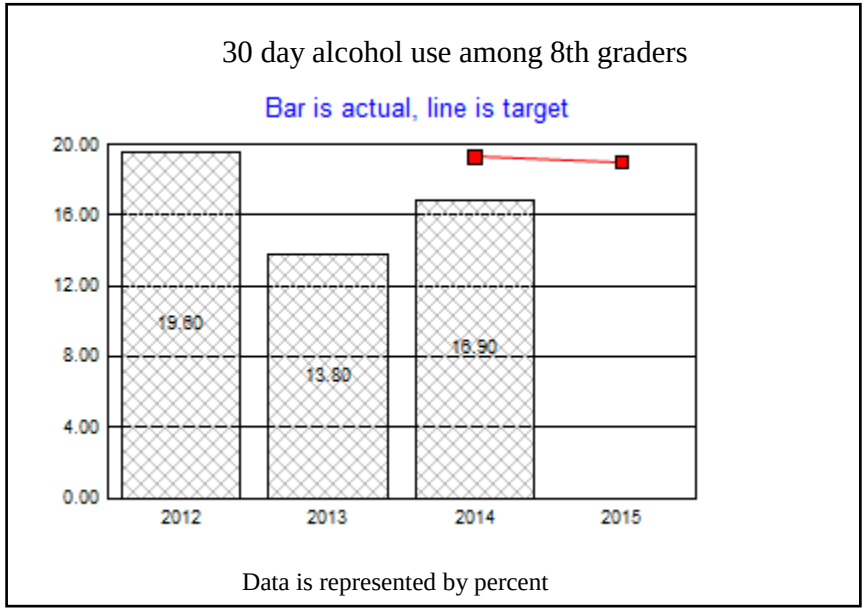
6. WHAT NEEDS TO BE DONE

Oregon needs to continue providing opportunities for youth to engage in positive, safe and healthy alternatives to drug use. Providing communities with adequate prevention funding to implement comprehensive evidence-based programs would give youth those opportunities. Parents who set clear and specific rules for their children continue to be a major prevention strategy to address illicit drug use.

7. ABOUT THE DATA

Data is extracted from the Oregon Student Wellness Survey / Health Teens Survey. The survey is administered annually to 6th, 8th and 11th graders across the state.

KPM #10	30 DAY ALCOHOL USE AMONG 8TH GRADERS - Percentage of 8th graders who have used alcohol in the past 30 days.	2009
Goal	Better health	
Oregon Context	Better health	
Data Source	Student wellness survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: integrating primary and behavioral health.There is a comprehensive approach to addressing underage drinking issues and intervening when underage drinking has occurred. This includes a variety of community and county level programs funded with

state and federal dollars. In the comprehensive planning conducted at the County and Tribal levels, all 36 counties and 9 tribes prioritized underage drinking as the number one concern. Accordingly they have implemented programs to directly address underage drinking including minor decoy and controlled party dispersal programs, reward and reminder programs for alcohol retailers, shoulder tap (third party sales) operations, strategic media advocacy efforts directed at social policies related to underage drinking and parent programs that aid the parents in setting clear and specific guidelines concerning alcohol and other drug use.

2. ABOUT THE TARGETS

Targets are based on trend data and the annual reduction necessary to meet the Healthy People 2020 goal of a 10% reduction.

3. HOW WE ARE DOING

In 2012, 19.6% of 8th graders had at least one drink of alcohol in the past 30 days; in 2014, the rate decreased slightly to 16.9%, meeting the 2014 target.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

Perceptions of youth being caught – either in possession or purchasing alcohol – can be a major determinant in whether or not they use. Parental attitudes towards alcohol use have a tremendous effect on youth use. Youth whose parents feel that alcohol use is a “rite of passage” or that “kids will be kids” have much higher rates of drinking than those whose parents are clear that youth should not drink. Unfortunately, all too many Oregon parents still provide youth with a “safe” place to drink by providing the alcohol, taking away car keys so they don’t drive, or both. These mixed messages give youth the impression that it’s okay to drink, as long as they don’t drive.

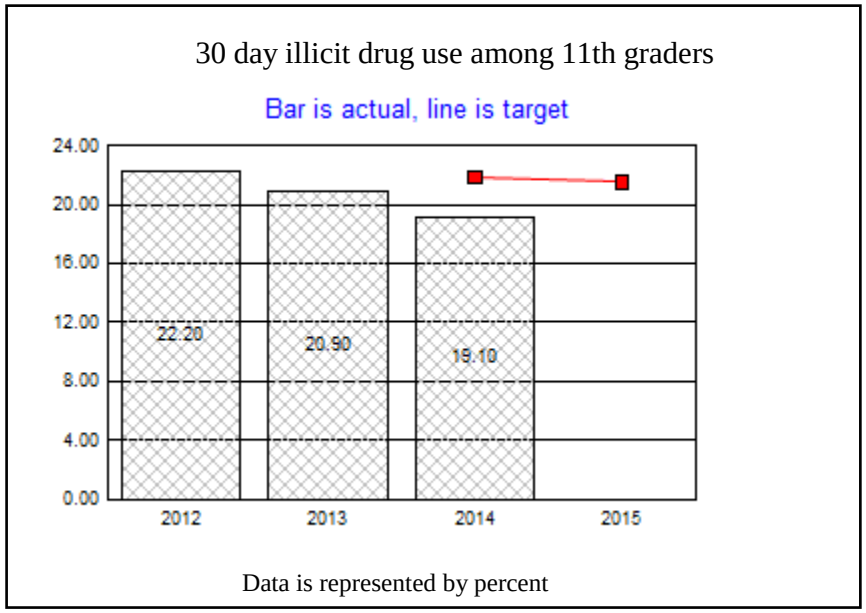
6. WHAT NEEDS TO BE DONE

Oregon needs to continue providing opportunities for youth to engage in positive, safe and healthy alternatives to alcohol use. Providing communities with adequate prevention funding to implement comprehensive evidence-based programs would give youth those opportunities. In addition, continued and consistent enforcement of current laws across the state would provide a constant message that Oregon does not tolerate underage drinking. Statewide media should continue to provide messages to parents that it’s against the law to provide alcohol to minors, as well as the importance of having well-defined expectations of their children regarding alcohol use.

7. ABOUT THE DATA

Data is extracted from the Oregon Healthy Teens Survey / Student Wellness Survey. The survey is administered annually to 8th and 11th graders across the state.

KPM #11	30 DAY ILLICIT DRUG USE AMONG 11TH GRADERS - Percentage of 11th graders who have used illicit drugs in the past 30 days.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Student wellness survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: integrating primary care and behavioral health.
Addictions and Mental Health Division (AMH) uses a comprehensive approach to addressing illicit drug use issues and intervening when illicit drug use has occurred. This includes

a variety of community and county level programs funded with state and federal dollars.
In the comprehensive planning conducted at the County and Tribal levels all 36 counties and 9 tribes prioritized underage drinking as the number one concern. Closely associated with underage drinking is the use of marijuana. Marijuana is sometimes referred to at the 'turn-key drug' leading to other illicit drug use. Counties and Tribes have implemented programs to directly address underage drinking and illicit drug use. These include strategic media advocacy efforts directed at parents to set clear and specific guidelines for their children's not using alcohol and other drugs. AMH will continue to provide community grants to implement programs to reduce underage drinking and illicit drug use on the local level.

2. ABOUT THE TARGETS

Targets are based on trend data and the annual reduction necessary to meet the Healthy People 2020 goal of a 10% reduction.

3. HOW WE ARE DOING

In 2012, 22.2% of 11th graders had used an ilicit drug in the past 30 days; in 2014, this decreased to 19.1%, meeting the 2014 target.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

Favorable attitudes on the part of youth about using alcohol and other drugs can be a major predictor of their use. Parental attitudes towards drug use have a tremendous effect on youth use. Youth whose parents feel that drug use is a "rite of passage" or that "kids will be kids" have much higher rates of illicit drug use those whose parents are clear that youth should not use drugs.

6. WHAT NEEDS TO BE DONE

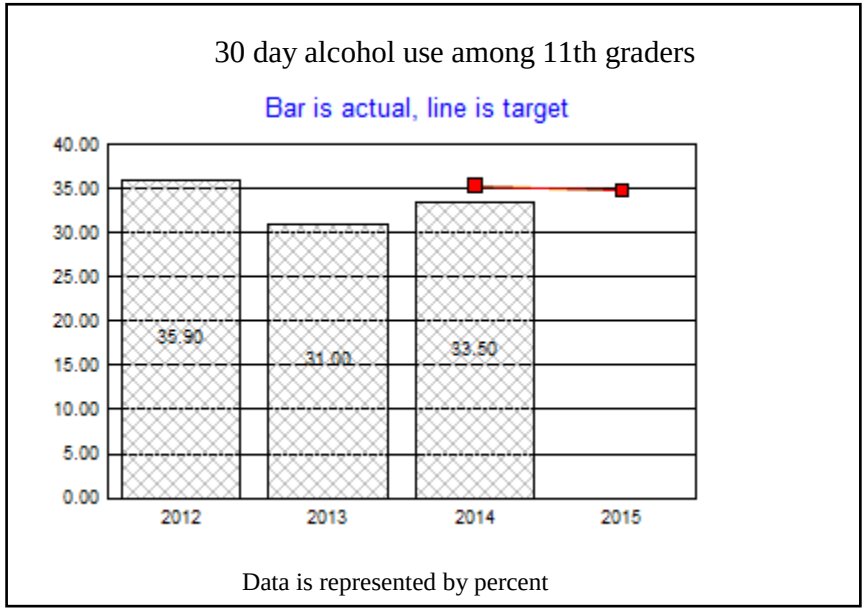
Oregon needs to continue providing opportunities for youth to engage in positive, safe and healthy alternatives to drug use. Providing communities with adequate prevention funding to implement comprehensive evidence-based programs would give youth those opportunities. Parents who set clear and specific rules for their children continue to be a major prevention strategy to address illicit drug use.

7. ABOUT THE DATA

Data is extracted from the Oregon Healthy Teens Survey / Student Wellness Survey. The survey is administered annually to 6th, 8th and 11th graders across the state.

OREGON HEALTH AUTHORITY	II. KEY MEASURE ANALYSIS

KPM #12	30 DAY ALCOHOL USE AMONG 11TH GRADERS - Percentage of 11th graders who have used alcohol in the past 30 days.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Student wellness survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: integrating primary care and behavioral health.There is a comprehensive approach to addressing underage drinking issues and intervening when underage drinking has occurred. This includes a variety of community and county level programs funded with

state and federal dollars. In the comprehensive planning conducted at the County and Tribal levels, all 36 counties and 9 tribes prioritized underage drinking as the number one concern. Accordingly they have implemented programs to directly address underage drinking including minor decoy and controlled party dispersal programs, reward and reminder programs for alcohol retailers, shoulder tap (third party sales) operations, strategic media advocacy efforts directed at social policies related to underage drinking and parent programs that aid the parents in setting clear and specific guidelines concerning alcohol and other drug use.

2. ABOUT THE TARGETS

Targets are based on trend data and the annual reduction necessary to meet the Healthy People 2020 goal of a 10% reduction.

3. HOW WE ARE DOING

In 2012, 35.9% of Oregon 11th graders had at least one drink of alcohol in the past 30 days; in 2014 this decreased slightly to 33.5%, meeting the 2014 target.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

Perceptions of youth being caught – either in possession or purchasing alcohol – can be a major determinant in whether or not they use. Parental attitudes towards alcohol use have a tremendous effect on youth use. Youth whose parents feel that alcohol use is a “rite of passage” or that “kids will be kids” have much higher rates of drinking than those whose parents are clear that youth should not drink. Unfortunately, all too many Oregon parents still provide youth with a “safe” place to drink by providing the alcohol, taking away car keys so they don’t drive, or both. These mixed messages give youth the impression that it’s okay to drink, as long as they don’t drive.

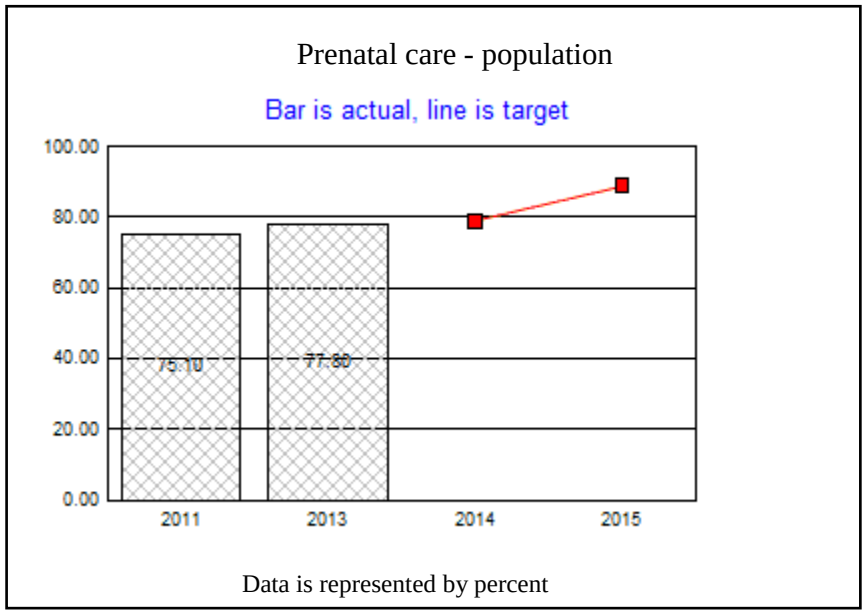
6. WHAT NEEDS TO BE DONE

Oregon needs to continue providing opportunities for youth to engage in positive, safe and healthy alternatives to alcohol use. Providing communities with adequate prevention funding to implement comprehensive evidence-based programs would give youth those opportunities. In addition, continued and consistent enforcement of current laws across the state would provide a constant message that Oregon does not tolerate underage drinking. Statewide media should continue to provide messages to parents that it’s against the law to provide alcohol to minors, as well as the importance of having well-defined expectations of their children regarding alcohol use.

7. ABOUT THE DATA

Data is extracted from the Oregon Healthy Teens Survey / Student Wellness Survey. The survey is administered annually to 8th and 11th graders across the state.

KPM #13	PRENATAL CARE (POPULATION) - Percentage of women who initiated prenatal care in the first 3 months of pregnancy.	2013
Goal	Better care/access; lower cost; better health	
Oregon Context	Better care/access; lower cost; better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

Outreach and link women to early and adequate prenatal care
Oregon Mothers Care (OMC), a statewide initiative to improve access to early prenatal care, provides services throughout Oregon at 29 sites serving 26

counties. The program links women to health insurance enrollment and health care providers, and is funded by Title V, along with local funds. The OMC program has developed partnerships among public and private agencies to streamline, coordinate, and promote access to prenatal services. Project components include a referral and support system for prenatal services, including dental services, and an ongoing public awareness, outreach, and education campaign.

An MCH warm-line assists pregnant women to access prenatal care services and other services in their community. The warm-line is now a part of the statewide 211 info line. This allows 24 hours a day, 7 days a week as well as on-line access to comprehensive community based information and referral.

Statewide home visiting system

Prenatal Home Visiting programs work to increase access and effective utilization of prenatal care and other services for high risk pregnant women. Oregon was awarded both formula and competitive Maternal and Infant Early Childhood Home Visiting (MIECHV) grants. The grants are enhancing access to both clinical and home visiting services through expansion of Healthy Families America/Healthy Start, Early Head Start, and Nurse Family Partnership home visiting services. Public Health Nurse Maternity Case Management (MCM) and home visiting services are offered through local health departments.

Collaboration with state public health partners

Ongoing collaboration with state public health partners (reproductive health, family planning and WIC) ensures that education about the importance of prenatal care is discussed and women who screen positive for pregnancy are referred to early care.

Surveillance and data collection

Administration and analysis of the PRAMS survey of post-partum women to collect information related to prenatal care access for surveillance and program planning. Oregon PRAMS data has been continuously collected since 1998 and provides information about utilization, access, and quality of prenatal care.

Policy advocacy for early prenatal care system and quality improvements

Supporting CCOs in achieving early prenatal care for members by developing resources and offering technical assistance for CCOs and local public health authorities.

Medicaid provides prenatal health coverage for undocumented women. As of October 2013, Medicaid coverage for prenatal services is available to pregnant women who would otherwise be eligible for OHP except for their immigration status. Initially a pilot project in two counties, the program is now statewide.

2. ABOUT THE TARGETS

Early initiation of prenatal care maximizes opportunities for women to prepare for labor/delivery, motherhood and the longterm health of both child and mother. The desired direction of change is to increase the percent of women who initiate prenatal care in the first 3 months of their pregnancy.

3. HOW WE ARE DOING

The rate of first trimester prenatal care has risen from 70.2% in 2008 to 77.8 in 2013. Starting in 2008, there was a change in how prenatal care was calculated from the birth certificate making trend analysis prior to that time difficult.

4. HOW WE COMPARE

The overall rate in Oregon nears the HP 2020 objective of 77.9%, however rates vary by race/ethnicity and maternal age. According to the March of Dimes Peristats, in 2012, Washington's rate was 73.5% and California's 82.8%, compared to 76.3% in Oregon.

5. FACTORS AFFECTING RESULTS

Women give a variety of reasons for not accessing early prenatal care. Women may not feel that early care is important, may not know they are pregnant, or may be experiencing barriers such as lack of insurance coverage, inability to get an appointment or unreliable transportation.

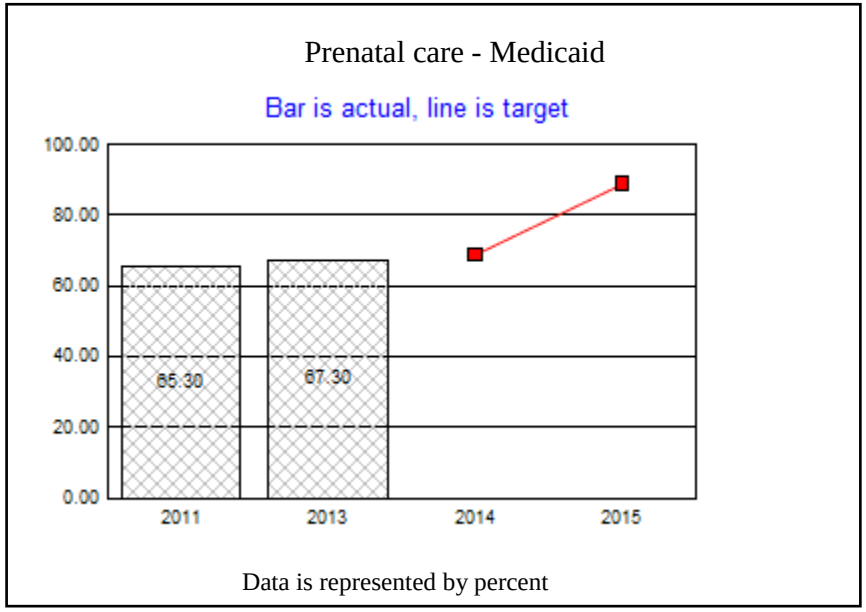
6. WHAT NEEDS TO BE DONE

Opportunities to increase rates of early prenatal care have arisen as the Affordable Care Act (ACA) is implemented and health care transformation efforts in Oregon move forward. Medicaid expansion and the creation of Oregon's Health Insurance Marketplace (Cover Oregon) mean that more women are eligible for insurance regardless of pregnancy status. More insured women will hopefully mean that more women will have established care providers who can either provide or refer for prenatal care. In addition, the Affordable Care Act includes a mandate for health insurance to cover preventative services including preconception health visits. Preconception health visits are an opportunity to teach women about the importance of early prenatal care.

7. ABOUT THE DATA

Prenatal care initiation is calculated from birth certificates and reported out by calendar year of the child's birth. It is calculated from several variables: (1) date of first prenatal care visit; (2) first day of pregnancy and (3) definition of first trimester. (1) Date of first prenatal care visit depends on mother's prenatal care chart being available or mother's recall. (2) First day of pregnancy depends on mother's recall of the date on which her last menstrual period began. This date is sometimes imputed by taking Clinical Estimate of Gestation and calculating first day of pregnancy. (3) First trimester is often but not universally defined as the first 91 days since the date on which the mother's last menstrual period began.

KPM #14	PRENATAL CARE (MEDICAID) - Percentage of women who initiated prenatal care within 42 days of enrollment.	2013
Goal	Better care/access; lower cost; better health	
Oregon Context	Better care/access; lower cost; better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

Outreach and link women to early and adequate prenatal care
Oregon Mothers Care (OMC), a statewide initiative to improve access to early prenatal care, provides services throughout Oregon at 29 sites serving 26

counties. The program links women to health insurance enrollment and health care providers, and is funded by Title V, along with local funds. The OMC program has developed partnerships among public and private agencies to streamline, coordinate, and promote access to prenatal services. Project components include a referral and support system for prenatal services, including dental services, and an ongoing public awareness, outreach, and education campaign.

An MCH warm-line assists pregnant women to access prenatal care services and other services in their community. The warm-line is now a part of the statewide 211 info line. This allows 24 hours a day, 7 days a week as well as on-line access to comprehensive community based information and referral.

Statewide home visiting system

Prenatal Home Visiting programs work to increase access and effective utilization of prenatal care and other services for high risk pregnant women. Oregon was awarded both formula and competitive Maternal and Infant Early Childhood Home Visiting (MIECHV) grants. The grants are enhancing access to both clinical and home visiting services through expansion of Healthy Families America/Healthy Start, Early Head Start, and Nurse Family Partnership home visiting services. Public Health Nurse Maternity Case Management (MCM) and home visiting services are offered through local health departments.

Collaboration with state public health partners

Ongoing collaboration with state public health partners (reproductive health, family planning and WIC) ensures that education about the importance of prenatal care is discussed and women who screen positive for pregnancy are referred to early care.

Surveillance and data collection

Administration and analysis of the PRAMS survey of post-partum women to collect information related to prenatal care access for surveillance and program planning. Oregon PRAMS data has been continuously collected since 1998 and provides information about utilization, access, and quality of prenatal care.

Policy advocacy for early prenatal care system and quality improvements

Supporting CCOs in achieving early prenatal care for members by developing resources and offering technical assistance for CCOs and local public health authorities. **Medicaid provides prenatal health coverage for undocumented women.** As of October 2013, Medicaid coverage for prenatal services is available to pregnant women who would otherwise be eligible for OHP except for their immigration status. Initially a pilot project in two counties, the program is now statewide.

2. ABOUT THE TARGETS

Early initiation of prenatal care maximizes opportunities for women to prepare for labor/delivery, motherhood and the long term health of both child and mother. The desired direction of change is to increase the percent of women who initiate prenatal care in the 3 months of their pregnancy. The 2014 KPM target is the 2012 national Medicaid 75th percentile (for administrative data only). This is also the 2013 benchmark for the CCOs, which will be revisited by the Metrics & Scoring Committee annually.

3. HOW WE ARE DOING

The rate of first trimester prenatal care for Medicaid has increased slightly from 65.3% in 2011 to 67.3% in 2013, still shy of the 69% target.

4. HOW WE COMPARE

Oregon's 2013 performance is close to the national 2012 75th percentile for Medicaid (administrative data only); however, Oregon's Medicaid rate is still below the first trimester prenatal care rate for the general population.

5. FACTORS AFFECTING RESULTS

Women give a variety of reasons for not accessing early prenatal care. Women may not feel that early care is important, may not know they are pregnant, or may be experiencing barriers such as lack of insurance coverage, inability to get an appointment or unreliable transportation.

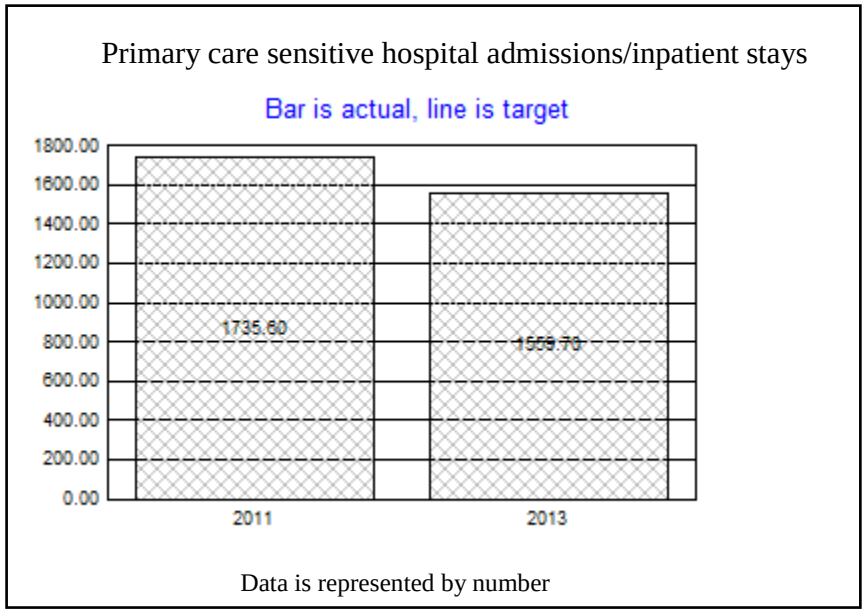
6. WHAT NEEDS TO BE DONE

Opportunities to increase rates of early prenatal care have arisen as the Affordable Care Act (ACA) is implemented and health care transformation efforts in Oregon move forward. Medicaid expansion and the creation of Oregon’s Health Insurance Marketplace (Cover Oregon) mean that more women are eligible for insurance regardless of pregnancy status. More insured women will hopefully mean that more women will have established care providers who can either provide or refer for prenatal care. In addition, the Affordable Care Act includes a mandate for health insurance to cover preventative services including preconception health visits. Preconception health visits are an opportunity to teach women about the importance of early prenatal care.

7. ABOUT THE DATA

Calendar year. This measure is calculated using administrative data only; in 2014, the measure will include medical record review, which will give a more accurate report of the timeliness of prenatal care for Medicaid.

KPM #15	PRIMARY CARE SENSITIVE HOSPITAL ADMISSIONS/INPATIENT STAYS - Rate per 100,000 client years of admissions (for 12 diagnoses) that are more appropriately treated in an outpatient setting.	2013
Goal	Lower cost; better health	
Oregon Context	Lower cost; better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: Reducing preventable rehospitalizations.

2. ABOUT THE TARGETS

Targets have not yet been established. The statewide performance measure targets under the CMS waiver call for a 10% reduction in these admission rates.

3. HOW WE ARE DOING

In 2011, the composite rate for all prevention quality indicators was 1,735.6/100,000 member years; in 2013, the composite rate had decreased to 1,559.7/100,000 member years, a trend in the right direction.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As more data are collected, we will have a better understanding of the factors affecting results.

6. WHAT NEEDS TO BE DONE

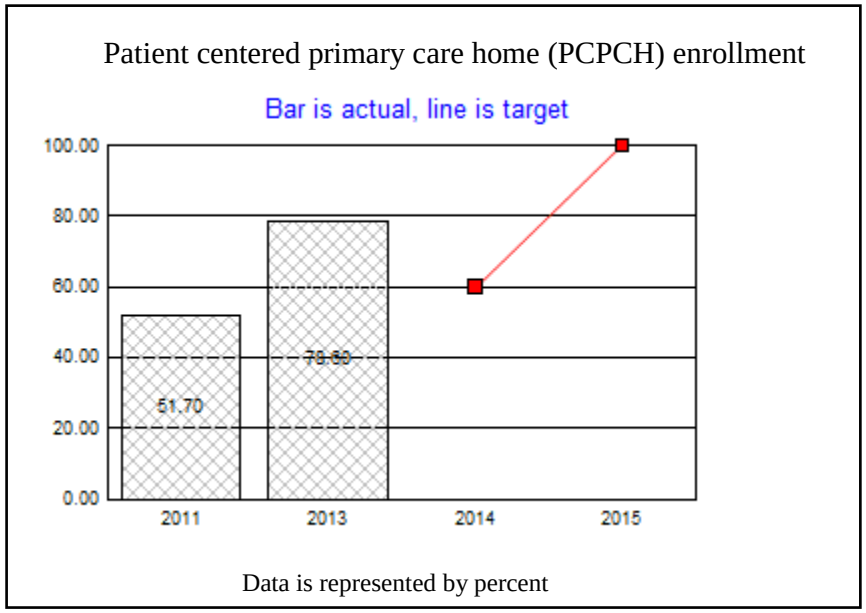
As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year, administrative data; data are reported per 100,000 member years.

OREGON HEALTH AUTHORITY	II. KEY MEASURE ANALYSIS

KPM #16	PATIENT CENTERED PRIMARY CARE HOME (PCPCH) ENROLLMENT - Number of members enrolled in patient-centered primary care homes by tier.	2013
Goal	Better care/access	
Oregon Context	Better care/access	
Data Source	Patient-Centered Primary Care Home enrollment data are reported quarterly by CCOs.	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Areas: Improving access to effective and timely care; Improving primary care for all populations.

2. ABOUT THE TARGETS

These targets have been established to achieve the goal of having 100% of Medicaid members enrolled in a recognized patient-centered primary care home. This aligns with the CCO incentive measure target.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2011, 51.8 percent of Medicaid members were enrolled in a certified patient centered primary care home. This increased to 78.6 percent by the end of 2013, well above the 2014 target of 60 percent. All but one CCO saw increased PCPCH enrollment between 2011 and 2013. Additional comparisons will be made in future reports.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

Coordinated care organizations are driving improvement on this measure through two main efforts: (1) working with contracted providers to go through the PCPCH recognition process, and (2) preferentially assigning members to certified PCPCHs. As we collect more data, we will have a better understanding of the factors affecting the results.

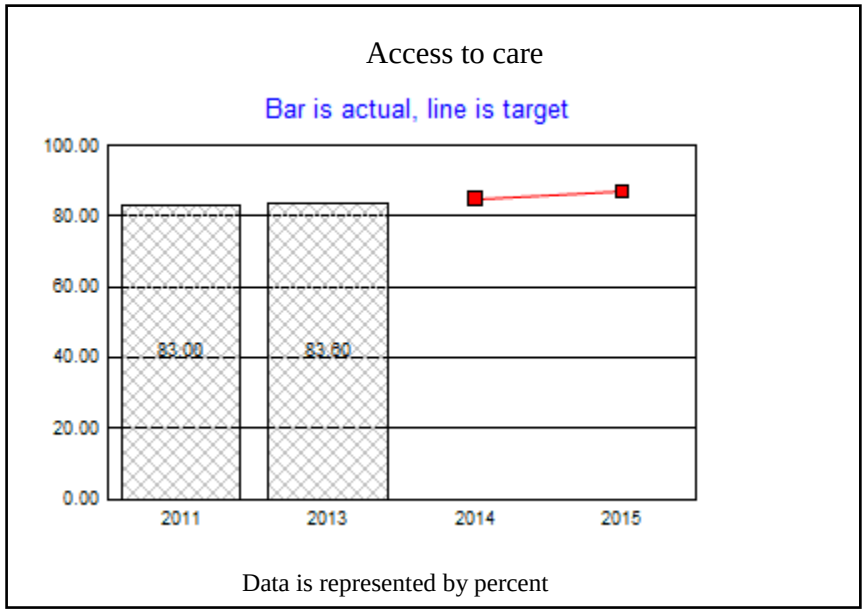
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year. Data are self-reported by CCOs as part of their contractually required provider network capacity / network adequacy reporting.

KPM #17	ACCESS TO CARE - Percentage of members who responded "always" or "usually" too getting care quickly (composite for adult and child).	2013
Goal	Better care/access; better health	
Oregon Context	Better care/access; better health	
Data Source	CAHPS Health Plan survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: Improving access to effective and timely care.

2. ABOUT THE TARGETS

Targets are based on the 2012 National Medicaid 75th percentile.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2011, 83 percent of adults and children received appointments and care when they needed them. In 2013, this increased slightly to 83.6 percent, still below the benchmark of 87.0 percent. This increase was seen in 10 of the 15 Coordinated Care Organizations (CCOs).

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

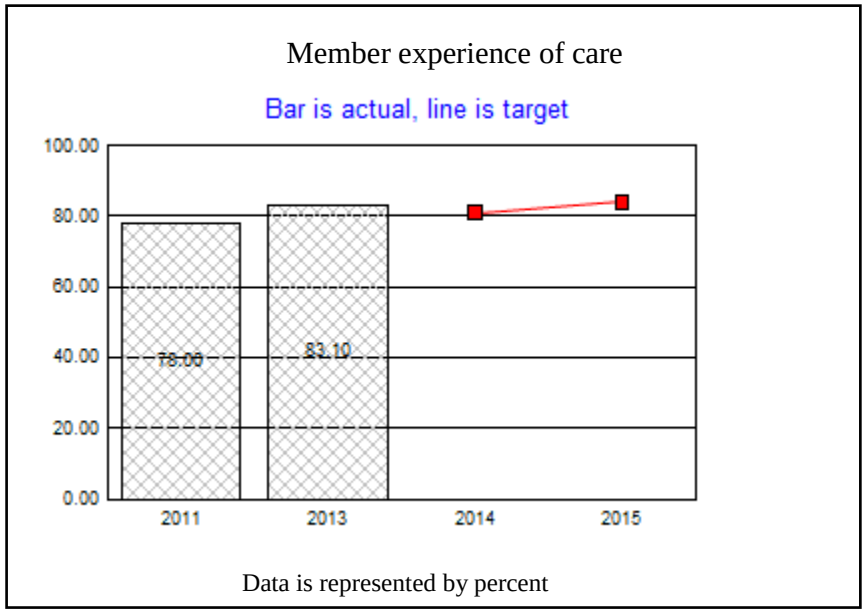
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year. This KPM reports the percentage of members who responded "always" or "usually" to getting care quickly. Results are a composite of adult and child survey questions.

KPM #18	MEMBER EXPERIENCE OF CARE - Composite measurement: how well doctors communicate; health plan information and customer service (Medicaid population).	2013
Goal	Better care/access	
Oregon Context	Better care/access	
Data Source	CAHPS Health Plan survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: Improving access to effective and timely care.

