
FALL 2016 DHS|OHA CASELOAD FORECAST

Budget Planning and Analysis
Office of Forecasting, Research and Analysis

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Office of Forecasting, Research & Analysis

500 Summer Street N.E.
Salem, Oregon 97301
Voice: 503-947-5185
TTY: 503-945-6214
Fax: 503-378-2897



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EXECUTIVE SUMMARY

The 2015-17 **Supplemental Nutrition Assistance Program (SNAP)** biennial average forecast is 405,142 households, which is 0.2 percent lower than the Spring 2016 forecast. The 2017-19 biennial average forecast is 371,503 households, which is 8.3 percent lower than the 2015-17 forecast average.

The 2015-17 **Temporary Assistance to Needy Families (TANF)** biennial average forecast is 23,299 families, which is 0.9 percent lower than the Spring 2016 forecast. The 2017-19 biennial average forecast is 21,241 families, which is 8.8 percent lower than the 2015-17 forecast average.

The 2015-17 **Child Welfare (CW)** biennial average forecast is 21,293 children, which is 0.4 percent higher than the Spring 2016 forecast. The 2017-19 biennial average forecast is 21,584 children, which is 1.4 percent higher than the 2015-17 forecast average.

The 2015-17 **Vocational Rehabilitation (VR)** biennial average forecast is 9,570 clients, which is 2.8 percent higher than the Spring 2016 forecast. The 2017-19 biennial average forecast is 10,275 clients, which is 7.4 percent higher than the 2015-17 forecast average.

The 2015-17 **Ageing and People with Disabilities Long-Term Care (LTC)** biennial average forecast is 34,086 clients, which is slightly lower than the Spring 2016 forecast. The 2017-19 biennial average forecast is 36,561 clients, which is 7.3 percent higher than the 2015-17 forecast average.

The 2015-17 **Intellectual and Developmental Disabilities Case Management (I/DD)** biennial average forecast is 25,309 clients, which is slightly higher from the Spring 2016 forecast. The 2017-19 biennial average forecast is 28,218 clients, which is 11.5 percent higher than the 2015-17 forecast average.

The 2015-17 **Health Systems Medicaid (HSM)** biennial average forecast is 1,116,810 clients, which is 0.4 percent lower than the Spring 2016 Forecast. The 2017-19 biennial average forecast is 1,057,045 clients, which is 5.4 percent lower than the 2015-17 forecast average.

The 2015-17 **Mental Health (MH)** biennial average forecast is 45,646 adults, which is 0.5 percent higher than the Spring 2016 Forecast. The 2017-19 biennial forecast average is 47,523 adults, which is 4.1 percent higher than the 2015-17 forecast average.

INTRODUCTION

This document summarizes the Fall 2016 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 in the spring and fall each year. DHS caseload forecasts cover the major program areas administered by the department: Self Sufficiency Programs, Child Welfare, Vocational Rehabilitation, Aging and People with Disabilities, and Intellectual and Developmental Disabilities. OHA caseload forecasts cover the major program areas of Health Systems: Medicaid 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, and through the annual forecast quality report which compares forecast accuracy across programs and over time.¹

1. For more information, please visit <http://www.oregon.gov/DHS/BUSINESS-SERVICES/OFRA/Pages/About-Us.aspx>

Forecast Environment and Risks

Oregon's economy continues to recover from the 2008-2009 Great Recession. Since the recovery began, Oregon has steadily gained jobs and recently entered "full-throttle growth" mode. In 2015, job growth reached its highest level in 20 years. Oregon job gains are outpacing the average state, and wages are growing in all parts of the state. Participation in the labor force has improved from its recession-era low, but remains below historic averages. Much of this is driven by demographics – baby boomers retiring and voluntarily exiting the workforce and younger adults staying in school longer; however, some is also due to a lack of job opportunities and the business cycle.

According to the U.S. Bureau of Labor Statistics, in 2015, 11.7 percent of potential workers in Oregon said they were unemployed, marginally attached to the workforce, or were working part-time involuntarily (due to economic reasons). That is higher than the national average and affects DHS clients. An examination of employment among adults on SNAP in 2013 and 2014 shows that although almost half of them are employed, 70 percent of those who are employed are working less than full-time (defined as 30 hours per week) and forty percent work less than half-time. The most common employment for SNAP recipients fall into three primary industries – Food Services, Social Assistance, and Retail Trade – that tend to offer few full-time jobs. This helps explain why Oregon's SNAP caseload has remained stubbornly high in spite of overall job gains.

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

cuts that limit eligibility for some programs.

The Office of Economic Analysis (OEA) identifies major risks to Oregon's economy in its quarterly forecasts. Some of the major risks listed in the third quarter 2016 edition are volatility of the U.S. economy in general, the strength of the housing market, the affordability of housing, the drought impacting the western states, and restructuring of federal timber payments. The full OEA economic forecast can be found at <http://www.oregon.gov/DAS/OEA/pages/index.aspx>.

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. In addition, some new policies lack the necessary case history to be used accurately in forecasts. Future policy changes or uncertainty about recent policy changes represent a major risk to the caseload forecasts.

Oregon Minimum Wage

Enacted in the 2016 legislative session, Senate Bill 1532 establishes a series of increases to the Oregon minimum wage beginning July 2016 and continuing in phases through July 2022. These phased increases are specified at three separate rates for different parts of the state. The Portland Metro area will have a rate higher than the standard, and certain specified “Non-urban” counties will have a rate slightly lower than the standard. More on the rates can be found at the Oregon Bureau of Labor and Industries website: <http://www.oregon.gov/boli/Pages/index.aspx>.

A good deal has been written about the economic effects of an increase in minimum wage. Summarizing the various arguments and evidence is beyond the scope of this document; however, there is no clear consensus on the impact of a minimum wage increase on public assistance caseloads. Given this lack of consensus, the minimum wage increase must be considered a risk to the forecast. The Office of Forecasting Research and Analysis will monitor caseloads and wages paid to those on our caseloads for evidence of a minimum wage effect.



Department of Human Services

Total Department of Human Services Biennial Average Forecast Comparison

	2015-17 Biennium			% Change Between Forecasts	Fall 2016 Forecast			% Change Between Biennia
	Spring 16 Forecast	Fall 16 Forecast	Change		2015-17	2017-19	Change	
Self-Sufficiency								
Supplemental Nutrition Assistance Program (Households)	405,818	405,142	-676	-0.2%	405,142	371,503	-33,640	-8.3%
Temporary Assistance for Needy Families - Basic & UN (Families: Cash Assistance)	23,508	23,299	-209	-0.9%	23,299	21,241	-2,057	-8.8%
Child Welfare (children served)								
Adoption Assistance	11,245	11,141	-104	-0.9%	11,141	11,135	-6	-0.1%
Guardianship Assistance	1,585	1,555	-30	-1.9%	1,555	1,690	135	8.7%
Out of Home Care ¹	7,004	7,092	88	1.3%	7,092	7,173	81	1.1%
Child In-Home	1,375	1,505	130	9.5%	1,505	1,586	81	5.4%
Vocational Rehabilitation								
	9,310	9,570	260	2.8%	9,570	10,275	705	7.4%
Aging & Physical Disabilities								
Long-Term Care: In Home	18,155	17,959	-196	-1.1%	17,959	19,982	2,023	11.3%
Long-Term Care: Community Based	11,834	11,886	52	0.4%	11,886	12,456	570	4.8%
Long-Term Care: Nursing Facilities	4,184	4,241	57	1.4%	4,241	4,123	-118	-2.8%
Intellectual and Developmental Disabilities								
Total Case Management Enrollment ²	25,281	25,309	28	0.1%	25,309	28,218	2,909	11.5%
Total I/DD Services	19,141	19,254	113	0.6%	19,254	21,009	1,755	9.1%

1. Includes residential and foster care.

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

Self Sufficiency Programs (SSP)

In July 2016 there were 398,352 households (706,792 persons) receiving SNAP benefits, which constitutes approximately 17.4 percent of all Oregonians. The SSP portion of SNAP (made up mostly of parents and children) rose rapidly in 2009 and continued to grow until leveling off in mid-2012 when it began its decline. The caseload has declined by 67,106 households since June 2012. The smaller APD SNAP caseload (designed for people aged 60 and older) also rose rapidly due to the Great Recession, but now is returning to its traditional, less-steep growth pattern. The combined 2015-17 SNAP biennial average forecast is 405,142 households, which is 0.2 percent lower than the Spring 2016 forecast. The projected biennial average for 2017–19 is 371,503 households, which is 8.3 percent lower than the 2015-17 biennial average forecast.

APD SNAP is in the pilot phase of increasing from 12-month to 24-month redeterminations (the formal scheduled re-evaluation of eligibility). When this policy is implemented statewide it may decrease the “churn” in the APD SNAP caseload. Churn occurs when clients do not complete the redetermination process in a timely manner and temporarily drop off the caseload. All other things being equal, implementation of this change could increase the total caseload, and should be considered a risk.

The federal government reinstated the “Able Bodied Adults without Dependents” or ABAWD rule in January 2016 for Washington and Multnomah Counties. The ABAWD rule is a three-month limit to SNAP benefits that applies to non-disabled adults without dependents age 50 and under. Oregon was granted an exemption from this time limit for all counties during the Great Recession. As a result of the reinstatement of ABAWD in Washington and Multnomah counties, caseloads dropped by between 5 and 6 percent. Despite the fact that these counties are the most populous in the state, the reduction had only a modest effect on the overall statewide caseload. The rule is due to be applied to Clackamas County in the fall of 2016, and may be applied to other counties through the coming years.

Although reintroduction of this rule is likely to have only a minor impact on the caseload, it must be considered a risk to the forecast.

In addition, the SNAP caseload could be affected by the issues stated in the “Forecast Environment and Risks” section, above.

Temporary Assistance for Needy Families (TANF) – In April 2016, there were 23,007 families receiving TANF benefits, representing 63,088 persons. Starting in January 2008, the TANF caseload underwent nearly uninterrupted growth until leveling off in mid-2012. After a seasonal increase in the winter of 2012-2013, the caseload declined rapidly, and is currently 13,604 cases below its February 2013 peak, a drop of approximately 37 percent. The 2015-17 TANF biennial average forecast is 23,299 families, which is 0.9 percent lower than the Spring 2016 forecast. The 2017-19 biennial average is 21,241 families, which is 8.8 percent lower than the biennial average forecast for 2015-17.

TANF Reinvestment and Data Accuracy

The 2015 Legislature passed House Bill 3535 and House Bill 5026. Taken together, these two acts provide the statutory authority and funding to modify TANF in order to provide better opportunities for families to successfully transition out of the program. This set of policy changes are commonly called “TANF Reinvestment.” These reforms began in May 2016.

The elements of TANF Reinvestment that were expected to impact caseloads – and have therefore been built into the forecast – included an increase in the income limit for existing TANF households, expanding the definition of a caretaker relative, the elimination of deprivation as an eligibility requirement, and the creation of a post-TANF Employment Payment (TANF-EP) which provides a cash payment for three months to TANF households exiting TANF due to employment.

Additional elements of TANF Reinvestment which are not forecast, but are considered risks included increasing the use of support and stabilization services to prevent families from entering TANF; and increased client engagement.

Implementation of TANF Reinvestment has led to unintended consequences in the area of data accuracy. For caseloads to be accurately forecast, a case must be in one program – and only one program – within a given month. In the early months of TANF Reinvestment (starting in May 2016) it appeared that cases were being counted in both the TANF category as well as the post-TANF Employment Payments category. In order to reconcile this duplicate count, cases that appeared in both categories were counted only in the TANF-EP caseload, and dropped from the active TANF caseload. This reduced the number of TANF cases, putting them more in line with prior forecast assumptions. The Fall 2016 forecast is based on this revised caseload count.

Given that budget and program timing dictated that the forecast be completed before these data accuracy issues could be fully investigated and understood, the Fall 2016 TANF forecast and the caseload actuals it is built upon must be considered subject to revision. This possibility must be considered a risk to the forecast.

In addition to the risks associated with TANF Reinvestment, the caseload could also be affected by the more general demographic and economic issues stated in the “Forecast Environment and Risks” section of this document.

Because of the increases due to TANF reinvestment, the overall caseload is expected to essentially flatten over this biennia and the next, but with small seasonal increases during the winter months and decreases in the summer.

Pre SSI – The 2015–17 biennial average forecast is 517 families, which is 4.2 percent lower than the Spring 2016 forecast. This decrease is due to a reduction in the number of backlogged cases being addressed by staff. With the backlog addressed, the caseload is forecast to return to its recent historical level. The 2017-19 biennial average caseload is expected to be 512 families, which is 0.8 percent

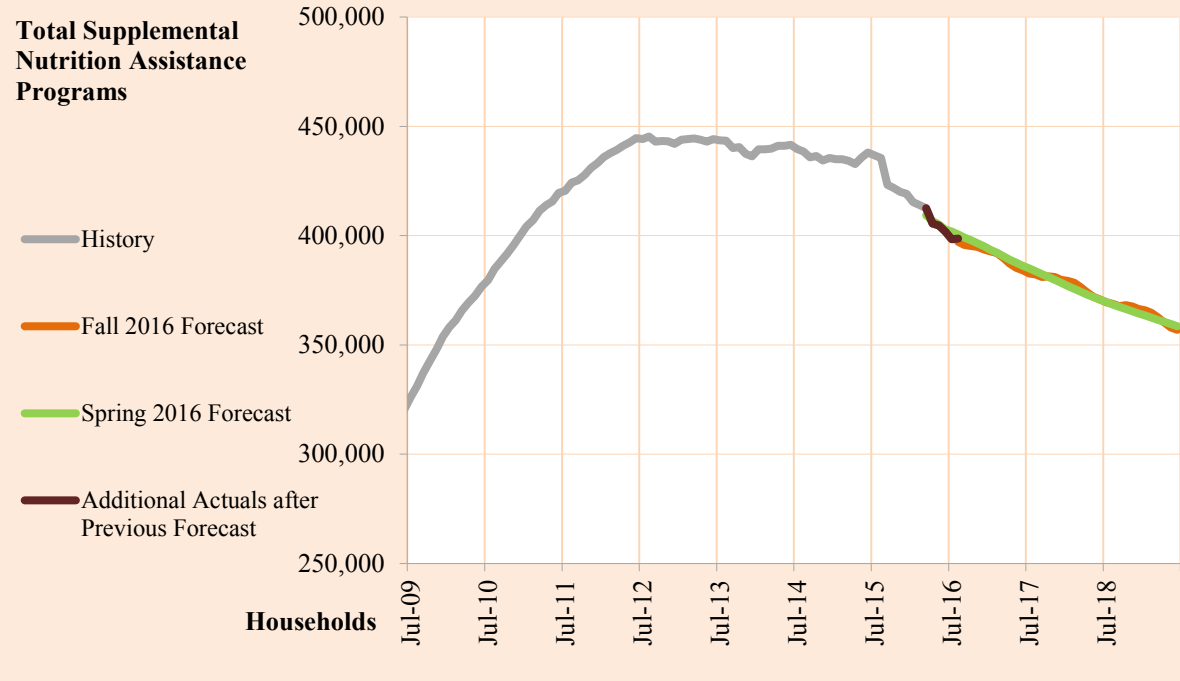
lower than the forecast for the current biennium.

Temporary Assistance for Domestic Violence Survivors (TA-DVS) – In the past, the portion of the TA-DVS program that was forecast in this document was limited to those domestic violence survivors who accepted TA-DVS payments (which are used to help defray the costs of housing). Over the course of the past few years, the proportion of TA-DVS clients being seen in DHS field offices but NOT accepting TA-DVS payments has grown. This is likely due to the inadequacy of housing payments at a time of high rents and limited housing availability. This dichotomy has led us to expand the forecast to include both TA-DVS with payments and TA-DVS without payments.

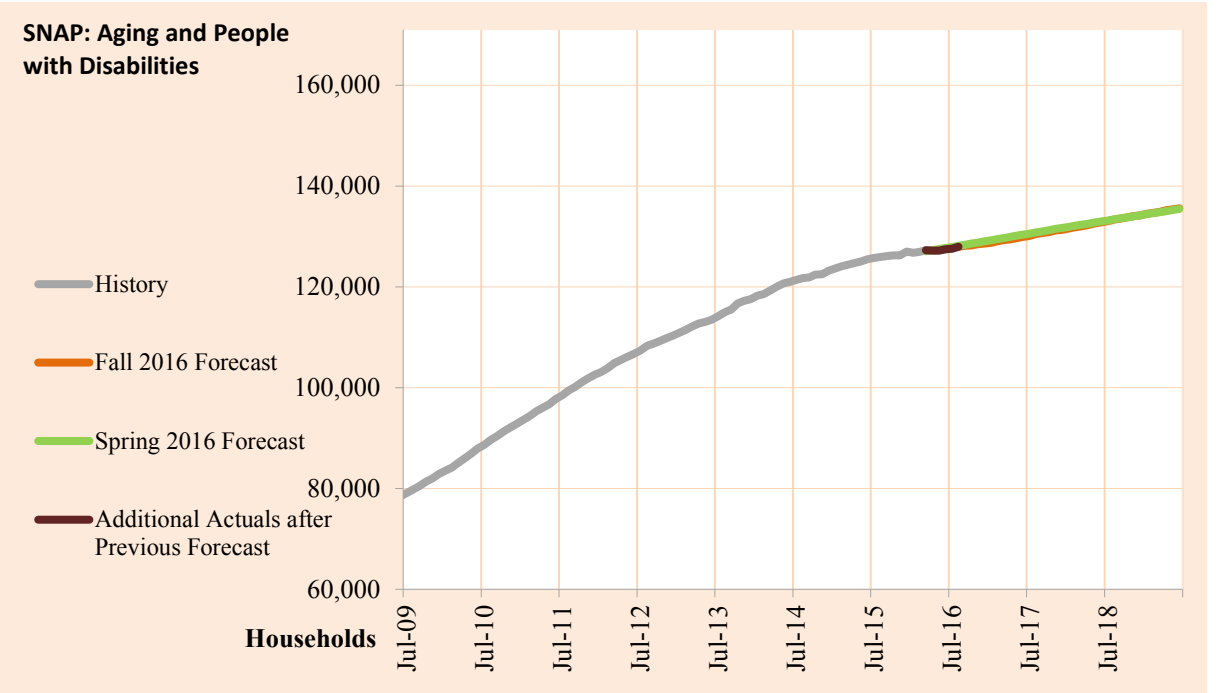
The TA-DVS with-payment caseload is a relatively small caseload that has been falling steadily amid strong seasonal fluctuations. After reaching an historic low in January 2016 of 311 cases, it began its usual seasonal increase before that usual increase also faltered. The TA-DVS with-payment caseload is expected to continue falling, with a 2015–17 biennium average projected at 377 families, which is 6.8 percent lower than the Spring 2016 forecast. The caseload is expected to continue to fall to 282 families per month during the 2017–19 biennium.

The TA-DVS without-payment caseload has been holding relatively steady despite the decreases in the with-payment category. TA-DVS without-payment is expected to average 1,184 cases per-month through the remainder of the 2015-17 biennium, and average 1,188 cases per month in the 2017-19 biennium, a change of only 0.3 percent.

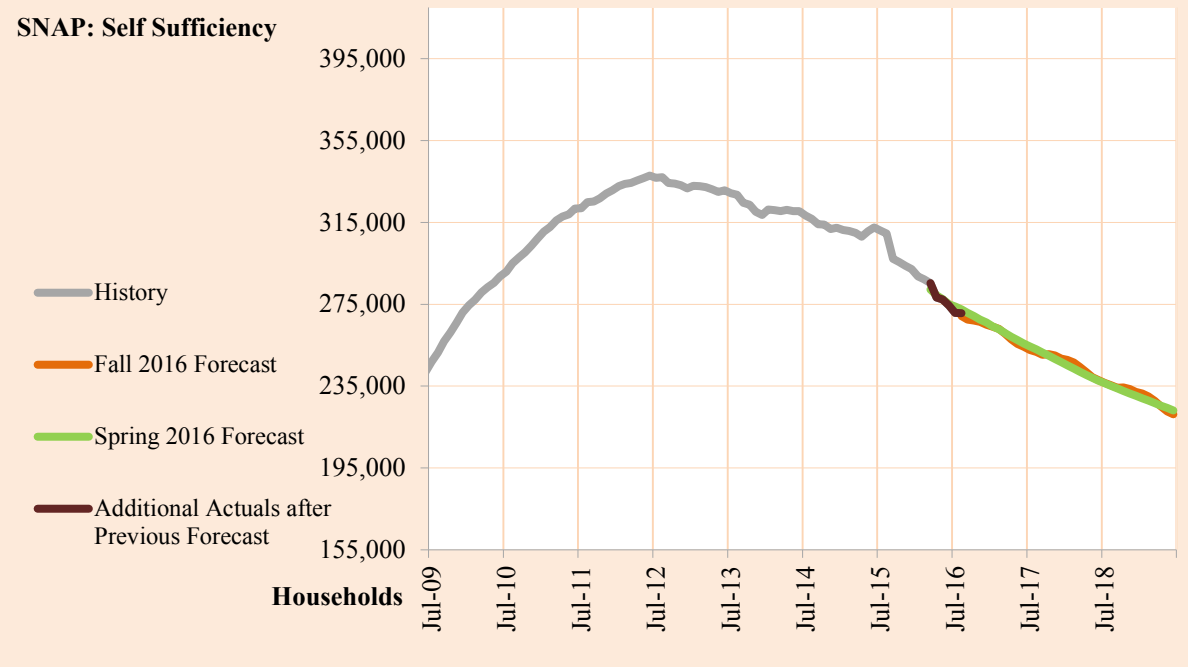
Total Supplemental Nutrition Assistance Programs



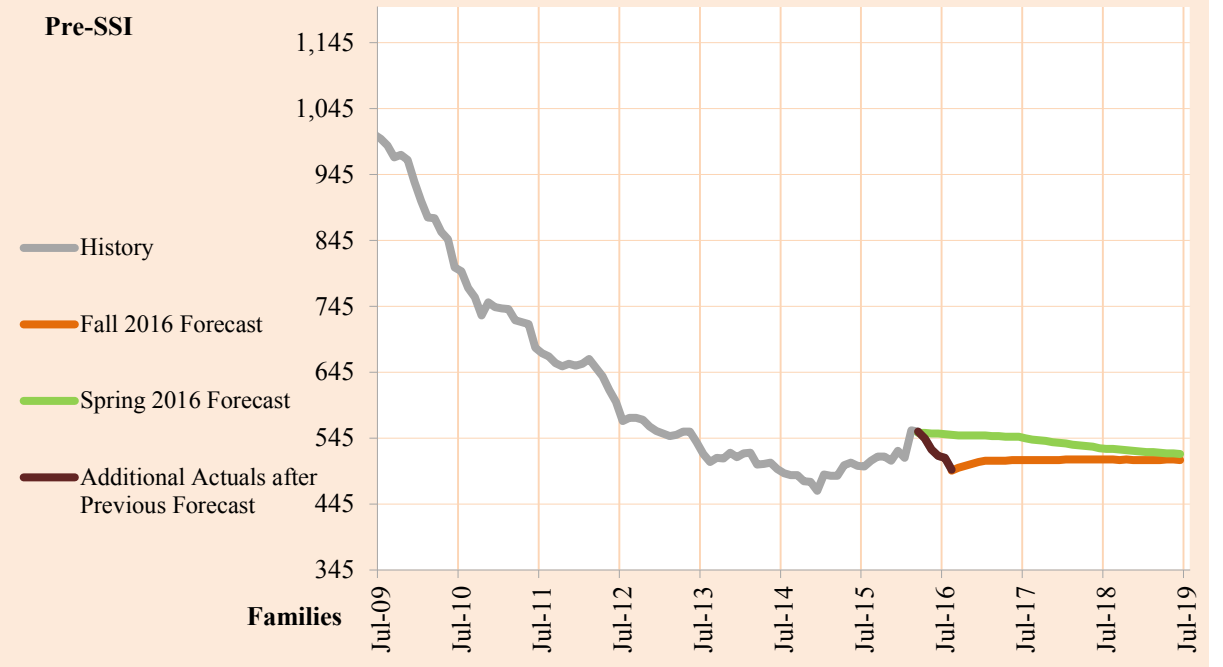
SNAP: Aging and People with Disabilities