2. ABOUT THE TARGETS

Targets are based on the 2012 National Medicaid 75th percentile.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2011, 78 percent of adults and children reported they received needed information or help and thought they were treated with courtesy and respect by customer service staff. In 2013, the rate increased to 83.1 percent, just shy of the benchmark of 84.0 percent, but still notable considering this increase occurred as CCOs were newly established. This increase from 2011 to 2013 was seen across 13 of the 15 CCOs.Additional comparisons will be made in future reports.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

6. WHAT NEEDS TO BE DONE

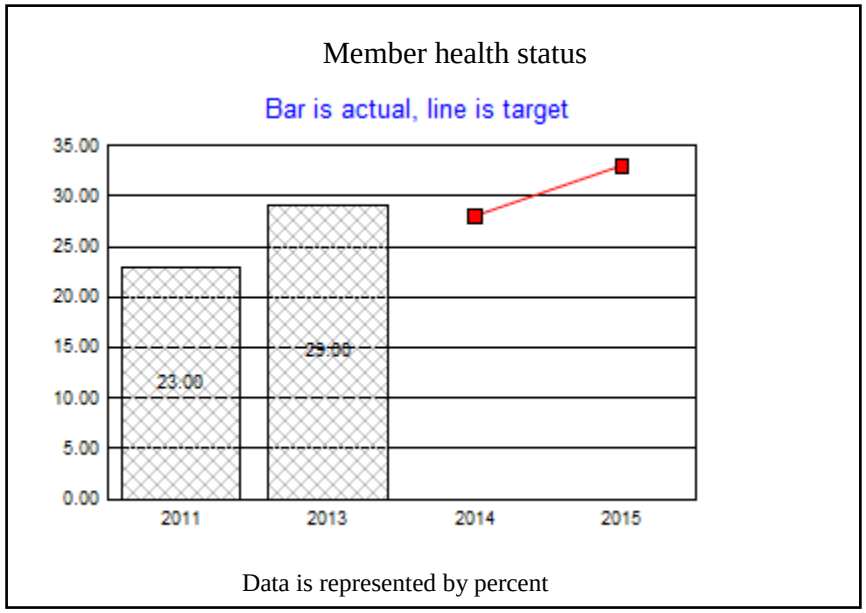
As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year. This KPM reports on the following elements: getting care needed; getting care quickly; how well doctors communicate; health plan information. Results are a composite of adult and child survey questions.

OREGON HEALTH AUTHORITY	II. KEY MEASURE ANALYSIS

KPM #19	MEMBER HEALTH STATUS - Percentage of CAHPS survey respondents with a positive self-reported rating of overall health (excellent, very good).	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	CAHPS survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Areas: Addressing discrete health issues; improving primary care for all populations.

2. ABOUT THE TARGETS

The targets are based on the National Medicaid 75th percentile.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2011, 23% of CCO enrollees responding to the CAHPS survey had a positive self-reproted rating of overall health (excellent or very good). In 2013, this had increased to 29%, meeting the 2014 target.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

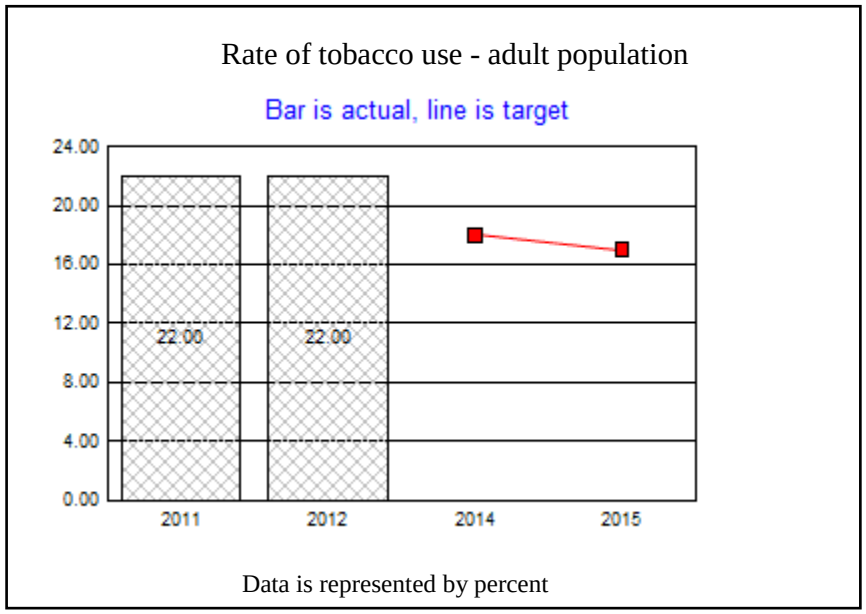
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year. The results report the percentage of CAHPS survey respondents with a positive self-reported rating of overall health.

KPM #20	RATE OF TOBACCO USE (POPULATION) - Rate of tobacco use among adults.	2002
Goal	Better health	
Oregon Context	Better health	
Data Source	BRFSS	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

The goal of the Oregon Tobacco Prevention and Education Program (TPEP) is to reduce tobacco use among all Oregonians. This is accomplished by focusing on the components of the World Health Organization's MPOWER framework: **Monitor** tobacco use and prevention policies, **Protect** people from tobacco smoke, **Offer** help to quit tobacco use, **Warn** about the dangers of tobacco, **Enforce** bans on tobacco advertising, promotion and sponsorship, and **Raise** the price of tobacco. This work is undertaken by the county, tribal and

state tobacco programs working synergistically to ensure that every Oregonians experiences the benefits of tobacco prevention work in the places where they live, work, play, and learn. No single component of Oregon's TPEP is solely responsible for reducing tobacco use–a comprehensive approach must be employed to effectively decrease tobacco use.

2. ABOUT THE TARGETS

Tobacco use is the leading preventable cause of death in Oregon and the nation. Cigarette smoking is the most common form of tobacco use. Quitting tobacco at any age has significant health benefits. Successful efforts to decrease the prevalence of tobacco use among all Oregon adults and Oregon adults who are covered by Medicaid will lead to reduced morbidity and mortality. This in turn will contribute substantially toward the OHA|DHS vision of "a healthy Oregon" in the short-term and long-term.

3. HOW WE ARE DOING

In 2012, the proportion of adult tobacco users in the Medicaid population was 43 percent higher than among the general adult population (34% versus 22%).

4. HOW WE COMPARE

Other groups report cigarette smoking prevalence alone, rather than tobacco use prevalence, so no external data are readily available to compare against.

5. FACTORS AFFECTING RESULTS

The Centers for Disease Control and Prevention Office of Smoking and Health has developed an evidence-based funding model for countering the health and economic destruction of tobacco use. The recommended model funds programs to prevent initiation of tobacco use among young people, to promote quitting among adults and young people, to eliminate exposure to secondhand smoke, and to identify and eliminate tobacco-related disparities. For Oregon, the recommended funding is $11.60 per capita, which equates to $43 million annually. This recommendation represents just a fraction of the cost of tobacco use, with more than $2.5 billion lost to medical care and lost productivity annually in Oregon.
During the 2013-2015 biennium Oregon is slated to receive about $2.87 per capita for tobacco prevention from all funding sources, which is 28% of CDC's recommended funding for tobacco prevention. This is comparable with what was allotted to Oregon tobacco prevention a dozen years ago, however, funding levels have been much lower in the years in between. TPEP also received approximately $2.87 per capita during the 2001-2003 biennium, but was temporarily shuttered when the Legislature directed the allocated revenues elsewhere. After this interruption, smoking among pregnant women and adolescents stopped decreasing, and per capita consumption of cigarettes increased for the first time since the program was first implemented.

6. WHAT NEEDS TO BE DONE

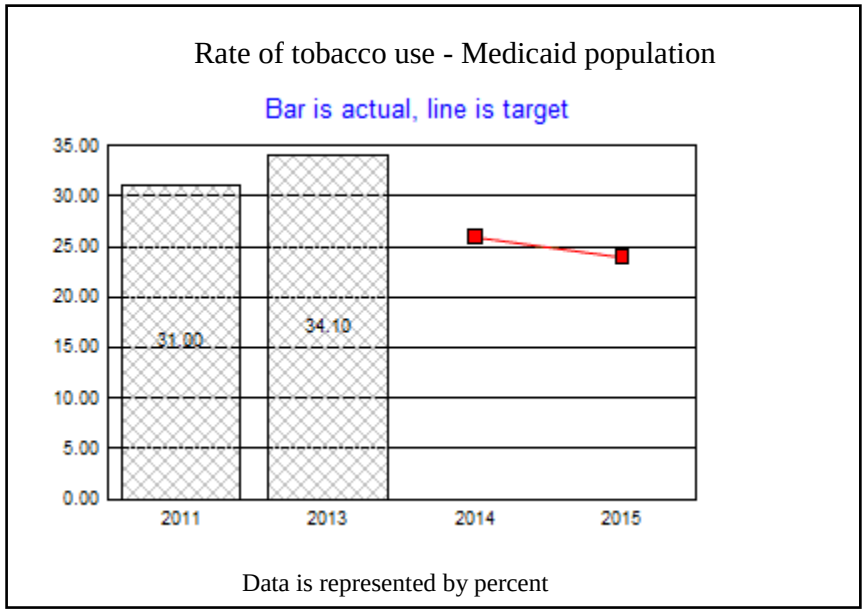
Studies in Oregon and in other states have shown that decreases in funding for tobacco prevention lead to decreased success in reducing tobacco use, and conversely, increases in funding for tobacco prevention lead to increased success in reducing tobacco use. To keep youth and young adults from starting to smoke, protect Oregonians from

secondhand smoke, identify and eliminate tobacco-related disparities and help smokers quit, funding for comprehensive tobacco control needs to be increased. Prior successes in Oregon and a substantial evidence-base from elsewhere tell us that a comprehensive program is the most effective means to counter the devastating effects of tobacco.

7. ABOUT THE DATA

Tobacco use prevalence among adult Oregonians is available annually and reported once per calendar year. The estimate is derived from the Oregon Behavioral Risk Factor Surveillance System (BRFSS), a telephone-administered survey of adults that examines health related behaviors. Advantages associated with this data source include its widespread use across the nation, permitting national and cross-state comparison (although, as mentioned previously, other groups report cigarette smoking rather than tobacco use).The Oregon BRFSS began including cellular telephones in its sample in 2010, which improved the representativeness of the estimate. Data collected in 2010 and later, however, cannot be compared with earlier years. "Tobacco use" is defined as having smoking at least 100 cigarettes in a lifetime and currently smoking every day or some days, and/or currently using chewing tobacco, snuff, or snus every day or some days.

KPM #21	RATE OF TOBACCO USE (MEDICAID) - Percentage of CCO enrollees who currently smoke cigarettes or use tobacco every day or some days.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	CAHPS survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

The goal of the Oregon Tobacco Prevention and Education Program (TPEP) is to reduce tobacco use among all Oregonians. This is accomplished by focusing on the components of the World Health Organization's MPOWER framework: **Monitor** tobacco use and prevention policies, **Protect** people from tobacco smoke, **Offer** help to quit tobacco use, **Warn**

about the dangers of tobacco, **Enforce** bans on tobacco advertising, promotion and sponsorship, and **Raise** the price of tobacco. This work is undertaken by the county, tribal and state tobacco programs working synergistically to ensure that every Oregonians experiences the benefits of tobacco prevention work in the places where they live, work, play, and learn. No single component of Oregon's TPEP is solely responsible for reducing tobacco use–a comprehensive approach must be employed to effectively decrease tobacco use.

2. ABOUT THE TARGETS

Tobacco use is the leading preventable cause of death in Oregon and the nation. Cigarette smoking is the most common form of tobacco use. Quitting tobacco at any age has significant health benefits. Successful efforts to decrease the prevalence of tobacco use among all Oregon adults and Oregon adults who are covered by Medicaid will lead to reduced morbidity and mortality. This in turn will contribute substantially toward the OHA|DHS vision of "a healthy Oregon" in the short-term and long-term.

3. HOW WE ARE DOING

In 2012, the proportion of adult tobacco users in the Medicaid population was 43% higher than among the general adult population (34% vs 22%). The tobacco use prevalence increased in the Medicaid population from 31% in 2011 to 34% in 2013.

4. HOW WE COMPARE

Among data included in the national CAHPS survey database, in 2013, 69% of Medicaid members nationally reported they currently smoke or use tobacco every day, some days or not at all, compared to the Oregon rate of 34%.

5. FACTORS AFFECTING RESULTS

The Centers for Disease Control and Prevention Office of Smoking and Health has developed an evidence-based funding model for countering the health and economic destruction of tobacco use. The recommended model funds programs to prevent initiation of tobacco use among young people, to promote quitting among adults and young people, to eliminate exposure to secondhand smoke, and to identify and eliminate tobacco-related disparities. For Oregon, the recommended funding is $10.09 per capita, which equates to $39.3 million annually. This recommendation represents just a fraction of the cost of tobacco use, with more than $2.5 billion lost to medical care and lost productivity annually in Oregon.

During the 2013 - 2015 biennium Oregon is slated to receive about $2.87 per capita for tobacco prevention from all funding sources, which is 28% of CDC's recommended funding for tobacco prevention. This is comparable with what was allotted to Oregon tobacco prevention a dozen years ago. However, funding levels have been much lower in the years in between. TPEP also received about $2.87 per capita during the 2001-2003 biennium, but was temporarily shuttered when the Legislature directed the allocated revenues elsewhere. After this interruption, smoking among pregnant women and adolescents stopped decreasing and per capita consumption of cigarettes increased for the first time since the program was first implemented.

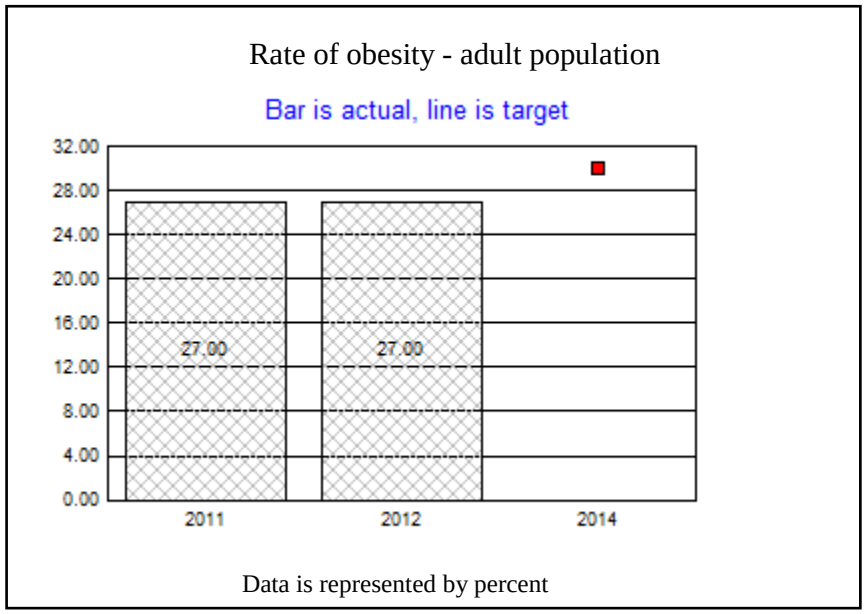
6. WHAT NEEDS TO BE DONE

Studies in Oregon and in other states have shown that decreases in funding for tobacco prevention lead to decreased success in reducing tobacco use, and conversely, increases in funding for tobacco prevention lead to increased success in reducing tobacco use. To keep youth and young adults from starting to smoke, protect Oregonians from secondhand smoke, identify and eliminate tobacco-related disparities and help smokers quit, funding for comprehensive tobacco control needs to be increased. Prior successes in Oregon and a substantial evidence-base from elsewhere tell us that a comprehensive program is the most effective means to counter the devastating effects of tobacco.

7. ABOUT THE DATA

Tobacco use prevalence among adult Oregonians on Medicaid is on an annual reporting cycle, computed once per calendar year. The estimate is derived from the Oregon Consumer Assessment of Healthcare Providers and Systems (CAHPS), a survey that examines experiences with health plans and their services among Medicaid enrollees.

KPM #22	RATE OF OBESITY (POPULATION) - Percentage of adults who are obese among Oregonians.	2010
Goal	Better health	
Oregon Context	Better health	
Data Source	Behavioral Risk Factor Surveillance System (BRFSS)	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

In 2013, the Oregon Public Health Division was awarded funding from the Centers for Disease Control and Prevention (CDC) to reduce obesity as part of an integrated cooperative agreement to prevent and control diabetes, heart disease, obesity and associated risk factors, and promote school health. Ultimately a comprehensive, coordinated, statewide obesity prevention program/initiative will be required to slow the increase in obesity. These resources are not sufficient to build a comprehensive program, although they will allow

some efforts to start.

2. ABOUT THE TARGETS

Over the past two decades, obesity has become a national and state health crisis. In Oregon, obesity contributes to the deaths of about 1,500 Oregonians each year, making it second only to tobacco as the state's leading cause of preventable death. Obesity is also a major risk factor for chronic diseases such as diabetes, cancer, high blood pressure, high cholesterol, arthritis, heart disease and stroke. Since 1990, Oregon's adult obesity rate has increased 121 percent. If Oregon remains on this trajectory, children born today will not live as long as their parents or grandparents do.

In Oregon, medical costs related to obesity among adults were estimated to have reached $1.6 billion in 2006, with $339 million of that paid by Medicare and $333 million paid by Medicaid. In addition, people affected by obesity are estimated to have annual medical costs $1,429 higher than non-obese people. Obesity prevalence grew steadily in Oregon and the U.S between 1990 and 2010, and has remained flat since. In 2010, CDC launched a new methodology for calculating BRFSS estimates, which appears to increase many estimates, but is designed to produce more representative, accurate estimates. Considering these factors, the trajectory for obesity is estimated to reach around 30% in the general population by 2017 so the target was set to be 30% or less. Since Oregon has limited funding for obesity prevention and control, targets were modest.

3. HOW WE ARE DOING

In 2012, the proportion of adults who are obese in the Medicaid population was 52% higher than the proportion of adults who are obese in the general population (41% vs 27%).

4. HOW WE COMPARE

Recently released data from the CDC's national Behavioral Risk Factor Surveillance System (BRFSS) indicate that Oregon's obesity prevalence is tied for 23rd/24th place in the nation among all states and the District of Columbia (Oregon, 27.3%; range: Colorado, 20.5% –Louisiana, 34.7%.) Estimates of obesity prevalence among the Medicaid population by state are not available.

5. FACTORS AFFECTING RESULTS

Poor nutrition and lack of physical activity are the main factors driving obesity in Oregon. Obesity results from calorie consumption that exceeds the number of calories expended. Since calorie consumption is difficult and costly to assess accurately, eating ≥5 servings of fruits and vegetables a day is used as marker of a healthy diet. Regular physical activity is also a critical component of weight control.

During 2011, fewer than one in four Oregon adults consumed ≥5 servings of fruits and vegetables per day, which has been relatively unchanged since 1996. Among youth the situation is similar: about one in four Oregon eighth-graders consumed five or more servings a day of fruits and vegetables in 2013. Young people also drink a lot of sugary beverages: about 12 percent of eighth-graders report drinking an average of one or more soft drinks a day. This means that about one in ten eighth-graders consume enough soda to add more

than 1,000 extra calories to their diets each week.

In 2011, 24% of adult Oregonians met aerobic and muscle strengthening recommendations for physical activity. In 2013, 60% of Oregon eight-graders met physical activity recommendations of getting one or more hours of activity on most days of the week.

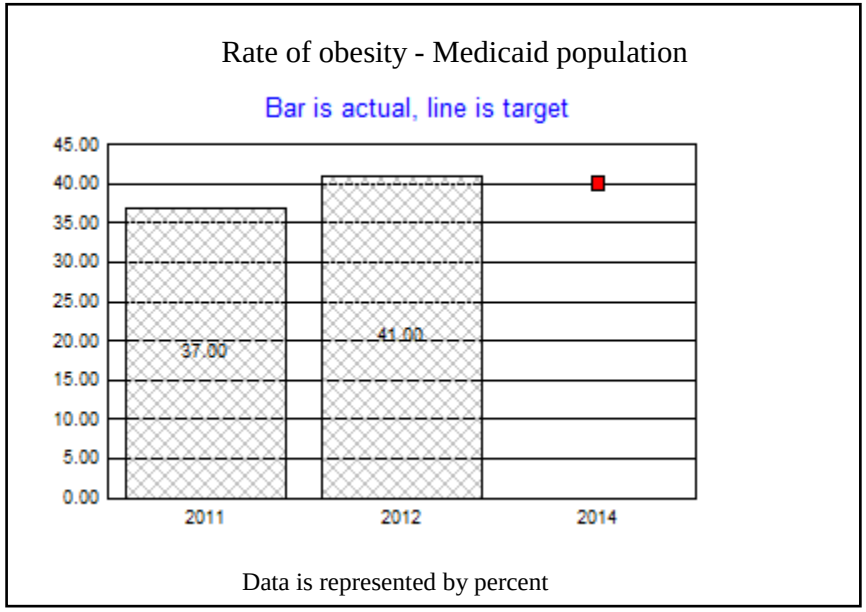
6. WHAT NEEDS TO BE DONE

Comprehensive, collaborative statewide and community-based obesity prevention programs that include standards for physical activity and nutrition can make it easy for children and adults to access healthy foods and physical activities where they live, work, play and learn. Unless appropriate steps are taken to curb the obesity crisis in Oregon, the costs in Oregon lives and dollars will be too great for the state to sustain. Obesity is a preventable disease. It occurs in predisposed children and adults living in environments that promote eating too many calories and too little physical activity. Like other chronic diseases, prevention is the optimal approach and is our strategy to address this public health crisis.

7. ABOUT THE DATA

Obesity prevalence among adult Oregonians is available annually and computed once per calendar year. It is derived from calculations of body mass index (BMI) from the Oregon Behavioral Risk Factor Surveillance System (BRFSS), a telephone-administered survey that examines health-related factors including height and weight. Advantages associated with this data source include its widespread use across the nation, permitting national and cross-state comparisons. The Oregon BRFSS began including cellular telephones in its sample in 2010, which improved the representativeness of the estimate. Data collected in 2010 and later, however, cannot be compared with earlier years. One disadvantage of these data is that respondents tend to give responses that skew their BMI slightly lower (either by over-reporting height or under-reporting weight), although over time this bias is assumed to be relatively constant.

KPM #23	RATE OF OBESITY (MEDICAID) - Percentage of Medicaid population who are obese.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

In 2013, the Oregon Public Health Division was awarded funding from the Centers for Disease Control and Prevention (CDC) to reduce obesity as part of an integrated cooperative agreement to prevent and control diabetes, heart disease, obesity and associated risk factors, and promote school health. Ultimately a comprehensive, coordinated, statewide obesity prevention program/initiative will be required to slow the increase in obesity. These resources are not sufficient to build a comprehensive program, although they will allow

some efforts to start.

2. ABOUT THE TARGETS

Over the past two decades, obesity has become a national and state health crisis. In Oregon, obesity contributes to the deaths of about 1,500 Oregonians each year, making it second only to tobacco as the state's leading cause of preventable death. Obesity is also a m ajor risk factor for chronic diseases such as diabetes, cancer, high blood pressure, high cholesterol, arthritis, heart disease and stroke. Since 1990, Oregon's adult obesity rate has increased 121 percent. If Oregon remains on this trajectory, children born today will not live as long as their parents or grandparents do. In Oregon, medical costs related to obesity among adults were estimated to have reached $1.6 billion in 2006, with $339 million of that paid by Medicare and $333 million paid by Medicaid. In addition, people affected by obesity are estimated to have annual medical costs $1,429 higher than non-obese people. Obesity prevalence grew steadily in Oregon between 1990 and 2010, and has remained flat since. In 2010, CDC launched a new methodology for calculating BRFSS estimates, which appears to increase many estimates, but is designed to produce more representative, accurate estimates. Considering these factors, the trajectory for obesity is expected to reach around 30% in the general population by 2017 so the target was set to be 30% or less. Since Oregon has limited funding for obesity prevention and control, targets were modest.

3. HOW WE ARE DOING

In 2012, the proportion of obese adults in the Medicaid population was 52% higher than the proportion of obese adults in the general population (41% vs. 27%). The 2012 data show an increase in the proprtion of obese adults in the Medicaid population, from 37% to 41%.

4. HOW WE COMPARE

Recently released data from the CDC’s national Behavioral Risk Factor Surveillance System (BRFSS) indicate that Oregon’s obesity prevalence is tied for 23rd/24th place in the nation among all states and the District of Columbia (Oregon, 27.3%; range: Colorado, 20.5% –Louisiana, 34.7%.) Population-based estimates of obesity prevalence among the Medicaid population by state are not available.

5. FACTORS AFFECTING RESULTS

Poor nutrition and lack of physical activity are the main factors driving obesity in Oregon. Obesity results from calorie consumption that exceeds the number of calories expended. Since calorie consumption is difficult and costly to assess accurately, eating ≥5 servings of fruits and vegetables a day is used as marker of a healthy diet. Regular physical activity is also a critical component of weight control.

During 2011, fewer than one in four Oregon adults consumed ≥5 servings of fruits and vegetables per day, which has been relatively unchanged since 1996. Among youth the

situation is similar: about one in four Oregon eighth-graders consumed five or more servings a day of fruits and vegetables in 2013. Young people also drink a lot of sugary beverages: about 12 percent of eighth-graders report drinking an average of one or more soft drinks a day. This means that about one in ten eighth-graders consume enough soda to add more than 1,000 extra calories to their diets each week.

In 2011, 24% of adult Oregonians met aerobic and muscle strengthening recommendations for physical activity. In 2013, 60% of Oregon eight-graders met physical activity recommendations of getting one or more hours of activity on most days of the week.

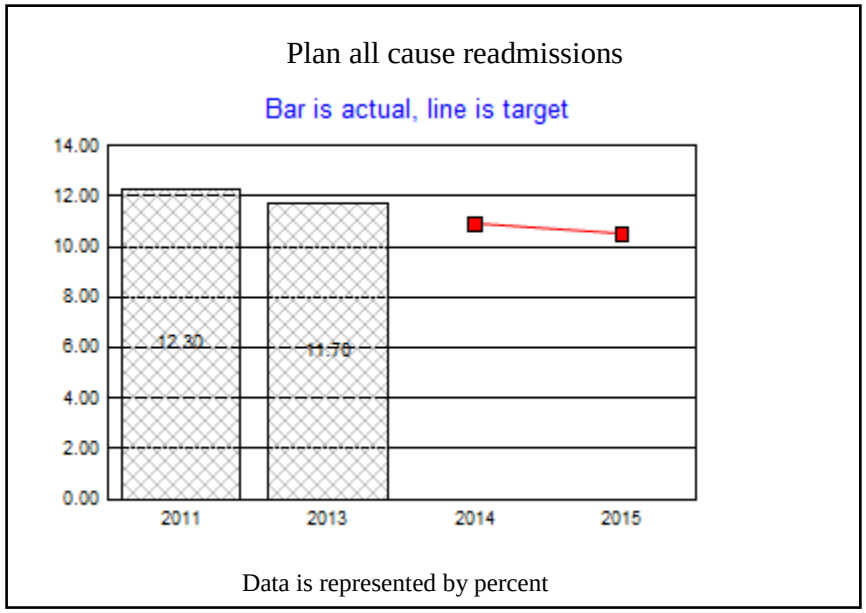
6. WHAT NEEDS TO BE DONE

Comprehensive, collaborative statewide and community-based obesity prevention programs that include standards for physical activity and nutrition can make it easy for children and adults to access healthy foods and physical activities where they live, work, play and learn. Unless appropriate steps are taken to curb the obesity crisis in Oregon, the costs in Oregon lives and dollars will be too great for the state to sustain. Obesity is a preventable disease. It occurs in predisposed children and adults living in environments that promote eating too many calories and too little physical activity. Like other chronic diseases, prevention is the optimal approach and is our strategy to address this public health crisis.

7. ABOUT THE DATA

Obesity prevalence among Oregon adult Medicaid recipients is available annually and computed once per calendar year. It is derived from calculations of body mass index (BMI) from the Oregon Behavioral Risk Factor Surveillance System (BRFSS), a telephone-administered survey that examines health related factors including height and weight. Advantages associated with this data source include its widespread use across the nation, permitting national and cross-state comparisons. The Oregon BRFSS began including cellular telephones in its sample in 2010, which improved the representativeness of the estimate. Data collected in 2010 and later, however, cannot be compared with earlier years. One disadvantage of these data is that respondents tend to give responses that skew their BMI slightly lower (either by over-reporting height or under-reporting weight), although over time this bias is assumed to be relatively constant. OHA Health Analytics is investigating other means by which to collect these data in the future, including Oregon Consumer Assessment of Healthcare Providers and Systems (CAHPS), online health assessments, or the Medicaid BRFSS, which is a special administration of a BRFSS-like survey to Medicaid enrollees.

KPM #24	PLAN ALL CAUSE READMISSIONS - Percentage of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for members 18 years and older.	2013
Goal	Lower cost	
Oregon Context	Lower cost	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: Reducing preventable rehospitalizations.

2. ABOUT THE TARGETS

Targets were created using an average of the 2012 Commercial and Medicare 75th percentiles. For this KPM, lower is better.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2011, 12.3 percent of adult patients who had a hospital stay were readmitted for any reason within 30 days of discharge. By 2013, the readmission rate had improved slightly to 11.7 percent. Nine CCOs also saw improvements in their readmission rates and two CCOs saw no change in their rates. Readmissions were reduced across African Americans, American Indian/Alaskan Natives, Asian Americans, and Whites, but increased for Hispanics and Hawaiian/Pacific Islanders. Additional comparisons will be made in future reports.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

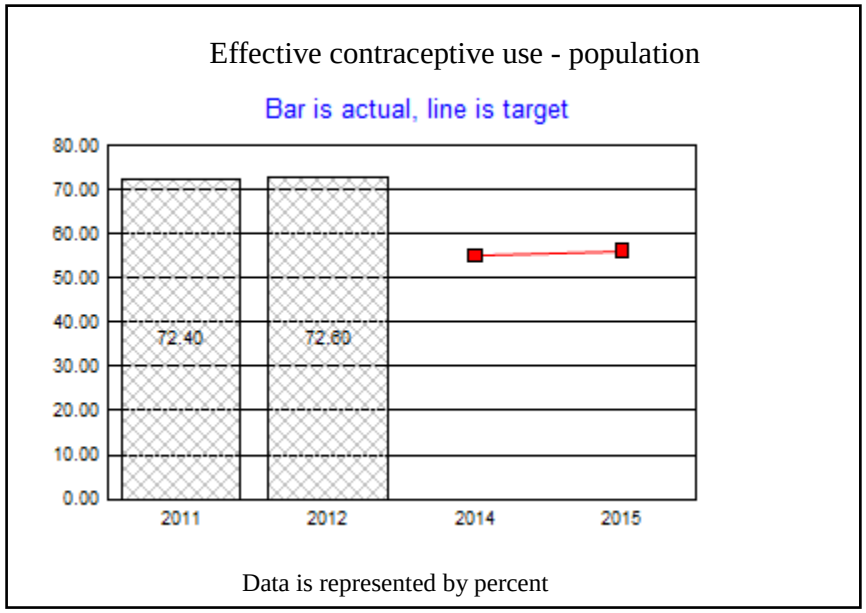
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year.

KPM #25	EFFECTIVE CONTRACEPTIVE USE (POPULATION) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Behavioral Risk Factor Surveillance System (BRFSS)	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: Improving primary care for all populations.

2. ABOUT THE TARGETS

Targets are based on preliminary calendar year 2011 baseline data. Higher is better. Targets may need to be revised to reflect updated performance data.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. The effective contraceptive rate for the general population is just below the Medicaid rate in the baseline year; the general population rate increased slightly in 2012, compared to a larger increase in the Medicaid population. Additional comparisons will be made in future reports.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

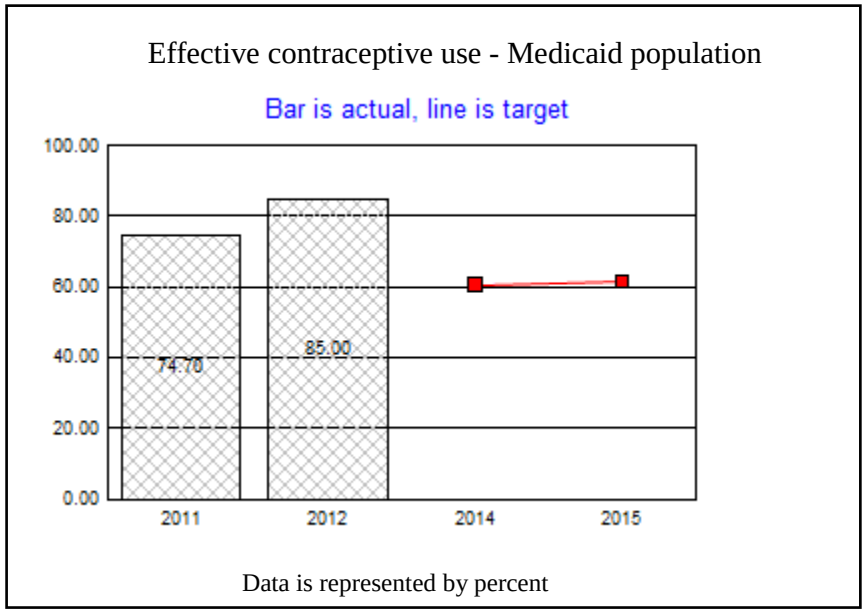
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year 2011 and 2012. Revised estimates for 2011 and updated data for 2012 have been calculated; missing and incomplete information that was previously included in the preliminary 2011 data have been removed from the analysis, resulting in an increase to the rates.

KPM #26	EFFECTIVE CONTRACEPTIVE USE (MEDICAID) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Behavioral Risk Factor Surveillance System (BRFSS)	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: Improving primary care for all populations.

2. ABOUT THE TARGETS

Targets are based on preliminary calendar year 2011 baseline data. Higher is better. Targets may need to be revised to reflect updated performance data.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. The Medicaid rate of effective contraceptive use holds just above the rate for the general population. The Medicaid rate has increased from 2011 to 2012, although some of the increase may be due to fluctuations in measurement due to small numbers. Additional comparisons will be made in future reports.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

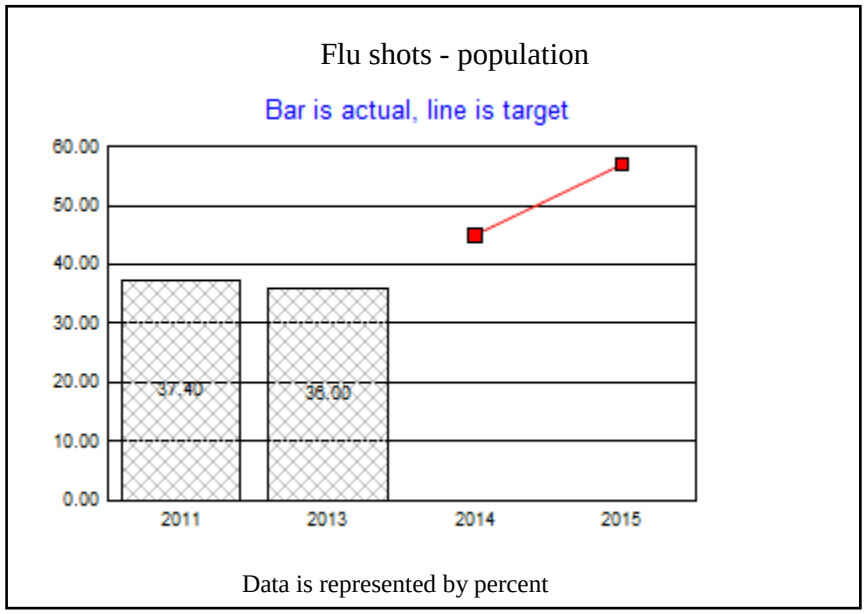
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year 2011 and 2012. Revised estimates for 2011 and updated data for 2012 have been calculated; missing and incomplete information that was previously included in the preliminary 2011 data have been removed from the analysis, resulting in an increase to the rates.