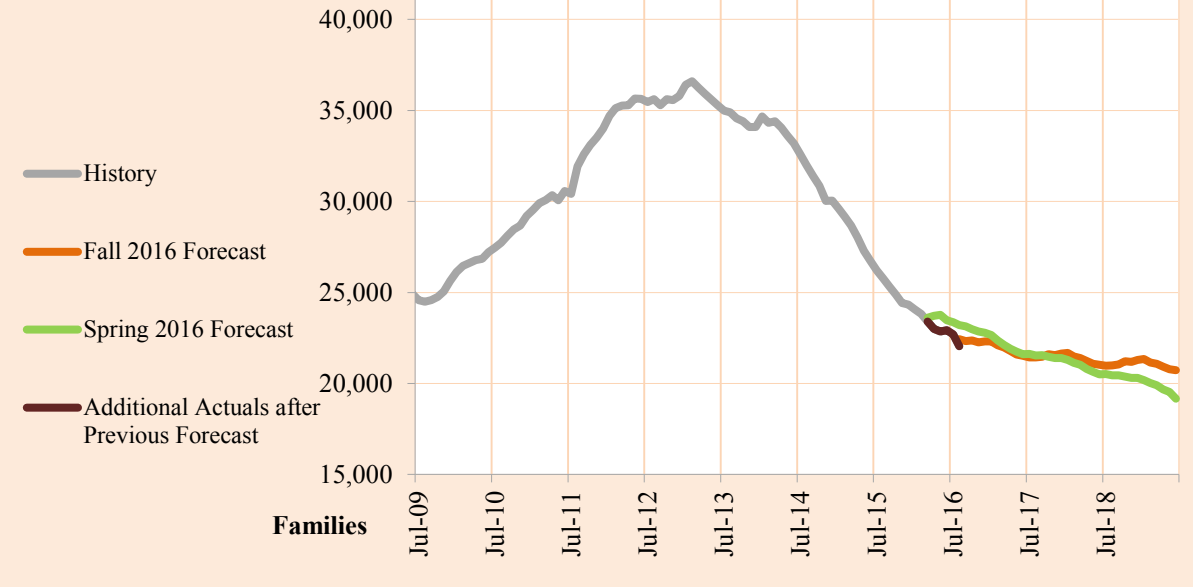
SNAP: Self Sufficiency



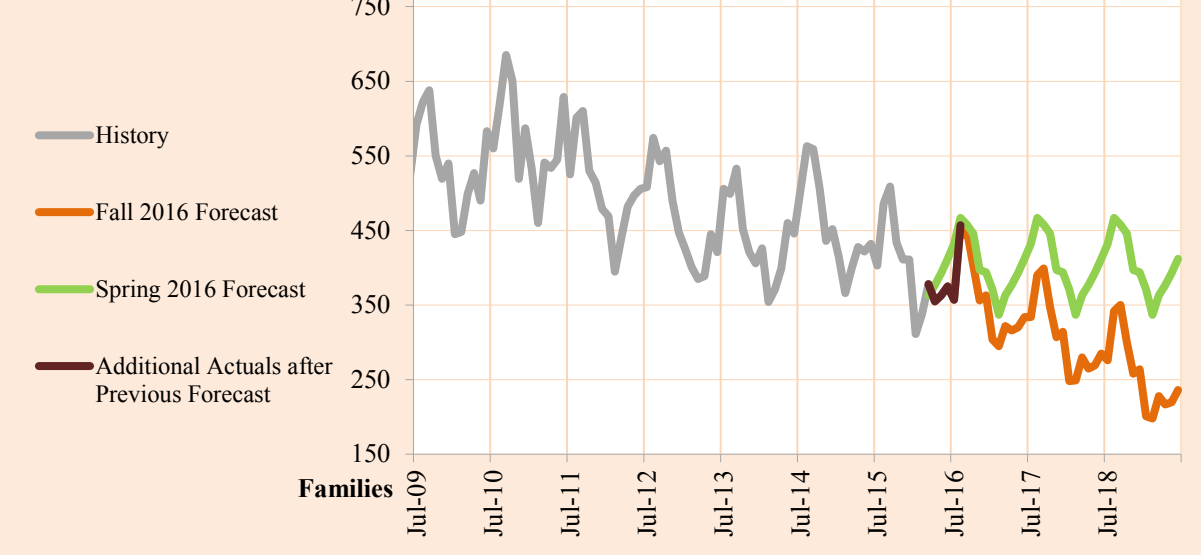
Pre-SSI



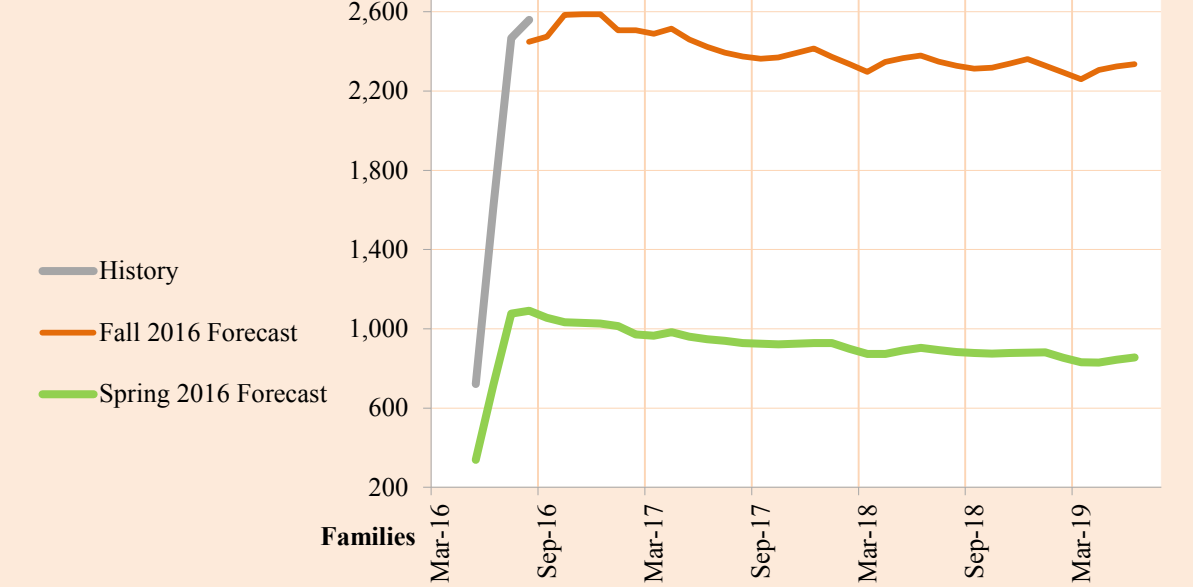
Total Temporary Assistance for Needy Families



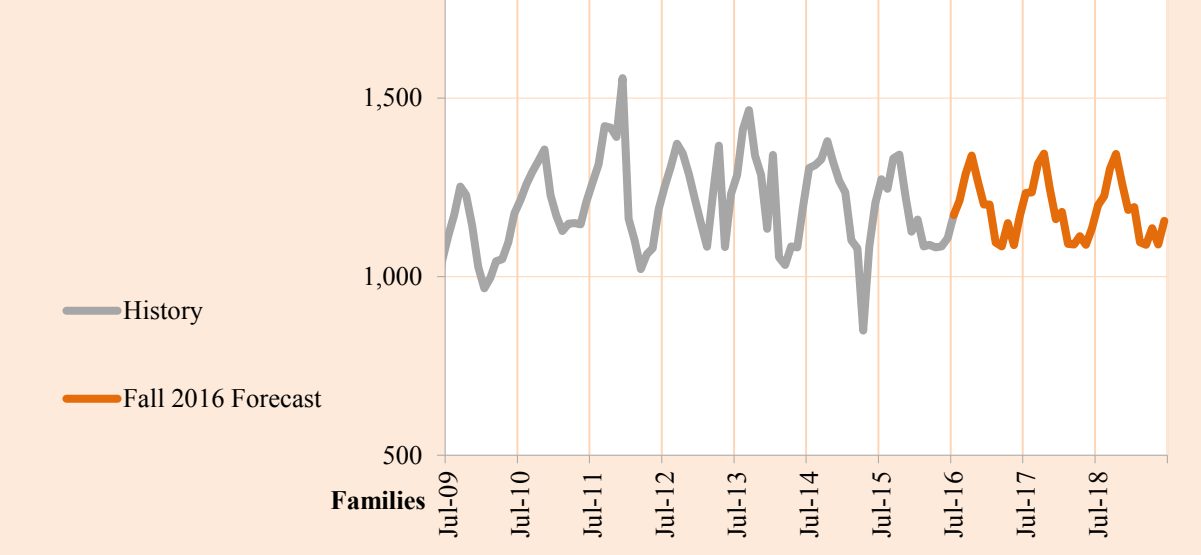
Temporary Assistance for Domestic Violence Survivors - with Payments



Temporary Assistance for Needy Families - Employment Payments



Temporary Assistance for Domestic Violence Survivors - without Payments



Self Sufficiency Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			% Change Between Forecasts	Fall 2016 Forecast			% Change Between Biennia
	Spring 16 Forecast	Fall 16 Forecast	Change		2015-17	2017-19	Change	
SELF SUFFICIENCY PROGRAMS								
Supplemental Nutrition Assistance Program (Households)								
Children, Adults and Families	277,902	277,427	-475	-0.2%	277,427	238,594	-38,832	-14.0%
Aging and People with Disabilities	127,916	127,716	-200	-0.2%	127,716	132,908	5,193	4.1%
Total SNAP	405,818	405,142	-676	-0.2%	405,142	371,503	-33,640	-8.3%
Temporary Assistance for Needy Families (Families: Cash/Grants)								
Basic	20,303	20,113	-190	-0.9%	20,113	19,046	-1,067	-5.3%
UN	3,205	3,186	-19	-0.6%	3,186	2,195	-991	-31.1%
Total TANF	23,508	23,299	-209	-0.9%	23,299	21,241	-2,057	-8.8%
TANF Employment Payments	1,165	2,269	1,104	94.8%	2,269	2,348	79	3.5%
Pre-SSI	540	517	-23	-4.3%	517	512	-4	-0.8%
Temp. Assist. For Dom. Violence Survivors (Families)								
TADVS: With Payment	404	377	-28	-6.8%	377	282	-94	-25.0%
TADVS: Without Payment*	-	1,184	-	-	1,184	1,188	4	0.3%
Total TADVS	-	1,561	-	-	1,561	1,471	-90	-5.8%

*TADVS: Without Payment is a new forecast category.

Child Welfare (CW)

Four main groups are forecast for Child Welfare: Adoption Assistance, Guardianship Assistance, Out of Home Care, and Child In-Home. Children may move between these groups, and typically enter the Child Welfare system via an Assessment. The number of children on open assessments has climbed over the past several years, however a plateau is expected, as there is an executive directive for branches to complete assessments in less than sixty days.

Adoption Assistance – This caseload exhibited moderate growth beginning in early 2012, but during the second half of 2015 the caseload leveled off. Since January 2016, there has been a slow decline to the caseload due to an increase in children aging out. Almost all new clients are from paid foster care so changes to the foster care caseload can directly increase or decrease the adoption assistance caseload. The caseload is expected to average 11,141 for the 2015-17 biennium, which is 0.9 percent lower than the Spring 2016 forecast. The caseload is expected to average 11,135 over the 2017-19 biennium, which is 0.1 percent lower than the 2015-17 biennial average forecast.

Guardianship Assistance – This caseload has exhibited steady growth for its entire history. The caseload grew 5 percent from March 2015 to March 2016. Policies are in place to shorten the length of time to permanent placement, so this caseload will continue to increase as children move out of foster care. In recent months, however, workers have been re-prioritizing work around safety issues and this may be affecting caseload numbers. Recent caseload numbers following the Spring 2016 forecast were about 1.5 percent lower than forecasted. The new forecast for 2015-17 caseload is expected to average 1,555 for the 2015-17 biennium, which is 1.9 percent lower than the Spring 2016 forecast. The caseload is expected to average 1,690 over the 2017-19 biennium, which is 8.7 percent higher than the 2015-17 biennial average forecast.

Out of Home Care – This caseload is comprised of paid foster care, non-paid foster care (including trial home visits), and residential care. Paid foster care is the largest portion of the group. The total foster care caseload experienced a 16.5

percent drop between 2010 and 2015, declining from 8,408 children in December 2010 to 7,024 children in December 2015. During this period, the number of children supervised in-home also declined overall, as well as the percentage of in-home children who transferred into foster care. Many initiatives now in place are designed to decrease the foster care caseload even though the child population in Oregon continues to grow. However, in recent months the caseload has leveled off and exhibited some growth. Between November 2015 and March 2016 the caseload grew 1.3 percent. The caseload is expected to average 7,092 for the 2015-17 biennium, which is 1.3 percent higher than the Spring 2016 forecast. The caseload is expected to average 7,173 over the 2017-19 biennium, which is 1.1 percent higher than the 2015-17 biennial average forecast.

Child In-Home – Following implementation of the OR-KIDS data system in 2011, this caseload exhibited an almost continuous decline until 2015. Since January 2015 the caseload has been climbing. In March 2016 the caseload rose to 1,572, and between April 2015 and March 2016 the caseload increased 22 percent. Recent increases are likely due to a change in reporting. There has been an increase in data entry, which may reflect a more accurate number of children served in-home. The caseload is expected to average 1,505 for the 2015-17 biennium, which is 9.5 percent higher than the Spring 2016 forecast. The caseload is expected to average 1,586 over the 2017-19 biennium, which is 5.4 percent higher than the 2015-17 biennial average forecast.

Risks and Assumptions

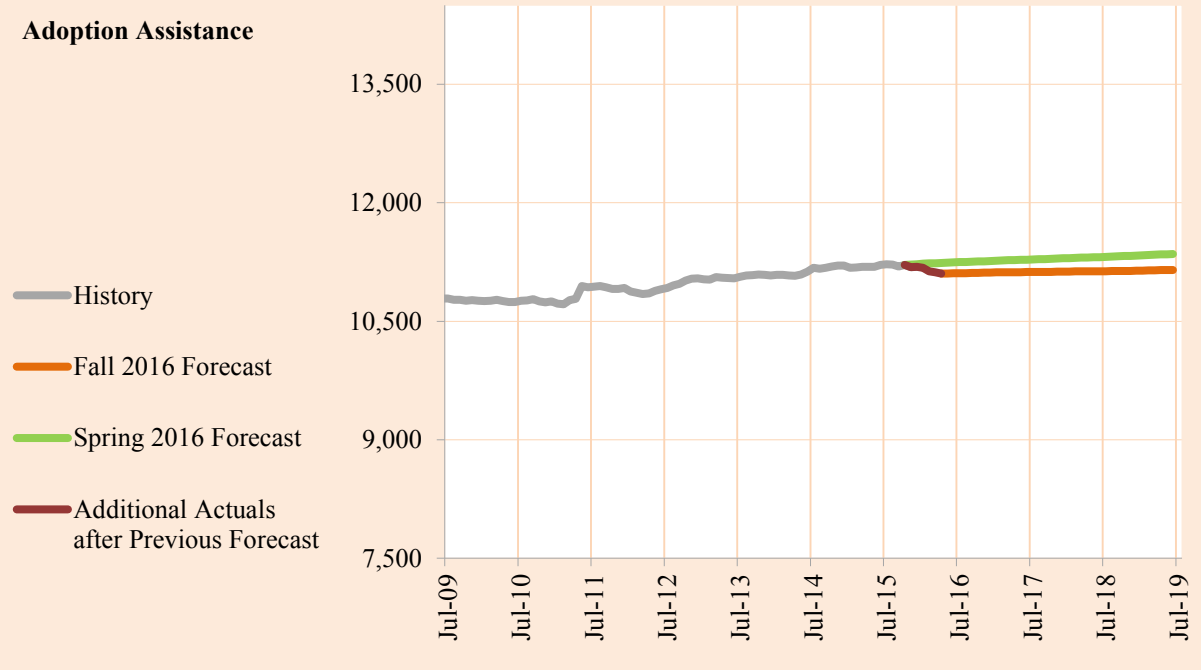
In the past year the Child Welfare Program has experienced changes in leadership, and there is a new review process for licensed residential facilities. Since January 2016, there has been a shift in prioritization to child protective services work, and this may affect Adoption Assistance and Guardianship Assistance caseloads.

Risks to the Out of Home Care caseload mainly involve the treatment foster care program. Providers may close suddenly or not accept referrals. They also

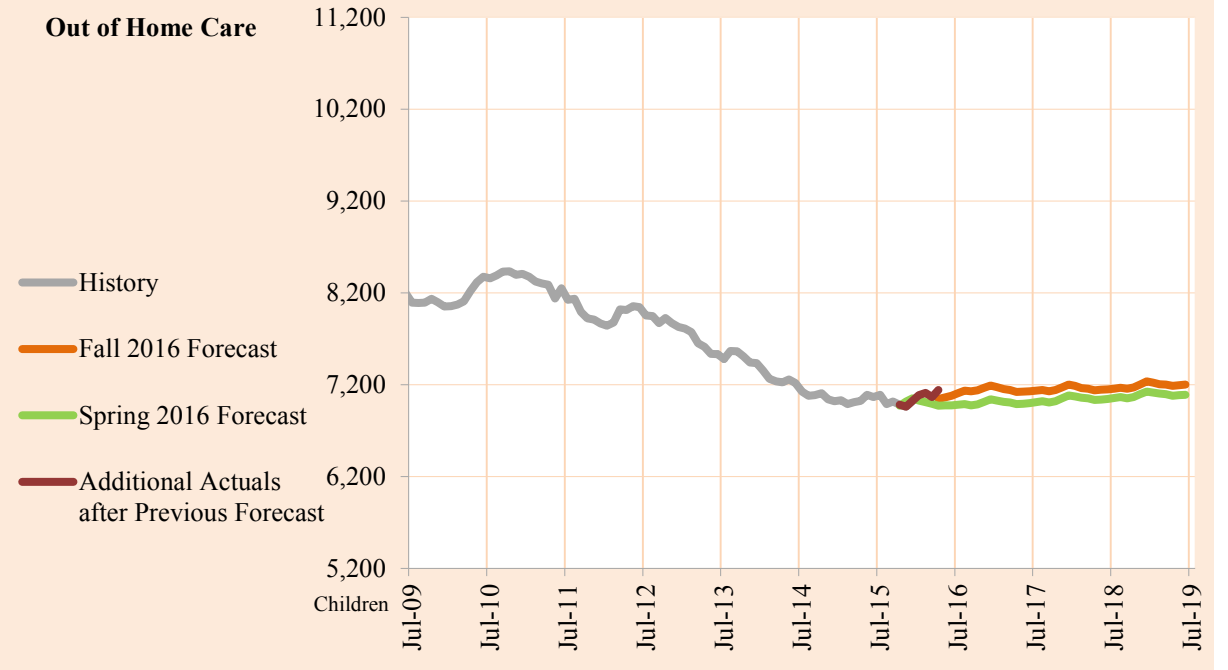
face challenges recruiting foster parents. There may be a need for services but a lack of people to provide those services. As new programs start, it is unknown how quickly the beds will fill.

The Child In-Home data are still being worked on and checked. The percentage of case plans entered into the system increased for the first half of 2016. This led to more children being counted in the Child In-Home caseload. Another risk to the forecast of the Child In-Home caseload is the number of overdue or unclosed assessments that have not been entered into the data system. In May 2016 a clean-up effort around overdue assessments began, and overdue assessments have started to decline. The Child In-Home caseload may increase as a result.