KPM #27	FLU SHOTS (POPULATION) - Percentage of adults ages 50-64 who receive a flu vaccine.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Behavioral Risk Factor Surveillance System (BRFSS)	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

The Oregon Immunization Program supports the efforts of its various public and private partners (e.g., pharmacies, healthcare institutions, long-term care facilities) to immunize adults against influenza. These activities include: the work of Oregon's lifespan immunization coalition, Immunize Oregon; projects such as the 2013-2014 Adult Immunization Special Project, which sought to strengthen the adult immunization infrastructure; protocols and legislation supporting pharmacy vaccination practices; and the provision of

technical support to public and private providers. We also promote the use of the ALERT Immunization Information System (IIS). Pharmacists and providers that receive state-supplied vaccine are required to report vaccinations into this system.

2. ABOUT THE TARGETS

The goal is to increase influenza immunization rates to meet the Healthy People 2020 objective of 80% for individuals 18-64 years of age.

3. HOW WE ARE DOING

In 2012, 37% of 50-64 year olds in Oregon had received an influenza vaccination in the past 12 months. This measure has shown little improvement over the years.

4. HOW WE COMPARE

In 2012, 37% of 50-64 year olds in Oregon had received an influenza vaccination in the past 12 months. In comparison, 42.7% of people in this age range, nationwide, received an influenza vaccination. State-specific vaccination rate estimates range from 32.6% to 51.1%.

5. FACTORS AFFECTING RESULTS

Immunization rates are influenced by public perception of the need for and efficacy of vaccinations. Factors that negatively influence rates include: the absence of policies that motivate health systems to routinely vaccinate all clients and employees (although improvement has been seen on this point in recent years), limited funding for adult immunizations, and challenges around increasing provider use of the ALERT IIS – the statewide immunization registry – that could provide immunization information for providers about their adult populations. During the 2007 legislative session, HB 2188 passed expanding ALERT IIS to a lifespan registry, and during the 2011 legislative session, HB 2371 passed stating that VFC and 317 providers need to report all administered doses to ALERT IIS. Pharmacies are now also required to report all administered vaccines to the ALERT IIS. Over the next few years as the IIS collects and processes data, the IIS will contain more comprehensive immunization histories across the lifespan, which will help healthcare providers identify candidates for vaccine and potentially send out reminders to clients to seek out an influenza immunization every year.

6. WHAT NEEDS TO BE DONE

Depending on available resources and with the support of Immunize Oregon, we plan on the following:

- Continue to educate the public and healthcare providers about the benefits of influenza vaccinations
- Continue to support efforts to increase vaccination of health care workers
- Increase the number of adult providers who report vaccination information to the ALERT IIS
- Assess adult population capture in the IIS to produce near real-time estimates of coverage, by county, throughout the flu season
- Continue to promote the administration of influenza vaccine whenever immunization providers give any other immunization, such as pneumococcal vaccine or

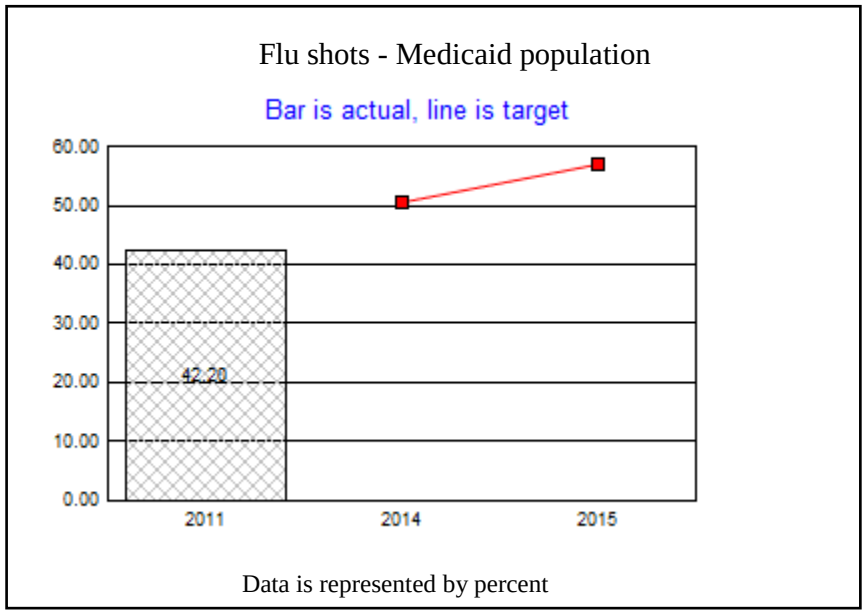
tetanus/diphtheria/pertussis vaccine

- Continue to partner with pharmacies, as these are commonly the vaccination venues for older adults

7. ABOUT THE DATA

Reporting period - calendar year. This measure presents the percent of adults, 50-64 years of age, who reported receiving an influenza vaccination in the previous 12 months as reported on the Behavioral Risk Factor Surveillance survey (BRFSS). [Survey question: During the past 12 months, have you had a flu shot?]. Please note that although responses can be for either intra-muscular or nasal vaccine, the nasal vaccine is only given up through age 49. Data for 2013 were not yet available at the time of this writing. Beginning in 2011, a different weighting system was used such that estimates before 2011 are not directly comparable to those for 2011 and subsequent years.

KPM #28	FLU SHOTS (MEDICAID) - Percentage of adults ages 50-64 who receive a flu vaccine.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Behavioral Risk Factor Surveillance System (BRFSS)	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

The Oregon Immunization Program supports the efforts of its various public and private partners (e.g., pharmacies, healthcare institutions, long-term care facilities) to immunize adults against influenza. These activities include: the work of Oregon's lifespan immunization coalition, Immunize Oregon; projects such as the 2013-2014 Adult Immunization Special Project, which sought to strengthen the adult immunization infrastructure; protocols and legislation supporting pharmacy vaccination practices; and the provision of

technical support to public and private providers. We also promote the use of the ALERT Immunization Information System (IIS). Pharmacists and providers that receive state-supplied vaccine are required to report vaccinations into this system.

2. ABOUT THE TARGETS

The goal is to increase influenza immunization rates to meet the Healthy People 2020 objective of 80% for individuals 18-64 years of age.

3. HOW WE ARE DOING

In 2012, 37% of all 50-64 year olds in Oregon (not just Medicaid recipients) had received an influenza vaccination in the past 12 months. This measure has shown little improvement over the years.

4. HOW WE COMPARE

In 2012, nationwide, 42.7% of all people in this age range received an influenza vaccination. State-specific vaccination rate estimates range from 32.6% to 51.1% with Oregon's rate at 37%.

5. FACTORS AFFECTING RESULTS

Immunization rates are influenced by public perception of the need for and efficacy of vaccinations. Factors that negatively influence rates include: the absence of policies that motivate health systems to routinely vaccinate all clients and employees (although improvement has been seen on this point in recent years), limited funding for adult immunizations, and challenges around increasing provider use of the ALERT IIS – the statewide immunization registry – that could provide immunization information for providers about their adult populations. During the 2007 legislative session, HB 2188 passed expanding ALERT IIS to a lifespan registry, and during the 2011 legislative session, HB 2371 passed stating that VFC and 317 providers need to report all administered doses to ALERT IIS. Pharmacies are now also required to report all administered vaccines to the ALERT IIS. Over the next few years as the IIS collects and processes data, the IIS will contain more comprehensive immunization histories across the lifespan, which will help healthcare providers identify candidates for vaccine and potentially send out reminders to clients to seek out an influenza immunization every year.

6. WHAT NEEDS TO BE DONE

Depending on available resources and with the support of Immunize Oregon, we plan on the following:

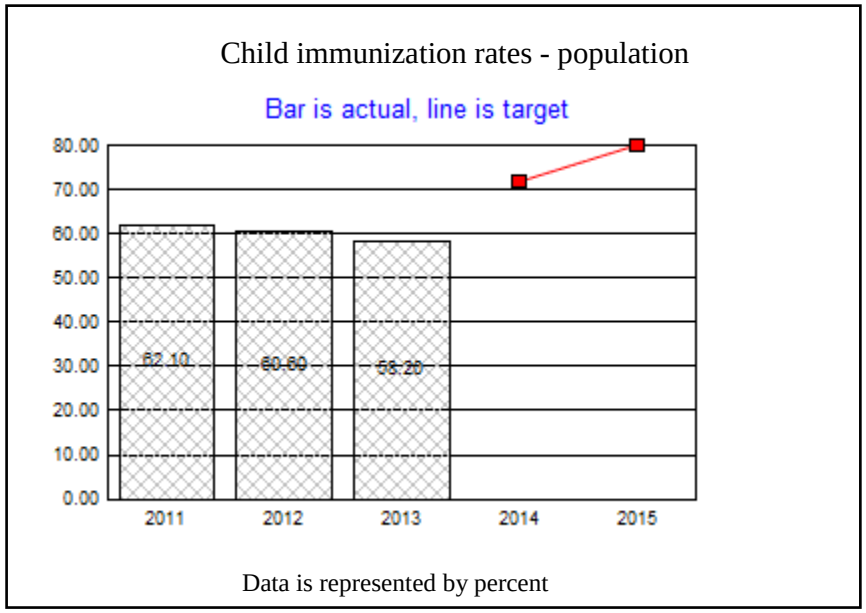
- Continue to educate the public and healthcare providers about the benefits of influenza vaccinations
- Continue to support efforts to increase vaccination of health care workers
- Increase the number of adult providers who report vaccination information to the ALERT IIS
- Assess adult population capture in the IIS to produce near real-time estimates of coverage, by county, throughout the flu season

· Continue to promote the administration of influenza vaccine whenever immunization providers give any other immunization, such as pneumococcal vaccine or tetanus/diphtheria/pertussis vaccine
· Continue to partner with pharmacies, as these are commonly the vaccination venues for older adults

7. ABOUT THE DATA

Reporting period – calendar year. This measure presents the influenza immunization rate among Medicaid recipients, 50-64 years of age. The source of the immunization data is the ALERT IIS, which is a statewide system that records reported immunization data from 100% of public providers and 93% of private providers. Rates are obtained by matching Medicaid enrollees from the MMIS/DSSURS system against information in the ALERT IIS.

KPM #29	CHILD IMMUNIZATION RATES (POPULATION) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

The Vaccines for Children program supplies vaccine and technical assistance to private and public providers who serve eligible children. The ALERT Immunization Information System (IIS) maintains a database of all reported vaccine for provider reference and identifies all shots due. Pharmacists and providers that receive state-supplied vaccine are

required to report vaccinations into this system. Vaccines, funds, and technical assistance are provided annually to local health departments to improve immunization coverage rates for children. Education and training opportunities are offered for public and private providers throughout the year to provide up-to-date information about vaccine efficacy, safety, and reporting, as well as storage and handling.

2. ABOUT THE TARGETS

The goal is to increase immunization rates to meet the Healthy People 2020 objective of 80% coverage for the 4:3:1:3:3:1:4 series. The rate is calculated for the percent of children immunized with four or more doses of diphtheria, tetanus and pertussis (DTaP); three or more doses of polio; one or more doses of measles, mumps, rubella (MMR); three or more doses of *Haemophilus Influenzae* type b; three or more doses of hepatitis B; one or more doses of varicella, and four or more doses of pneumococcal conjugate vaccine (4:3:1:3:3:1:4).

3. HOW WE ARE DOING

The 4:3:1:3:3:1:4 rate for children 24-35 months of age in 2013 is 58.2%. This is a decline from 60.6% in 2012 and 62.1% in 2011.

4. HOW WE COMPARE

This KPM reflects children 24-35 months olds with vaccines reported to the statewide immunization information system (IIS). A national comparison is difficult because national data is based on the National Immunization Survey (NIS), which is a telephone survey that samples a limited number of Oregon residents 19-35 months of age. However, the national NIS rate for the 4:3:1:3:3:1:4 series in2012 was 68.4% (+/- 1.4%), with 68.7% (+/- 6.7%) for Oregon, 65.2% (+/- 7.2%) for Washington, and 63.0% (+/- 8.2%) for Idaho.

5. FACTORS AFFECTING RESULTS

Completion of the four-dose PCV series has declined from 77..8% in 2010, 75.6 in 2011, and 73.7% in 2013. Other vaccines in the 4:3:1:3:3:1:4 series have stayed generally stable during that time. The Immunization Program oversees the Vaccines for Children (VFC) program, a federally funded entitlement that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. The success of VFC is based upon partnership between the Oregon Immunization Program and public and private providers. Ninety-five percent of Oregon's childhood immunizations are captured in the ALERT IIS, which is used to estimate immunization rates, while also providing a clinical record for providers to accurately assess the vaccine needs of individual children. Other influences include parent and provider knwoledge, attitudes, and practices.

6. WHAT NEEDS TO BE DONE

To continue our success, OHA needs to:

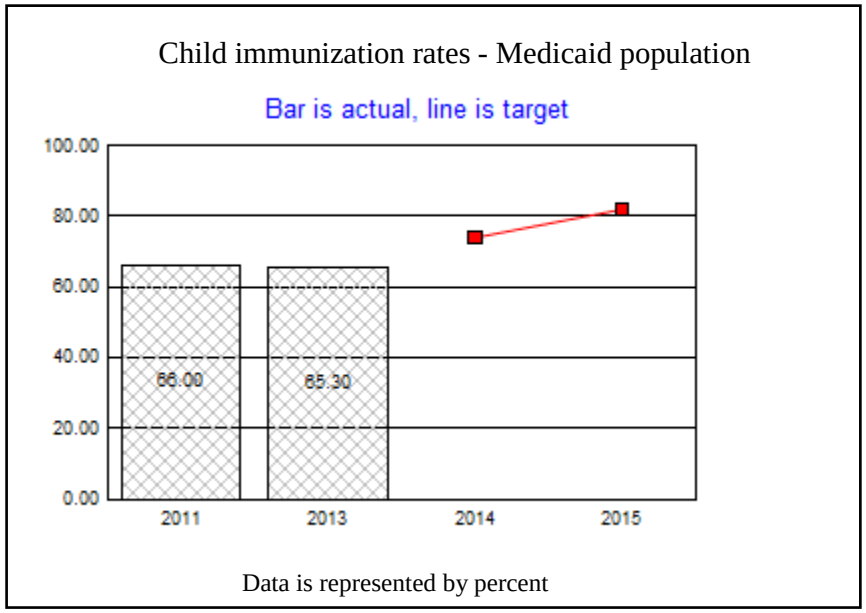
- Continue to provide funding, vaccines, and consultation to all local health departments
- Continue to work with other OHA programs to identify referral and assessment opportunities

· Continue to work with internal and external partners to effectively communicate with consumers regarding vaccine safety and the importance of receiving vaccines according to the ACIP-recommended vaccine schedule
· Continue to work with the Centers for Disease Control and Prevention (CDC), vaccine manufacturers, and providers to assure that appropriate strategies are in place for storage and handling of vaccines, as well as strategies specifically designed to respond to a vaccine shortage
· Support the implementation of SB 132, which requires parents, who are seeking non-medical exemptions from vaccinations, to submit either a provider signature or a certificate verifying that they have received education about the risks associated with not immunizing their child

7. ABOUT THE DATA

Reporting cycle – calendar year. This measure presents the statewide immunization rate for children 24 to 35 months of age. The data source is the ALERT IIS, which is a statewide system that records reported immunization data from 100% of public providers and 93% of private providers. The immunizations assessed include 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B, 1 Varicella and 4 PCV (4:3:1:3:3:1:4).

KPM #30	CHILD IMMUNIZATION RATES (MEDICAID) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

The Vaccines for Children program supplies vaccine and technical assistance to private and public providers who serve eligible children. The ALERT Immunization Information System (IIS) maintains a database of all reported vaccine for provider reference and identifies all shots due. Pharmacists and providers that receive state-supplied vaccine are

required to report vaccinations into this system. Vaccines, funds, and technical assistance are provided annually to local health departments to improve immunization coverage rates for children. Education and training opportunities are offered for public and private providers throughout the year to provide up-to-date information about vaccine efficacy, safety, and reporting, as well as storage and handling.

2. ABOUT THE TARGETS

The goal is to increase immunization rates to meet the Healthy People 2020 objective of 80% coverage for the 4:3:1:3:3:1:4 series. The rate is calculated for the percent of children immunized with four or more doses of diphtheria, tetanus and pertussis (DTaP); three or more doses of polio; one or more doses of measles, mumps, rubella (MMR); three or more doses of *Haemophilus Influenzae* type b; three or more doses of hepatitis B; one or more doses of varicella, and four or more doses of pneumococcal conjugate vaccine (4:3:1:3:3:1:4).

3. HOW WE ARE DOING

In 2011, the Medicaid baseline rate used for CCO incentive measure calculation was 66.0%; this decreased slightly in 2013 to 65.3%.

4. HOW WE COMPARE

The National Immunization Survey (NIS) involves a telephone survey that samples Oregon residents 19-35 months of age. The national rate for the 4:3:1:3:3:1:4 series in 2011-12 was 68.4% (+/- 1.4%), with 68.4% (+/- 6.8%) for Oregon, 61.7% (+/- 8.4%) for Washington, and 61.4% (+/- 8.0%) for Idaho.

5. FACTORS AFFECTING RESULTS

The Immunization Program oversees the Vaccines for Children (VFC) program, a federally funded entitlement that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. The success of VFC is based upon partnership between the Oregon Immunization Program and public and private providers. Ninety-five percent of Oregon's childhood immunizations are captured in the ALERT IIS, which is used to estimate immunization rates, while also providing a clinical record for providers to accurately assess the vaccine needs of individual children. Other influences include parent and provider knowledge, attitudes, and practices.

6. WHAT NEEDS TO BE DONE

To continue our success, OHA needs to:

- Continue to provide funding, vaccines, and consultation to all local health departments
- Continue to work with other OHA programs to identify referral and assessment opportunities
- Continue to work with internal and external partners to effectively communicate with consumers regarding vaccine safety and the importance of receiving vaccines according to the ACIP-recommended vaccine schedule

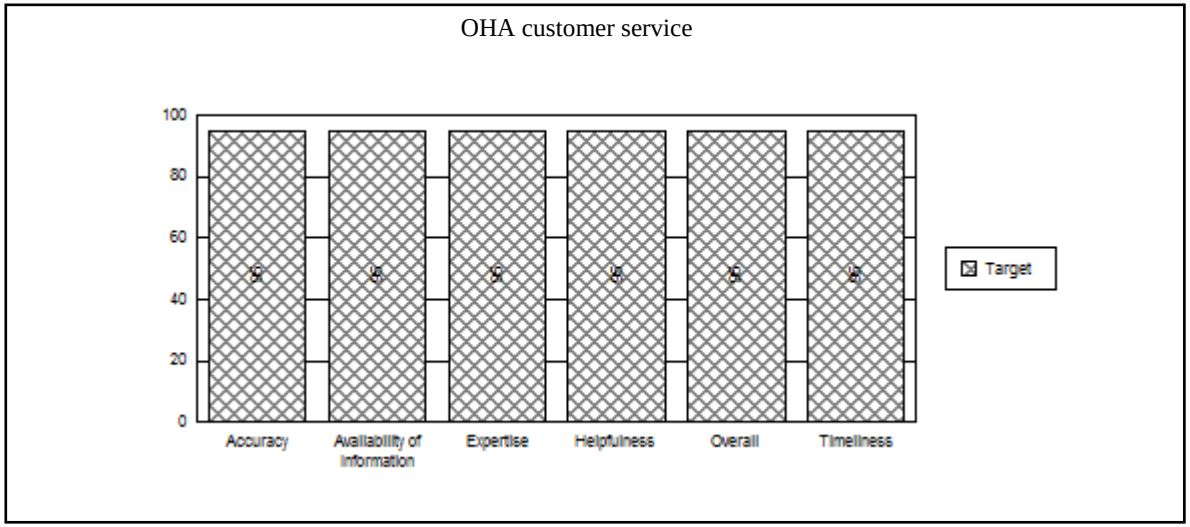
· Continue to work with the Centers for Disease Control and Prevention (CDC), vaccine manufacturers, and providers to assure that appropriate strategies are in place for storage and handling of vaccines, as well as strategies specifically designed to respond to a vaccine shortage

· Support the implementation of SB 132, which requires parents, who are seeking non-medical exemptions from vaccinations, to submit either a provider signature or a certificate verifying that they have received education about the risks associated with not immunizing their child.

7. ABOUT THE DATA

Reporting period – calendar year. This measure presents the two-year old child immunization rate among Medicaid recipients. The immunizations assessed include 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B, 1 Varicella and 4 PCV (4:3:1:3:3:1:4). The source of the immunization data is Medicaid administrative claims data, combined with ALERT IIS, which is a statewide system that records reported immunization data from 100% of public providers and 93% of private providers. Rates are obtained by matching Medicaid enrollees from the MMIS/DSSURS system against information in the ALERT IIS.

KPM #31	CUSTOMER SERVICE (OHA) - Percentage of OHA customers rating their satisfaction with the agency's customer service as "good" or "excellent" overall, timeliness, accuracy, helpfulness, expertise, availability of information.	2006
Goal	OHA Mission: Helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.	
Oregon Context	OHA Mission: Helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.	
Data Source	Surveys - TBD	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

OHA is fundamentally changing the way we do business to provide more effective and efficient services and improve our own accountability. The goal is to build a foundation for continuous improvement so we are always doing our best work by routinely measuring our performance and resolving issues. Our transformation efforts will result in reduced red tape, reduced wait time for clients and improved customer service.

2. ABOUT THE TARGETS

Targets were established from previous customer service results.

3. HOW WE ARE DOING

There is no data available for OHA overall at this time.The Oregon Educator's Benefit Board conducted a survey of members. The results for the time period of October 2-12 - September 2013 are as follows:Timeliness of services provided = 84.5%Ability to provide services correctly the first time = 83.6%Helpfulness of staff = 84.1%Knowledge and expertise of staff = 83.1%Availability of information = 78.7%Overall service = 83.0%

4. HOW WE COMPARE

At this time, we are unable to compare our results to other agencies and organizations.

5. FACTORS AFFECTING RESULTS

As we collect new data, we will have a better understanding of the factors affecting the results.

6. WHAT NEEDS TO BE DONE

As we continue transforming the health systems in Oregon, we need to establish a more thorough and sustainable way to collect feedback from those we serve. We will be putting those pieces in place over the next year.

7. ABOUT THE DATA

Calendar year.

OREGON HEALTH AUTHORITY	III. USING PERFORMANCE DATA
Agency Mission: Helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.	

Contact: Cathy Iles, OHA Director's Office	**Contact Phone:** 503-602-1507
Alternate:	**Alternate Phone:**

The following questions indicate how performance measures and data are used for management and accountability purposes.	
1. INCLUSIVITY	*** Staff :** Staff are involved in the identification and refinement of Key Performance Measures. Feedback is sought to validate the measures. Over the next biennium, staff will become more involved in identifying, tracking and using performance metrics to make improvements to the work we do. These metrics should ultimately link to our KPMs or other high-level measures and inform us of our progress. *** Elected Officials:** Elected officials provide input to the agency KPMs, targets and strategies. *** Stakeholders:** Customer feedback is gathered to help guide strategies for effective service delivery. We continue to work closely with Legislative Fiscal Office and DAS Budget and Management to ensure we are making continuous improvements to our KPMs so they provide useful and relevant information for decision-making and management. *** Citizens:** Community forums related to budget development and priority-setting are a way to identify and validate priorities, expectations and performance areas.
2 MANAGING FOR RESULTS	OHA continues to develop an internal performance management system that will provide a foundation for measuring the effectiveness of the routine work, actively managing breakthrough initiatives, conducting regular check-ins to review results and engage in continuous improvement. As we start to connect the performance management system throughout the organization it creates a line of sight for employees to understand the impact of their work on the mission, vision and goals of the agency.
3 STAFF TRAINING	Management and staff continue to receive training related to continuous improvement and Lean tools. Training in both online and classroom formats is available. The courses are introducing staff to the principles and concepts for thinking about work in terms of systems, processes and continuous improvement. A component of these trainings focus on metrics and how to effectively measure the results of our work. People are becoming more familiar with using data and

	information to inform our strategies and decision-making. Required courses for managers teach about creating a culture of continuous improvement to achieve results to become a high-performing organization. Workshops help prepare managers to assist their work groups to establish and sustain Lean Daily Management elements and practices, and improve their ability to guide work teams to constructively and practically select and use metrics to improve their work.
4 COMMUNICATING RESULTS	*** Staff :** The annual performance report is posted online and used for information sharing. Regular communication to staff reinforces the importance of gathering and using data to inform decision-making and understanding the effectiveness of our programs. *** Elected Officials:** The annual performance report is posted online and included in the agency request document for purposes of sharing performance results, showing accountability, and informing the budget development process. KPMs are presented during the Ways & Means presentations to describe program results. *** Stakeholders:** The annual performance report is posted online and used for information sharing. *** Citizens:** The annual performance report is posted online and used for information sharing.

Program Area	Agency	Project Name	Project Description	Estimated Start Date	Estimated End Date	Project cost to date	ARB Estimated 15-17 Costs	ARB All biennia total project cost	Base or POP	Included in GB (Y/N)	GB Estimated 15-17 Costs	GB Estimated All Biennia Total Project Cost	Comments
Human Services	DHS/OHA	OAAPI-APD	This is a POP to develop a streamlined and integrated statewide adult abuse and report writing system. Phase I planning was approved by the Eboard in March 2014. This POP assumes the planning is completed and the Phase II development is ready to proceed based on the Phase 1 business case and solicitation documents. It is also planned to keep close connection between programs, OIS, DAS, and LFO on the gate review processes and progress of this project. The need for a stable, integrated Abuse Data and Report Writing system is critical as Oregon faces an aging population, an annual increase of 5-8% in abuse referrals, and an increased need for services across all demographics. Given the nature of the services provided to vulnerable Oregonians by OAAPI and its partners, we cannot afford to place our trust in a disconnected assortment of legacy data systems that do not give us the information we need to protect victims of abuse effectively and develop prevention efforts proactively. Currently all funding is assumed as GF but DHS is pursuing other avenues of Federal Funds that may or may not become available. Assumes $2 million of Q-bond available.	May-14	Jun-17	$ -	$3,437,494	$ 3,437,494	POP	Y	$ 3,437,494	$ 3,437,494	$500,000 allocated at May 2014 E-Board for planning
Human Services	DHS/OHA	REaL-D	This POP supports architecting and implementing a master client data collection solution to address the needs of the current and future client data collection requirements for unified data collection to address health and service equity for all programs and activities within DHS. DHS and OHA have developed policies for collecting, analyzing, and reporting meaningful race, ethnicity and language and disability data across DHS and OHA which was built on the foundation of the U.S. Office of Management and Budget's (OMB) Directive 15 (revised 1997) and adds key elements that will improve the quality of the data gathered. This POP addresses both the business and technical changes required to create a unified, sustainable model for collecting client data across both agencies. Assumes 1 million in Q-bond availability. Phase I planning is being done during the 2013-15 biennium.	Aug-14	TBD	$ -	$3,514,796	$ 5,000,000	POP	Y	$ 1,743,644	$ 1,743,644	
Human Services	DHS/OHA	Collective Bargaining and Federal Rule Change Placeholder DOL Provider Time Capture	This is a placeholder for the system modifications that may be required to support the outcome of the 2015-2017 Collective Bargaining Agreements and any decision coming out of the session to account for Federal Department Of Labor rule changes in I/DD, APD and AMH.	TBD	TBD	TBD	TBD	TBD	N/A	Y	TBD	TBD	$96,153,846 is included in GB to cover increased program costs as well as the cost of any needed system modifications.

Program Area	Agency	Project Name	Project Description	Estimated Start Date	Estimated End Date	Project cost to date	ARB Estimated 15-17 Costs	ARB All biennia total project cost	Base or POP	Included in GB (Y/N)	GB Estimated 15-17 Costs	GB Estimated All Biennia Total Project Cost	Comments
Human Services	DHS/OHA	MMIS: ICD - 10	ICD -10 is an enhancement to the MMIS system interfaces based on two final rules published by the Federal Department of Health and Human Services under the Administrative Simplification provision of HIPAA. It will modify MMIS to meet HIPAA requirements for updated medical code set standards; from ICD-9x to ICD-10-CM, & ICD-10-PCS	Jun-13	Oct-15	$ 1,124,738	$4,487,452	$ 8,920,449	Base				
Human Services	DHS/OHA	WIC EBT (TWIST EBT, eWIC)	The WIC EBT project will establish an Electronic Benefit Transaction system that is similar to the EBT system used currently for SNAP benefits.	Dec-11	Feb-16	$ 2,732,258	$2,630,014	$ 7,572,533	Base				
Human Services	DHS/OHA	HIV-CAT (CAREAssist)	The HIV care and Treatment Program provides high quality. Cost effective services that promote access to and ongoing success in treatment for people with HIV/AIDS in Oregon. The Card Assist 2.0 project will replace the existing Care Assist application and other related legacy solutions with a new web application in an effort to improve workflow, increase productivity, and address issues with current legacy system.	TBD	TBD	$ -	$2,250,000	$ 2,250,000	Base				
Human Services	DHS/OHA	OHIT 1.5	OHIT Phase 1.5 includes 3 projects with technology components. The name and description of each are: Provider Directory; Establishing provider information repository services including a statewide provider directory, affiliating providers to their practice locations and identifying their health information exchange "addresses". This supports exchange of health information, analytics needed for quality improvement efforts and population management. Common Credentialing: Meets requirements under SB604 including the ability to streamline credentialing, establish a single entry point for providers and payers, and keep date in the provider directory current. Clinical quality metrics: Establishes a registry to capture provider's clinical metrics from their electronic health records, including the 3 clinical CCO quality pool metrics (diabetes poor control, hypertension, depression screening)	Aug-14	Jan-16	$ -	$29,329,201	$ 29,329,201	POP/Base				This figure is the two year estimated cost for FFY15 and FFY16, where FFY15 is the approximate period for development and implementation and FFY16 is the approximate first full year of operation (at the time estimates were developed). The estimate included vendor contracts for Provider Directory, the CQMR Registry, Common Credentialing, and the Systems Integrator - $26,365,263; and internal staffing costs across these projects - $1,451,375 for a total of $27,816,638. The QA vendor estimate is $712,563 and the technology consultant is estimated to be $800,000, which brings a total to $29,329,201. This includes POP, Base budget, and Transformation dollars combined.

Program Area	Agency	Project Name	Project Description	Estimated Start Date	Estimated End Date	Project cost to date	ARB Estimated 15-17 Costs	ARB All biennia total project cost	Base or POP	Included in GB (Y/N)	GB Estimated 15-17 Costs	GB Estimated All Biennia Total Project Cost	Comments
Human Services	DHS/OHA	MMIS Hardware Refresh	Modernize the MMIS infrastructure and sized for client usage plans and future growth. These updates will continue the viability of maintenance contracts and uphold SLAs relating to potential outages caused by end-f-life hardware. The current MMIS infrastructure has many components that were part of the original implementation and are past end-of-life. The expansion of Medicaid eligibility has increased the number of clients far beyond what the system was originally expected to handle. The future number of clients over the next five years is estimated based on forecasting and is expected to continue growth. The current Hewlett Packard Enterprise Services (HPES) contract 113737 for the replacement Medicaid Management Information System (MMIS) is set to be extended to February 28, 2017 for the balance of the three, one year extensions.	Oct-14	Oct-16	$ -	$8,000,000	$ 12,000,000	Base				
Human Services	DHS/OHA	MAGI Medicaid Transition Project & MAGI Medicaid System Transfer Project	A technology transition project approved by the Centers for Medicare and Medicaid Services (CMS) through the Spring and Summer of 2014 will move the eligibility and enrollment technology from Cover Oregon to the federally facilitated marketplace (FFM) and move the MAGI Medicaid eligibility back to OHA with a new system. With the beginning of open enrollment in November of 2014, Cover Oregon's technology transition to the FFM was completed. The MAGI Medicaid System Transfer project will be a separate project that will transfer an existing ACA-compliant MAGI Medicaid eligibility and enrollment system from another state. Deloitte Consulting as the single system integrator will be responsible for completing the system transfer work. Additionally, there are a number of technology services that are being developed to make the Kentucky system work in Oregon (Identity & Access Management, Document Management, FFM Account Transfer & Minimum Essential Coverage Check, as well as key interfaces with MMIS and a state wage data source for income verification)	11/17/2014	ll	$ 61,242,756	TBD	$ 61,242,756	POP				In July 2014, all remaining federal funds approved through Advanced Planning Documents (APD) to DHS and OHA were repurposed to fund the IT work necessary for OHA to transition eligibility and enrollment. At the time the Governor's Budget was finalized OHA was coordinating with CMS to outline Federal participation in costs of the MAGI Medicaid System Transfer Project for Federal Fiscal year 2014 and 2015.