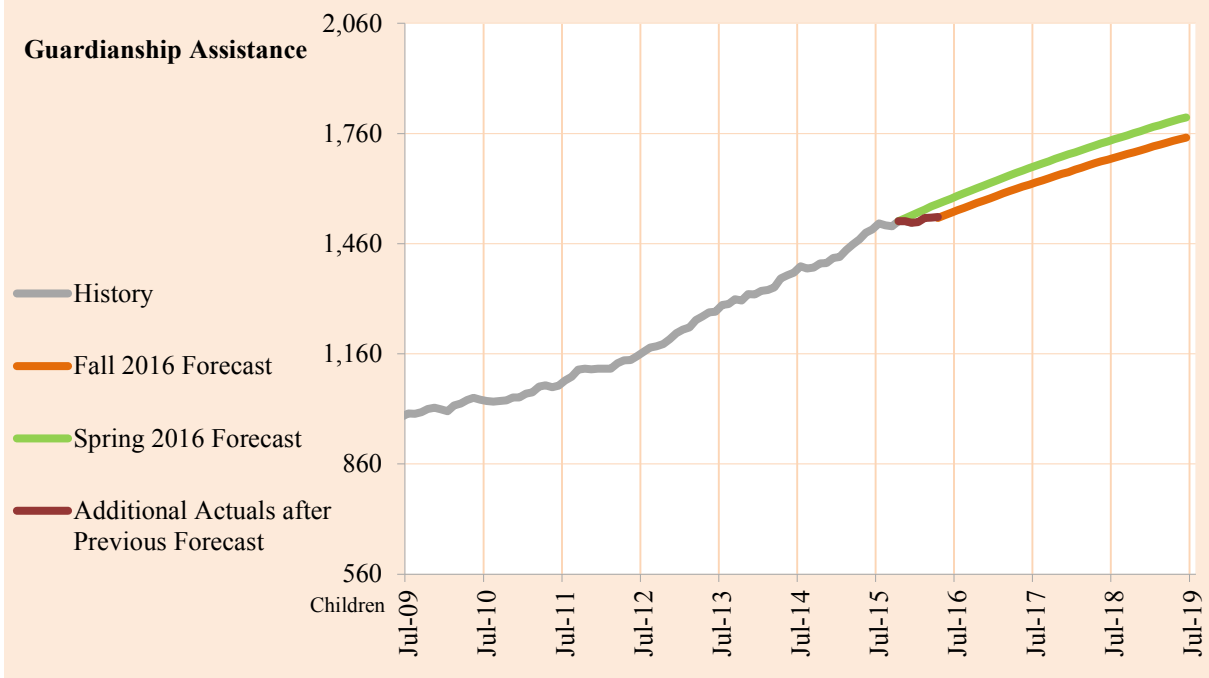
Adoption Assistance



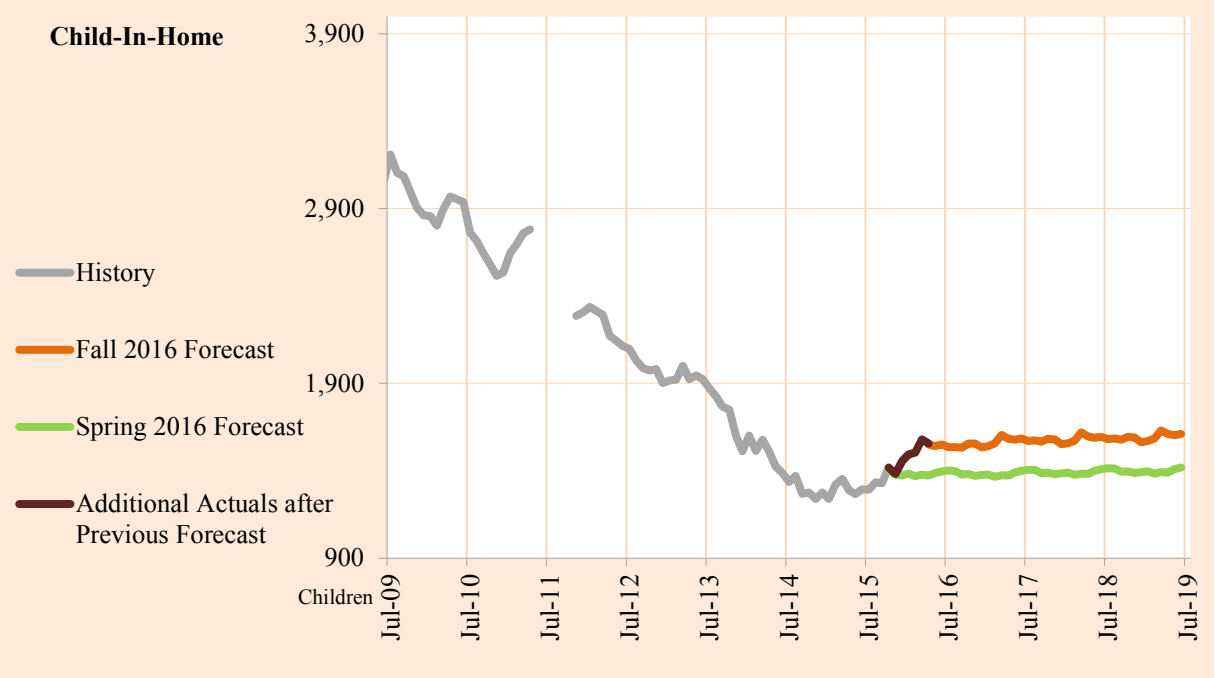
Out of Home Care

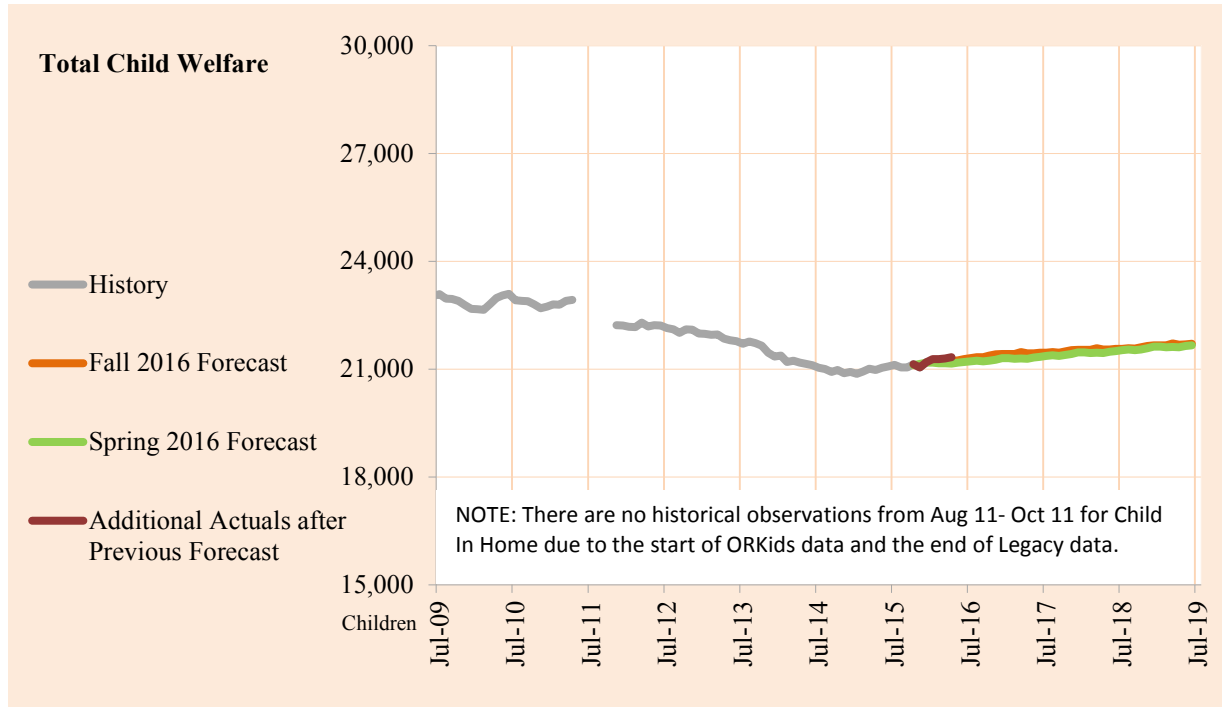


Guardianship Assistance



Child-In-Home





Child Welfare Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			% Change Between Forecasts	Fall 2016 Forecast			% Change Between Biennia
	Spring 16 Forecast	Fall 16 Forecast	Change		2015-17	2017-19	Change	
CHILD WELFARE (Children)								
Adoption Assistance	11,245	11,141	-104	-0.9%	11,141	11,135	-6	-0.1%
Guardianship Assistance	1,585	1,555	-30	-1.9%	1,555	1,690	135	8.7%
Out of Home Care ¹	7,004	7,092	88	1.3%	7,092	7,173	81	1.1%
Child In-Home	1,375	1,505	130	9.5%	1,505	1,586	81	5.4%
Total Child Welfare	21,209	21,293	84	0.4%	21,293	21,584	291	1.4%

1. Includes residential and foster care.

Vocational Rehabilitation (VR)

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

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

These changes are all fairly complex and interwoven, and have combined to have substantial impacts on the VR caseload. This recent period of rapid change started approximately in January of 2015 and changes are expected to continue through at least the next biennium.

Prior to the Spring 2016 forecast, only the total program caseload was officially forecast. Although counts for the Application, Eligibility, In Plan and Post Employment Services stages of VR were forecasted and shared internally, they were not published in the official forecast. Due to changes in the last year that have impacted how clients move through the program stages, the official forecast now includes the caseload for each stage of VR rather than just the total.

The most significant ongoing change is a large increase in the number of clients who are currently In Plan, receiving services. Policy and process changes have also resulted in larger numbers of clients applying for service each month, particularly from individuals with I/DD.

Since individuals with I/DD typically have more completed paperwork when they apply, they move through the Application and Eligibility stages faster. This has resulted in a substantial decrease in the average number of clients who have been determined eligible, but who are not yet In Plan each month. So while the number of clients In Plan has increased substantially, there are also fewer clients waiting at the Eligibility stage. Consequently, the total number of clients in VR has risen only modestly. This is a significant increase in clients receiving services that would be largely invisible to anyone looking only at the total number of people served by the VR program.

Risks and Assumptions

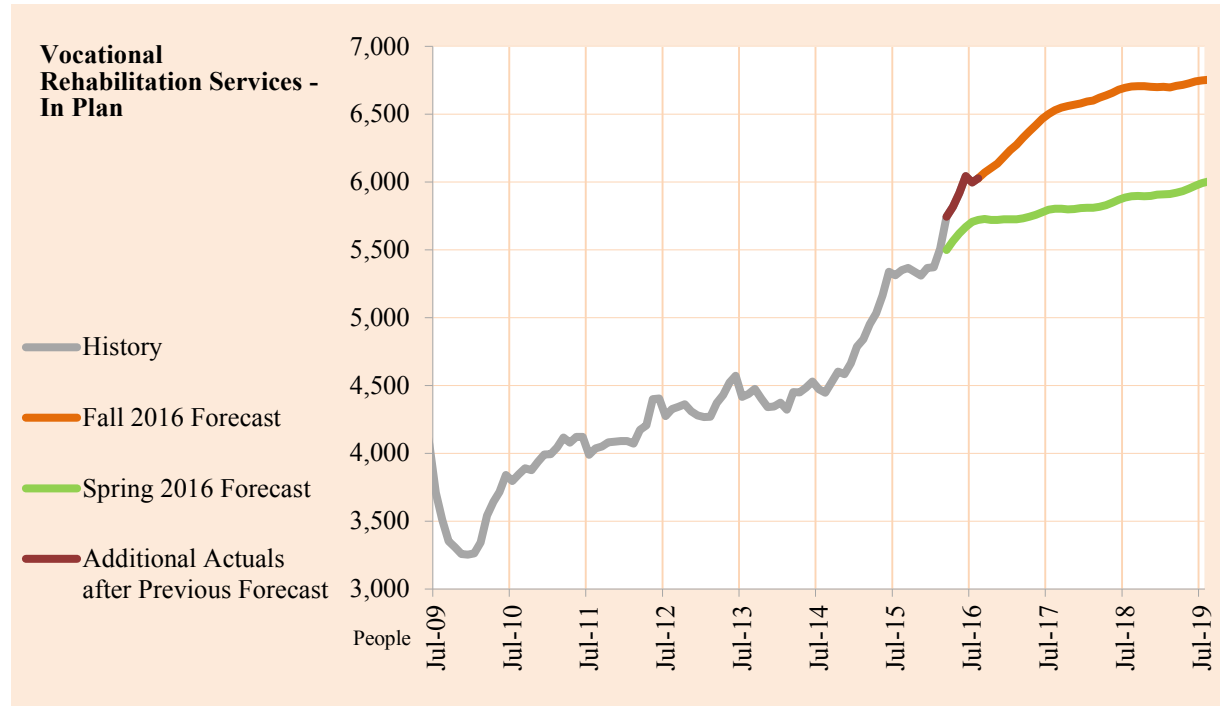
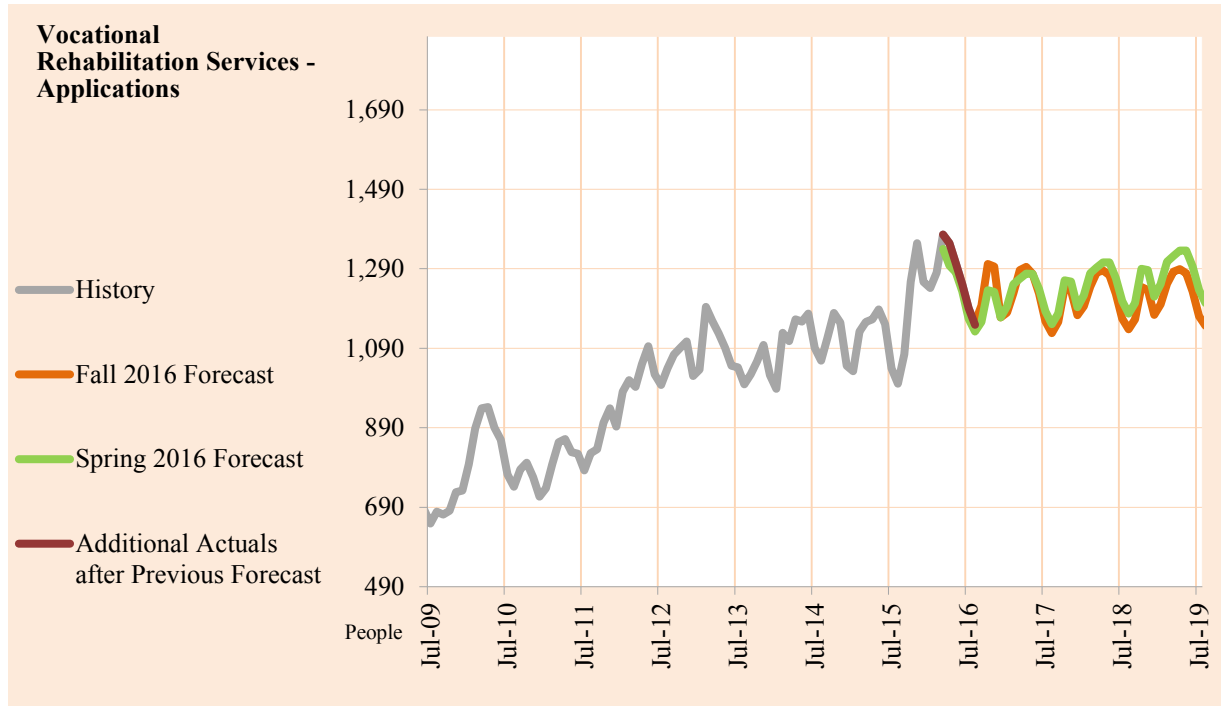
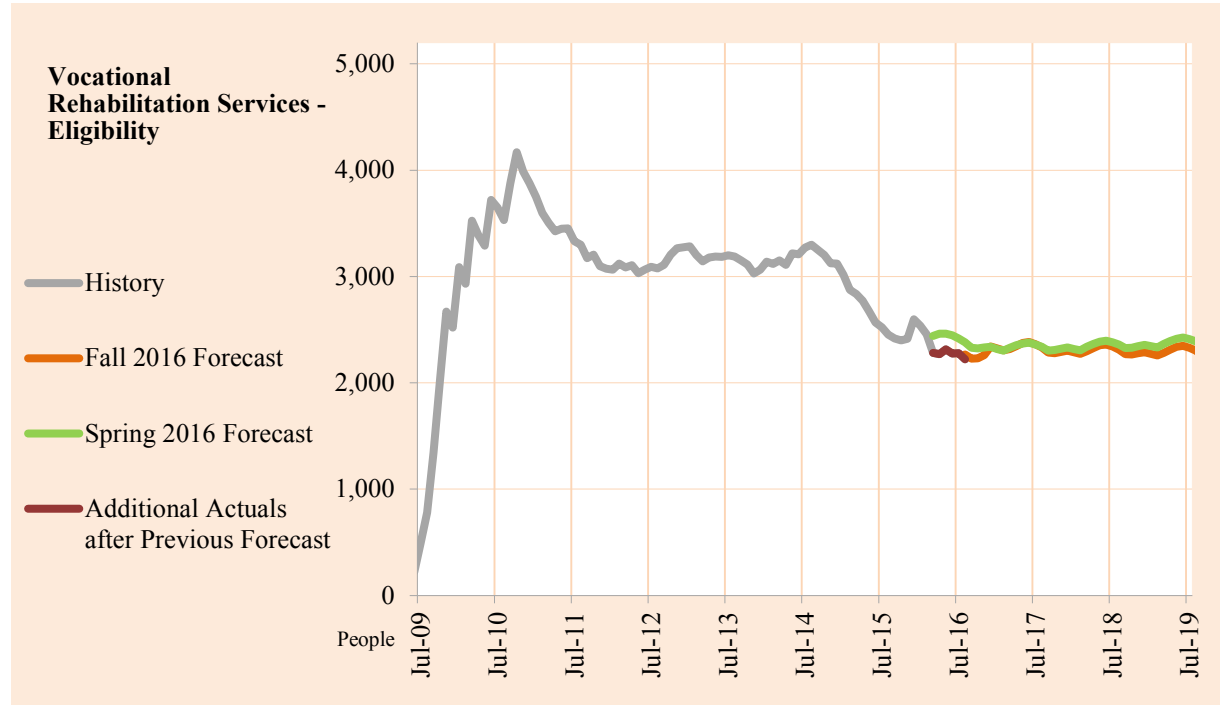
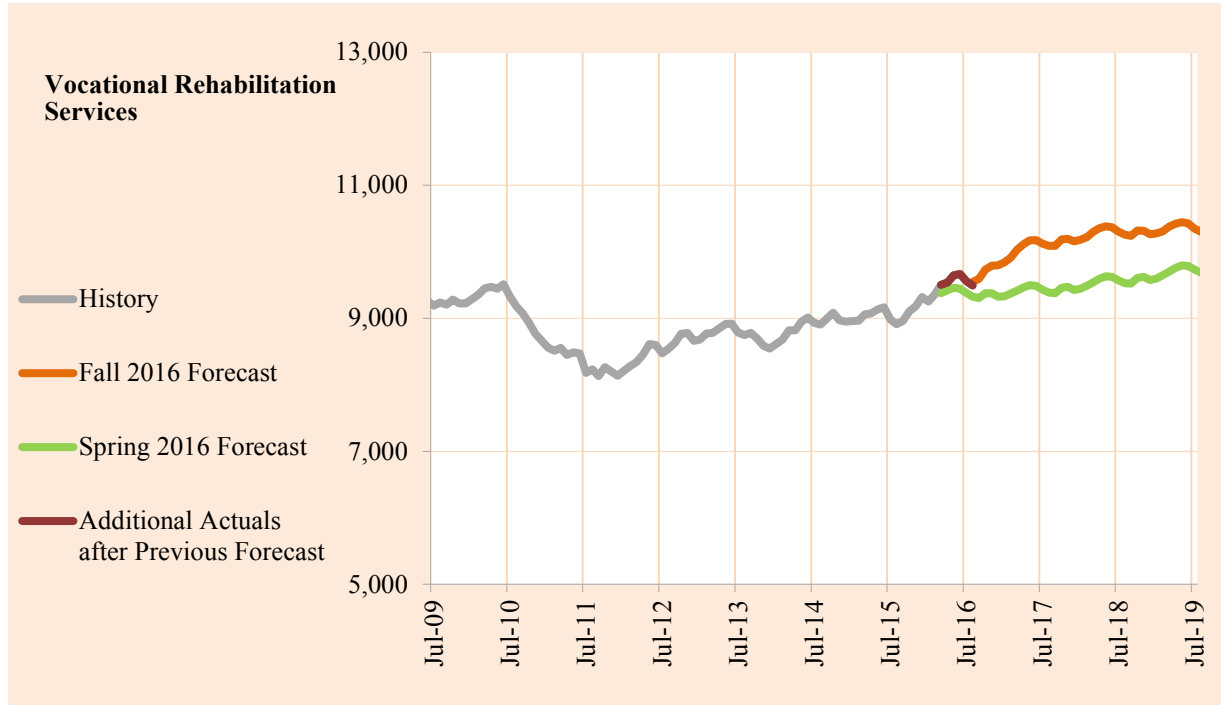
There is a risk that the program may have to enter order of selection in the 2017-19 biennium. This could happen if the program has insufficient funds to provide services to all eligible clients. The program did receive some federal re-allotment dollars recently, but insufficient state funds in the 2017-19 budget could also trigger order of selection, changing caseloads dramatically.