Program Area	Agency	Project Name	Project Description	Estimated Start Date	Estimated End Date	Project cost to date	ARB Estimated 15-17 Costs	ARB All biennia total project cost	Base or POP	Included in GB (Y/N)	GB Estimated 15-17 Costs	GB Estimated All Biennia Total Project Cost	Comments
Human Services	DHS/OHA	Non-MAGI Eligibility Automation project,	Department of Human Services (DHS) seeks $7.5MTF ($6.75MFF, $0.75MGF) to implement a planning effort to prepare for the implementation of an eligibility system for its non-MAGI (Modified Adjusted Gross Income) Medicaid programs. DHS is committed to completing thorough planning to provide a framework for phased delivery of functionality that demonstrates meaningful progress in short increments of time. The recent decision by the Center for Medicaid and Medicare Services (CMS) to extend 90/10 funding for Medicaid eligibility systems provides substantial resources to help the Department of Human Services proceed with this planning work. A recent CMS site visit provided Oregon with an understanding of CMS' expectation that it proceed with automation of the eligibility and case management for the non-MAGI Medicaid population as soon as possible after successful completion of the MAGI Medicaid Transition Project.	1-Jun-15	30-Jun-17	$ -	$7,500,000	$ 7,500,000	POP	Y	$ 7,500,000	$ 7,500,000	This replaced "modernization" in the DHS budget as a project. In initial conversations, DHS, working with the Office of Information Services, believes that a transfer system solution serves as the likely best alternative to minimize risk and increase likelihood of successful completion. For transfer systems to be successful, it is important to pick a state that most closely models Oregon's non-MAGI programs in order to minimize the amount of customization that must be made to support DHS's business needs. Because Oregon has been on the leading edge of policy waivers in this area, it is unlikely that any transfer system will be a perfect match. However, it is the desire of DHS to choose a system that has a majority match for functionality, and then to increment the delivery of additional functionality in small phased implementations.

Oregon Health Authority
AUDIT RESPONSE REPORT

1. OHA: Improve Controls over Child Enrollment Reporting and Advertising Expenditures, audit # 2011-19 (dated September 2011)

   - We recommend OHA management develop a consistent process to compile and review the bonus award enrollment figures for future submissions. We also recommend OHA management work with the Federal government to adjust the bonus award amount.

   To qualify for a CHIPRA performance bonus payment, a state must apply to the federal government and demonstrate it meets two criteria, defined in CHIPRA law:
   - *It implemented specific program features that are known to promote enrollment and retention of children in medical coverage; and*
   - *Its enrollment of children in Medicaid increased above the CHIPRA enrollment target.*

   If a state meets both criteria, the state qualifies for a bonus award based on the number of children exceeding the target. As mentioned in the report, for federal fiscal year 2009 (the first year states could qualify for CHIPRA bonuses) OHA applied for and received a CHIPRA bonus for $1.6 million. The federal government awarded only eight other states CHIPRA bonuses for 2009. For federal fiscal year 2010, OHA applied for and received a CHIPRA bonus for $15 million. The federal government awarded only 14 other states CHIPRA bonuses for 2010. As identified in the audit, OHA over reported its 2010 enrollment count by approximately 7,400 non-citizen children. As a result, the federal government awarded OHA approximately $4.5 million more than it should have received. OHA still qualifies for a bonus of more than $10 million.

   OHA took a number of steps to correct the 2010 bonus award. OHA contacted the federal government about the enrollment reporting error. OHA stopped drawing bonus money from the federal account, leaving

approximately $5 million unspent from which the federal government will adjust the original grant award. OHA corrected, tested, and documented the data query used for CHIPRA enrollment reporting. OHA also submitted to the federal government a revised enrollment count for 2010.

Based on the revised enrollment count, the federal government recalculated Oregon's 2010 bonus award. Based on this recalculation, the federal government decreased OHA's unspent award by $4,488,017 on August 1, 2011.

Moving forward, OHA management will review in detail the data query criteria and data query results with Information Services staff and staff responsible for caseload monitoring before each year's submission of its Medicaid enrollment of qualifying children. OHA will also compare the data query criteria and results with the prior year's data pull to identify any issues.

OHA will utilize the improved process to pull and review the enrollment data for federal fiscal year 2011 in early October to be submitted before the federal deadline of November 1, 2011.

OHA followed the action plan as provided above. OHA management met and reviewed the details of the data query criteria and data query results with staff responsible for pulling the data. The query information was compared to the federal policies and guidance to ensure compliance. The query results were verified to not include non-citizen children who are required to be excluded from the enrollment count. The query results were also compared with the prior year's data pull. No issues were identified. OHA submitted the enrollment count to the federal government on October 31, 2011. The Office of Forecasting, Research and Analysis retains documentation of the data query criteria and query results.

OHA established a documented procedure to finalize the state's enrollment figures for CHIPRA Performance Bonus submissions. For each year's submission, OHA management reviews and follows the procedure to ensure: 1) Staff use the correct computer query and criteria for pulling the enrollment data; 2)

The query results are compared to the previous year's results to identify any potential issues; and 3) the information is reviewed with OHA management for final approval.

- To strengthen its controls over the Healthy Kids advertising expenditures, OHA and Healthy Kids management should:
  - ensure purchase orders and contracts are in place as appropriate, and are properly executed;
  - implement an effective payment tracking process to reduce the risk of overpayment;
  - ensure timely delegation of signature authority;
  - obtain and retain proof of performance documentation that clearly supports the services provided;
  - correct the recording errors identified during the audit; and
  - determine and resolve the effect of the incorrect reimbursement rate resulting from the miscoded transactions.

Oregon Healthy Kids is a tremendously important program for families across the state. The new Oregon Health Authority, Office of Healthy Kids was created in August 2009, and since then has enrolled about 94,000 more children into the health coverage they need. As a result, Oregon cut its child uninsurance rate in half during this time, a significant achievement. We appreciate the efforts of the Oregon Audits Division to help us make this highly successful program even stronger.

Healthy Kids instituted a tighter tracking and filing system for:

- *purchase orders, invoices and contracts that will help make sure that all required documentation is obtained and saved; and*
- *advertising purchases will explicitly require proof of purchase in all advertising contracts.*

Although Healthy Kids staff did catch the duplicate payment found by the audit prior to the start of the audit and received a credit for the remaining $541 outstanding costs, we are in agreement that more systemized tracking methods could further reduce the possibility of any future over or duplicate payments.

Office of Healthy Kids staff met with staff from other programs within the Department of Human Services to review their invoice tracking tools and will require all invoices be checked against purchase orders and payments before being submitted for payment.

While Healthy Kids no longer purchases advertising services, Healthy Kids instituted a tighter tracking and filing system for purchase orders, invoices and contracts to help make sure that all required documentation was obtained and saved. In addition, Healthy Kids instituted a tighter tracking and filing system for advertising purchases and explicitly required proof of purchase in all advertising contracts. Healthy Kids staff continues to use these tighter manual paper processes for tracking other contracts as a safeguard.

While Healthy Kids advertising has been fully concluded, extensive tracking of other expenditures (i.e. grant expenditures) has been established within the outreach division, in collaboration with OHA budget and the Office of Financial Services.

DHS and the Oregon Health Authority (OHA) have updated their delegated authority policy, procedures and form, and implemented a new delegated system that provides better tracking and reporting of delegations. In addition, the agency completed a full roll-out of the new delegation form for all staff with expenditure authority. The Office of Financial Services has established a database where authority for all individuals can be viewed. Healthy Kids staff are fully aware of signature authority requirements and ensure on an ongoing basis that all program elements of the delegation of authority process are being duly observed.

Signature authority delegation has also become a part of the onboarding process for relevant staff within the Office of Client and Community Services outreach division, where Health Kids outreach was also managed.

Further, the three coding errors identified during the audit have been corrected and the appropriate reimbursement rate recorded.

2. DHS and OHA: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2011, audit # 2012- 08, (dated March 2012)

   - We recommend department management verify that the initial upload of pharmacy rates in MMIS are complete and accurate.

   OHA changed our reimbursement methodology for all enrolled pharmacy providers that serve recipients of Medical Assistance Programs (MAP) from a "lesser of" methodology that reimbursed either a percentage discount off of the Average Wholesale Price (AWP); the Federal Upper Limit (FUL) or the pharmacy's Usual and Customary (U&C) to a "lesser of" methodology based on the Actual Acquisition Cost (AAC) of individual drugs paid by pharmacies to wholesalers or the Wholesale Acquisition Cost (WAC) when an AAC has not been determined; the FUL or U&C. This "lesser of" methodology ensures that pharmacy rates in the MMIS are complete.

   As an early adopter of a more transparent methodology, Oregon Medicaid hired a contractor in 2010 to perform data collection and rate setting functions for our more than 700 enrolled pharmacy providers, to implement the new AAC methodology which became effect on January 1, 2011, with the initial upload to the MMIS.

   We agree to review the initial upload of pharmacy rates into the MMIS to ensure completeness and accuracy. Staff now review reports generated from the MMIS after each weekly rate load that identify both changes in rates for individual drugs and an error report that identifies whether the load was stopped or unsuccessful in any way.

   OHA staff also compares the system generated reports against a weekly report from our rate setting contractor that identifies changes in rates for individual drugs from week to week including those for the initial load. This review allows us to verify that rates have been loaded into the MMIS correctly and resolve

any issue or anomalies in the event a rate is loaded incorrectly and to monitor drugs with significant changes in cost from week to week.

The contractor Oregon Medicaid hired to establish the AAC rates is also responsible for addressing pharmacy disputes when reimbursement is below their respective acquisition cost which further serves as a safeguard to ensure accuracy.

Reports are sent by the contractor on Mondays and are verified with loaded rates in MMIS on Wednesdays. Reports are verified and then scanned.

- We recommend department management develop procedures to ensure that balance transfers pertaining to prior fiscal years are properly recorded and do not misstate current year fund balances.

In January 2010 Medicaid and CHIP Federal rules changed related to client citizenship documentation requirements. This change allowed the Department to reclassify expenditures from GAAP General Fund to GAAP Health & Social Services Fund for current and prior fiscal years.

These types of adjustments are often large and require complex analysis to determine the appropriate accounting in current and prior periods.

On June 27, 2013, the State Financial Reporting unit sent a year end task list to all Shared Services staff that included a training section on prior period adjustments. Additional prior period adjustment training was sent on June 10, 2013 to all staff in the Office of Financial Services newsletter that included a training section on prior period adjustments. The State Financial Reporting unit provided prior period adjustment training on March 19, 2013 during a Receipting Unit continuous improvement meeting. The Grant Accounting manager now requires staff to submit balance transfer documents that affect prior periods to State Financial Reporting unit for prior period adjustment consideration.

- We recommend department management strengthen controls to ensure documentation is maintained in the case files sufficient to demonstrate compliance with federal requirements.

One of the missing applications was for an Adoption Assistance case that began in 2002. Due to prior audit findings for Title IV-E in late 2009, the department instituted a process where the Adoptions Assistance Unit reviews the applications to ensure all documentation which supports the eligibility determination (Title XIX or Title IV-E) is attached. Although this process was not administered retroactively, due to the volume of cases and the lack of resources, cases moving forward should have appropriate documentation. The eligibility for this case was retroactively reviewed and found Title IV-E eligible, thus categorically eligible for Medicaid.

The second missing application was used to apply for Self-Sufficiency program benefits. The application was initially processed by a case worker who determined Supplemental Nutrition Assistance Program (SNAP) eligibility. The same application was used, by a different case worker, to determine Medicaid eligibility, however the application did not get returned to be filed in the case record. The case record was subsequently transferred to a different branch office, and the application could not be located. It has since been located. The DHS Family Services Manual provides procedures and outlines the steps for transferring case files between branch offices. In addition, DHS Imaging and Records Management Services (IRMS) provides services including imaging of documents and "open archiving" of case records to reduce the volume of applications and case file documents retained in branch offices. DHS sent staff an Informational Transmittal reminding staff of the case file transferring procedures and providing a link to IRMS services information. In addition, DHS published an article in the "On-Target" newsletter for Self-Sufficiency staff about ensuring case files are complete prior to transferring to a different case worker or branch. DHS also added information to the Family Services Manual and Business Procedures manual regarding case file transfer processes internally within a branch. DHS will also research the questioned costs for the Adoption Assistance case and reimburse the Centers for Medicare and Medicaid Services (CMS) the appropriate federal funds. The department hopes to complete this adjustment by June 30, 2012.

DHS will review the case with undocumented income verification and reimburse CMS any federal funds as appropriate based on this review. The department will also address documentation requirements at the next Area Agencies on Aging (AAA) / Seniors and People with Disabilities (SPD) Field Managers meeting and in the newsletter to field staff by June 30, 2012.

To reduce barriers to access and eligibility, the OHA Medical Programs (formerly DHS Medical Programs) have implemented policies that allow a medical program eligibility determination using a previously submitted application, whether or not the prior application was for medical benefits. During this time (the period under review), it was the caseworker's responsibility to remember and obtain any additional information, such as private health insurance, needed to determine medical program eligibility.

The department continues to proactively strengthen controls over the eligibility determination process. Within the past 17 months, updates have been made to the Legacy computer systems to revise a field in the Client Maintenance (CM) system. This is now a mandatory field, requiring data entry by the case worker when setting up the medical case. The purpose of this field is to identify whether or not an individual has third-party insurance. Training for this systems' change, along with other medical policy changes, was delivered statewide to field staff beginning in the fall of 2010. In addition, the training material is posted on the Self-Sufficiency Program, Medical Program Staff Tools website.

Medical program eligibility worker training includes guidance on how to process eligibility decisions. In addition, instruction is given to participants on how to "interview" to ask questions to ascertain eligibility information not captured on the current application in the case file, including whether or not individuals have private health insurance. The new data field and purpose is also explained in detail during the trainings.

DHS also researched the questioned costs for both of the cases missing the private health care information and determined no reimbursement to CMS was necessary.

DHS reviewed the case with the private dental insurance and found that no reimbursement of CMS was required. The department also addressed reviewing applications for insurance policy disclosure and the requirement to send the information to HIG in a newsletter to field staff and addressed these issues at an AAA/APD Field Managers meeting in September 2012. All actions on this recommendation were completed in August 2013.

- We recommend department management implement controls to ensure correct rates are used when calculating the Medicare Part B buy-ins and reimburse the federal agency for the overdrawn ARRA funds.

In April 2011, the ARRA enhanced FMAP rate was reduced. The Medicare Part B buy-in calculations are performed in an excel spreadsheet. In April, the department inadvertently retained the prior quarter's FMAP rate resulting in an over-draw of the ARRA funds. We have since added a box to the excel spreadsheet used in calculating the buy-in and have it highlighted as a reminder to verify the rate being used prior to draw. We have refunded the overdrawn funds to CMS.

The FMAP is now reviewed prior to the draw to ensure an accurate rate. Also, instead of the rate being included in the formula and updating the formula, a box was created to enter the rate and the formula is based on that box.

- We recommend department management ensure the review for suspension and debarment is documented in accordance with department policy.

The Office of Contracts and Procurement (OC&P) reviewed the internal procedure, "Federal Debarment and Suspension Confirmation" and the "OC&P File Checklist" to ensure they comply with the federal debarment requirements. The procedure is in compliance with these requirements. The importance of checking debarment was discussed at the OC&P Unit meeting February 22, 2012. An individual conference was held with staff that had a file without debarment documentation to discuss and document the issue.

OC&P management staff enhanced the training regarding debarment for new OC&P staff. Debarment is listed on the OC&P File Checklist, included in the Contract Processing Standards and a link is included on the OC&P intranet site.

- We recommend department management ensure adequate review of the various calculations of the cost pool statistics is performed.

The Office of Financial Services implemented a new cost allocation model in July 2011. The manual intervention of the remaining spreadsheet is to be eliminated by September 2012. The current model in use has eliminated the possibility of this human error happening again.

The implementation of the portal for the "grant-phase look-up" (the last major excel spreadsheet) was implemented February 1, 2013. The cost allocation system no longer relies on any spreadsheet maintenance and is updated by a user interface.

3. DHS and OHA: Strategies to Better Address Federal Level of Effort Requirements, audit # 2012- 11, (dated April To maximize state resources, allocate General Funds strategically, and ensure continued compliance with Level of Effort requirements, we recommend management from Oregon agencies subject to federal Level of Effort requirements:

   - encourage program staff to work with their federal agency contact to understand possible financial sources available to meet Level of Effort requirements, including funds outside of those directly budgeted for that program;
   - work with the Legislative Fiscal Office to make information available to Oregon Legislative members explaining Level of Effort requirements and consequences for lack of compliance;

- conduct regular communications among program, financial, and budget staff within each agency to discuss Level of Effort compliance and cross-program expenditure possibilities; and
- strengthen certification procedures across programs to allow more cross-program expenditures while ensuring compliance with federal mandates.

While OHA and DHS generally agree that the recommendations are reasonable expectations, we are concerned that the report contains no specific analysis explaining if the additional efforts it recommends will generate benefits in excess of their anticipated additional costs. It is also unclear to OHA and DHS management how these recommendations should be prioritized amongst the other activities available to the agencies to improve efficiency and effectiveness. With that said, we do see opportunities to make improvements to our communication and coordination processes within the two agencies and with our other state and federal partners.

As can be seen in the report, Level of Effort is a very complex subject due to all the different grants and specific rules each grant requires. As such it can be difficult to apply general statements and recommendation regarding Level of Effort (LOE) requirements to all of the grants listed in the audit. For some of the grants administered by OHA and DHS, some of the specific details of the above recommendation do not apply. For the Medicaid and the Children's Health Insurance Program, the LOE requirements are eligibility based and not expenditure level based. Another grant, the Senior Community Services Employment Program, only requires that placement of an enrollee not supplant normally budgeted positions or contract work at the host agency. There are also grants, such as the Block Grants for the Prevention and Treatment of Substance Abuse, that have historically only allowed expenditures from the recipient agency in determining compliance with the LOE requirement.

OHA and DHS agree that Oregon agency management (including program, fiscal and budget staff) need to understand their grant requirements. We also agree, and do, actively work with the Legislative Fiscal Office (LFO), and the Department of Administrative Services, Chief Financial Office (CFO) to communicate, maintain and ensure compliance with these grant requirements. While we also feel for many of the grants

administered by OHA and DHS, we are currently engaged in these discussions at the level necessary, there may be some efforts that could be improved.

Both agencies will review our current communication and coordination efforts related to the individual grants identified in the report to determine if improvements are needed. This will include consideration of a more formalized internal and external meeting structure to discuss ongoing LOE issues and possible changes in other agency programs that may impact LOE (both opportunities and challenges when programs are reduced).

DHS and OHA are consistently looking for ways to increase MOE in some grants and ensure the legislature is aware of impacts to MOE on others. DHS and OHA strive to understand all grant Matching and MOE requirements and look for innovative ways to maximize both.

Management of LOE and Maintenance of Effort (MOE) is an ongoing focus within the agencies as part of successfully managing our federal grants. As MOE and Matching requirements do change with new grants this is never truly complete. In addition, staff turnover requires "white" papers and other trainings, including self-directed training, on LOE requirements in both DHS and OHA. In addition, at times other agency grants are needed to be researched. This is an ongoing part of what DHS and OHA do to manage grants.

For some grants, such as TANF, we spend significant time analyzing funding opportunities and have put in place a "certification process" as a way to both have routine communications with partner agencies and document other agency LOE related expenditures. We continue to partner with non-traditional MOE programs such as the food banks to explore possible additional opportunities. We also agree there may be additional funding opportunities available and will work with CFO and LFO as necessary to resolve cross-agency issues as they arise.
In fiscal year 2013, OHA leveraged an additional $230 million in federal funds as part of the five year Medicaid waiver with Center for Medicare and Medicaid Services (CMS) known as DSHP (Designated State

Health Programs.) Investments by CMS in DSHP are a strong partnership between OHA and the federal government deemed necessary to implement the health system transformation.

We will continue to review our programs to determine if there is funding that is in excess of current grant requirements that could help other programs or grants meet their LOE needs. We will continue to work with LFO and CFO to help facilitate the communication of new opportunities as they arise, keeping in mind sufficient analysis is always necessary prior to using any new LOE source to meet specific grant expenditure level requirements.

Both agencies recently made changes to internal grant application processes which enhanced the communication between program and fiscal staff prior to the grant applications being submitted. Both agencies have also continued to actively work with the LFO, and DAS-CFO to communicate, maintain and ensure compliance with these grant requirements. This includes recent detailed history and estimates for the Governor's Budget Process to allow BAM to account for MOE issues as much as possible in the 2013-15 budget process. The agencies have communicated to LFO and CFO any LOE/MOE requirements that are directly tied to all reduction options that might be considered to meet statewide revenue shortfalls. In addition, the agencies continue to work with other internal programs, agencies or private entities to maximize MOE.

4. OHA: Children's Mental Health: Ensuring Access and Sustaining Services, audit # 2012- 16, (dated May 2012)

    - We recommend the Division, in its administration of mental health services, develop better information on service utilization by population. These efforts could include:
    - developing and reporting comparative data to monitor service utilization by population, including Hispanic children, girls aged 2-13, and younger children;
    - reviewing and comparing strategies that address utilization differences;

- developing targets that assist in addressing differences between populations; and
- Identifying and disseminating best practices for increasing the use of mental health assessments for younger aged children.

In our current and ongoing work, we address these issues in a variety of ways.

- *AMH collaborates with the Department of Human Services Child Welfare on issues affecting both systems, including measures to increase the assessments for children in foster care within 60 days of placement in out-of-home care, the appropriate use of psychotropic medications and the Statewide Children's Wraparound Initiative.*
- *Through the Community Mental Health Block Grant, AMH reports to the Substance Abuse and Mental Health Services Administration (SAMHSA) on a number of National Outcome Measures. One of these measures is to maintain or increase the proportion of children from Native American, Hispanic, African American, or Asian ethnic backgrounds receiving publicly funded mental health services, so that the proportion of the population receiving services will match or exceed the proportion of the State's children within the same ethnic population.*
- *AMH staff developed a collaborative training with the Mental Health Organization (MHO) children's systems coordinators focusing on assessment and evidence based treatment of young children birth through 5 years using Child Parent Psychotherapy.*
- *AMH participates in the Coalition of Advocates for Equal Access for Girls. The mission and activities of the coalition aims to ensure that girls receive equal access to all of the appropriate gender specific support and services they need to develop to their full potential. Coalition membership includes representatives from AMH, other state agencies, and private non-profit organizations. This coalition also has legislative support.*

AMH will continue disseminating Parent Child Interaction Therapy (PCIT), the evidence-based practice for young children 2-7 years old with disruptive behavior disorders with a focus on serving children from Hispanic families in proportion to their presence in the county population.

Enrollment and encounter data from Oregon's Medicaid Management Information System (MMIS) were compiled and analyzed to determine statewide and regional utilization of mental health services overall and within the populations specified in the audit report. These utilization rates were compared with target ranges based on national studies of the prevalence of mental health needs among similar child subpopulations.

The Addictions and Mental Health (AMH) Children's Team and Office of Health Analytics are transitioning the progress reporting metrics to a new interactive dashboard format. Reporting on comparative data as requested has been slower than expected during the development of the AMH Dashboard, but will improve the ability to track metrics when fully implemented. On October 23rd, 2014 OHA released the first CCO Metrics Dashboard. This replaces the prior progress reports and provides enhanced functionality, including the ability to filter measures by population subgroups. The tool also allows users such as Coordinated Care Organizations (CCOs) and Mental Health Organizations (MHOs) to drill down to actionable member-level data within the same file and allows the ability to filter key measures by population characteristics such as age, race, ethnicity, zip code and eligibility category.

During the baseline study period of calendar years 2009, 2010 and 2011, quarterly utilization of mental health services averaged 5.3% of all children age 0-17 enrolled in Medicaid services in Oregon. The quarterly rates ranged between 4.8-5.8% in a seasonal cycle with higher utilization in winter and spring and lower rates in summer and fall.

The most recent update of the AMH Dashboard covers the five calendar quarters from April 1, 2013 to June 30, 2014. During this time the average quarterly percentage of OHP-eligible children in Oregon who received mental health services was 7.1%, ranging from 6.8% to 7.5% by quarter. In the second quarter of 2014 7.0% were served, compared to 7.5% in the second quarter of 2013.

The three populations identified in the Audit report followed similar patterns, but with lower percentages served.

- *Among younger girls the percent served remains at about 1.5 percentage points below the rates among all children. The average percent served over the five quarters is 5.6%, ranging from 5.3% to 6.1%. These rates fall well within the target range of 2.1-8.9% established by the workgroup convened by AMH (see Recommendation #3).*
- *Compared to all OHP-eligible children, children of Hispanic or Latino ethnicity were much less likely to receive mental health services, averaging 3.9% served over five quarters, compared to 7.1% overall. This is the only group whose percent served was higher in the second quarter of 2014 than in the same quarter in 2013. However, the rates hovered at or just below the target range of 4.1-9.0%.*

Although the percent served among young children (0-6 years) trailed the other groups, they were within the target range of 2.0-5.3% for this group. The five-quarter average was 2.8%, with a steady decline from 3.1% in the second quarter of 2013 to 2.7% in the same quarter of 2014.

To adequately address the difference in service utilization, understanding why those rates exist is critical. Several factors contribute to under-reporting of mental health needs and under-utilization of mental health services among various populations.

The comparatively small proportion of young children served may reflect the fact that mental health problems are conceptualized by the treatment community as social emotional delays to be addressed by child development early intervention services until age 3 or older. Children who suffer from emotional and behavioral disorders whose behaviors are disruptive are far more likely to be referred to treatment services than individuals who internalize their emotional and behavioral disorders. Research indicates gender differences in stress responses. Females, as group, tend to have more internalizing behavior and males tend to demonstrate more externalizing behavior even at very young ages. This may explain in part why fewer young and latency aged girls' access mental health services. Additionally, the perception of mental health services as stigmatizing by Latino families is more prevalent than it is with Caucasian families. Latinos are

twice as likely to seek treatment for mental disorders in general health care settings as opposed to mental health specialty settings. This suggests that a culturally sensitive way for AMH to approach mental health services for Latino children and families would be to ensure that primary health care providers are equipped to provide appropriate services and referrals, including closer collaboration between mental health and primary care practitioners serving Latino families.

AMH has added services to young children birth to five years to our Strategic Plan. The following actions items are currently being implemented:

Young Children and Latino Outreach and Service

- *AMH has funded the training and development of 12 new sites, in addition to the existing four sites, to provide Parent Child Interaction Therapy (PCIT), an evidence-based practice therapy for young children 2-7 years of age with disruptive behavior disorders, and young children who have experienced abuse and neglect. All of the new PCIT sites have bi-lingual/bi-cultural staff and are required as part of their AMH funding to provide outreach to the community.*
- *AMH and the Early Learning hubs are collaborating to ensure early screening and assessment to identify younger children in need of mental health services and to increase referral for younger children to appropriate services.*
- *In an effort to address gaps in mental health workforce regarding early childhood, AMH is collaborating with Portland State University (PSU) to provide scholarships for the PSU Infant Toddler Mental Health Graduate Certificate Program.*

Girls and Latinos

- *Integration between primary care settings and behavioral health will increase access for populations who are unlikely to self refer to specialty behavioral health, including the Hispanic population and girls.*
- *AMH has contracted with the Oregon Pediatric Society to provide adolescent depression screening training for primary care practitioners for all children, ages 12 to 24 during well-care appointments*

and linking those primary care practitioners to local mental health resources when mental health services are required.

- *AMH and Public Health increased the availability of mental health clinicians in School Based Health Centers. Sixteen counties received notification of awards in December of 2013. The School-Based Health Center Mental Health Expansion Grants were awarded to 16 counties to support mental health capacity within the school-based health center system by:*
- *Adding mental health staff and expanding current mental health staff hours, with the ability to collect and report mental health encounter visits; and /or*
- *Supporting mental health projects within the school-based health center system, including:*
  - *Implementation of a mental health screening tool or framework*
  - *Implementation of a mental health telehealth project*
  - *Implementation of a Youth Advisory Committee (YAC) and mental health research project*
  - *Integration of a data capturing system*
  - *Support equity and cultural competency*
- *Many of the SBHCs serve elementary, middle and high schools. Ten of the SBHC clinics will work with the Oregon Pediatric Society to implement the adolescent depression screening as a piloted effort to improve referral. This will increase mental health identification for under-represented populations.*

AMH contracted with OHSU to implement OPAL-K a psychiatric access line. OPAL-K provides free, same-day child psychiatric phone consultation to primary care clinicians in Oregon. OPAL-K is collaboration between OHSU's Division of Child and Adolescent Psychiatry, the Oregon Pediatric Society (OPS) and the Oregon Council of Child and Adolescent Psychiatry (OCCAP).
The program expands the availability of high-quality mental health treatment to Oregon youth via timely psychiatric consultation, clinician education, primary care treatment processes and connections with mental health professionals throughout the state. Many children and adolescents in Oregon with mental health issues remain untreated or experience significant delays before beginning treatment. OPAL-K provides the support that primary care clinicians (PCCs) need to care for more patients in their medical home. With OPAL-K, PCCs can treat youth with mental health issues right away rather than placing patients on waiting

lists to receive care. The program also offers evidence-based support to clinicians in need of psychiatric treatment information. OPAL-K can help reduce long delays for diagnosis and initial treatment. Earlier intervention may decrease complications of untreated mental disorders including hospitalizations and suicides. Overall OPAL-K helps build a system that allows PCCs to deliver the best possible care.

Additionally
AMH has implemented Measures and Outcome Tracking System (MOTS) which allows for increased client detail tracking. It requires providers to include non-Medicaid client service data.

A work group with participants from AMH, the Office of Equity and Inclusion, Portland State University, and other agencies conducted a review of research on the prevalence of mental health needs within each of the identified populations. The group identified statewide utilization target ranges, based on synthesis of findings from these studies. They are:

Children age 0-6:	*between 2.0% and 5.3%*
Girls age 2-13:	*between 2.1% and 8.9%*
Hispanic children:	*between 4.1% and 9.0%*

These target ranges will be shown on the quarterly utilization reports.

In 2014 AMH coordinated and provided funding for any therapist previously trained in Child Parent Psychotherapy (CPP) to have their training updated to the newest protocols, including adherence to fidelity. CPP is an evidence-based parent-child mental health treatment model for children 0-6yrs. that have experienced trauma.

In April and September of 2014, AMH funded Regional trainings for therapists to provide Parent Child Interaction Therapy (PCIT). They are receiving on-going training and support to develop evidence-based practice therapy programs for young children 2-7 years of age. All PCIT sites submit quarterly reports to

AMH with citing outcome data. There are currently 16 counties with PCIT programs receiving some level of AMH funding and PCIT is being provided in 30 physical locations. Between 2012 and the beginning of 2014, the number of PCIT therapists expanded from 33 to 82. Thirteen of these therapists speak Spanish. There are PCIT therapists fluent in each of the following other languages: Dutch, German, Korean, and Vietnamese. Another basic training in PCIT is expected to be held in February of 2015. All sites provided AMH funding for PCIT are also engaging in on-going consultation with their PCIT trainers for at least a year after their initial training.

AMH created a scholarship program for ten clinicians to participate in the Portland State University Infant Toddler Mental Health Graduate Certificate Program. This will increase the number of mental health clinicians trained to recognize the developmental and mental health needs to children birth through age 3 years old.

The Oregon Health Authority is a participant in the development of the early learning hubs and AMH is working with the Early Learning Division Council to ensure that there are strong linkages between early childhood mental health providers and local hubs.

AMH collaborated with Child Welfare to transfer the Child and Adolescent Needs and Strength Screening (CANS) administration from Child Welfare to mental health through the Coordinated Care Organization (CCO) contracts. Beginning July 1, 2014, the mental health system started to administer CANS on all children within 60 days of being brought into child welfare custody. By having mental health professionals administer the CANS they will be coupled with the mental health assessment to provide a more comprehensive assessment and to inform the treatment plan. Because the CANS is child welfare's current rate setting tool, this is expected to increase children's access to mental health professionals, increasing the number of mental health assessments provided to younger aged children and therefore increase services. Additionally, the CANS tool has a tailored version to accurately assess the needs and strengths of young children.

- We recommend the Division improve the continuity of mental health care for children by:
  - ensuring that assessed children who need and desire mental health services receive services in a timely fashion;
  - ensuring that the reasons for children experiencing lengthy breaks in services are captured in case file documentation;
  - periodically analyzing the reasons for service breaks; and
  - ensuring that providers make adequate efforts to re-engage children when unplanned service breaks occur, and that they document these efforts.

OHA agrees that for children with unmet service needs, it is important to ensure that gaps in service provision are identified and addressed so they can continue making progress at home, in school, and with friends.

The following are examples of our current and ongoing efforts to address these issues:

- *AMH reviews Community Mental Health Programs through site reviews and issues Certificates of* Approval for one, two or three years for programs that are in substantial compliance with the Oregon *Administrative Rules. These site reviews address issues of access to services, engagement and follow up for initial approval or renewal of Certificates of Approval for Community Mental Health Programs.*
- *Mental health providers follow a standardized process for identifying children with high mental health needs and providing a comprehensive, coordinated array of services that are family and youth driven. The Level of Service Intensity Determination Process is to determine the intensity of service needs for children and adolescents with emotional, behavioral, and developmental challenges and to identify children and adolescents who would benefit the most from intensive service coordination planning. The Level of Service Intensity Determination Process provides a uniform and common framework to identify service intensity needs that can be used to inform service planning.*
- *Families, children (when appropriate) or adolescents receiving the Integrated Service Array develop their own teams which coordinate their services.*

AMH also planned to initiate the following additional actions to improve the continuity of mental health care for children.

- *Prior to each site review, AMH Compliance Specialists will review service utilization data to identify gaps in accessing services following a mental health assessment, service breaks or during transitions from one type of mental health service to another. They will follow up by reviewing documentation in client charts. AMH's goal will be to incorporate the review of service breaks, engagement and documentation into the regular site review schedule by November 1, 2012. AMH has identified the Client Process Monitoring System (CPMS) enrollment and termination data and Medicaid Management Information System (MMIS) encounter data as the data sources for identifying gaps in service for children moving between levels of service intensity, including post residential treatment. AMH has communicated with stakeholders, including community mental health programs and the MHO children's systems coordinators of the process for reviewing client charts during site certification or re-certification. AMH has also communicated the process to compliance specialists and other staff conducting site reviews. AMH staff are using this information to review client charts identified through data analysis for gaps in service for children receiving services in the Integrated Service Array.*
- *Through CCOs, the system shifts to outcome based performance rather than management of processes. The OHA Outcomes Group will establish monitoring mechanisms for CCO compliance with the outcome measure for clinical follow up within 14 days of transition from a hospital or residential treatment program. The Metrics and Scoring Committee, established in 2012 as a result of SB 1580 (Section 21), has the responsibility of setting overall metrics for CCOs. Over the past several months, the committee has been working to finalize a set of metrics to be used for incentive purposes with the CCOs. One example of a metric relevant to the age group discussed in the SOS audit report is follow-up care within seven days after hospitalization. Another metric is insuring that children taken into DHS custody are given a mental health assessment within 60 days. These metrics, as well as others decided by the committee, will be tracked in aggregate in addition to several demographic breakouts, including race, ethnicity, gender, and age groups. The overall goal is to evaluate CCOs based on relevant metrics and not just the volume of service generated.*

- *AMH and the Office of Information Services (OIS) initiated the web-based Children's Progress Review reporting system for children enrolled in Intensive Community-based Treatment and Support Services and the Statewide Children's Wraparound Initiative project sites. This system will be upgraded to include the Level of Service Intensity Determination Process which will provide real time data for individuals receiving services at the clinic, MHO or CCO and state levels. This will provide the opportunity for more detailed analysis of services, services breaks and recipients. The Children's Progress Review System has been upgraded to include all children served in the Integrated Service Array (ISA) and Statewide Children's Wraparound Initiative (SCWI) project sites. Level of Service Intensity determination data, which determine entry into the ISA, will also now be submitted through this data reporting system. Real time data regarding quarterly outcomes for individuals receiving services, and parental/caregiver perception of progress while receiving services, will be obtained using the Integrated Service Array/SCWI Progress Review (ISA/SCWI PR) and the Behavioral and Emotional Rating Scale, version 2 (BERS-2) for parents. These data can be reviewed at the community mental health program, CCO or state level by individuals with access to the system, for their particular system. This provides the opportunity to track data changes for individuals and groups over time. Data in this system can be matched with MMIS data (claims, service recipients) to further delineate service breaks related to outcome data.*

AMH is able to provide oversight, contract management and incentives for children insured by Medicaid. The private insurance system is outside of the oversight of the Oregon Health Authority.

AMH conducts reviews of Community Mental Health Programs (CMHP). Within the site review chart review is completed to track access to services and time span between referral to first appointment. In addition, access to services is evaluated through consumer and stake holder interview to ensure community needs are met and access to services is family driven.

For children with Medicaid insurance, there are protections in place to ensure expediency within the contract between the Oregon Health Authority and CCO's in the event that a family, guardian or youth requests mental health services from a certified mental health provider. Additionally some CCOs have

incentivized active engagement of clients by measuring the timeframe from assessment to first appointment by offering bonus payments.

At this juncture, the CCO's are highly motivated by the current metrics of which two are directly related to children's mental health. AMH has established monitoring mechanisms for CCO compliance with an incentivized outcome measure for clinical follow up within 7 days of transition from an inpatient psychiatric hospitalization.

As CCOs shift their payment to mental health providers away from a fee for service payment model to payment based on good client outcomes, we anticipate better overall care including more intensive services for at risk children and youth at the beginning of treatment when engagement is critical.

It was AMH's intention to sample 30 CMHP files of youth who were determined to have gaps in claims/encounter data. This list was provided to the CMHP review team and reasons for gaps were documented. This procedure occurred on five reviews during 2013. This process was not consistent over all CMHP reviews due to work force shortages. Following some CMHP site reviews, AMH staff reported verbally or by filling out a form provided prior to the review, on the extent to which the files examined during the review adequately documented the circumstances and follow-up efforts pertaining to each break in services found.

CMHPs received technical assistance regarding documentation best practices. CMHPs are encouraged to document all efforts made to engage and provide outreach to children and families receiving services. Some CMHPs retroactively were able to do document the reason the gap in service during the AMH review. Going forward AMH will provide CMHPs with technical assistance to ensure contracted providers will be expected to document client cancellations or do not show for appointments and furthermore, document the attempts to re-engage the client in services when appropriate.

While documenting breaks in service and follow-up is best practice, this is not specified in the Oregon Administrative Rule. AMH does not have the authority or personnel to monitor and ensure best practices are enforced. No further action will be taken other than continuing to providing technical assistance on best practices when appropriate.

Analyzing data to determine unplanned service breaks is not currently feasible at the State level given the existing payment and data infrastructure. The CCOs are responsible for assuring that continuity of services is maintained and that long breaks between services are identified, documented, monitored and, when necessary, addressed.

During Community Mental Health Program (CMHP) site reviews a sampling of open and closed records are consistently reviewed at least every three years. Service breaks are analyzed and checked during these routine reviews for adequate documentation as well as adequate out-reach on behalf of the CMHP. In higher levels of care, such as Intensive Treatment Services, these records are reviewed by the contracting CMHP as well as AMH if the program is a day treatment or residential provider.

An additional review is conducted by the Office of Licensing and Regulatory Oversight annually and records and gaps in services are analyzed at this time as well.

As mentioned above, AMH continues to include in CMHP sites reviews, chart audits to track gaps in services and reengagement and outreach efforts. Technical assistance is provided regarding engagement strategies to reengage children. Providers are encouraged to ease access to services. As the CCO development shifts the incentives from being reimbursed based on individual services and rewarded for improved outcomes, we anticipate a great emphasis on completed treatment episodes and outreach to "at risk" clients when there is a break from service.

Within the 2014-2015 biennium an additional 4-6 Wraparound sites will be added to the System of Care across the state. This will infuse additional intensive care coordination into the system ensuring

reengagement and client retention efforts. Care coordination at this intensity will decrease service breaks for children and youth who are significantly at risk for bad outcomes if services cease prematurely.

In addition, in this biennium four Youth Hubs will be created across the state targeting the 14-24 year old population. There are distinct service components within this model to include outreach, engagement; recovery oriented planning and creating social support systems. Peer support provided by young adult peers is a critical component of this model, particularly for young adults who are disengaged or reluctant to access services.

5. OHA: Safe Drinking Water Revolving Loan Fund for the Fiscal Year Ended June 30, 2011, audit # 2012-19, (dated June 2012)

   - We recommend agency management:
     - Reconcile, at a minimum, the state's accounting records for revenues and expenditures for each set aside with the federal cash reimbursement system when closing a grant award and ensure any adjustments identified are researched and corrected prior to submission of the final report;
     - Reverse the accounting entry made in December 2011 that moved revenue from current grant awards to older grant awards;
     - Determine whether the $28,274 in valid expenditures identified for grant awards 04, 05 and 06 can be moved to open grant awards enabling the agency to be reimbursed;
     - Obtain state funding for the $10,484 of expenditures incurred at some point in time but never drawn to cover the cash expended; and
     - Return $7,160 in federal revenue/cash currently recorded in grant award 06 to the U.S. Environmental Protection Agency (EPA).

The Oregon Health Authority researched the impact of moving the identified $28,274 revenue and its impact on phases 04, 05 and 06. The program discussed with EPA the option of moving funds between grants to correct prior errors. After we finalized phases 04, 05 and 06 we contacted the EPA requesting their direction as to the final disposition of the $7,160 recorded in grant award 06. The Office of Financial Services also worked with the program to determine the appropriate adjustment of the $10,484.

A follow up letter was sent to the EPA Region 10 Coordinator describing the audit finding and asking for specific guidance regarding the $900 net balance remaining after the funds were reconciled and adjusted. EPA requested that the remaining funds be rolled into the current year funds.

6. DHS/OHA: Health and Human Service Caseload Forecasting: Ways to Increase Confidence, audit # 2013-03, (dated February 2013)

   DHS and OHA agree that accurate caseload forecasts are critical for agency budgeting and legislative allocation of limited state funds. Since both agencies are required to report to the Emergency Board and would prefer to avoid unnecessary rebalances, both agencies have a strong incentive to support forecasts which are neither too high, nor too low.

   As documented in the report, the DHS and OHA Office of Forecasting, Research and Analysis (OFRA) has knowledgeable staff, uses reasonable methodologies, and produces forecasts that are generally accurate, have improved over time, and have no indication of overall bias. It was also determined that OFRA's forecasts are only marginally less accurate than those produced by Washington State's independent Caseload Forecasting Council. OFRA performs an array of supplemental research, analysis, and consulting services for DHS and OHA that would still be needed if the unit was moved out of the agencies.

   The report also notes that forecasts are inherently uncertain for a variety of reasons. However, DHS and OHA believe that federal and state policy and procedures have the largest impact, with economic and

demographic impacts secondary. While the forecasting unit strives for accuracy, subsequent adjustments and corrections are to be expected. The realistic expectation of inaccuracy is one of the primary reasons the forecast is updated twice each year and incorporated into the budget adjustment requests submitted to the Emergency Board.

The report describes how the forecasted 2011-13 caseload for Aid to the Blind and Disabled program (ABAD) varied over the course of seven forecast cycles. DHS and OHA generally agree with the basic facts as presented, but not with the view expressed in the report that the error was due to a lack of independence or that more than half of the error was not justified by the information available at that time. The majority of the caseload increase which ultimately proved to be wrong was discussed and approved in the fall 2010 forecast by the Medical Assistance Program Caseload Advisory Committee, which included staff from both the Department of Administrative Services (DAS), Budget and Management Division (BAM) and the Legislative Fiscal Office (LFO). While not noted in the Fall 2010 DHS and OHA Caseload Forecast report, one of the factors that contributed to the inaccuracy was the fact that Social Security had experienced a steep increase in disability applications since the Great Recession began. This had been widely reported in the national press, so forecasting unit staff considered it reasonable to anticipate some increase to the rate of growth for the ABAD caseload.

DAS Budget Policy Analysts and LFO staff have participated in the caseload forecasting process for many years. In addition, since DHS and OHA split into separate agencies in July 2011, formalized governance processes have been created to oversee all shared services units, including forecasting. As mentioned in the report, the forecast unit administrator reports to the DHS Chief Financial Officer and the OHA Budget Director, and the unit itself operates under authority of the DHS and OHA Joint Operations Steering Committee (JOSC). JOSC has authorized two governance documents that pertain to the forecasting unit: a Service Level Agreement which lays out the unit's key responsibilities and deliverables, and a Caseload Forecast Advisory Committee Charter which specifies the authority, roles, and responsibilities of the committees, their members, and the forecast unit.

The forecasting unit has also documented key processes and established performance metrics. Documentation includes monthly forecast accuracy reports, methodology(s) used to create the forecast for each caseload area, key process flow charts, an annual calendar for scheduled work, and a unit performance scorecard.

DHS and OHA strive to be transparent. To that end, an internet website has been created that is expected to go live within the next two weeks. It will be easily accessible from both the DHS and OHA home sites. The new website will include work products (e.g. caseload forecasts and monthly variance reports), administrative documents (e.g. materials on governance and methodology, names of advisory committee members, etc.), and links to other forecasting units. DHS and OHA have been routinely posting forecasts online and the bi-annual forecasts going back to 2006 are currently available.

- To improve the independence, oversight, and transparency of the forecast unit, we recommend the Department of Human Services and the Oregon Health Authority:

  - Consider creating a policy oversight committee responsible for review and adoption of caseload forecast policies and procedures, and to help ensure forecaster independence.

    A technical oversight committee was created to:
    1) *Review and make recommendations to the DHS|OHA Joint Operations Steering Committee (JOSC) concerning the forecast unit's policies, procedures, governance, methodologies, etc.*
    2) *Serve as an independent channel for forecasters (or anyone else) to raise issues they perceive as jeopardizing or affecting forecast quality or forecaster independence.*

    A charter for the committee was drafted and reviewed by DHS COO, OHA COO, DAS CFO and LFO. The charter was submitted to JOSC and received final approval on November 21, 2013. Committee members were recruited, with recommendations solicited from Senator Devlin, John Mullin (HSCO), DHS|OHA executive and program leadership, DAS and LFO.

- Continue using the eight caseload forecast advisory committees as the arena to debate forecast risks, assumptions and methodology, and to advise the forecasters on the caseload forecast numbers.

  The forecasting unit continues to use Caseload Forecast Advisory Committees to provide information on factors that impact program utilization, and to provide input on the proposed forecasts. Occasionally committees are added or discontinued when the forecasting need change.

- Consider adding additional external representation to the eight advisory committees from the public, academic, non-profit, and/or private sectors.

  Solicitations for volunteer committee members were sent to Senator Devlin, John Mullin (HSCO), DHS|OHA executive and program leadership, DAS and LFO. We identified one or two additional participants for most of the committees – in time to participate in our summer 2013 mid-cycle meetings. We will continue to seek external participants to bring into the process.

  In addition, the forecasting unit will continue to periodically survey external stakeholders who are not on the committees to get their input on the factors driving caseload changes.

- Record meeting minutes of the eight advisory committees that at a minimum include the key information or issues discussed and the advisory committee's advice on the forecast numbers.

  In early 2013 templates were created to capture meeting notes during both forecast development and mid-cycle meetings. The forecast meeting template was used and refined in spring 2013 and will be used on a regular basis going forward. The mid-cycle meeting template will be used and refined during the summer of 2013.

- Regularly evaluate the forecasts and publish an annual accuracy tracking report. Include in the tracking report an analysis of both the accuracy and statistical bias of the forecasts. Use the results to identify improvements in assumptions and methodologies.

  DHS and OHA understand the importance of tracking and reporting forecast accuracy and using that information to identify possible improvements. The forecasting unit has tracked and reported forecast accuracy (by program area) for many years through Monthly Caseload Variance Reports which were shared routinely with all caseload forecast committee members. Starting in March 2013, these monthly reports have been posted to the new Forecasting website.

  Starting in Fall 2013, the forecasting unit will produce a new annual report which will provide a more summarized, but comprehensive view on the accuracy of the caseload forecasts across program areas and over time.

- Continue efforts to create a public web page dedicated to the forecast unit, and post its methodologies, advisory committee membership, advisory committee meeting minutes, forecast accuracy tracking reports, and the semiannual caseload forecast reports.

  In February 2013, the forecasting unit launched a public web page: http://www.oregon.gov/dhs/ofra/Pages/index.aspx

  The forecasting page can be accessed directly (single click) from both the DHS and OHA home pages, and contains work products (e.g. caseload forecasts, client overlap charts, ad hoc research reports), accuracy reports, administrative documents (e.g. governance materials, committee membership, process flowcharts, forecasting methodology), etc.

- Include in the published semiannual caseload forecast reports additional detail on risks, assumptions, uncertainties, and how these factors could affect caseload estimates.

  When the Spring 2013 forecast was published the sections describing risks, assumptions and uncertainties were expanded. Going forward, the forecasting unit will strive to further expand this content.

7. DHS and OHA: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2012, audit # 2013- 07, (dated March 2013)

- We recommend OHA management improve controls by considering the design and implementation of a reconciliation process to ensure transfer transactions are properly and completely recorded and ensuring adequate supervisory review of recorded transactions. Supervisory review could include a review of the SFMA to HPT tracking log to ensure all transfers are included and accurately reflected in SFMA.

  During fiscal year 2012, the department used transfers to allocate Healthcare Provider Tax (HPT) from the Department of Human Services to the Oregon Health Authority. Coding errors resulted in a $29 million understatement in the Other Revenues object, and an overstatement in the Healthcare Provider tax object by the same amount. Total revenue recorded was correct. The error was not caught in the supervisory review. The revenue report review did not occur prior to year-end close. To correct these errors from occurring in the future, we will increase the frequency of the revenue report review and provide training to receipting staff who transfer these revenues.

During a March 2013 Receipting Unit Continuous Improvement meeting; State Financial Reporting unit distributed copies of audit adjustment 12-01 to staff, and provided training on the importance of correct coding of provider tax and other receipts. To reduce receipting errors, during Fiscal Year 2013 Office of Financial Services staff increased their reconciliation of the receipt holding grant.

- We recommend DHS and OHA management implement procedures for reviewing and evaluating program changes to identify any necessary revisions in financial reporting to ensure compliance with GAAP. We also recommend management consider the need to revise the billing process or prepare year-end adjustments to ensure transactions involving shared services are reported in conformity with generally accepted accounting principles.

  The Department of Human Services and Oregon Health Authority became separate accounting entities in fiscal year 2012. In order to maximize operational efficiency, these agencies retained shared administrative service functions. In the short timeline that was provided, the agency developed a shared service model and a new cost allocation and billing process that ensured the appropriate costs were billed to each agency. The agency did not consider the impact this model would have on the consolidated financial statements and that the materiality threshold would necessitate setting up an Internal Service Fund. The agency had Department of Administrative Services, Statewide Accounting and Reporting Services, set up a new GAAP fund (5006- Health Service Fund) that will be used to report the 2013 fiscal year-end adjustments for shared services in both agencies. DHS and OHA are preparing for the 2013 - 2015 biennium by setting up a new D23 fund pointing to this new Internal Service fund to properly record the accounting transaction during the normal course of business rather than as a continual year-end adjustment.

  GAAP Fund (5006- Health Services Fund) was created by SARS on February15, 2013, with a July 1, 2012, effective start date. For Fiscal Year 2013, SARS will make an adjusting entry at year-end supplied by the DHS/OHA State Financial Reporting unit to properly record the activity of the Internal Service Fund. The new D23 fund (fund 3470) has been set-up in DHS/OHA that points to GAAP Fund 5006 to properly record

the daily operations of the shared services units for the AY2015 activities. All necessary structure has been updated using this new D23 fund beginning with July 1, 2013, activities.

- We recommend OHA management ensure staff obtain a better understanding of the PEBB program and timing of program related revenues and expenditures to ensure accurate and complete year-end reporting in compliance with GAAP. We also recommend management implement procedures for reviewing and evaluating program changes and ongoing business practices to identify any necessary revisions in financial reporting to ensure compliance with GAAP.

  During fiscal year 2012, the Oregon Health Authority assumed responsibility for PEBB and OEBB from the Department of Administrative Services (DAS). OHA replicated the GAAP fund structure that was in place at DAS. This structure included six D23 funds pointed to GAAP fund 1108 (Health and Social Services Fund) and five D23 funds pointed to GAAP fund 5001 (Central Services Fund). The new healthcare surcharges were placed in the PEBB Operations fund which is pointed to GAAP fund 1108. In fiscal year 2012 the Office of Financial Services had several conversations with Statewide Accounting and Reporting Services regarding the proper treatment of the funds for PEBB and OEBB which have historically been inconsistent. Rather than make a singular adjustment to one surcharge we rather chose to engage in an enterprise discussion with SARS on the proper accounting treatment for each of these programs. We will continue to work with SARS in 2013 since we have not fully resolved all of the inconsistencies in the PEBB and OEBB fund structure.

  In the future, the Office of Financial Services, as a shared service, will consult with PEBB staff to identify correct balances to ensure accurate and complete year-end reporting in compliance with GAAP. We will also continue to work with the Department of Administrative Services, Statewide Accounting and Reporting Services, on reviewing and evaluating significant program changes within the agency.

  To ensure correct Fiscal Year 2013 GAAP classification of PEBB, on March 15, 2013, Shared Services staff met with SARS staff/management and discussed correct GAAP fund classification of the PEBB funds. PEBB Operations Fund 3456 was the remaining fund not yet reclassified to the Internal Services Fund. As a

meeting outcome, SARS and Shared Services agreed to repoint fund 3456 to the Internal Services Fund. At Fiscal Year 2013 end, PEBB Operation Fund activity was reported in the Internal Services Fund.

To ensure correct accrual amounts, Fiscal Year 13 PEBB accrual amounts were calculated by Shared Services staff in consultation/review with PEBB staff.

- We recommend department management fully capture all PEBB funds as part of the statewide cost allocation plan.

  DHS and OHA Office of Financial Services Shared Services became responsible for the PEBB A-87 reporting in FY2012. During that reporting period, staff was trained on the correct method for reporting the PEBB operations fund, stabilization fund, and the insurance fund. DHS and OHA Office of Financial Services Shared Services has implemented this procedure and has continued it with the Fiscal Year 2013 reporting period.

  The 2012 A-87 report was prepared by the Oregon Health Authority, and included the PEBB Operations, PEBB Stabilization and PEBB Self Insurance Funds. Corrections for years 2010 and 2011 were calculated by the Department of Administrative Services and resulted in remaining excess fund balances. This resulted in additional Federal payback calculation of $124,824.00 that was paid to the Department of Health and Human Services VIA Department of Administrative Services. Detail on the 2010 and 2011 remaining excess fund balance calculations can be obtained from the Department of Administrative Services.

  DHS and OHA Office of Financial Services Shared Services will work with DAS Shared Financial Services to determine if any additional corrections for calendar year 2010 and fiscal year 2011 are necessary.

- We recommend that authority management maintain evidence of the initial and monthly database checks for enrolled providers and we recommend department management maintain evidence of the initial EPLS database checks.

The permanent corrective action the authority is initiating is to add a separate "check box" for each required compliance verification effort (such as checking the various excluded databases) to the provider enrollment panel within the Medicaid Management Information System (MMIS). This corrective action is being initiated by submitting a MMIS change request, and then the change request will be reviewed by multiple business entities, prioritized and then run through OHA's normal MMIS change workflow process. This prioritization effort, because of competing resources and statutorily required program changes, often delays simple change request for many months, or even longer.

In anticipation of a potential delay in implementing this permanent MMIS correction due to impending federally required MMIS changes, including the completion of 5010 and the upcoming ICD-10 changes, the authority has already implemented an interim process to document our efforts to exclude sanctioned providers based on the existing monthly Medicare Exclusion Database (MED) process. The MED is downloaded and cycled through the enrolled provider database contained within the MMIS on a monthly basis. Any individuals or entities identified as a result of this monthly process are reported through the MMIS. Once this report is produced, it must be manually worked to end the active status of any listed providers or entities. As this report is worked each month, our new interim process is to record any action taken, the date the report is worked and who worked it directly on the printed document. Once this information is captured, the documented and initialed report is filed for future reference or audit purposes.

This authority interim process is not intended to ultimately be the permanent corrective action, but has been operationalized to bridge the anticipated gap in time until the permanent MMIS changes to the provider enrollment panel correction can be completed.

For those providers that the department qualifies, the department has also developed and implemented a tracking tool that lists the provider name and all of the systems that are required to screen providers. The tool includes the date of the verification. Many of the department's providers are qualified by the authority. Those providers will not be included in this tracking tool.

The required screening for applying providers is occurring as outlined in the Division of Medical Assistance Programs' enrollment procedures. Additionally, to document this effort is occurring, a change request to our Medicaid Management Information System (MMIS) was written. This change request modified the provider subsystem to allow an enrollment specialist to document within the MMIS that the required screening checks had been successfully completed. This change request was completed and deployed the week of August 25, 2014. This change will apply to all new OHA enrolled and department MMIS enrolled providers after that date. It is anticipated that all providers in MMIS will be reviewed as part of the ACA revalidated by March 2016. In addition to MMIS, APD Provider Relations uses the eXPRS provider enrollment system to capture the required database checks for the ODDS providers enrolled through eXPRS. Finally, APD Provider Relations will also continue to maintain spreadsheets of the required database checks for the OrAccess enrollment system. APD Provider Relations conducts all of the required database checks for the APD provider populations upon enrollment and renewal, including EPLS aka SAM and documents this in the systems or spreadsheets if the system does not have the capability.

- We recommend department management implement procedures to ensure the department uses the federal financial participation rate in effect at the time a transaction is recorded and reimburses the federal agency for the overdrawn ARRA funds.

  In March 2013, the agency completed an in-depth review of all expenditures receiving ARRA funds that occurred July 1, 2011 and later to ensure the proper federal financial participation rate was used. An entry was completed in the Statewide Financial Management System (SFMA) to adjust the excess ARRA funds and the Centers for Medicare and Medicaid Services (CMS) will be refunded for the overdrawn funds. The adjustment was completed March 19, 2013. The PCAs associated with current period activity have been disabled. All prior period activity is reviewed each quarter to ensure compliance.

- We recommend management implement procedures to periodically test edits in the MMIS. We also recommend management review the claims that should have been rejected by these edits to determine their appropriateness.

  The Oregon Health Authority (OHA) agrees with the need to conduct tests that periodically validate the edits within the Medicaid Management Information System (MMIS). All edits were tested when the MMIS became operational in December 2008 using a parallel testing method, which compared the results of the new MMIS to the results of the old Legacy MMIS using identical claims. Both systems were to produce identical results, and if differences were identified, the reasons responsible for the differences were identified and corrected. Since the completion of this parallel testing, any new edits or changes to existing edits since then have been thoroughly tested in the MMIS test environment before moved into the production environment. In addition to these testing efforts, it is thought prudent to periodically test the operational edits to ensure all continue to operate as expected and that no unintended changes had been introduced into the production environment by edit changes that may adversely affect any MMIS edit functionality.

  Correct adjudication of Medicaid claims and encounters is a priority for the Oregon Health Authority (OHA). In early 2013, a change request to correct the system functionality within the Medicaid Management Information System (MMIS) regarding age and gender restrictions functionality was discussed. Recognizing the immediate need, a more expedient work-around response was created to strengthen the rules around age and gender procedures. Modifications to the claim rule tables for age and gender restrictions were put in place until the MMIS Restrictions Panel could be corrected. These diagnosis restrictions were inserted into the claim rule tables on February 19, 2013.

  In an attempt to confirm that these rules were functioning correctly, a process to randomly pull 35 claims per quarter to be manually checked by staff was initiated using dates of service starting in the first quarter of 2013. The goal of this process was to see if each claim adjudicated properly based on its unique data parameters, including age and gender restrictions. No issues were found processing the claims dataset from

the first quarter of 2013. Review of subsequent quarters has been delayed due to heavy workloads brought about by Coordinated Care Organization (CCO) evolutions to cover dental and mental health, ICD-10 implementation work and the manual enrollment processes associated with the Patient Protection and Affordable Care Act of 2010 (ACA) Medicaid expansion. While the manual review has been delayed, the random sample of claims has been captured each quarter. Going forward, the random claim pull will be modified to specifically focus on age and gender related procedures and other key edits, such as provider and client eligibility. Additionally, the manual review of these claim data sets will be prioritized higher until the permanent panel correction can be finalized.

The lack of functionality of the MMIS Restriction Panel was again brought forth in late 2013. Work on the permanent correction to the Restriction Panel began in December 2013, with the creation of a change request. Now recognized as a high priority requirement, the notice to proceed for the change request was authorized on March 4, 2013.In user acceptance testing, additional issues were identified, so work continues on the permanent correction. It is anticipated the correct panel functionality will be restored as of January 31, 2015.

- We recommend management implement and follow internal controls to ensure the review for suspension and debarment is performed and documented for all contracts, including price agreements.

  The Office of Contracts and Procurement (OC&P) contacted the Oregon Department of Administrative Services (DAS) Procurement Services and requested contractor self-certification language relating to suspension and debarment be added to DAS statewide price agreements. DAS reports this amendment is being made to their statewide agreements as they come up for review.

  The Office of Contracts and Procurement also added debarment and suspension vendor self-certification language to all DHS and OHA purchase orders processed effective March 18, 2013.

- We recommend the department update the cost allocation plans to reflect current practices and ensure future changes are communicated timely.

  Historically the agency submitted biennial updates to the cost allocation plan, and submitted changes to the plan annually when significant changes were made. There were not significant modifications to the plan during the last audit year so an update was not submitted to the Division of Cost Allocation.

  The agency agrees that updates to the plan should be submitted annually, even if no changes are made. Further, the agency communicated with the Division of Cost Allocation seeking guidance on their process for the submission of amendments to the public assistance cost allocation plans regarding mid-year modifications.

  Amendments to the DHS and OHA Cost Allocation Plans were submitted to the Division of Cost Allocation on June 6, 2013, for review. These amendments were to take effect with the start of Fiscal Year 2014.

8. DHS/OHA: Public Assistance: Improve Eligibility Procedures and Consider Approaches of Other States audit # 2013- 10, (dated May 2013)

   This audit compared five data sets to records of people receiving benefits under three federal programs: Medicaid, the Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF).

   These programs weave together to form Oregon's safety net. During the recent recession and over the past several years, the Legislature and two governors have made strategic policy choices designed to strengthen that net and keep families stable until they can get back on their feet.

   The periods covered in the audit varied but most were for the fiscal years 2011 and 2012. Over those two years, the combined benefits administered were $11.7 billion. The three programs served 1.4 million

Oregonians for those two years. The audit initially questioned benefits totaling about $2.8 million, approximately 0.02 percent of the combined costs of the program over the two years.

For the purposes of this audit, the Secretary of State used five data sets to compare records of people receiving benefits under Medicaid, SNAP and TANF

- *Social Security death records;*
- *Oregon Lottery winners;*
- *State prisoners;*
- *PERS retirees; and*
- *DHS/OHA employees.*

The audit found 5,018 record matches across the five categories. A matched record does not mean an incorrect benefit. DHS/OHA review determined that the information presented in the audit would not have changed the benefits for about 3,200 matches based on current law and policy. Another 600 of the death record matches found the person on the record and the actual benefit recipient were not the same person, and subsequent analysis would not have changed the benefits. Miscoding of the Social Security number (SSN) in the computer system was the most common reason for this occurrence.

In about 1,200 of the 5,018 matches, the people initially appeared ineligible and may have received a benefit they should not have received. This is about 0.09 percent of the combined enrollment of the three programs.

The agencies continue to strive for the greatest accuracy. This audit pointed out a few areas where changes in policy or practice could enhance accuracy even further.

The audit also looked at policies developed by the Legislature and Governor's office to provide public services to Oregonians living in poverty and protect our most vulnerable citizens. Under statute and through

policy, DHS and OHA have streamlined the eligibility processes and reduced unnecessary bureaucratic barriers that slow critical services to people in need and create waste and inefficiency in the system.

This has been a successful strategy as evidenced by how low-income Oregonians fared during the recent recession compared to other states. Since 2008, the number of people receiving SNAP has increased substantially. Despite the record-level caseloads, Oregon made process improvements that reduces the wait time for food benefits from more than one week to same day or next day service for most participants. Since 2008, the number of people receiving Medicaid has also increased substantially and overall accuracy rates have held steady or improved.

During the recession, the children's uninsurance rate dropped from 12.3 percent to 7.2 percent, providing financial stability to the families of more than 100,000 children. From 2009-2011, Oregon was one of the top two states for reducing the number of children without coverage. Also during the recession, SNAP was a key factor in holding the state's food insecurity rate steady. Now that these policies are in place and have proven to be effective, it is time to close the large lump sum loopholes in a way that allows Oregon to continue providing services to our state's most vulnerable people effectively and efficiently without letting people who can support themselves slip through.

The audit raised questions of both accuracy and policy. DHS and OHA continue to believe that there is an appropriate trade-off between these goals.

More complex eligibility criteria impose higher administrative costs, often result in more inaccurate eligibility determinations, and restrict access to the program -- even among those who are eligible under the more complex requirements. Since 2002, Oregon has made strategic choices to streamline policies and reduce unnecessary red tape – while keeping adequate oversight – to help our state's people with very low incomes receive the services they need so they can get back on their feet. As a result, the hunger rate has stayed stable in our state as it has increased in others. And our rate of uninsured children has plummeted.

The key is to balance the need for benefits with policies that make sure only qualified people receive them. That is the course both agencies have pursued for more than a decade.

DHS and OHA have taken numerous actions related to the original audit recommendations. These actions, and those that are still in process, are outlined below. In summary, the two agencies have reviewed the 5,018 cases originally identified as having a match to one of the databases used by the Secretary of State auditors. DHS and OHA have, or are in the process of writing overpayments, further researching or recovering about $1.8 million in benefits identified during this review. In addition, hundreds of staff from both agencies have been trained on improved verification processes and tools. DHS has asked for approval of waivers that allow changes in SNAP client change reporting requirements. The new centralized EBT card replacement unit has been expanded and now provides card replacement services statewide. Analysis of the effectiveness of identified federal databases have been tested and others continue to be reviewed. Various other internal processes have been reviewed and improved.

Below is a listing of the original recommendation and the specific actions that have been taken to address the findings in the report.

- Work with the Governor and the Legislature to consider changes to Oregon's public assistance eligibility and reporting options, balancing the neediest with the most prudent use of public resources.

  DHS and OHA continue to improve public assistance eligibility systems to ensure accuracy and reduce administrative costs. DHS and OHA continue to be committed to working with the Legislature, the federal government, and our partners to adjust policies to help the neediest Oregonians in ways that are productive, minimize administrative costs and avoid using resources where they are not needed. DHS and OHA have also continued to support Congressional efforts to end SNAP benefits for substantial lottery and gambling winners.

A waiver allowing DHS to act on returned mail was approved for implementation September 2013. An informational memorandum transmittal was provided to our field staff on August 15, 2013, to provide guidance on the new policy.

The SNAP program also reviewed policy options with partners regarding resource limits on the TANF funded resource information pamphlet, which qualifies many SNAP clients to be categorically eligible. The program adopted a state option to put an asset test on this program. DHS developed policy and training for this change and began implementation in January 2014. The resource limit is $25,000 in liquid assets. SNAP also submitted a waiver request that would allow clients in the Simplified Reporting System (SRS) to report resource changes mid-certification period when this liquid asset resource limit is met. DHS submitted this request to the Food and Nutrition Service (FNS) on October 18, 2013. However, with the passage of the Farm Bill, states are allowed to end SNAP benefits for substantial lottery or gambling winners. In Oregon we have defined substantial as $25,000. The bill also encouraged data exchanges with state lottery and gaming departments. We are currently working on setting up such an agreement with the Oregon Lottery.

At the time of the audit, adults covered by the Oregon Health Plan (OHP) Standard benefit package and children on OHP Plus had 12-month continuous eligibility. In general, continuous eligibility means that once an individual is determined eligible for Medicaid, the state may provide up to 12 months of eligibility, without a redetermination, regardless of changes in income or most other circumstances which otherwise would render the individual ineligible for Medicaid. OHA had intended to submit a request for an amendment to the state's 1115 Medicaid Demonstration, to become effective with implementation of the Affordable Care Act provisions in January 2014, that would have authorized expanding 12-month continuous eligibility for all adults on OHP. In response to the audit, DMAP was discussing including in its amendment request exceptions to the continuous eligibility policy that would require OHP recipients to report large lump sums, such as lottery winnings, and have them count for eligibility.

However, in May 2013, prior to the state's submission of such a request, the federal Centers for Medicare and Medicaid Services (CMS) issued clarification about what a 12-month continuous eligibility waiver for all adults might involve in 2014, including a potential reduction to a state's Medicaid match rate.

In February 2014, the federal Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) offered states the opportunity to apply for an opportunity to implement 12-month eligibility for adults, with an adjusted FMAP rate. The State has elected not to pursue this option at this time due to the reduction of available federal matching funds and the impact on the state budget of such an implementation. Oregon continues to implement 12-month continuous eligibility for children.

- Work with the Governor and the Legislature to reconsider the state's Medicaid waiver provision that exempts new income and assets from review during a 12-month medical certification.

  Under the regulations for the Affordable Care Act (ACA)at 42 CFR § 435.916, periodic redeterminations of Medicaid eligibility, the federal government requires that the agency must re-determine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months, must have procedures designed to ensure that recipients make timely and accurate reports of any change in circumstances that may affect their eligibility during the 12-month certification period and must promptly re-determine eligibility when it receives information about changes in a recipient's circumstances that may affect eligibility. Also, if the agency has information about anticipated changes in a recipient's circumstances, it must re-determine eligibility at the appropriate time based on those changes.