There is also a risk that additional clients from the ‘woodwork effect’ of the settlement may drive application numbers above those forecast.

Pre-employment Transition Services started in October 2014. This is a new mandate of the Workforce Investment and Opportunity Act (W.I.O.A.) designed to help high school students with disabilities make the transition to employment or higher education. This mandate includes a 15 percent set aside of the Federal dollars each year, to be spent on specific core services. The five core services being;

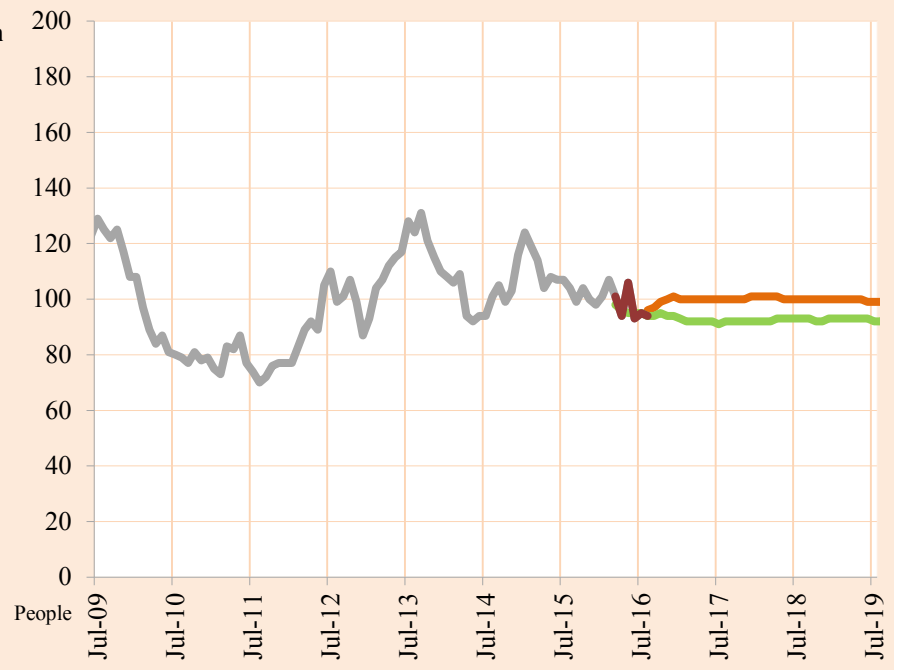
- Job exploration counseling
- Work-based learning experiences
- Counseling on opportunities for enrollment in comprehensive transition or postsecondary educational programs at institutions of higher education
 - Workplace readiness training to develop social skills and independent living
 - Instruction in self-advocacy

It is expected to have an impact on VR caseload, but as a new mandate, its full impacts are not yet known.



Vocational Rehabilitation Services - Post Employment Services

- History
- Fall 2016 Forecast
- Spring 2016 Forecast
- Additional Actuals after Previous Forecast



Vocational Rehabilitation Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			% Change Between Forecasts	Fall 2016 Forecast			% Change Between Biennia
	Spring 16 Forecast	Fall 16 Forecast	Change		2015-17	2017-19	Change	
VOCATIONAL REHABILITATION								
Application	1,224	1,238	14	1.1%	1,238	1,219	-19	-1.5%
Eligibility	2,407	2,359	-48	-2.0%	2,359	2,305	-54	-2.3%
In Plan	5,582	5,872	290	5.2%	5,872	6,650	778	13.2%
Post Employment Services	97	100	3	3.1%	100	100	0	0.0%
Total Vocational Rehabilitation	9,310	9,570	260	2.8%	9,570	10,275	705	7.4%

Aging and People with Disabilities (APD)

Historically, Oregon's Long Term Care (LTC) services were provided under the authority of a Medicaid 1915 (c) Home and Community-Based Services (HCBS) Waiver. Starting in July 2013, Oregon began offering services through the Community First Choice Option under 1915 (k) of the Social Security Act (referred to as "K Plan"); and now most services are provided through the K Plan rather than the HCBS Waiver.

During the last 13 years, the total Long-Term Care (LTC) caseload has varied from a high of 31,500 clients in November 2002 to a low of 25,900 clients in May 2008; with slightly more than half of that decline occurring between November 2002 and June 2003 when the LTC eligibility rules were modified to cover only clients in Service Priority Levels 1 to 13. From 2008 to 2013 the caseload grew by an average of 2.5 percent a year, despite a serious recession, driven in part by a significant growth in the number of Oregon seniors. Between 2014 and 2015 the average annual caseload grew by 6.7 percent due to factors such as implementation of the K Plan, expansion of Medicaid, and policy changes to make in-home care more attractive. We will not know for some time how long this new trend will continue.

Total Long-Term Care (LTC) – A total of 33,815 clients received long-term care services in April 2016. The 2015-17 biennial average is projected to be 34,086 clients, which is slightly lower than the Spring 2016 Forecast. The 2017-19 forecast is 7.3 percent higher than the forecast for 2015-17.

The LTC forecast is divided into three major categories: In-Home, Community-Based Care (CBC), and Nursing Facilities. Most of the projected increase from 2015-17 to 2017-19 is in In-Home Care. In-Home Care continues to be a popular placement choice, particularly since 2013 when APD implemented several changes designed to make In-Home services comparatively more attractive to clients. CBC is still forecasted to grow, although at a reduced rate to reflect the anticipated shift toward In-Home Care. Community-Based Care will continue to be a stable placement choice for many LTC clients because this type of care is easier to set up

and coordinate than In-Home Care and because hospitals prefer discharging patients to higher service settings in order to reduce the risk of repeat emergency visits or readmission. On the other hand, Medicaid reimbursement rates continue to lag behind private market rates, thus making Medicaid clients relatively less attractive to CBC providers.

In-Home Care – In April 2016, 17,779 clients received In-Home Care, which accounted for 52.6 percent of total LTC services. The 2015-17 biennial average forecast of 17,656 clients is slightly lower than the Spring 2016 forecast. The 2017-19 forecast is expected to be 11.3 percent higher than 2015-17, and by June 2019 In-Home Care is projected to be 55.4 percent of total LTC services.

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

Community-Based Care (CBC) – In April 2016, 11,815 clients received Community-Based Care, which accounted for 34.9 percent of total LTC. The 2015-17 projected biennial average is 11,886 clients, which is slightly higher than the Spring 2016 forecast. The 2017-19 projection is 4.8 percent higher than 2015-17, and by June 2019 Community-Based Care is forecasted to be 33.7 percent of total LTC.

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

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

Nursing Facility Care – In April 2016, 4,221 clients received Nursing Facility Care, which accounted for 12.5 percent of total LTC. The 2015-17 biennial average forecast is 4,241 clients, slightly higher than the Spring 2016 forecast. The 2017-19 projection is 2.8 percent lower than 2015-17, and by June 2019 Nursing Facility Care is forecasted to be 10.9 percent of Total LTC.