Under OAR 410-200-0235, Oregon Administrative Rules drafted to comply with the ACA, OHP enrollees are required to report changes in circumstances affecting eligibility for beneficiaries within 30 calendar days of their occurrence. This includes:

(A) A change in source of income.

(B) A change in employment status.

1) For a new job, the change occurs the first day of the new job.

2) For a job separation, the change occurs on the last day of employment.

(C) A change in earned income more than $100. The change occurs upon the receipt by the beneficiary of the first paycheck from a new job or the first paycheck reflecting a new rate of pay.

(D) A change in unearned income more than $50. The change occurs the day the beneficiary receives the new or changed payment.

1) A change is considered reported on the date the beneficiary or authorized representative reports the information to the Agency.

2) A change reported by the beneficiary or authorized representative for one program is considered reported for all programs administered by the Agency in which the beneficiary participates.

This administrative rule became effective October 1, 2013.

- Take the necessary steps to gain access to the SSA's real time, online verification system and implement its use statewide.

Culminating an effort that had been underway prior to the beginning of the audit, DHS and OHA have been certified by the Social Security Administration (SSA) to receive the real-time online verification system data. DHS and OHA made the new application available to field staff in August 2013 and sent a transmittal

explaining the new screens to the field on September 4, 2013. DHS Central Office also reviews SSA-related error reports.

- Require initial verification and continual monitoring procedures for categorically eligible recipients. Promptly notify SSA of any information that may disqualify an individual from receiving SSI benefits.

  The department contacted the SSA's Regional Office in Seattle to confirm whether or not the local offices should be accepting information about potential additional income being received by SSI recipients. The SSA Regional Office confirmed that their local offices should be accepting this information and looking into it. Aging and People with Disabilities (APD) re-established procedures for all staff to follow, wherein they will report to SSA when they learn of additional income that was not previously known.

  A note was added to the Aging and People with Disabilities (APD) Oregon Supplemental Income Program (OSIP) Manual in July 2013 instructing workers to complete and send SSA a SDS 538A form when assets are identified that would result in the ineligibility for Oregon Supplemental Income Program Medical (OSIPM) if an individual were not assumed eligible. This process is now reinforced in training provided to staff.

- Provide caseworkers with clear policies, procedures and guidance on eligibility verification processes that comply with federal regulations.

  Please see below.

- Provide caseworkers with regular training on verification processes and provide them with appropriate guidance.

  Please see below.

- Ensure program managers are provided adequate training on federal requirements for their programs.

  DHS and OHA continue efforts to improve training and guidance on eligibility policies and procedures. We are developing better analysis of error trends that allow us to target education around specific areas of eligibility and to monitor improvement. We will continue to incorporate information from this audit into the targeting process. In addition, we have developed new tools, including quick reference guides, regional training events and special newsletters to improve results.

  Some of the specific efforts include a policy transmittal sent to all Oregon Department of Human Services Self Sufficiency and Aging and People with Disabilities field staff on April 15, 2013, regarding the use of Social Security Numbers and T-numbers for the SNAP program and a special edition "On Target/In the Loop" newsletter that was sent to staff in June 2013 in response to the findings from the audit. This was in addition to the article that had already been included in the May 2013" In the Loop" newsletter. A documentation matrix was also developed and distributed to staff as a quick reference guide.

  In addition, the department has developed information for branches to place in their lobbies discussing the need for clients to secure their cards, and Communications has incorporated card safety and security information into the Oregon Trail Card web page and client notices. This is one of our highest traffic sites.

  DHS has completed 27 meetings throughout the state where we shared information regarding the audit, with tips, tricks and tools (including the documentation matrix mentioned above) to avoid the types of errors that were found in the audit. In total, more than 400 field staff representing APD, Self Sufficiency and Child Welfare staff attended the trainings. Staff members attending the trainings take materials back to their offices to share with co-workers who were unable to attend. All training materials were also posted to the Regional Meetings website.

  Affordable Care Act (ACA) trainings given to the OHA Statewide Processing Center in September and October 2013 incorporated some of the issues noted in the recommendations from the audit report. Items

addressed in these trainings include identifying and addressing SSN mismatches and using information obtained from the federal hub to verify information provided by applicants. Additional training materials have been developed which focus entirely on issues identified through the audit.

Information regarding verifying SSN's via the legacy system has been included in training material that began to be presented to staff in late May 2014. Also included in the training material is information about how the SSN is verified via the federal hub when the request for health coverage has been approved by the Siebel system. OHA Statewide Processing Center also has material available to staff outlining the procedure for verifying the SSN of individuals newly added to the legacy system.

- We recommend that DHS/OHA Office of Payment Accuracy and Recovery obtain access to and use the SSA Death Master File as the primary data source for matching to death records.

  This recommendation is partially implemented. The Office of Payment Accuracy and Recovery (OPAR) agreed to explore the use of the SSA Death Master File. OPAR currently uses Oregon's Vital Records data as its primary data source. We do this because it is the most accurate source of date of death data for our client population. The SSA file would give us access to out-of-state deaths, and this could have value as a primary source for this specific information.

  OPAR ordered the most recent quarterly SSA Death Master File. Upon receipt we evaluated the usefulness of the out-of-state information provided by SSA as a pilot project. The OPAR Data Match Unit (DMU) completed a cost benefit analysis of using the SSA Death Master File and found a potential savings in year one of $3,000. Subsequent years could potentially show a savings of approximately $7,000 a year. To realize this savings, DMU staff would have to be taken off other assignments such as the Incarceration project. This would result in a loss of cost avoidance of $27,000 in the first year and $23,000 in successive years.

  As a result, OPAR will put this match concept on indefinite hold until full staffing of the Data Match Unit can be achieved at which point installation of this match would be reconsidered.

- We recommend that DHS/OHA Office of Payment Accuracy and Recovery use the SSA Prisoner Verification System the agency has access to as part of its information exchange agreement with SSA.

  This recommendation is partially implemented. OPAR is in the process of addressing the technical issues that accompany accessing the SSA Prisoner Verification System data, however this process is on hold until additional staff resources can be provided. Once these issues are addressed and overcome, OPAR will look to include use of this data as a part of its Corrections Match process.

- We recommend that DHS/OHA Office of Payment Accuracy and Recovery work with Oregon State Lottery and other state agencies to obtain access to client information that can affect eligibility, such as earned income through winnings and retirement payments.

  This recommendation is partially implemented. DHS is currently working with the Oregon State Lottery (OSL) on processes to help with the identification and intervention of prize payments to assist with resource identification of eligibility and recovery of monies owed. Currently, DHS has Legislative support for a concept requiring information sharing between OSL and DHS. If all goes well, a concept will be introduced in the 2015 legislative session.

  We continue to work with the Oregon State Lottery as we attempt to determine the best way to accomplish effective information sharing as recommended by the audit. Work on regular access to PERS information is on hold until the work on Lottery data is completed, though the process established for ad hoc PERS access will continue as needed.

- Continue work to identify recipients with large numbers of reportedly lost or stolen cards and implement a process for follow-up and possible investigation.

DHS initially created a central unit to replace lost or stolen cards in 2012 and to take actions to reduce the number of replacement cards and prevent misuse. As noted in our original response, the new process has reduced the issuance of replacement cards.

Statewide rollout of the centralized electronic benefit transfer (EBT) card replacement unit process was implemented January 15, 2014. This unit is now the primary replacer of all lost or stolen cards, except for specific exceptions outlined in the Field Business Procedures Manual. DHS sends a letter to households with four or more cards replaced in the last twelve months to reinforce that clients need to secure their card. The process is statewide and has reduced the number of replacement cards by 19% since the Replacement line started.

- We recommend that DHS/OHA Office of Payment Accuracy and Recovery review remaining matches and take necessary action to recover overpayment through collection efforts up to and including prosecution.

  This recommendation has been implemented. As discussed in detail below, all of the potential overpayments identified and forwarded to OPAR are in various stages of investigation, overpayment writing, and recovery. Those warranting additional investigation for fraud have been forwarded by DHS and OHA to OPAR's Fraud Investigation Unit as appropriate. In addition, DHS and OHA have followed up with health plans and providers to recover inappropriate Medicaid payments.

  The audit report identified 5,018 case matches involving about $34.5 million in benefits. As we mentioned in our original response, most of these matches did not indicate inappropriate payments. In 3,183 cases (involving $24.2 million in benefits) the match information provided during the audit would not have changed the benefits these clients received under state policy and federal law. In addition, 609 matches (involving $7.5 million in benefits) were death match cases in which the deceased person in the SSA file was not the same as the person receiving benefits. The most common cause of these mismatches was incorrect entry of an individual's Social Security Number in the program's system.

This left 1,226 cases involving about $2.8 million in benefits as possibly issued in error. Since our original response we have further analyzed the 1,226 possible error cases.

- *We have recovered about $500,000 in Medicaid capitation payments from managed care plans for 289 deceased persons and 159 persons who had some period of incarceration. These figures include some costs incurred outside of the original audit period. We are also pursuing an additional approximately $483,000 in capitation payments for deceased or incarcerated Medicaid clients from terminated health plans. We may not recover some of these payments if the provider is no longer operating.*
- *We have recovered about $33,000 in fee-for–service Medicaid costs from providers who billed for services after the clients date of death. We are continuing our review of another approximately $7,000 in fee-for-service Medicaid payments.*
- *We recaptured approximately $54,000 in unspent SNAP benefits remaining in 184 deceased client accounts.*
- *We forwarded 21 PERS Medicaid matches for deceased client cases involving about $406,000 in benefits to our Estates Administration Unit. In total, 15 of these cases (those without a living spouse) involving about $297,000 have been worked. This resulted in about $8,000 in collections from estates. While there were additional questionable SNAP cases involving deceased persons, we do not collect SNAP benefits from estates.*
- *We did not attempt to collect overpayments on 54 SNAP cases involving about $18,000 in benefits used after the client died, largely because identification of the user and collection is difficult for the amounts involved.*
- *Based on federal guidance and state policy, we did not pursue overpayments on 219 incarcerated SNAP cases involving about $101,000 in issued benefits.*
- *In 55 cases involving about $181,000, we did not pursue overpayments from providers for services provided clients due to our error.*
- *We have written 102 client overpayments involving about $558,000 in total benefits. Included in this total are 88 PERS recipient related overpayments involving over $514,000 in SNAP, Medicaid and*

TANF benefits. In many cases, the overpayment amounts were different than the amount of benefits originally questioned in the audit.

- *After our review, we were able to determine that about $613,000 in SNAP, Medicaid and TANF benefits provided to PERS recipients were appropriate. We also found appropriate approximately $72,000 in Medicaid benefits provided to lottery winners.*
- *We are still reviewing three cases for possible SNAP and Medicaid overpayments involving about $1,000 in payments.*
- *We determined that some of the remaining questioned payments were appropriate or partially appropriate, we lacked critical information, or the amount was too small to justify the cost of collection.*

9. OHA: Safe Drinking Water Revolving Loan Fund for the Fiscal Year Ended June 30, 2012, audit # 2013-12, (dated May 2013)

- We recommend the department continue to refine their financial reporting process to accurately adjust the Safe Drinking Water financial statements to comply with Generally Accepted Accounting Principles.

  In this reporting period $241,586 of additional expenditures and federal revenue were incorrectly accrued on the paper financial statements. A review process has been put in place to double check the paper financial statement adjustments made to accruals in the future.

  We agree that the prior year's accruals were not properly reversed. A review process has been put in place to double check paper financial statement entries including accruals in the future.

- During the current engagement, we performed procedures to follow up on the prior year's internal control deficiency and noted that partial corrective action had been taken to address the recommendations. The agency completed reconciliations for grant phases 04, 05, and 06 and identified the same discrepancies and

reversed the accounting entry in April 2013. The agency initiated contact with the Environmental Protection Agency in May 2013 to address the last three recommendations, but has not yet reached a resolution with the Environmental Protection Agency.

During the interim period the Office of Financial Services completed a reconciliation of the accounting records for each set aside to the federal cash reimbursement system (ASAP). The following entries will be made to the state's accounting system to ensure there is a complete match with the EPA draw accounts in ASAP. These entries will not result in any modification to the closed FFR's nor result in any federal draws against closed grants in ASAP.

The state's accounting system showed excess revenues in the loan fund for grant year200 4 of $287,258.02 and the Admin set-aside in grant year 2006 showed excess revenue/expenses of $7,160.44. We did an adjustment to move $283,022.82 to Local set-aside in grant year2005 and $10,495.64 to State Program Management in grant year 2004 in order to align with the federal system and reports. After this adjustment there will be an excess of $900.00 that is due to the EPA. A letter was sent to EPA which outlined these adjustments and requested a process to return the excess $900 due to EPA.

Once the entries were made, the state's accounting system will be a complete match with the EPA draw accounts in ASAP and the reported FFR's for grant years2004, 2005 and 2006.

Correspondence was subsequently received from EPA instructing the program to apply the excess $900 to offset current period expenditures.

10. DHS and OHA: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2013, audit # 2014- 09, (dated April 2014)

- We recommend department management improve controls in the Receipting Unit to ensure all checks are safeguarded, properly tracked and accounted for in the financial records.

  The agency appropriately segregates the duties of handling checks in its Salem facility. Under the current system, checks received by mail are sorted by category, recorded by count and delivered to the staff member that is responsible for that category. The item count can be reconciled from the online deposit system reports to an excel spreadsheet created by the unit.

  The count and amount of checks received through this process is a small portion of the total revenue recorded by the Receipting unit.

  We have strengthened internal controls on the handoff of checks by including, in addition to a count of checks, the dollar amount, reconciliation, and a check redistribution log. We continue to look for opportunities to reduce the risk by reducing the number of checks received in the agency.

- We recommend department management align policies and procedures with governmental accounting standards to record expenditures in the proper period and we recommend management provide training to staff to ensure that prior period adjustments are utilized when appropriate.

  Each year the agency records regular, routine transactions to refinance revenue and expenditures related to lagged receipt of various revenue sources. As mentioned in the audit finding, these are normal transactions that occur as part of our regular business process.

  In 2009, due to the large dollar amount of these transactions, the agency asked for advice from the Department of Administrative Services, Statewide Accounting and Reporting Services (SARS) on the proper use of prior period adjustments for these transactions. In response, SARS stated, "it's not appropriate to incorporate a prior period adjustment into a routine practice. Prior period adjustments should be reserved for (those infrequent) corrections of errors." This advice was consistent with both the Oregon Accounting

Manual (OAM) 15.85.00.PO and related governmental accounting standards outlined in Governmental Accounting Standards Board (GASB) circulars.

During the 2013 statewide financial audit, auditors again recommended prior period adjustments for routine transactions. On December 3, 2013, the agency, Secretary of State Auditors and SARS met again to discuss the issue. At the meeting, SARS leadership agreed with the auditors that these transactions could, most likely, require prior period adjustments. The agency stated their belief that use of prior period adjustments for routine transactions was contrary to the OAM and GASB.

To ensure that the agency was not in violation of OAM, the agency stated that it would change the practice of recording prior period adjustments (to include material routine transactions) if the OAM were updated to reflect the change.

On December 5, 2013, SARS updated OAM 15.85.00 to include new language on when to record a prior period adjustment for these types of transactions.

Since the change in language in the OAM, the unit has started reviewing all adjustments that occurred during fiscal year 2014 to see if prior period adjustments needed to be done. Clarification to staff of the change in the OAM occurred through the use of Office of Financial Services newsletter, training information shared with Grant Accounting unit, and a process update to improve ability to capture data that would need prior period adjustments.

- We recommend department management review and revise accrual methodologies for revenues and expenditures, as necessary, and perform periodic retrospective comparisons of accruals to actual amounts to ensure the accrual methodologies are reasonable.

Due to an error during year-end reporting the healthcare provider tax (HPT) revenue, drug rebate revenue and Medicaid Management Information Systems, expenditure accrual estimates were based on a 60-day rather than a 90-day availability period. This accounted for three of the four audit comments in this finding.

As a corrective action, beginning in fiscal year 2014, the Statewide Financial Reporting unit will modify its processes to ensure all governmental fund accrual calculations are based on the 90-day availability period. If actual HPT revenues are not known during month 13 financial adjustment periods, the agency will use estimates such as trends and projections that are based on Generally Accepted Accounting Principles (GAAP). The estimates will be compared to actuals for reasonableness.

Statewide financial reporting timelines require agencies to record accrual estimates within approximately 30 days after the end of the fiscal year even though the accrual period doesn't end until 90 days after the end of the fiscal year. This timeframe produces variances between the estimates and actuals. The fiscal year 2013 variances were partially due to the inherent nature of using estimates. The $17.4 million and the $7.5 million variances seem high, but only make up 6.4% and 2.8% of the total accrual of $270 million.

Although variances of actuals and estimates are expected, the agency agrees that accrual amounts should be compared to actuals, and future accrual modifications should be implemented as needed. Therefore, as a corrective action, beginning in 2014 the Statewide Financial Reporting unit will implement a yearly review of its operating statements to document variances and adjust accruals if needed.

The Statewide Financial Reporting unit has reviewed and updated accrual methodologies as appropriate.

- We recommend department management implement internal controls to ensure that all insurance premium revenue due to the department is received, properly classified, and properly recorded.

  The agency reported the correct amount of Oregon Medical Insurance Pool (OMIP) and the Federal Medical Insurance Pool (FMIP) cash in Fiscal Year 2013. We agree that $5 million of this cash was

incorrectly classified as insurance premium revenue, and instead should have been classified as reduction of expenditures. The incorrect classification had no equity impact on the GAAP fund.

The error occurred primarily because the agency received incomplete revenue reports from Regence in fiscal year 2013. Therefore, beginning in fiscal year 2014, as a corrective action the agency will obtain detailed reports from Regence and adjust its records to correctly classify and report the insurance premiums and reductions of expenditures.

The FMIP program closed at the end of fiscal year 2013, but the OMIP program was open through the end of December 2013, and the six months of operation will be included in the agency analysis.

To address audit finding 13-004, in fiscal year 2014 the agency has obtained detailed reports from Regence necessary to determine the source of cash remitted by Regence, and appropriately recorded the cash received based on information available at the time. These reports were received and incorporated in the accounting record on an ongoing basis during fiscal year 2014.

Additionally, to ensure all insurance premiums due to the agency are remitted by Regence, the agency is utilizing the methodology used in the audit analysis, multiplying monthly member contract counts by the relevant premium rates, and reconciling the results with amounts reported and deposited by Regence for the months the programs were open in fiscal year 2014. This analysis was completed for the OMIP program based on information available at accounting close for fiscal year 2014 in September 2014, and the calculated variance was within one percent.

- We recommend department management improve controls to ensure account balances are accurately stated and reconciled to supporting documentation.

We have inventoried and affirmed the existence of the assets in the building and building improvement account. We have not identified any other buildings or building improvements that had not been listed. We

have reviewed the calculations on the asset spreadsheet and corrected any errors identified. We have implemented controls to ensure accuracy going forward including post-review of recorded entries to documentation and calculations.

- We recommend department management gain better understanding of controls already in place and implement the necessary complementary controls to provide assurance that all drug rebate revenue is correctly calculated, invoiced, received, and recorded in the accounting system.

  The CareAssist program is administered by the Office of Pharmacy Programs. The program requested and received a response from HRSA/Office of Pharmacy Affairs (OPA) which indicates that the federal agency is strengthening its process for oversight of the pharmaceutical manufacturer's compliance with providing rebates to 340B covered entities and the accuracy of the rebates provided. The actual calculations of the rebate amounts will still be privileged information and will be only for internal OPA use. The program received guidance from HRSA and will develop a mechanism by which rebates received by CAREAssist are compared over time to identify a variance of more than an expected percentage. The process will be a report automatically generated from the database and will allow the program to follow up with both the manufacturer and OPA for an explanation for the variance.

  The Medicaid Pharmacy program is administered through the Division of Medical Assistance Programs (DMAP). While the program had a number of existing reviews, these reviews lacked a formal process, and lacked formal documentation of the review. Program staff will be developing formal processes to adequately oversee the contractor's invoicing of drug rebate. Program staff will work to develop sound methods of documenting the drug rebate invoicing process. Program staff is also working with the contractor to develop additional controls around disposition of payments and delinquent payment by developing and using existing MMIS reports for review. Each month for our Rebate meeting, a check off list has been created and after each meeting, the signed check off list is scanned along with reports reviewed.

The agency has historically contracted with a third-party vendor to provide independent assurance over the controls utilized by Hewlett Packard for the Medicaid Management Information System. The agency is in the process of issuing a Request for Proposal (RFP) to select an independent contractor to perform annual MMIS controls audits. The RFP statement of work includes the review of drug rebate processing. The agency will be issuing the RFP in early 2015.

- We recommend department management correct the transactions processed with this incorrect coding. We also recommend department management ensure system coding is appropriately updated to allow only current FMAP rates to be used.

  The department has implemented a process change related to Program Cost Account (PCA) structure. The Office of Financial Services (OFS) now enters an 'effective end date' on PCA's to prevent a PCA from being used on a transaction after the grant period has closed.

  The four identified transactions have been corrected in the accounting system with balance transfers. Additional research is being done to ensure there are no additional documents that need adjustment. The change in process was implemented March, 2014.

- We recommend management develop a plan based on current resources to ensure the timely completion of provider health and safety standard surveys for nursing facilities.

  Oregon has a long history of meeting the Centers for Medicare and Medicaid Services (CMS) performance standards related to surveying facilities in fewer than 15.9 months. The Nursing Facility Licensing Unit is dedicated to bringing our CMS performance standard back into compliance and we are anticipating reaching compliance in early 2016. Over the past four years various staffing resource issues, such as the position freeze and mandatory furloughs, have significantly affected our ability to complete our work timely. In fact, our vacancy rate for surveyors reached 34% by the end of the freeze. Implementation of the Quality Indicator Survey (QIS) also contributed to our failure to meet the CMS performance standards. In addition

to the general difficulties inherent of a new process and system, this new federally mandated survey process has increased our required survey team size (particularly for small facilities), increased training requirements, and lengthened total survey time.

Over the past four years we have implemented several continuous improvement activities that have resulted in efficiency gains to the survey process, in turn reducing the amount of time it takes to survey a provider. Those efficiencies have resulted in a 33% reduction in new surveyor training time. We have made efforts to minimize survey related travel and made a 10% reduction in report writing time. We have implemented an Electronic document workflow process, streamlined our report review process to facilitate a faster turnaround time between surveys, and provided provider training on how they can prepare for the new QIS process. Additionally, since July 2013 we have hired a significant number of new surveyors. This has been offset by a number of retirements and staff resignations.

Over the coming two years, we will take a number of steps to bring the department into compliance. By February 2015, we plan to make job offers on all current surveyor vacancies. By September 30, 2015, all new surveyors will be trained, Surveyor Minimum Qualifications Test (SMQT) certified and QIS registered. During this time we will also assess the survey and training teams to optimize production, optimize survey and surveyor turnaround time, evaluate utilization of CMS approved survey contractor to help us complete surveys and evaluate our surveyor recruitment process to enable us to reach better and more qualified applicants. We have also begun bringing retired and resigned surveyors back on a temporary basis to perform surveys.

Our goal is to achieve compliance, and to have no facility with a survey interval over 12.9 months (which is well below the required 15.9 months). We estimate this will be achieved in early 2016.

- We recommend authority management develop a plan that identifies key MMIS edits and implement procedures to periodically test key system edits to ensure they are functioning as intended. We also

recommend management review the claims that should have been rejected by age and gender restriction panel edits to verify those claims are appropriate.

Correct adjudication of Medicaid claims and encounters is a priority for the Oregon Health Authority (OHA). In early 2013, auditors found that the system functionality within the Medicaid Management Information System (MMIS) regarding age and gender restrictions was not as expected. A change request to correct this functionality was discussed. Recognizing the immediate need, a more expedient work-around response to strengthen the rules around age and gender procedures was created. Modifications to these claim rule tables for age and gender restrictions were put in place until the MMIS Restrictions Panel could be corrected. These diagnosis restrictions were inserted into the claim rule tables on February 19, 2013.

In an attempt to confirm that these rules were functioning correctly, a process to randomly pull 35 claims per quarter to be manually checked by staff was initiated using dates of service starting in the first quarter of 2013. The goal of this process was to see if each claim adjudicated properly based on its unique data parameters, including age and gender restrictions. No issues were found processing the claims dataset from the first quarter of 2013. Review of subsequent quarters has been delayed due to heavy workloads brought about by Coordinated Care Organization (CCO) evolutions to cover dental and mental health, ICD-10 implementation work and the manual enrollment processes associated with the Patient Protection and Affordable Care Act of 2010 (ACA) Medicaid expansion. While the manual review has been delayed, the random sample of claims has been captured each quarter. Going forward, the random claim pull will be modified to specifically focus on age and gender related procedures and other key edits, such as provider and client eligibility. Additionally, the manual review of these claim data sets will be prioritized higher until the permanent panel correction can be finalized.

With the claim rule table modifications completed, the lack of functionality of the MMIS Restriction Panel was again brought forth in late 2013. Work on the permanent correction to the Restriction Panel began in December 2013, with the creation of a change request. Now recognized as a high priority requirement, the notice to proceed for change request was authorized on March 4, 2013. In user acceptance testing,

additional issues were identified, so work continues on the permanent correction. It is anticipated the correct panel functionality will be restored as of January 31, 2015.

- We recommend authority management maintain evidence of the initial and renewing database checks for enrolled providers.

  It is important to the Division of Medical Assistance Programs (DMAP) that all program integrity requirements to keep excluded persons or entities from participating in the Medicaid programs be followed. Checking the multiple exclusion databases for newly enrolling Medicaid providers has been operational since March, 2011, when the Patient Protection and Affordable Care Act of 2010 (ACA) became effective. The processes necessary to comply with these checks are documented within the provider enrollment policy and procedures manual.

  In addition to newly enrolling providers, all providers within the Medicaid Management Information System (MMIS) are checked against the Medicare Exclusion Database (MED) on a monthly basis. This monthly MED search results in a report being produced that indicates possible matches to excluded individuals or entities. This report is then worked by staff who are tasked to make a determination on the validity of a possible match. If the match is verified, the excluded individual or entity would immediately be terminated from the Medicaid program. These processes contribute to the high levels of confidence that no excluded individuals or entities are participating in the Oregon Medicaid programs.

  A prior audit found that historical documentation of these database checks was not sufficient. To address this, an MMIS change request was written on March 28, 2013. This change request will expand the provider panel to include a series of check boxes where the enrollment staff could record what databases were checked and when they were checked. The initial estimated completion date for change request was October 31, 2013. Due to other priorities, work to get the change request completed did not occur until late March 2014. This change has now been completed and deployed the week of August 25, 2014.

These exclusion database check boxes will be applied to newly enrolling providers. All providers will be documented for exclusion checks upon the completion of the ACA provider revalidation requirement. This revalidation requirement is targeted for completion in March 2016.

- We recommend authority management develop a security plan that addresses all federally required components, develop and implement a formalized risk analysis program, and ensure system security reviews are conducted timely for all applicable systems involved in the administration of the Medicaid program.

  We agree the Department of Human Services and Oregon Health Authority have not completed all the elements of a formal ADP risk analysis and security review of the Medicaid systems. However, as we have previously communicated, the agencies have traditionally relied on third-party assessments (such as the SOC1 report from TKW), audits from Office of Inspector General, Secretary of State, and the Enterprise Security Office's Annual Information Systems Business Risk Assessment report to provide this information. Security control assessment is included in these assessments. Vulnerability assessment scans of the MMIS system software are periodically performed at least every three years or whenever major changes are made to the system. The last assessment took place in August 2012. The next assessment is scheduled for later in 2014. We use these audits and reports, as well as leveraging reports from the Privacy and Incident Response section, to assist in that determination. While not strictly a formal risk assessment per se, it does provide an analysis of controls from both a system as well as program perspective. In addition, Information Security and Privacy Office (ISPO) staff have conducted security walk-throughs of the State Data Center on a number of occasions as required by the Internal Revenue Service (IRS). The agencies also have the Change Activity Board (CAB) and the Architectural Review Board which gives/requires the Information Security and Privacy Office (ISPO) the opportunity to review proposals for security issues and impact on the IT security environment.

  We also agree that we need to develop a formal risk assessment and security review program based in industry standards and best practices that assesses risks for programs as a whole and not on a system-by-system basis. ISPO has hired a position for this activity and expects to have it in operation by June 30, 2014.

It is envisioned that this program will be policy based. The program will use tools and techniques based on National Institute of Technology and Standards (NIST) principles and standards. The overarching goal is to ensure that security risk analysis is conducted when appropriate on a regularly scheduled basis. It is expected that the program will work closely with the Internal Audits and Consulting Unit to ensure that peer review of findings is included as an integral part of the ongoing risk assessment program.

The Information Security and Privacy Office (ISPO) is currently in the process of performing a Risk Assessment (RA) on the MMIS System and anticipates the RA will be completed by March 2015. ISPO is also on track to perform vulnerability assessments on MMIS in the Summer of 2015. We anticipate that a number of subsystems that "feed" into or use output from MMIS may also be candidates for evaluation. This is dependent on ensuring that the evaluations will not disrupt the transition from the Cover Oregon (CO) Health Insurance Exchange or the contingency support efforts for CO during the Magi/Medicaid and Qualified Health Plan Transition project. We anticipate that evaluation of those systems will occur during the 3rd and 4th quarter of 2015. ISPO's RA program is in the operational pilot stage. Staff have undergone formal training by ISACA and have successfully conducted two pilot assessments to fine tune the tool selection and processes. The overarching policy is in development as part of a revised security policy set due to go forward for approval February 2015.

- We recommend management strengthen its review of balance transfers to ensure costs are not charged to a grant outside of its period of availability. We further recommend management consider implementing a process to limit the charging of costs to a closed grant thereby minimizing the need for corrections.

  Currently, the Immunization section follows the Center for Public Health Practice process, which is, as follows:

  1. *Section fiscal analyst prepares documentation of the original transaction from SFMA with an explanation on why the transfer is requested.*
  2. *Request is submitted to the Practice Program Support Manger (PSM) for review and approval.*

3. *If approved, PSM emails request to the Office of Financial Services (OFS).*
4. *Request is reviewed by OFS divisional liaison.*
5. *If approved, adjustment is entered by OFS.*

Going forward, step 1 above will be expanded to include attaching source documentation from the original transaction. This will allow confirmation that the adjustment is appropriate to the period of availability. A new procedure has been developed to establish a more uniform method for making adjustments. The new expense transfer adjustment policy became effective on June 1, 2014.

- We recommend management ensure the appropriate report is submitted at the end of the grant period. We also recommend management strengthen its reconciliations of Federal Financial Reports to ensure accounting records fully support reported amounts.

  Management emphasized the need for staff to properly identify individual grant reporting requirements and stressed the need to communicate effectively between program staff and the Office of Financial Services (OFS). OFS will review adjustment requests for effective dates and invoice descriptions to determine validity of expenditures. OFS staff will review the Notice of Award and determine if the financial report should be an interim, quarterly, annual or final report. OFS staff will monitor grants after federal reporting has occurred to ensure no additional entries are made and make sure accounting structure is shut down to prevent future occurrences. OFS will expand queries of the datamart to measure expenditures by grant component.

  All adjustments are reviewed by either the Grant Accountant or Division Coordinator to ensure adjustments are in accordance with the notice of award. The invoice description and the date of the original are reviewed. All adjustments are entered by the Grant Accountant or Division Coordinator and then released by a manager or other employee. The Grant Accountant runs a query and verifies on the 66 screen in SFMA no activity has occurred on a closed grant.

- We recommend management ensure controls are in place to review and retain reports used to justify payroll funding splits. Management should ensure funding splits entered into OSPA are appropriate, including those with differences noted during the audit.

  The Oregon Immunization Program developed a process for centralized tracking of payroll documents and assigned responsibility to specific positions. Immunization staff was trained on the improved workflow for payroll documents. This process was tested from July 2013 through January 2014, and formalized in Unit Guideline OPS001 (dated January 28, 2014).

11. OHA: Safe Drinking Water Revolving Loan Fund for the Fiscal Year Ended June 30, 2013, audit # 2015-01, (dated January 2015)

- We recommend the agency continue to refine their financial reporting process to accurately adjust the Safe Drinking Water financial statements to comply with GAAP.

  We agree with the finding. We have incorporated the adjustments and resubmitted the appropriate financial statements. A process has been developed and documented for the creation and review of these financial statements. An appropriate review will be done by the Statewide Financial Reporting Unit going forward.

- We recommend the agency review its process to ensure payroll charged to a program is allowable and unallowable payroll is detected and corrected timely.

  We agree with the finding that an error was made in our payroll coding. The employee's time was coded to the Technical Assistance set-aside when it should have been coded to our other fund fee based program, Operator Certification. An adjustment to correct this error has been made, and will be reflected in the Fiscal Year 2014 expenditure reports. We are now more closely reviewing our time and activity reports to help us avoid similar miscoding in the future.

OHA Audits in 2013 – 2015

2013-2015 Internal and External Audits and Reviews for OHA

Internal Audits and Consults

Name of Audit:	MMIS Implementation - Reporting and Documentation Provider Payments
OHA Programs:	Medical Assistance Programs, Information Services
Status:	Completed
Name of Audit:	Targeted Case Management (TCM)
OHA Programs:	Medical Assistance Programs, Public Health, Shared Services
Status:	Completed
Name of Audit:	Federal Reporting and MMIS Interface
OHA Programs:	Medical Assistance Programs, Shared Services
Status:	Completed
Name of Audit:	Information Technology Security Program
OHA Programs:	Information Services
Status:	In Progress
Name of Audit:	OPAR Internal Fraud Detection
OHA Programs:	Agency Wide
Status:	In Progress
Name of Audit:	Cost Allocation Planning and Accuracy
OHA Programs:	Shared Services
Status:	In Progress
Name of Audit:	SPOTS Audit 2013
OHA Programs:	Agency Wide
Status:	In Progress
Name of Audit:	Staff Safety
OHA Programs:	Agency Wide
Status:	In Progress
Name of Audit:	Medical Program Enrollment Review
OHA Programs:	Medical Assistance Programs
Status:	In Progress

Name of Audit:	Internal Payroll Time Code Reviews
OHA Programs:	Agency Wide
Status:	In Progress
Name of Audit:	IT Access Controls
OHA Programs:	Information Services
Status:	In Progress
Name of Audit:	Staff Safety II
OHA Programs:	Agency Wide
Status:	In Progress
Name of Audit:	Contract Development and Administration
OHA Programs:	Agency Wide
Status:	In Progress
Name of Audit:	Performance Measurement
OHA Programs:	Agency Wide
Status:	In Progress
Name of Audit:	IT Controls Self-Assessment MMIS (Consult)
OHA Programs:	Information Services
Status:	Completed
Name of Audit:	Internal Fraud Communications (Consult)
OHA Programs:	Shared Services
Status:	Completed
Name of Audit:	Douglas County Return of Mental Health Program (Consult)
OHA Programs:	Addictions and Mental Health
Status:	In Progress
Name of Audit:	Blue Mountain Recovery Center Cost Settlement FYE 06-30-12 (Consult)
OHA Programs:	Addictions and Mental Health, Shared Services
Status:	In Progress
Name of Audit:	Cost Allocation Communications (Consult)
OHA Programs:	Shared Services
Status:	In Progress
Name of Audit:	Ethics Structural Review (Consult)
OHA Programs:	Agency Wide
Status:	In Progress

Contracted Audits and Reviews

Name of Audit:	Acumentra Oregon Health Plan's Managed Health Care 2013 External Quality Review
OHA Programs:	Addictions and Mental Health, Medical Assistance Programs
Status:	Completed
Name of Audit:	Acumentra Information System Capabilities Assessment 2014 External Quality Review
OHA Programs:	Medical Assistance Programs
Status:	In Progress
Name of Audit:	TKW Audit of MMIS Controls
OHA Programs:	Medical Assistance Programs, Information Services
Status:	Completed
Name of Audit:	Disproportionate Share Hospitals FY2010
OHA Programs:	Medical Assistance Programs
Status:	Completed
Name of Audit:	Disproportionate Share Hospitals FY2011
OHA Programs:	Medical Assistance Programs
Status:	In Progress
Name of Audit:	FMIP Financial Statements Review
OHA Programs:	OHA Policy (OPHP), Shared Services
Status:	Completed
Name of Audit:	FMIP Financial Statements Review (Program Closeout)
OHA Programs:	OHA Policy (OPHP), Shared Services
Status:	Completed
Name of Audit:	FMIP and OMIP Refund Assessment and Claims Audits
OHA Programs:	OHA Policy (OPHP)
Status:	Completed

Secretary of State Audits

Name of Audit:	Statewide Single Audit Year Ending 6-30-2013
OHA Programs:	Agency Wide
Status:	Completed
Name of Audit:	Oregon State Hospital Audit
OHA Programs:	Addictions and Mental Health
Status:	In Progress

Name of Audit: Statewide Single Audit Year Ending 6-30-2014
OHA Programs: Agency Wide
Status: In Progress

Name of Audit: Safe Drinking Water Revolving Loan Fund Agreed Upon Procedures for Fiscal Year Ending 6-30-2013
OHA Programs: Public Health, Shared Services
Status: Completed

Name of Audit: Statewide IT Systems Development
OHA Programs: Information Services, Shared Services
Status: In Progress

Federal Audits and Reviews

Name of Audit: IRS Office of Safeguards Review 2011
OHA Programs: Information Services, Shared Services
Status: Completed

Name of Audit: HHS OIG Physician Administered Drugs FFS
OHA Programs: Medical Assistance Programs
Status: Completed

Name of Audit: HHS OIG Physician Administered Drugs MCO
OHA Programs: Medical Assistance Programs
Status: Completed

Name of Audit: CMS Home and Community Based Services (HCBS) Support Services Waiver Audit
OHA Programs: Medical Assistance Programs
Status: Completed

Name of Audit: GAO Psychotropic Medications Prescribed to Foster Care Children Follow-up
OHA Programs: Addictions and Mental Health, Medical Assistance Programs
Status: Completed

Name of Audit: CMS Provider Tax Financial Review
OHA Programs: Medical Assistance Programs, Shared Services
Status: In Progress

Name of Audit: HHS CMS Pre-existing Condition Insurance Pool (PCIP)
OHA Programs: OHA Policy (OPHP)
Status: Completed

Name of Audit:	HHS CMS Evaluation of Health Home Benefit Option
OHA Programs:	OHA Policy
Status:	In Progress

Name of Audit:	HHS OIG Review of Drug Rebates
OHA Programs:	Medical Assistance Programs
Status:	Completed

Name of Audit:	EPA Lead-based Paint Grant Review
OHA Programs:	Public Health, Shared Services
Status:	Completed

Name of Audit:	HRSA Ryan White CAREAssist Program Review
OHA Programs:	Public Health
Status:	Completed

Name of Audit:	CMS Medicaid Program Integrity
OHA Programs:	Medical Assistance Programs, Shared Services
Status:	Completed

Name of Audit:	NRC- Radiation Protection Services (RPS) Audit
OHA Programs:	Public Health
Status:	Completed

Name of Audit:	Payment Error Rate Measurement (PERM) FFY 2014
OHA Programs:	Medical Assistance Programs, Shared Services
Status:	In Progress

Name of Audit:	EPA Safe Drinking Water Revolving Loan Fund SFY 2013
OHA Programs:	Public Health
Status:	Completed

Name of Audit:	SAMHSA Projects for Assistance in Transition from Homelessness (PATH) Site Visit
OHA Programs:	Addictions and Mental Health, Shared Services
Status:	Completed

Name of Audit:	Office of Family Planning, Region X Title X Family Planning Program Review
OHA Programs:	Public Health
Status:	Completed

Name of Audit:	CMS Home and Community Based Services (HCBS) Medically Involved Children's Waiver Review
OHA Programs:	Medical Assistance Programs
Status:	Completed
Name of Audit:	SAMHSA Substance Abuse Prevention and Treatment (SAPT) Core Technical Review
OHA Programs:	Addictions and Mental Health, Shared Services
Status:	In Progress
Name of Audit:	CDC Immunization Program 2014 Site Visit
OHA Programs:	Public Health
Status:	Completed
Name of Audit:	CMS Home and Community Based Services (HCBS) Medically Fragile Children's Waiver Review
OHA Programs:	Medical Assistance Programs
Status:	Completed
Name of Audit:	HUD Site Visit-HOPWA Audit
OHA Programs:	Public Health
Status:	Completed
Name of Audit:	SSA Oregon State Triennial Compliance Review
OHA Programs:	Agency Wide
Status:	Completed
Name of Audit:	SAMHSA Adult Mental Health-Mental Health Block Grant Audit
OHA Programs:	Addictions and Mental Health, Shared Services
Status:	In Progress
Name of Audit:	MIECHV/ECCS Grants Site Visit
OHA Programs:	Public Health
Status:	In Progress
Name of Audit:	WIC Vendor Management - Management Evaluation FY 2014
OHA Programs:	Public Health
Status:	Completed
Name of Audit:	IRS Office of Safeguards Review 2014
OHA Programs:	Information Services, Shared Services
Status:	Completed

Name of Audit:	HHS OIG Indian Health Services Financial Review
OHA Programs:	Medical Assistance Programs, Shared Services
Status:	In Progress
Name of Audit:	WIC Certification and Eligibility - Management Evaluation FY 2015
OHA Programs:	Public Health
Status:	In Progress
Name of Audit:	CMS Home and Community Based Services (HCBS) APD Waiver Review
OHA Programs:	Medical Assistance Programs
Status:	In Progress
Name of Audit:	HHS CMS Evaluation of 1915(k) Community First Choice State Plan Option (K Plan)
OHA Programs:	Medical Assistance Programs
Status:	In Progress
Name of Audit:	EPA Safe Drinking Water Revolving Loan Fund SFY 2014
OHA Programs:	Public Health
Status:	In Progress

Other Agency Reviews

Name of Audit:	Information Security Business Risk Assessment Report - 2013 (Department of Administrative Services Contract)
OHA Programs:	Information Services
Status:	Completed
Name of Audit:	Oregon Department of State Police Criminal Justice Information Services (CJIS) Information Technology Security Audit
OHA Programs:	Addictions and Mental Health, Public Health, Human Resources, Information Services, Shared Services
Status:	Completed

Oregon Health Authority
Staffing Ratio Report

OHA's mission given to us by the Governor, the Legislature and agency leadership is that we must ensure the agency can support a health care system that is patient-centered, coordinated and reduces waste and inefficiency.

We are approaching this in a way that balances the intent of House Bill 3165 (which was previously reported under the requirements of HB 4131,) the ongoing changes to the health delivery system and how OHA can support these changes long term, including the implementation of our management system. As of November 1, 2014 OHA has met our target of 1:11 and we will continue to monitor our monthly ratios to ensure on-going compliance.

PROGRAM PRIORITIZATION FOR 2015-17

Agency Name: Oregon Health Authority

2015-17 Biennium

Agency-Wide Priorities for 2015 -2017 Biennium

1	4			5	6	7	8	9	10	11	12	13	14
Priority (ranked with highest priority first)	**Program or Activity Initials**	**ORBITS DCR Title**	**Is Program leveraged for the DSHP Waiver?**	**Program Unit/Activity Description**	**Identify Key Performance Measure(s)**	**Primary Purpose Program-Activity Code**	**GF**	**LF**	**OF**	**NL-OF**	**FF**	**NL-FF**	**TOTAL FUNDS**
Agcy													
1	Medical Assistance Prgms-OHP Payment	OHP & CHIP	No	The Oregon Health Plan (OHP) provides physical health, mental health and dental services to qualifying low-income and vulnerable Oregonians. Medical Assistance Programs pays Coordinated Care Organizations to provide most of the care on a per capita basis with rates that are set by an independent actuary to reflect the cost of providing services. Some services are paid on a fee-for-service basis with rates that are typically less than cost. The Children's Health Insurance Program (CHIP) provides physical health, mental health and dental services to uninsured Oregon children. Medical Assistance Programs pays Coordinated Care Organizations to provide most of the care on a per capita basis with rates that are set by an independent actuary to reflect the cost of providing services. Some services are paid on a fee-for-service basis with rates that are typically less than cost.	Preventive services for OHP youth and adults, Preventive services for OHP children, Appropriate prenatal care for OHP clients, PQI Hospitalizations of OHP clients	12	790,620,363	-	1,885,394,144	-	9,552,040,142	-	12,228,054,649
2	Medical Assistance Prgms-OHP Payment	Non-OHP	Small amount	The Non-OHP budget includes the following: the Citizen/Alien Waived Emergency Medical (CAWEM) program, which provides emergency medical services to children and adults who are ineligible for medical assistance solely because they do not meet the Medicaid citizenship or immigration status requirements; the Health Insurance Premium program, which reimburses clients for employer-sponsored insurance premiums; "clawback" payments to the federal government to help pay for the Medicare Prescription Drug (Part D) program; and, the Qualified Medicare Beneficiaries (QMB) program that pays Medicare premiums, deductibles, and copayments for low-income clients.	Preventive services for OHP youth and adults, Preventive services for OHP children, Appropriate prenatal care for OHP clients, PQI Hospitalizations of OHP clients	12	341,181,408	-	4,646,577	-	318,770,826	-	664,598,811
3	Medical Assistance Prgms-OHP Payment	Pharmacy Programs	No	Pharmacy Programs provide all Oregonians access to reduced priced drugs through the Oregon Prescription Drug Program (OPDP). OPDP also provides consolidated purchasing power for the Oregon Education Benefit Board by jointly purchasing prescription drugs with the state of Washington through the NW Drug Consortium. Pharmacy Programs also provides health insurance to persons who are HIV positive through CAREAssist, Oregon's version of the Ryan White AIDS Drug Assistance Program.	Reduced cost of prescription drugs by consolidating all OHA drug purchasing in one. Provide drug assistance to individuals with the state who are HIV positive.	12	7,830,221	-	58,103,882	-	9,728,128	-	75,662,231
4	Addictions and Mental Health Program -	Alcohol and Drug Treatment	Small amount	Addiction clinical and recovery support services provide an array of medically necessary services tailored to individual clinical needs. These services are for individuals who are not eligible for Medicaid and who have no or sub-standard insurance benefits and financial resources to cover care. Treatment includes: standard and intensive outpatient treatment, 24-hour residential treatment, detoxification and withdrawal management, medications aimed to assist people stop using alcohol and opioids. Within each level or intensity of service, clients receive clinical assessments, individual, group and family counseling, case management and toxicology testing for presence of various substances of abuse. Recovery Services include, but are not limited to: Peer to peer mentoring, recovery coaching, life skills training, child care, and housing barrier removal.	Completion of alcohol & drug treatment, Alcohol & drug treatment effectiveness: Employment, Child reunification, School performance	12	32,269,709	-	14,310,379	-	46,846,112	-	93,426,200

Priority (ranked with highest priority first)	Program or Activity Initials	ORBITS DCR Title	Is Program leveraged for the DSHP Waiver?	Program Unit/Activity Description	Identify Key Performance Measure(s)	Primary Purpose Program-Activity Code	GF	LF	OF	NL-OF	FF	NL-FF	TOTAL FUNDS
5	Addictions and Mental Health Program	Community Mental Health	Partially	Community programs provide a range of services tailored to the consumer's needs, including community/outpatient intervention and therapy, case management, residential and foster care, supported education, acute hospital care, and crisis and pre-commitment services. The community also provides supervision and treatment for persons under the jurisdiction of the Psychiatric Security Review Board.	Mental health client level of functioning, Child & Adult Mental Health Services	12	275,850,912	-	39,140,505	-	161,635,950	-	476,627,367
6	Public Health Programs	Center for Prevention and Health Promotion	Yes	Responsible for chronic disease prevention and health promotion, injury prevention, Prescription Drug Monitoring program, Women, Infants and children (WIC) Nutrition program, family planning, oral health, prenatal care, newborn hearing screening, and school-based health centers.	Teen suicide, Tobacco use, Cigarette packs sold, Teen pregnancy, Early prenatal care	10	9,431,507	-	8,654,245	40,000,000	89,482,469	101,929,051	249,497,272
7	Public Health Programs	State Public Health Director	No	Responsible for state emergency preparedness, planning, and response.		8, 10	10,404,666	-	-	-	6,247,419	-	16,652,085
8	Public Health Programs	Center for Public Health Practice	Yes	Responsible for state support to local health departments core capacity in disease control and surveillance, HIV/STD/TB, immunization, statewide communicable disease control and testing, maintaining vital records and health statistics.	HIV rate, child immunizations, Influenza vaccinations for seniors	8,10	3,664,021	-	286,093	-	22,445,446	-	26,395,560
9	Public Health Programs	Center for Health Protection	Yes	Responsible for the State Drinking Water Program (Primacy) and EPA Revolving Loan Fund which provides approx. $12M annually to local water systems for capital improvement initiatives. Also identifying and preventing environmental and occupational safety hazards, and initiatives such as the health facilities licensure, quality improvement and regulation, medical marijuana, and Patient Safety Commission.		9,10	2,148,000	-	958,209	-	2,939,890	-	6,046,099
10	Addictions and Mental Health Program	State Hospital System	3 Non-Medicaid Gero units	The State Hospital System - with locations in Salem and Junction City provide 24-hour supervised care to people with the most severe mental health disorders, many of whom have either been civilly committed to the Department as a danger to themselves or others, or have been found guilty except for insanity, or require hospital care to restore competency in order that they may aid and assist in their own defense during a criminal proceeding.	OSH restraint rate, OSH length of stay (others to consider might be ratio of # served/# of budgeted beds, and/or recidivism/revocation rates. These new measures should be vetted a bit with Cabinet and or AMH, in light of the fact that KPMs are part of a larger OHA/DHS picture)	12	424,486,507	-	22,339,740	-	46,580,657	-	493,406,904

Priority (ranked with highest priority first)	Program or Activity Initials	ORBITS DCR Title	Is Program leveraged for the DSHP Waiver?	Program Unit/Activity Description	Identify Key Performance Measure(s)	Primary Purpose Program-Activity Code	GF	LF	OF	NL-OF	FF	NL-FF	TOTAL FUNDS
11	Addictions and Mental Health Program	Alcohol and Drug Prevention		Prevention programs help people make smarter life choices and reduce risk factors associated with alcohol and drug abuse. These services reduce the rate of underage drinking and the development of substance use disorders and associated health and social problems. Prevention services are available in every Oregon county. Community mental health programs (CMHPs), tribes and statewide contractors provide evidence-based services to prevent the problematic use of addictive substances and activities including alcohol and drugs.		12	433,927	-	1,151,370	-	10,736,202	-	12,321,499
12	Addictions and Mental Health Program	Gambling Treatment and Prevention	No	Gambling treatment and prevention programs provide an array of services tailored to the clients' needs. These include: assessment; individual, group and family counseling; and residential treatment.	Gambling Treatment Effectiveness	12	-	7,528,018	618,180	-	-	-	8,146,198
13	Addictions and Mental Health Program	State Delivered SRTF's	No	The state operated 16-bed facilities permit the safe movement of persons from the State Hospital(s) into the community that current providers choose not to serve.		12	5,518,675	-	509,163	-	2,085,627	-	8,113,465
14	Public Employee's Benefit Board	PEBB/Stabilization, Self Insurance, Flex Benefit, Fully insured Plans, and Optional Benefits	No	(1) There is created the Public Employees' Revolving Fund The balances of the Public Employees' Revolving Fund are continuously appropriated to cover expenses incurred in connection with the administration of ORS 243.105 to 243.285 and 292.051. Among other purposes, the board may retain the funds to control expenditures, stabilize benefit premium rates and self-insure. The board may establish subaccounts within the Public Employees' Revolving Fund. (2) There is appropriated to the Public Employees' Revolving Fund all unused employer contributions for employee benefits and all refunds, dividends, unused premiums and other payments attributable to any employee contribution or employer contribution made from any carrier or contractor that has provided employee benefits administered by the board, and all interest earned on such moneys. Fully insured premiums are treated as a pass-through account and funds are sent directly to the Fully Insured provider. (1) In addition to the powers and duties otherwise provided by law to provide employee benefits, the Public Employees' Benefit Board may provide, administer and maintain flexible benefit plans under which eligible employees of this state may choose among taxable and nontaxable benefits as provided in the federal Internal Revenue Code. (2) In providing flexible benefit plans, the board may offer: (a) Health or dental benefits as provided in ORS 243.125 and 243.135. (b) Other insurance benefits as provided in Optional benefits are insurance premiums paid by members and are treated as pass-through account and funds are sent directly to the Optional Benefit provider.	243.167 Public Employees' Revolving Fund; continuing appropriation to fund, 243.221 Options that may be offered under flexible benefit plan.	10			1,635,837,724				1,635,837,724
15	Oregon Educators Benefit Board (OEBB)	OEBB Stabilization	No	There is created the Oregon Educators Revolving Fund, separate and distinct from the General Fund. Moneys in the Oregon Educators Revolving Fund are continuously appropriated to the Oregon Educators Benefit Board to cover the board's expenses incurred in connection with the administration of ORS 243.860 to 243.886. Moneys in the Oregon Educators Revolving Fund may be retained for limited periods of time as established by the board by rule. Among other purposes, the board may retain the funds to pay premiums, control expenditures, stabilize premiums and self-insure.	243.884 Oregon Educators Revolving Fund; continuous appropriation to board; purposes; rules; moneys paid into fund	10	-	-	1,633,487,088	-	-	-	1,633,487,088

Priority (ranked with highest priority first)	Program or Activity Initials	ORBITS DCR Title	Is Program leveraged for the DSHP Waiver?	Program Unit/Activity Description	Identify Key Performance Measure(s)	Primary Purpose Program-Activity Code	GF	LF	OF	NL-OF	FF	NL-FF	TOTAL FUNDS
16	Private Health Partnerships	Oregon Transitional Reinsurance Pool (OTRP) program		The OTRP is a temporary measure to help stabilize individual market premiums during the transition to "guaranteed issue" health insurance coverage required by the ACA by covering a portion of exceptional claims costs for roughly 2,100 high-risk Oregonians. This program is scheduled in statute to close by the end of the 2015-2017 biennium, and at that point the OPHP budget structure also is expected to close.		10	-	-	363,651	103,500,000	-	-	103,863,651
17	Medical Assistance Prgms-OHP Payment	Law Enforcement Medical Account	Small amount	Law Enforcement Medical Account (LEMLA): The program pays medical claims for individuals who are injured in interactions with law enforcement. Law enforcement agencies submit claims to OHA when efforts to recover costs from the individuals or their insurance companies fail.		12	39,014	-	1,354,360	-	-	-	1,393,374
18	Health Policy Programs	OHIT Incentive Payments	No	The Medicaid Electronic Health Records Incentive Payment provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.			-	-	-	-	61,610,160	-	61,610,160
							1,903,878,930	7,528,018	5,307,155,310	143,500,000	10,331,149,028	101,929,051	$ 17,795,140,337

Oregon Health Authority 2015 – 2017 Governor's Budget

10% General Fund Reduction Options

A large proportion of the Oregon Health Authority's (OHA) budget is expended for services directly provided to clients.

General criteria and principles applied to the prioritized reduction list included:

- Identifying reductions that do the least harm to the fewest number of clients
- Applying the OHA goals of containing costs, improving quality and increasing access to health care
- Avoiding reductions that will shift people to a more costly service model within OHA or DHS
- Minimizing affect to OHA Health Systems Transformation efforts in 15-17
- Identifying where the Affordable Care Act (ACA) provide an opportunity to minimize impact on OHA clients/customers
- Minimizing potential for the reduction to impact OHA's ability to meet its obligations/commitments to Centers for Medicare and Medicaid Services (CMS) for the Designated State Health Programs Waiver (DSHP)
- Mitigating any impact for OHA's ability to meet its obligation to CMS for the 2% test

Any reductions necessary in General Fund would potentially affect the OHA programs in the following areas:

Central Office and Shared Services

Most of the Central Office and Shared Services General Fund is necessary for on-going commitments for which OHA does not materially have the option to reduce. Central, Shared, State Government Service Charges, and Debt Service on Capital Construction authorized in prior biennium, account for less than 6 % of this budget. Administrative cuts through staff reductions or vacancies, or cuts to professional service contracts have been implemented in prior biennia. As OHA continues with its' Health Systems Transformation efforts, any further reductions in these areas would have a direct impact for the Director's Office, as well as many of the OHA dedicated services (Budget Planning and Analysis, Communications, and Human Resources).

Medical Assistance Programs (Oregon Health Plan-OHP)

Reductions in the Medical Assistance Program (MAP) budget may jeopardize most of the $1.9 Billion in federal investment approved under the Designated State Health Programs (DHSP) Waiver in July 2012.

The first program reduction includes the option to make the mental health preferred drug list enforceable. ***This reduction was included as part of the 2015-17 Governor's Budget.***

The next items on the list are reductions that would eliminate Indirect and Direct Medical Education payments to teaching hospitals for graduate medical education; at the very time we need more trained medical professionals to serve our growing population. This reduction is not included in the Governor's Budget.

Services that would be reduced or eliminated include specific dental services, non-emergent dental coverage for OHP non-pregnant clients, therapy services, prosthetic devices, hearing aids, and chiropractic and podiatry services. Reducing the OHP list of prioritized services by 25 fewer lines, and eliminating outpatient mental health benefits under OHP for non-pregnant adults would be last. Obviously, some individuals could have immediate adverse impact to their health without these services; others could see their health deteriorate.

All reductions to OHP would require approval by the Center for Medicaid and Medicare Services (CMS) and most would be prohibited under the Special Terms and Conditions (STC) previously agreed upon by OHA and CMS. This reduction is not included in the Governor's Budget.

Public Health

Targeted reductions for 15-17 impact the public health system at both the local and the state level. None of the below reductions are included in the Governor's Budget.

The base support to local health departments (LHDs) would reduce the per capita support to less than 98 cents per year. Additionally, the position responsible for the biweekly CD Summary publication of public health recommendations and data for physicians and the medical community would be eliminated.

The State Public Health Lab would stop conducting antibiotic susceptibility testing. This may lead to more cases of Tuberculosis and advanced stages of other diseases.

Eliminating state support to LHDs for Sexually Transmitted Disease (STD) investigation services, could lead to an increase of disease transmission in communities of risk.

A contracted service for the follow up telephone survey of the Pregnancy Risk Assessment Monitoring (PRAMS) would be eliminated.

Lastly, reductions to both the WIC Senior Food Market and WIC Farmer's Market would cut food vouchers to thousands of seniors and families who rely upon the subsidy for fresh fruit and vegetables. This also reduces income for the vendors who promote and provide the healthy food options to local communities.

Addictions and Mental Health

Reductions specifically affecting the Oregon State Hospital system and Community Mental Health would include:

A longer phase-in to the reopening of one Gero-Neuro ward at the Oregon State Hospital, no cost of living increases to Community Mental Health (CMH) and Alcohol and Drug (A&D) treatment service contracts, and defer the capital improvement budget for the state hospitals. ***The Gero-Neuro ward reduction was included as part of the 2015-17 Governor's Budget.***

Amending the planned phase-in of residential treatment facility cottages at the Junction City facility would inhibit the ability of moving patients that are ready to move from the Secured Residential Treatment Facilities. By delaying or removing cottages as a phased in reduction, this will ultimately affect the ability to move patients to a community setting. ***This reduction was included as part of the 2015-17 Governor's Budget.***

Elimination of community mental health caseload funding will inhibit the ability for AMH to assist with discharging civilly committed individuals from the state hospital system, to community programs. This may also jeopardize Oregon's compliance with the Olmstead ruling. This reduction is not included in the Governor's Budget.

Elimination of the CMH Mental Health Services Fund for residential development may result in some facilities deteriorating and potentially becoming unsafe. This could affect the environment and livability of residential programs. This reduction is not included in the Governor's Budget.

Reductions to CMH direct contracts and flexible spending provisions will significantly affect those who are not covered by Medicaid. This too could result in increased lengths of stay in the OSH and increase the number of persons waiting in acute care for state hospitalization. This reduction is not included in the Governor's Budget.

Lastly, amending the planned phase in for Secured Residential Treatment Facilities by removing units would reduce overall capacity from 6 units to 4, and limits the available number of beds for patients. This reduction is not included in the Governor's Budget.

10% General Fund / 10% Other & Federal Fund Reduction Options for the 2015-2017 Biennium

Oregon Health Authority 2015 - 2017 Current Service Level Budget at Governor's Budget	**2,873,839,754**	**4,729,230,609**	**9,706,124,639**	**17,309,195,002**
10% Target	**287,383,975**	**472,923,061**	**970,612,464**	**1,730,919,500**

Does this affect DSHP Yes or No	Accumulative % Reduction of CSL GF	Agency Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	Employee FTE Affected	Impact of Reduction on Services and Outcomes
~~No~~	~~-0.37%~~	~~1~~	~~MAP~~	~~Make the mental health preferred drug list (PDL) enforceable. Prescribers of mental health medications would be required to adhere to the PDL. Exceptions to the PDL would be administered by prior authorization. An enforceable PDL for mental health medications would increase usage of preferred drugs. There would be no limitation on access to prescriptions under this reduction. Before being placed on the PDL, drugs are subjected to rigorous evidence review. LEGISLATIVE ACTION REQUIRED. CMS APPROVAL REQUIRED.~~	~~Y~~	~~(10,676,583)~~	~~(7,605,257)~~	~~(33,008,289)~~	~~(51,290,129)~~	~~0~~	~~0.00~~	~~Many mental health organizations, including the National Alliance of Mental Illness (NAMI), strongly oppose putting mental health drugs on an enforceable PDL stating that many drugs have little research or outcome data to be evaluated properly.~~
No	-0.56%	2	MAP	Eliminate the Indirect Medical Education (IME) component of the Graduate Medical Education (GME) program. The agency would eliminate Medicaid payments to teaching hospitals that help offset indirect costs associated with their GME programs. IME includes indirect costs that arise from the inexperience of residents such as extra medical tests and reduced productivity. CMS APPROVAL REQUIRED.	Y	(5,404,000)	-	(9,358,000)	(14,762,000)	0	0.00	This reduction would mean that hospitals would have less incentive to train new physicians. The impact on the provider workforce may limit access to quality health care for all Oregonians.
No	-1.04%	3	MAP	Eliminate the Direct Medical Education (DME) component of the Graduate Medical Education (GME) program. The agency would eliminate Medicaid payments to teaching hospitals that help offset costs associated with their graduate medical education programs. GME includes costs associated with stipends or salaries for residents, payments to supervising physicians, and direct program administration costs. CMS APPROVAL REQUIRED.	Y	(13,897,000)	-	(24,063,000)	(37,960,000)	0	0.00	This reduction would mean that hospitals would have less incentive to train new physicians. The impact on the provider workforce may limit access to quality health care for all Oregonians.
~~Yes~~	~~-1.35%~~	~~4~~	~~AMH-OSH~~	~~Remove phase-in to reopen one Neuro-Gero unit that was closed July 2013. The 2015-17 Current Service Level (CSL) included funding to re-open this unit, however this unit may remain vacant if the volume of aid and assist (370) caseload does not grow to the level that another unit is required to accommodate this caseload.~~	~~N~~	~~(8,839,080)~~			~~(8,839,080)~~	~~(43)~~	~~(43.00)~~	~~The closure of the Gero unit in 2013-15 removed 24 beds and moved patients formerly served at OSH into less restrictive community based programs that are a more appropriate level of care for these patients. The 2015-17 CSL included reopening this unit to add capacity at OSH in response to the growth in aid and assist 370 caseload growth. Leaving this unit vacant in 2015-17 would have little impact on services and outcomes, however if 370 caseload growth continues, OSH would have to reopen this unit to accommodate increased caseload in order to avoid more patients on the wait list for OSH services and longer wait times.~~
Yes	-1.39%	5	AMH-A&D Tx	Remove COLA for A&D Treatment	N	(1,071,396)	(578,313)	(1,664,164)	(3,313,873)	0	0.00	This action would eliminate the COLA planned for A&D treatment services. This is the first increase that service providers have had in years. Reducing the rate of funding paid to treatment providers as costs of doing business increase makes it more difficult to attract and retain qualified staff and to offer quality services to Oregonians in need.
Partially	-1.67%	6	AMH-CMH	Remove COLA for CMH	N	(8,096,927)	(639,151)	(4,022,480)	(12,758,558)	0	0.00	As actual costs do increase, this means there would be less ability to provide the same level of service to clients in the community programs. There is the possibility of reductions in workforce in community providers and the potential loss of some smaller providers due to the inability to secure funding through other sources.
No	-1.67%	7	AMH-Cap Imp	Reduce Capital Improvement Budget by 15%	N	(104,942)	-	-	(104,942)	0	0.00	This action defers the capital improvement budget for the fourth biennium in a row. Due to new construction for the Salem campus of the hospital system, and the planned construction of a new facility in Junction City, it is anticipated that the need for remodel or improvement projects is low, which will allow this move without great risk to the agency.