Affordable Care Act (ACA) Long-Term Care

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

These clients constitute a small sub set of the total LTC population, but their funding sources are significantly different. Consequently, OFRA is beginning to track these clients separately within the LTC population. Data allowing OFRA to know which individuals are ACA LTC has only recently become available. OFRA anticipates that when sufficient data is available, these clients will be forecast separately within the LTC caseload.

Risks and Assumptions

Patient Protection and Affordable Care Act of 2010 – Implementation of ACA changed the playing field for long-term care in Oregon and introduced significant new risks to the forecast. By shifting from operating under the HCBS Waiver to the K Plan in late 2013, the eligibility rules for long-term care were changed.

At roughly the same time, Oregon chose to extend Medicaid coverage (including long-term care) to a significantly larger pool of low income adults. To qualify for LTC under the prior HCBS Waiver, clients had to meet four separate criteria: 1) be assessed as needing the requisite Level of Care; 2) be over 65 years old or have an official determination of disability; 3) have income below 300 percent of SSI (roughly 225 percent of FPL); and 4) have very limited assets. However, under the ACA's K Plan option, clients only need to meet two criteria: 1) be assessed as needing requisite Level of Care, and 2) have income below 138 percent of FPL. Note that the HCBS Waiver allows clients with higher incomes than the K Plan; but the K Plan has no asset limits and no requirement that clients to be over 65 or officially determined disabled. Recent changes in the pattern of new clients entering long-term care indicates that the ACA (the combined effects of the K Plan and Medicaid expansion) is contributing to long-term care caseload growth. However, the new service use patterns have not yet emerged and normalized.

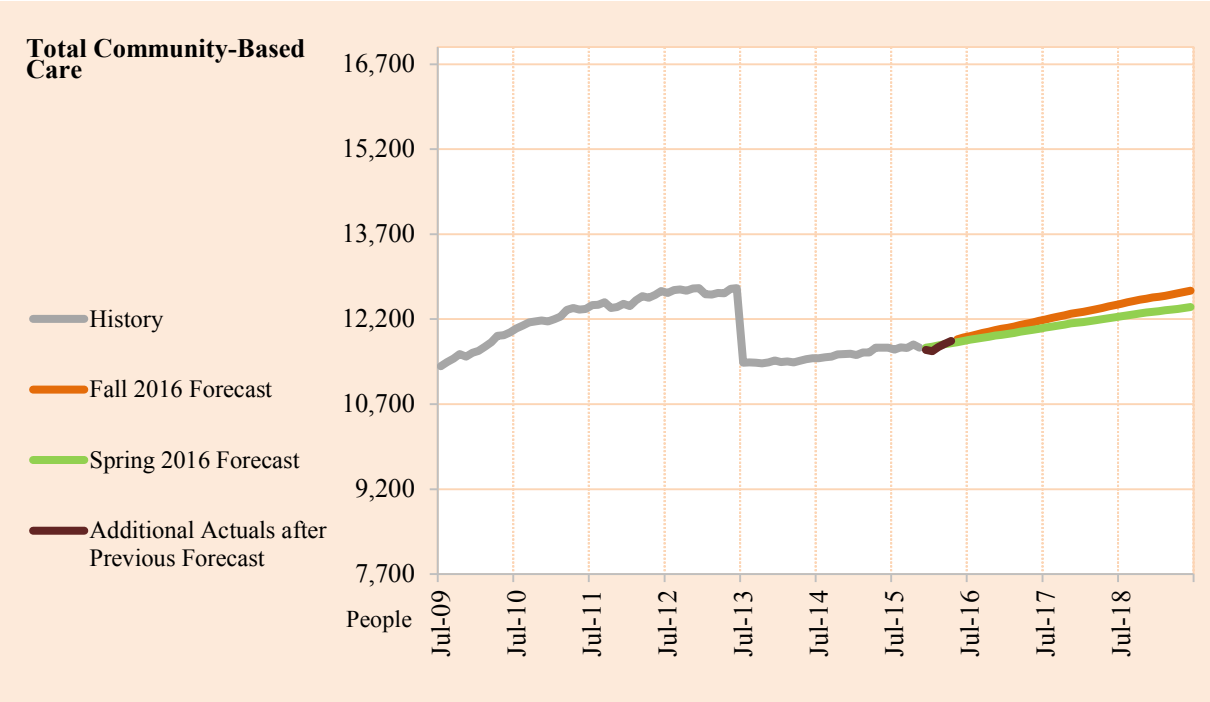
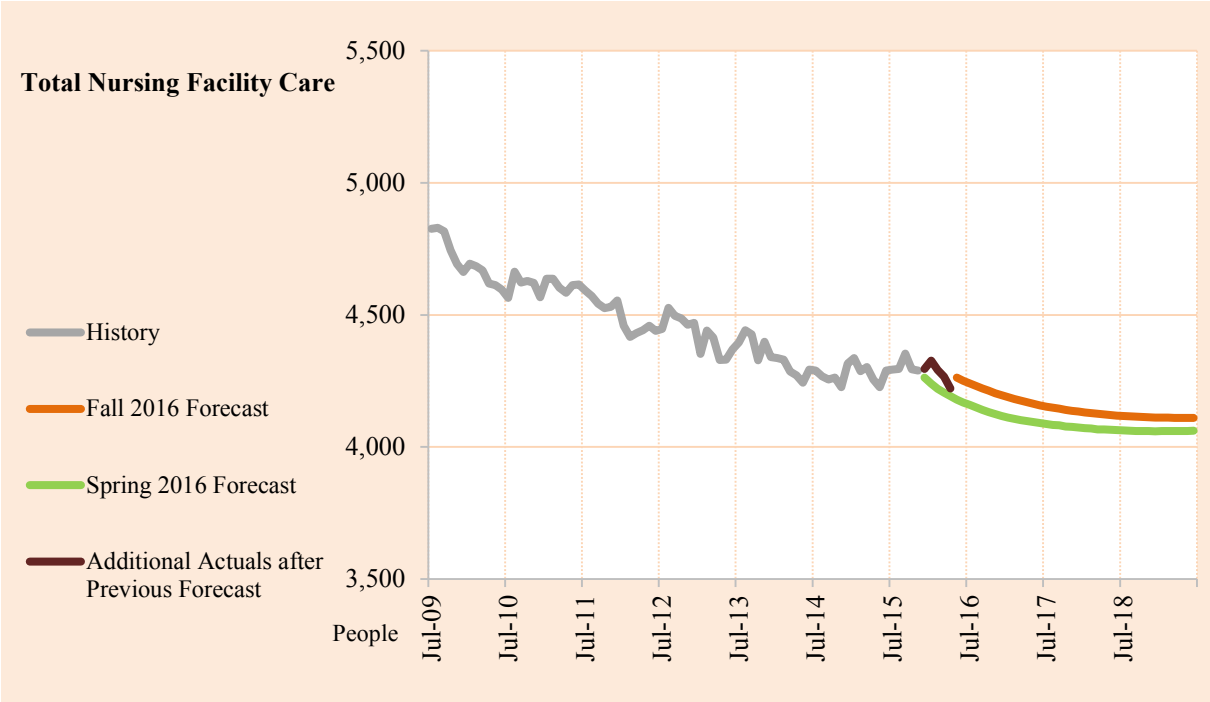
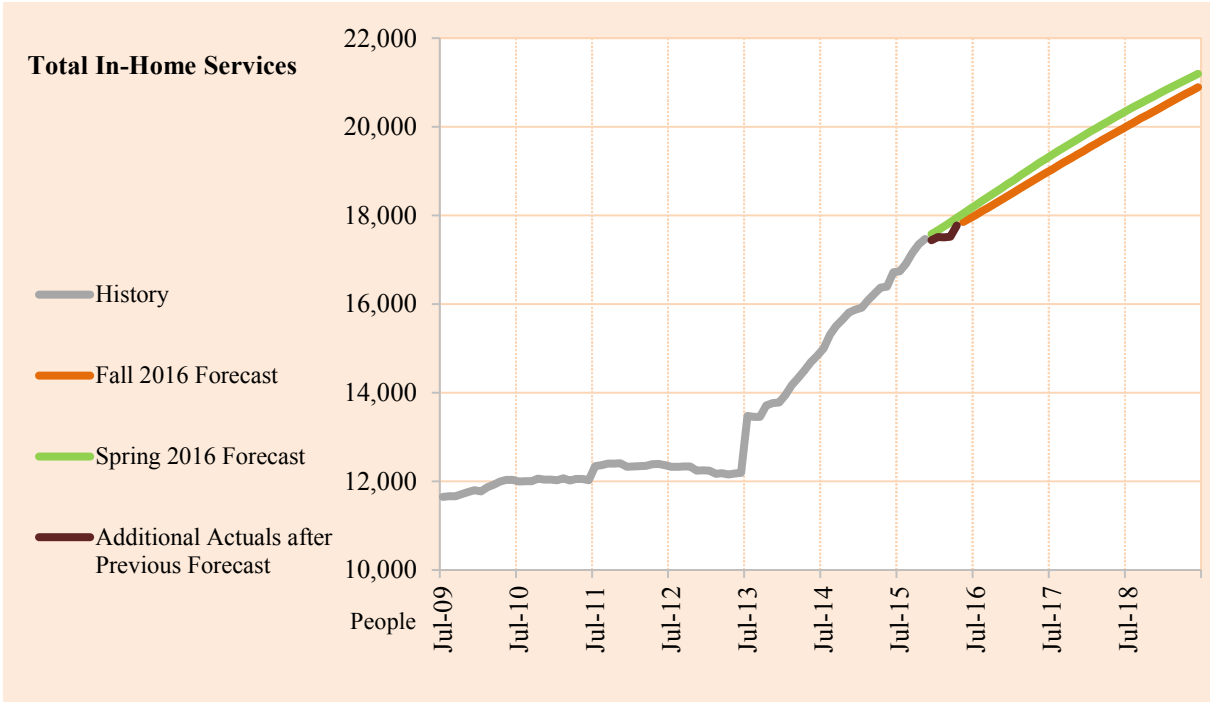
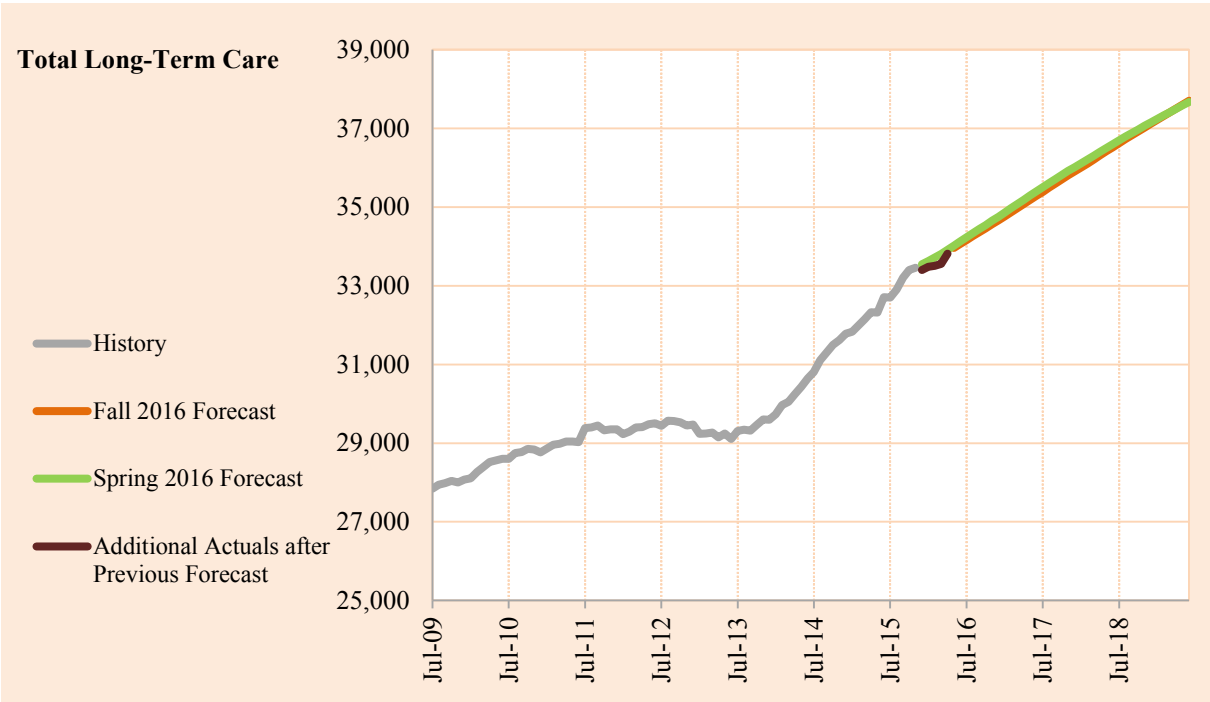
Policy and Program Changes – Another significant risk was created by policy and program changes implemented in 2013 which were designed to increase the attractiveness of In-Home Care relative to more expensive forms of care, and to delay or prevent individuals from even needing LTC assistance. While successful prevention measures should save money in the future, changes that make In-Home Care more attractive now could either reduce costs by leading clients to choose lower cost services, or increase costs by making accepting assistance more attractive.