10% General Fund / 10% Other & Federal Fund Reduction Options for the 2015-2017 Biennium

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Does this affect DSHP Yes or No	Accumulative % Reduction of CSL GF	Agency Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	Employee FTE Affected	Impact of Reduction on Services and Outcomes
No	-2.08%	8	MAP	Eliminate coverage for specific dental services for Oregon Health Plan (OHP) Plus adult clients. The agency would no longer cover the following dental services for adults (including pregnant adults) receiving the OHP benefit package: root canals for permanent teeth and retreatment of root canals (i.e., endodontics); full and partial dentures; and crowns. Oregon Health Plan coverage is based on the Prioritized List of Health Services. The dental services eliminated for OHP Plus adults under this reduction are those found on lines 414, 436,468, 477, 480 and 494 of the prioritized list. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions (STCs) prohibit the state from reducing eligibility or benefits.	Y	(11,608,334)	-	(35,194,521)	(46,802,855)	0	0.00	Adults receiving the OHP benefit package could end up requiring more teeth extracted if they cannot be restored. Loss of denture coverage would prevent these clients from getting dentures to replace missing teeth, which can result in difficulty eating and finding employment. With reduced dental benefits, clients may access the emergency department more often because of unmet dental needs.
No	-3.06%	9	MAP	Eliminate non-emergent dental coverage for OHP non-pregnant clients. OHP non-pregnant adults would have a reduced dental coverage package, which is limited to emergency dental services (e.g., acute infection or abscess, severe tooth pain, tooth re-implantation and extraction of symptomatic teeth). LEGISLATIVE ACTION REQUIRED. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions (STCs) prohibit the state from reducing eligibility or benefits.	Y	(28,162,526)	-	(182,784,206)	(210,946,732)	0	0.00	Non-pregnant adults who receive the OHP benefit package would receive a limited coverage dental package. A reduced dental coverage package would be limited to services requiring immediate treatment and are not intended to restore teeth. Services provided include treatment for the following: acute infection; acute abscesses; severe tooth pain; tooth re-implantation when clinically appropriate; and extraction of teeth, limited to those teeth that are symptomatic. Lack of comprehensive dental benefits and untreated oral health conditions can cause disfiguring tooth loss and decay that can limit employment options and lower self-esteem. Problems with oral health can exacerbate and cause other serious health conditions.
No	-3.09%	10	MAP	Eliminate coverage for therapy services for Oregon Health Plan (OHP) non-pregnant adults. The agency would eliminate physical therapy, occupational therapy, and speech therapy from the OHP benefit package for non-pregnant adults. LEGISLATIVE ACTION REQUIRED. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions (STCs) prohibit the state from reducing eligibility or benefits.	Y	(854,667)	-	(3,830,174)	(4,684,841)	0	0.00	Non-pregnant adult Oregon Health Plan clients needing these services would experience prolonged health care issues affecting their ability to become self-sufficient. Hospital stays and the length of time for recovery from orthopedic surgery would increase. This reduction would negatively impact the health system transformation work as fewer services and dollars would be available.
No	-3.13%	11	MAP	Eliminate coverage for prosthetic devices, hearing aids, chiropractic services and podiatry services for Oregon Health Plan (OHP) non-pregnant adults. The agency would eliminate coverage for prosthetic devices, hearing aids, chiropractic services, and podiatry services from the OHP benefit package for non-pregnant adults. LEGISLATIVE ACTION REQUIRED. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions (STCs) prohibit the state from reducing eligibility or benefits.	Y	(1,114,449)	-	(3,006,236)	(4,120,685)	0	0.00	Health care needs for a significant number of non-pregnant adult Oregon Health Plan clients, especially seniors and people with disabilities would go unmet. For example, individuals would live without prosthetic devices for amputated limbs; individuals with hearing impairments would go without necessary aids; and, individuals with diabetic or neuropathic conditions would go without foot care treatment. In some instances, other agency programs would have to fund these services. This reduction would negatively impact the health system transformation work as fewer services and dollars would be available.
No	-3.38%	12	MAP	Eliminate dental coverage for Oregon Health Plan (OHP) non-pregnant adults. The agency would eliminate the remaining non-pregnant adult dental coverage for the OHP benefit package. LEGISLATIVE ACTION REQUIRED. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions (STCs) prohibit the state from reducing eligibility or benefits.	Y	(7,318,868)	-	(39,585,128)	(46,903,996)	0	0.00	The lack of a dental benefit for non-pregnant adults on the Oregon Health Plan (OHP) would cause adverse effects on their physical health, such as diabetes and cardiovascular disease. Emergency room visits would increase. The OHP dental care organization infrastructure would be threatened with the loss of the adult population. This reduction would negatively impact the health system transformation work as fewer services and dollars would be available.
~~**No**~~	~~-3.43%~~	~~13~~	~~AMH JC~~	~~Amend JC Phase in - remove one of three Residential Treatment Facility (RTF) cottages phased in in 2015-17 CSL Assumes a 24 month reduction of funding for this cottage from the 2015-17 CSL and a reduction of CSL funded capacity of eight beds. Because most staffing for these cottages serve all three cottages, the staff and dollar reduction for each cottage phase in removal is not equivalent, rather it increases with each cottage phase-in removal.~~	~~N~~	~~(1,467,758)~~	~~(76,783)~~	~~(41,882)~~	~~(1,586,423)~~	~~(6)~~	~~(6.00)~~	~~Holding the phase in of this Junction City cottage will reduce the RTF transitional treatment capacity of the Junction City hospital by eight beds. Patients in the Secured Residential Treatment Facility (SRTF) units of the Junction City facility, that have recovered to the point that they are ready for an RTF transitional treatment setting may not be able to move into this setting due to limited capacity. This may result increased length of stay within the Junction City facility treatment units as patients ready for transition to community settings must wait until an opening becomes available.~~

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~~No~~	~~-3.54%~~	~~14~~	~~AMH-JC~~	~~Amend JC Phase-in - remove second of three RTF cottages phased-in in 2015-17 CS. Assumes a 24 month reduction of funding for this cottage from the 2015-17 CSL and an additional eight bed reduction of CSL funded capacity (a total of 16 beds). Because most staffing for these cottages serve all three cottages, the staff and dollar reduction for each cottage phase-in-removal is not equivalent, rather it increases with each cottage phase-in-removal.~~	~~N~~	~~(3,180,142)~~	~~(166,363)~~	~~(90,743)~~	~~(3,437,248)~~	~~(13)~~	~~(13.00)~~	~~Holding the phase in of this second Junction City cottage will reduce the RTF transitional treatment capacity of the Junction City hospital by an additional eight beds, total of 16. Patients in the Secured Residential Treatment Facility (SRTF) units of the Junction City facility, that have recovered to the point that they are ready for an RTF transitional treatment setting, are very likely to not be able to move into this setting due to limited capacity. This is likely to result increased length of stay within the Junction City facility treatment units as patients ready for transition to community settings must wait until an opening becomes available.~~
~~No~~	~~-3.70%~~	~~15~~	~~AMH-JC~~	~~Amend JC Phase-in - remove third of three RTF cottages phased-in in 2015-17 CSL. Assumes a 24 month reduction of funding for this cottage from the 2015-17 CSL and an additional eight bed reduction of CSL funded capacity (a total of 24 beds). Because most staffing for these cottages serve all three cottages, the staff and dollar reduction for each cottage phase-in-removal is not equivalent, rather it increases with each cottage phase-in-removal.~~	~~N~~	~~(4,403,274)~~	~~(230,349)~~	~~(125,645)~~	~~(4,759,268)~~	~~(18)~~	~~(18.00)~~	~~This action will put the phase-in of all Junction City cottages on hold and will reduce the RTF transitional treatment capacity of the Junction City hospital by an additional eight beds, total of 24. Patients in the Secured Residential Treatment Facility (SRTF) units of the Junction City facility, that have recovered to the point that they are ready for an RTF transitional treatment setting, will not have any availability to the Junction City RTF Cottage setting. This will result increased length of stay within the Junction City facility treatment units as patients ready for transition to community settings must wait until an opening becomes available.~~
No	-3.95%	16	AMH-CMH	Eliminate CMH Caseload Growth	N	(7,174,398)	-	(4,586,567)	(11,760,965)	0	0.00	This funding provides for the development of 4 Residential Treatment Homes for adults with special needs, 15 beds for geriatric patients with challenging needs at the state hospital and 20 additional persons to be served through the AMHI program. These programs will assist with discharge civilly committed individuals from the state hospital to community programs. The reduction will increase the length of time that adults with special needs reside in the state hospital beyond the time that they are deemed ready for discharge. This jeopardizes Oregon's compliance with Olmstead Act (Supreme Court Ruling)
No	-3.98%	17	AMH-CMH	Eliminate CMH's MHSF (Mental Health Services Fund) Residential Development	N	(1,000,000)	-	-	(1,000,000)	0	0.00	This fund is used to update and remodel existing residential programs to maintain safe and healthy environments for residents. Elimination of this funding will result in some program facilities deteriorating and potentially resulting in unsafe environments. This will erode the livability of residential programs for adults with a serious mental illness.
Yes	-4.00%	18	PH	State Support to Local Health Departments, 1st cut	N	(560,950)	-	-	(560,950)	0	0.00	Local County Public Health Departments (LPH) would receive $.98 per capita per year for public health services rather than $1.13 per capita per year. The impact by county would vary. These state funds are to conduct early detection, epidemiological investigations, and prevention activities to help report, monitor, and control communicable diseases, like influenza and foodborne illnesses. In addition, because these state dollars are used to provide the required match on federal funding sources including the Public Health Preparedness Program and Designated State Health Programs (DSHP), millions of dollars of other federal grant funds may be jeopardized.
No	-4.00%	19	PH	CD Summary & ACDP PH publishing (ACDP)	N	(137,501)	-	-	(137,501)	(1)	(1.00)	Loss of biweekly CD Summary publication of public health recommendation and data for physicians; and of posting of communicable disease data to web. The CD Summary has a cachet within the medical community; it has been called OPHD's flagship publication. Its loss may result in fewer physicians being attuned to public health priorities and recommendations. These are also means by which many OPHD programs "feed back" data to stakeholders -- a key component of disease surveillance and one expected by CDC funders; a reduction in such feedback may ultimately imperil federal funding. This action includes elimination of one position/FTE.

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No	-5.54%	20	MAP	Cover 25 fewer lines on Prioritized List of Health Services. Oregon Health Plan (OHP) coverage is based on the Prioritized List of Health Services, which ranks treatment and condition pairs in order of effectiveness. Starting January 1, 2013, OHP would cover lines 1 through 473. The agency would seek federal approval to no longer cover lines 474 through 498 for the OHP benefit package. LEGISLATIVE ACTION REQUIRED. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions (STCs) prohibit the state from reducing eligibility or benefits.	Y	(44,044,000)	-	(135,453,000)	(179,497,000)	0	0.00	This action would have a dramatic impact on health care services that are covered for all OHP clients, including pregnant women, children, and other groups. Coverage for treatments of conditions such as collapsed structure of a lung, hearing loss and neonatal eye infections would end. Conditions that may cause significant functional disability would no longer be covered, including urinary incontinence and osteoarthritis and uterine prolapse. Several mental health conditions would no longer be covered, including social phobias and obsessive compulsive disorders which would likely result in broader family and community impacts. In addition, coverage of many basic dental treatments, such as missing teeth, dental caries and dentures, would be eliminated for all eligibility groups. Elimination of coverage of this magnitude would make it very difficult for physical, dental, and mental health providers to deliver high quality, comprehensive care. This proposal would significantly increase administrative burden for providers and for the department.
No	-8.73%	21	MAP	Eliminate outpatient mental health benefits for Oregon Health Plan (OHP) non-pregnant adults. The agency would eliminate outpatient mental health coverage from the OHP benefit package for non-pregnant adults. LEGISLATIVE ACTION REQUIRED. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions (STCs) prohibit the state from reducing eligibility or benefits.	Y	(91,866,912)	-	(372,007,195)	(463,874,107)	0	0.00	This reduction would eliminate outpatient mental health services and community-based rehabilitative service provided to non-pregnant adults who receive the OHP Plus benefit package. While these services are optional, inpatient mental health services are not optional and not being eliminated. Mental health drugs would remain part of the benefit package for OHP Plus non-pregnant adults. This reduction would negatively impact the health of many OHP clients; hurt the community mental health delivery system; and, hurt the health system transformation efforts.
No	-8.76%	22	AMH-CMH	Reduce CMH Direct Contracts 50%	N	(862,000)	-	-	(862,000)	0	0.00	AMH has contracts with entities to provide essential services and supports. These include culturally specific services, supports to families with family members with a mental illness and crisis line services. The reduction will reduce the availability of a statewide suicide crisis line. Culturally specific services for the African American community will be reduced and families will increase the use of crisis services for their family member.
Yes	-8.77%	23	PH	STD Special Payment to Counties (HST)	N	(180,000)	-	-	(180,000)	0	0.00	Eliminated direct support to the only two counties receiving payment for STD investigation services. Jackson and Multnomah receive $45,000 per year. Could impact staffing at the Jackson and Multnomah Counties.
Yes	-8.78%	24	PH	Tuberculosis - Eliminate antibiotic susceptibility testing. (PHL)	N	(240,000)	-	-	(240,000)	(1)	(1.00)	M. tuberculosis from patients in local health depts, hospitals, and clinics may no longer be tested to see which antibiotic(s) may be effective for treatment. Multidrug-resistant (MDR) and extensively drug resistant (XDR) TB may not be detected and may spread in the population. More cases of TB and more advanced stages of disease may occur in Oregon. This action includes elimination of one position/FTE.
No	-8.78%	25	PH	MCH Monitoring (PRAMS-2) - supports staff Fed Grant for PRAMS	N	(106,977)	-	-	(106,977)	0	0.00	Eliminate contract for conducting key telephone surveys for PRAMS-2; follow up survey for 2 years of service.
Yes	-8.80%	26	PH	State Support to Local Health Departments, 2nd cut	N	(560,950)	-	-	(560,950)	0	0.00	Local County Public Health Departments (LPHD) would receive $.84 per capita per year for public health services rather than $.98 per capita per year. The impact by county would vary. These state funds are to conduct early detection, epidemiological investigations, and prevention activities to help report, monitor, and control communicable diseases, like influenza and foodborne illnesses. In addition, because these state dollars are used to provide the required match on federal funding sources including the Public Health Preparedness Program, and Designated State Health Programs (DSHP), millions of dollars of other federal grant funds may be jeopardized.

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No	-8.81%	27	PH	Senior Farmer Market - vouchers for Seniors to buy fruits/veggies	N	(239,090)	-	-	(239,090)	0	0.00	Provides $20 vouchers to low income seniors to purchase fresh locally grown fruits and vegetables This reduction may result in roughly 11,950 fewer vouchers to low income seniors. This also results in reduced income for vendors; and a modest reduction of access to healthy choices. No state match required.
Yes	-9.23%	28	AMH-CMH	Reduce CMH Flex Funding Contracts 20%	N	(11,939,125)	-	(9,782,810)	(21,721,935)	0	0.00	This reduction will significantly affect Oregonians with mental illness without Medicaid coverage. Access to crisis services, acute psychiatric treatment (in a hospital setting), medications and case management services will be reduced by this reduction. This will likely result in people becoming more ill, doing poorly in school, experiencing strained family relationships and in some instances people will become homeless or may be jailed. There will be increased demands on the crowded state hospital. These reductions could jeopardize the Maintenance of Effort requirements for the Mental Health Block Grant.
No	-9.70%	29	AMH-CMH	Reduce CMH's AMHI (Adult Mental Health Initiative) Program 41%	N	(13,739,354)	-	-	(13,739,354)	0	0.00	These funds are used to facilitate the transition of civilly committed adults from the state hospital to the community when they no longer need hospital level of care. These funds have resulted in the length of time waiting for discharge being reduced by 50%. Reduction of these funds will increase the length of stay in the hospital and increase the number of people waiting in acute care for state hospitalization which results in reduced access to acute care services. This jeopardizes Oregon's compliance with Olmstead.
~~**No**~~	~~-10.09%~~	~~30~~	~~AMH-JC~~	~~Amend JC Phase-in - remove one Secured Residential Treatment Facility (SRTF) unit (Forest 3) of the six units phased in in 2015-17 CSL. Results in five units open within the JC facility rather than the planned capacity of six units.~~	~~N~~	~~(11,079,468)~~	~~(437,786)~~	~~(316,146)~~	~~(11,833,400)~~	~~(53)~~	~~(53.00)~~	~~Holding the phase in of this SRTF unit will reduce capacity of the Junction City state Hospital by 25 beds and would further limit the availability of treatment of patients from the southern part of the state at a facility that is closer to their community and family. Less SRTF capacity will slow the transition of patient recovery from treatment units to SRTF settings to prepare patients for RTF settings and then community placement. This would result in more patients on wait lists for longer periods. In addition, this phase in adjustment would be contingent upon mandated state hospital facility caseload growth. While Guilty Except for Insanity (GEI) caseload growth currently is not growing at a pace to require another hospital unit be opened, growth in aid and assist 370 caseload does pose a significant risk to the need for additional capacity.~~
~~**No**~~	~~-10.40%~~	~~31~~	~~AMH-JC~~	~~Amend JC Phase-in - remove second SRTF unit (Mountain 3) of the six units phased in in 2015-17 CSL. Results in four units open within the JC facility rather than the planned capacity of six units.~~	~~N~~	~~(8,923,095)~~		~~(254,310)~~	~~(9,177,405)~~	~~(50)~~	~~(49.70)~~	~~Holding the phase in of this unit by 70% will reduce capacity of the Junction City state Hospital by an additional 25 beds and would further limit the availability of treatment of patients from the southern part of the state at a facility closer to their community and family. This phase in adjustment would be contingent upon mandated state hospital facility caseload growth. While Guilty Except for Insanity (GEI) caseload growth currently is not growing at a pace to require another hospital unit be opened, growth in aid and assist 370 caseload does pose a significant risk to the need for additional capacity.~~
No	-10.40%	32	AMH-CMH	Reduce rental assistance planned with Tobacco Tax investments.	N	-	(4,678,156)	-	(4,678,156)	0	0.00	This reduction would impact the rental assistance program It would mean discontinuing many programs funded by TTX. This would have an adverse impact to those individuals who are dependent upon assistance for housing.

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No	-10.41%	33	PH	WIC Farmers Market - vouchers for WIC participants to buy fruits/veggies	N	(306,900)	-	-	(306,900)	0	0.00	Provides vouchers in various denominations for low income families and WIC eligible families to purchase fruits and vegetables. This reduction would result in the loss of federal funding for this purpose as well. Additionally, there would be reduced income to vendors; and reduced access to healthy choices.
Yes	-10.41%	34	PH	Eliminate STD Program purchase of condoms (HST)	N	(50,000)	-	-	(50,000)	0	0.00	Loss of this funding will jeopardize the purchase of roughly 877,000 condoms. Condoms are an Evidence-Based cost effective intervention for both HIV and other STDs. Eliminating the ability to purchase and distribute to agencies serving at -risk populations could lead to increased disease transmission in populations that are already impacted by other health disparities.
Yes	-10.42%	35	PH	Tuberculosis - Eliminate rapid molecular detection. (PHL)	N	(145,000)	-	-	(145,000)	(1)	(1.00)	Confirmation of M. tuberculosis in patient samples or cultures may take 6-8 weeks instead of hours or days. TB may not be detected quickly enough to prevent community transmission. More cases of TB and more advanced stages of disease may occur in Oregon. This action includes elimination of one position/FTE.
No	-10.42%	36	PH	Cut County payments (Immunization)	N	(200,000)	-	-	(200,000)	0	0.00	The county payments are a significant portion of our GF dollars (59%). PH believes there is precedent in other states to reduce or cut these payments, yet the impact of the cuts may be felt across the counties who are doing significant work on behalf of Oregon citizens. PH is proposing an 15% cut to the County payments from our GF equaling $100,000 annually ($200,000/biennium). For every dollar cut from our GF, PH looses Medicaid match funding. Thus this cut would actually cost the counties $400,000 in funding that in turn significantly reduces their ability to deliver services and program activities to their county population. More cases of vaccine-preventable diseases may occur in Oregon.
No	-10.42%	37	OEBB	OEBB contracts with insurance carriers for employee benefit plans. The Non-Limited Budget is dedicated funding for payment of insurance benefit plans. OEBB is contractually obligated to pass-through to Insurance Carriers for claims and other taxes and fees at the state and federal level.	N	-	(172,786,565)	-	(172,786,565)	0	0.00	Taking reductions at 10% would potentially default OEBB in its contractual obligations with carriers. Major Plan Design changes could possibly hit the reduction targets but it would take a major reduction in the coverage OEBB provides to it members, and must also comply with the new federal health care reform requirements related to the total maximum individual and family out of pocket expenses allowable. OEBB benefits are funded through OF received from educational and local government entities, who are funded through various revenue streams that make up each of their total budgets. A significant portion of these entities revenue is received from state agencies and programs like the Department of Education. OEBB's goal is to provide high quality benefits for eligible employees and their dependents at the lowest possible cost, reducing the OEBB Non-limited budget will make providing high quality, low cost benefits difficult.
No	-10.42%	38	PEBB	PEBB contracts with insurance carriers for employee benefit plans. The Operating Budget for PEBB is 0.5%. The remaining 99.5% is Program Budget which is dedicated funding for payment of fully-insured benefit plans that PEBB is contractually obligated to pass-through or for self-insured plans' claims payments, and other taxes and fees at the state and federal level.	N	-	(164,413,249)	-	(164,413,249)	0	0.00	Taking reductions at any level may potentially default PEBB in its contractual obligations with carriers. Major Plan Design changes could possibly hit the reduction targets but it would take a major reduction in medical plan coverage and would jeopardize the stabilization of the statewide risk pool. A major shift in cost sharing between employee and employer could also potentially hit the reduction target but the reductions would have to be taken at the state agency budget level, as it passes employee benefit dedicated dollars through to PEBB.
No	-10.42%	39	MAP	Reduce program funding that is reliant upon Tobacco Tax revenues, reduce leveraged programs.	Y	-	(106,000,000)	(60,339,900)	(166,339,900)	0	0.00	To comply with 10% reductions in Other Fund and Federal Fund limitation, specified by HB 3182, MAP would have to reduce all programs receiving tobacco tax or Master Settlement Agreement revenues, and reduces or eliminates all leveraged program funding (including Federal Funds) effective 7/1/15

10% General Fund / 10% Other & Federal Fund Reduction Options for the 2015-2017 Biennium

Oregon Health Authority 2015 - 2017 Current Service Level Budget at Governor's Budget	**2,873,839,754**	**4,729,230,609**	**9,706,124,639**	**17,309,195,002**
10% Target	**287,383,975**	**472,923,061**	**970,612,464**	**1,730,919,500**

Does this affect DSHP Yes or No	Accumulative % Reduction of CSL GF	Agency Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	Employee FTE Affected	Impact of Reduction on Services and Outcomes
No	-10.42%	40	PH/HLO	Reduce or eliminate various PH Other Fund Programs and/or expenditures within the Health Licensing Office	N	-	(14,649,422)	-	(14,649,422)	(54)	(54.00)	As a compliance with requirements of House Bill 3182, Public Health and the Health Licensing Office would have to offer up unspecified O/F reductions in limitation. This reduction could significantly reduce or eliminate many of the PH programs funded through fees, or assessments and significantly affect the core PH infrastructure. Any O/F reductions in the Health Licensing Office would also have a material impact on their operations and ability to administer the multiple Boards they are responsible. HLO sets, communicates, licenses and enforces regulatory standards for multiple health and related professions.
				OHA TOTAL 10% REDUCTION OPTIONS		**(299,555,666)**	**(472,261,394)**	**(919,514,396)**	**(1,691,331,456)**	**(240)**	**(239.70)**	

OHA - Agency 44300 - List of 2013-15 Reclassifications

Position Number	Former PICS Repr	Former PICS Classification	Former PICS Rate	New PICS Repr	New PICS Classification	New PICS Rate	Amount of PICS Rate Change	Abolish/ Establish	Where Change Happened
0000113	OA	C0104	$ 2,352	n/a	n/a	0	$ (2,352)	Abolish	Feb 2014 Session
0000239	MMS	X7006	$ 5,839	n/a	n/a	$ -	$ (5,839)	Abolish	OHA-R13-15-01 (PFP)
0000266	OA	C0107	$ 2,899	OA	C0108	$ 2,899	$ -		Feb 2014 Session
0000669	OA	C3819	$ 4,019	n/a	n/a	0	$ (4,019)	Abolish	Feb 2014 Session
0000841	MMN	X3432	$ 4,809	n/a	n/a	0	$ (4,809)	Abolish	Feb 2014 Session
0000891	OA	C3819	$ 4,019	n/a	n/a	0	$ (4,019)	Abolish	Feb 2014 Session
0000924	OA	C3819	$ 4,413	n/a	n/a	0	$ (4,413)	Abolish	Feb 2014 Session
0001161	OA	C0107	$ 3,032	OA	C0108	$ 3,032	$ -		Feb 2014 Session
0001163	OA	C2328	$ 3,838	n/a	n/a	0	$ (3,838)	Abolish	Feb 2014 Session
0502121	UA	C1215	$ 3,652	UA	C1216	$ 3,652	$ -		OHA-R13-15-01 (PFP)
0508733	UA	C0873	$ 5,604	UA	C0872	$ 5,604	$ -		OHA-R13-15-01 (PFP)
0510816	UA	C0870	$ 4,020	n/a	n/a	$ -	$ (4,020)	Abolish	OHA-R13-15-01 (PFP)
1000061	MMS	X7010	$ 9,955	MMS	X7012	$ 9,955	$ -		OHA-R13-15-01 (PFP)
1000696	OA	C1487	$ 6,952	OA	C1488	$ 6,952	$ -		OHA-R13-15-01 (PFP)
1002970	OA	C0107	$ 2,775	OA	C0108	$ 2,775	$ -		Feb 2014 Session
1002971	OA	C0107	$ 2,775	OA	C0108	$ 2,775	$ -		Feb 2014 Session
1003392	OA	C1117	$ 4,413	n/a	n/a	$ -	$ (4,413)	Abolish	OHA-R13-15-01 (PFP)
1003683	OA	C3780	$ 3,838	n/a	n/a	0	$ (3,838)	Abolish	Feb 2014 Session
1003832	OA	C0104	$ 2,352	OA	C0107	$ 2,488	$ 136		Feb 2014 Session
1003869	OA	C0107	$ 2,899	OA	C0108	$ 2,899	$ -		Feb 2014 Session
1003870	OA	C0107	$ 2,775	OA	C0108	$ 2,775	$ -		Feb 2014 Session
1003871	OA	C0107	$ 2,899	OA	C0108	$ 2,899	$ -		Feb 2014 Session
1005093	OA	C1487	$ 6,952	OA	C1488	$ 6,952	$ -		OHA-R13-15-01 (PFP)
1005098	MMS	X7006	$ 8,206	n/a	n/a	$ -	$ (8,206)	Abolish	OHA-R13-15-01 (PFP)
1007516	MMS	X7006	$ 5,839	n/a	n/a	$ -	$ (5,839)	Abolish	OHA-R13-15-01 (PFP)
1007744	OA	C0107	$ 2,662	OA	C0108	$ 2,702	$ 40		Feb 2014 Session
1007745	OA	C0107	$ 2,775	OA	C0108	$ 2,775	$ -		Feb 2014 Session
1012519	OA	C0872	$ 4,628	n/a	n/a	0	$ (4,628)	Abolish	Feb 2014 Session
1012526	OA	C0104	$ 2,352	n/a	n/a	$ -	$ (2,352)	Abolish	OHA-R13-15-01 (PFP)
1012587	n/a	n/a	$ -	OA	C0862	$ 4,479	$ 4,479	Establish	Feb 2014 Session
1012588	n/a	n/a	$ -	OA	C0872	$ 4,697	$ 4,697	Establish	Feb 2014 Session
1012589	n/a	n/a	$ -	MMN	X0862	$ 4,881	$ 4,881	Establish	Feb 2014 Session
1012590	n/a	n/a	$ -	OA	C0870	$ 3,382	$ 3,382	Establish	Feb 2014 Session

Position Number	Former PICS Repr	Former PICS Classification	Former PICS Rate	New PICS Repr	New PICS Classification	New PICS Rate	Amount of PICS Rate Change	Abolish/ Establish	Where Change Happened
1012591	n/a	n/a	$ -	OA	C1118	$ 4,697	$ 4,697	Establish	Feb 2014 Session
1012592	n/a	n/a	$ -	OA	C5248	$ 4,479	$ 4,479	Establish	Feb 2014 Session
1013292	n/a	n/a	$ -	OA	C1245	$ 4,791	$ 4,791	Establish	OHA-R13-15-01 (PFP)
1013293	n/a	n/a	$ -	OA	C0119	$ 2,873	$ 2,873	Establish	OHA-R13-15-01 (PFP)
1013294	n/a	n/a	$ -	MMN	X0873	$ 5,764	$ 5,764	Establish	OHA-R13-15-01 (PFP)
1013295	n/a	n/a	$ -	MMN	X0856	$ 5,492	$ 5,492	Establish	OHA-R13-15-01 (PFP)
1013296	n/a	n/a	$ -	MMN	X0856	$ 5,492	$ 5,492	Establish	OHA-R13-15-01 (PFP)
1013297	n/a	n/a	$ -	MMN	X0856	$ 5,492	$ 5,492	Establish	OHA-R13-15-01 (PFP)
1013298	n/a	n/a	$ -	MMN	X0856	$ 5,492	$ 5,492	Establish	OHA-R13-15-01 (PFP)
1013299	n/a	n/a	$ -	MMN	X0856	$ 5,492	$ 5,492	Establish	OHA-R13-15-01 (PFP)
1013300	n/a	n/a	$ -	MMN	X0856	$ 5,492	$ 5,492	Establish	OHA-R13-15-01 (PFP)
1013301	n/a	n/a	$ -	UA	C0860	$ 3,450	$ 3,450	Establish	OHA-R13-15-01 (PFP)
1013302	n/a	n/a	$ -	OA	C5247	$ 3,781	$ 3,781	Establish	OHA-R13-15-01 (PFP)
1410062	MMS	X7006	$ 7,438	n/a	n/a	$ -	$ (7,438)	Abolish	OHA-R13-15-01 (PFP)
4420328	UA	C1482	$ 2,931	OA	C1484	$ 2,931	$ -		OHA-R13-15-01 (PFP)
6999976	OA	C1244	$ 4,079	n/a	n/a	$ -	$ (4,079)	Abolish	OHA-R13-15-01 (PFP)
6999978	OA	C5231	$ 3,077	OA	C5246	$ 2,817	$ (260)		OHA-R13-15-01 (PFP)
6999979	OA	C5231	$ 3,077	OA	C5246	$ 2,817	$ (260)		OHA-R13-15-01 (PFP)
6999980	OA	C5231	$ 2,942	OA	C5246	$ 2,817	$ (125)		OHA-R13-15-01 (PFP)
6999981	OA	C0104	$ 2,488	OA	C0108	$ 2,387	$ (101)		OHA-R13-15-01 (PFP)
6999984	OA	C5231	$ 2,817	OA	C5246	$ 2,817	$ -		OHA-R13-15-01 (PFP)
6999987	OA	C0211	$ 2,702	n/a	n/a	$ -	$ (2,702)	Abolish	OHA-R13-15-01 (PFP)
6999988	OA	C5231	$ 3,077	OA	C5246	$ 2,817	$ (260)		OHA-R13-15-01 (PFP)
6999990	OA	C0323	$ 3,225	OA	C0104	$ 2,387	$ (838)		OHA-R13-15-01 (PFP)
6999995	OA	C0323	$ 2,488	OA	C0107	$ 2,387	$ (101)		OHA-R13-15-01 (PFP)
9005038	MMS	X7008	$ 9,035	n/a	n/a	$ -	$ (9,035)	Abolish	OHA-R13-15-01 (PFP)
9005100	MMS	X7006	$ 6,134	n/a	n/a	$ -	$ (6,134)	Abolish	OHA-R13-15-01 (PFP)
9402649	OA	C1487	$ 6,952	OA	C1488	$ 6,952	$ -		OHA-R13-15-01 (PFP)
61			$ 186,005			$ 172,489	$ (13,516)		

UPDATED **OTHER FUNDS ENDING BALANCES FOR THE 2013-15 & 2015-17 BIENNIA**

Agency: OREGON HEALTH AUTHORITY
Contact Person (Name & Phone #): Sara Singer, 503-945-5629

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
Other Fund Type	Program Area (SCR)	Treasury Fund #/Name	Category/Description	Constitutional and/or Statutory reference	2013-15 Ending Balance In LAB	2013-15 Ending Balance Revised	2015-17 Ending Balance In CSL	2015-17 Ending Balance Revised	Comments
Limited	44300-010-40	0401	Other / Cost allocation	Statutory Ch. 668 Sec 2(2)	0	0	0	0	
Limited	44300-020-01	Fund 3402-Treasury account 1383, Grant #424000	Law Enforcement Medical Liability Account (LEMLA)	Section 118 of HB 2712 (2011 session) repealed ORS 137.309 which directed that a portion of court fines be deposited in the LEMLA account at state treasury. Section 51a directed that all assessments received on or after January 1, 2012 would be deposited in the Criminal Fine Account at state treasury.	2,785,416	0	0	0	The 11-13 Biennium budget reflected a $1.39 ml ending balance for LEMLA. This ending balance was empty limitation and carried into 13-15 and added to the 13-15 $1.3 ml ending balance. The LEMLA empty limitation ending balance was cleared from 15-17 CSL
Limited	44300-020-01	Fund 3448, Treasury Account #1385	Hospital Reimbursement Assessment(HRA)	Section 2, chapter 736, Oregon Laws 2003, as amended, establishes an Assessment on hospitals in the State that are non-waivered hospitals. HB 2216 in 2013	0	0	0	125,000,000	In 15-17 GBB MAP has budgeted an anticipated ending balance in Hospital Reimbursement Assessment
Limited	44300-020-02		PEBB Flex Benefit Admin	ORS 243.165	254,971	0	0	0	
Limited	44300-020-02		PEBB Self Insurance	ORS 243.165	111,378,851	0	0	0	
Limited	44300-020-02	Operations 4430000433	PEBB Operations	ORS 243.165	4,093,527	0	0	0	
Non-Limited	44300-020-03		OEBB Stabilization NL		5,900,000	5,900,000	7,613,000	7,613,000	Stabilization fund moved from NL to Ltd. in 15-17 GB
Limited	44300-020-03	4430001387 / OEBB Operating	OEBB Operations	Senate Bill 426; Section 12	1,496,300	1,496,300	883,545	883,545	
Limited	020-04	1394/TEMPORARY HIGH RISK POOL PROGRAM FD	Operations/FMIP Program	CH 47 OR LAW 2010 SPECIAL SESSION	5,335,515	0	0	0	Program closed at end of 11-13, runout complete by end of 13-15.
Non-Limited	020-04	1379/OREGON MEDICAL INSURANCE POOL ACCT	Operations/OMIP Program	OR LAW 2009 CH 595 1119-1120A, CH 695 S3	27,277,208	0	0	0	Program closed at end of Dec13, runout complete by end of 13-15. Treasury fund also contains Reinsurance program, which closes at end of 15-17; currently expected to net to zero biennially, but will update as administrative rules and associated timeframes finalized.
Limited	020-04	1380/FAMILY HEALTH INSURANCE ASSISTANCE	Operations/FHIAP Program Misc.	414.861	0	0	0	0	Fund reflected segregated training and collections revenue, program closed at end of Dec13.
Limited	443-020-05-02-00000	0401/General Fund	Beer and Wine	ORS 471.810	0	0	0	0	
Limited	443-020-05-02-00000	0401/General Fund	CFAA/DUII/IDPF	ORS 813.270	0	0	0	0	
Limited	443-020-05-03-00000	0401/General Fund	CFAA/DUII/IDPF	ORS 430.345	0	0	0	0	
Limited	443-020-05-07-00000	1382/Problem Gambling Treatment Fund	Lottery	ORS 413.522 and ORS 461.549	0	0	0	0	
Limited	443-020-05-01-00000	1386/CMH Community Housing Fund	Trust Fund, Dammasch 95% Proceeds	ORS 426.502 and ORS 426.508	5,726,586	5,726,586	5,726,586	5,726,586	This is a trust account not in AMH ORBITS
Limited	443-020-05-01-00000	1390/Oregon Health Authority Fund	Other	Chapter 595 Oregon Laws 2009 section SECTION 18, SECTION 10	0	0	0	0	Tobacco Tax. AMH will have an ending balance in Tobacco Tax at the end of 13-15 after the recent revision in Tobacco Tax revenue. It was used by CFO to backfill GF in the Governor's Budget.
Limited	443-020-06-00	480310 CP&HP JPMORGAN DAMAGES SETTLEMENT	Operations		4,300,000	4,800,000	0	50,000	Of the new one time revenue in 13-15 of $4.8 million, $500K in limitation was added to 13-15, with the rest expected to be spent in 15-17. At this point the $500K will also be spent n 15-17 due to delays in contracting. A small amount will carryforward into 17-19.
Limited	443-020-06-00	480352 OREGON MEDICAL MARIJUANA PROGRAM CERTIFI	Operations		3,000,000	5,000,000	0	3,000,000	Increased Medical Marijuana Revenue higher than previously projected, but IT upgrades expected in 15-17 will likely utilize some of the carryforward
Limited	443-020-06-00	480354 PRESCRIPTION DRUG MONITORING	Operations	ORS 431.962	676,604	704,000	0	50,000	Cyclical revenue needed to carryforward into new biennium to cover operating costs
Limited	443-020-06-00	480366 MEDICAL MARIJUANA DISPENSARY	Operations		0	1,300,000	0	300,000	Carryforward used to cover biennialization of program budget in 13-15 to 24 months in 15-17.
Limited	443-020-06-00	CFFH-ALERT CONTRIBUTORS	Operations		0	949,235	0	149,235	Hospitals and large providers donate to fund future improvements and upgrades on the Alert System. A plan to purchase and move to new servers and platforms is in development but will likely not happen until the 15-17 biennium. Estimates are set at $800,000 for this conversation at this time.
Limited	020-07	1502/HEALTH LICENSING OFFICE FUND	Operations/All HLO Board and Admin	2013 LAWS CHAP 568 ORS 676.625	48,775	2,881,495	0	2,576,345	Budgeted amounts reflects inadvertent reduction in revenues to match expenditures in ORBITS; will adjust in future iterations. 'Revised' columns reflect projected reserve amounts, which cover working capital needs for operational budgets. Months in excess of standard 3 months working capital (approx. 7-8 months in 13-15, 4-5 in 15-17, calculated based on average of actual and projected expenditures) in projected balances are necessary due to potential for litigation substantially impacting operations, as demonstrated repeatedly over the past decade.