Oregon Demographic Shift – In addition to internal policy and program related changes, external changes such as demographic shifts in Oregon's population also

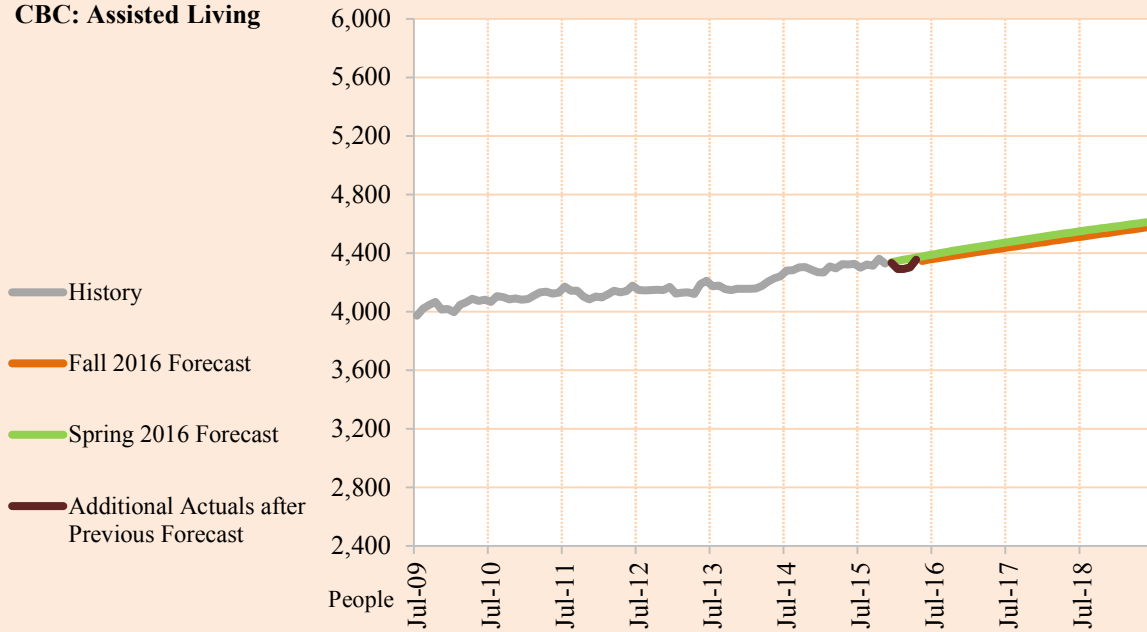
pose a risk to the forecast's accuracy over the longer term (for example, more seniors living longer, or the financial or physical health of those seniors). Oregon's population is aging, and elderly Oregonians are among the fastest growing segments of the state population. Oregonians with multiple chronic conditions in the 85 and older age group also risk depleting their resources, which will increase the likelihood they will become eligible for Long-Term Care programs.

The long-term care caseload forecast has a shorter time horizon of two to three years, while the Demographic forecast has a longer time horizon of five to ten years. This presents a challenge to properly account for the impact of demographic shifts on the long-term care caseload. The OFRA (caseload forecast) is much more responsive to internal policy and program changes than the indirect and external effect of demographic shifts in a shorter time horizon. OFRA recognizes, however, the importance of indirect impacts of Oregon demographic changes, especially in elderly population, and regularly monitors it.

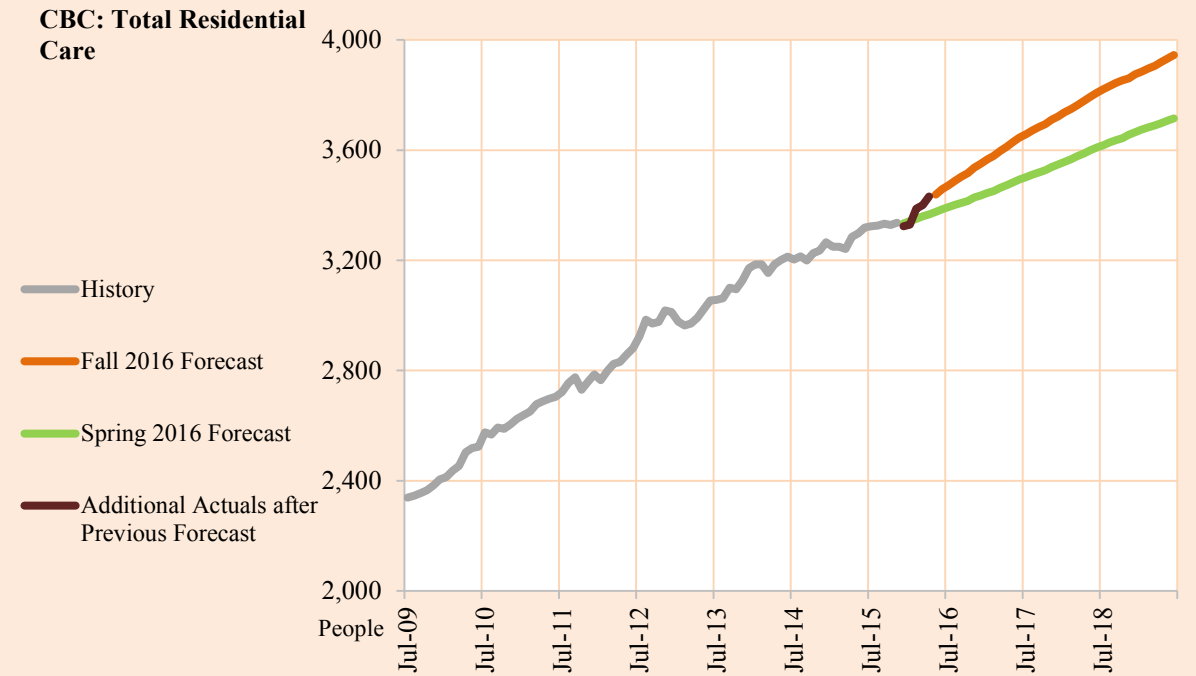
Oregon House Bill 2216 - Another factor that may impact LTC caseloads is Oregon HB 2216, passed in 2013, which calls for a statewide reduction in the Long-Term Care Nursing Facilities bed capacity.



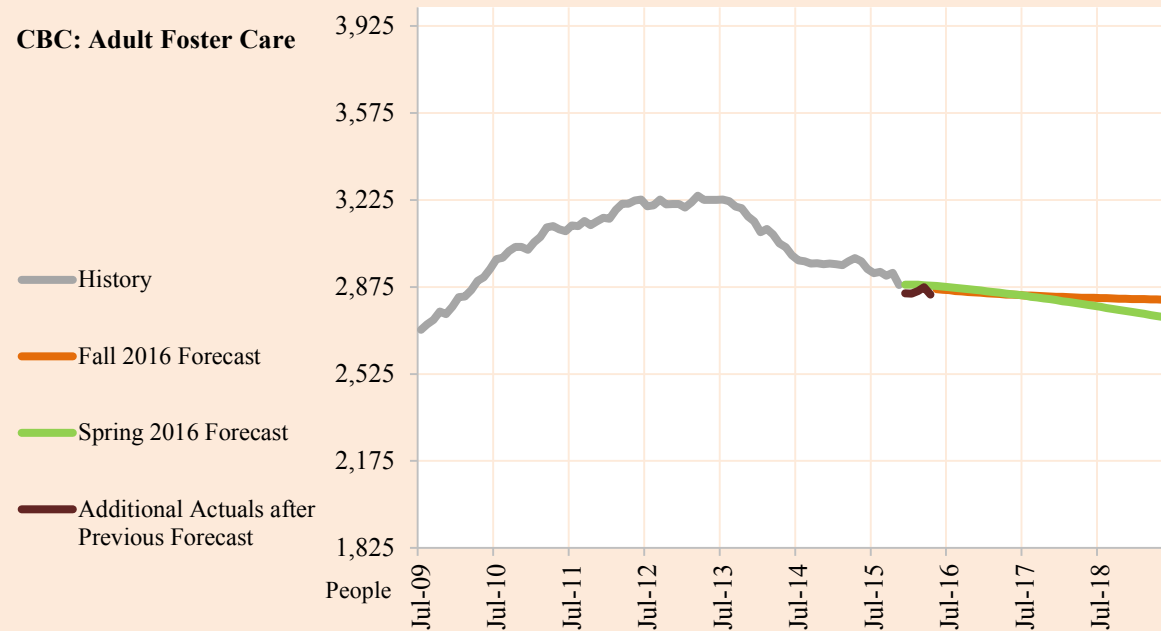
CBC: Assisted Living



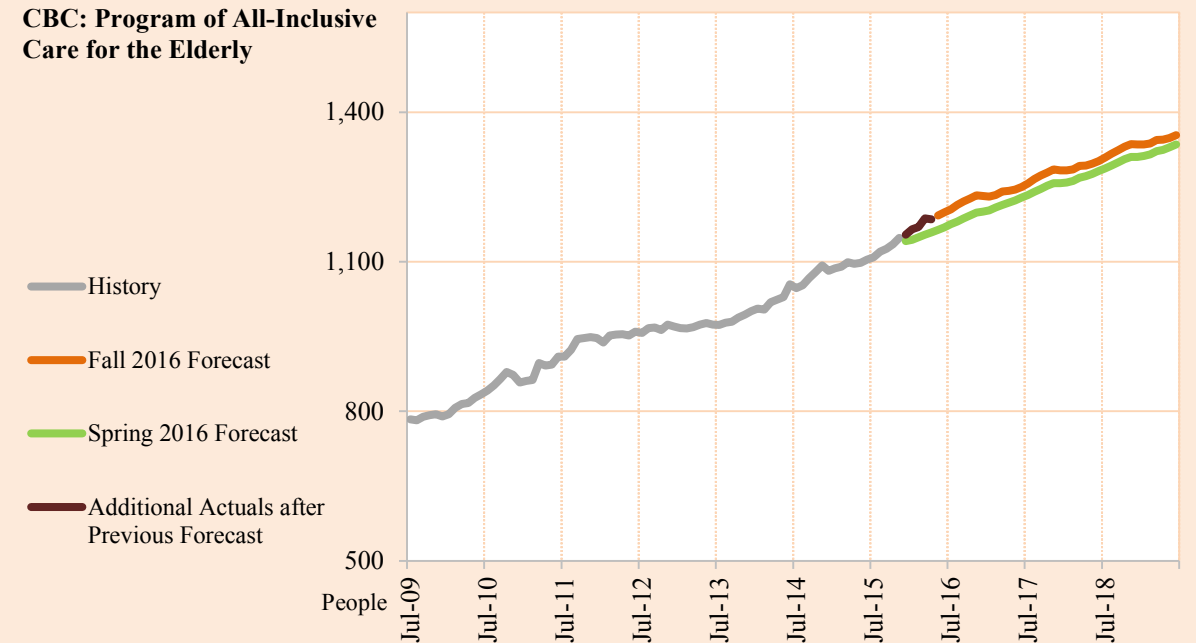
CBC: Total Residential Care



CBC: Adult Foster Care



CBC: Program of All-Inclusive Care for the Elderly



Aging and People with Disabilities Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			% Change Between Forecasts	Fall 2016 Forecast			% Change Between Biennia
	Spring 16 Forecast	Fall 16 Forecast	Change		2015-17	2017-19	Change	
AGING AND PEOPLE WITH DISABILITIES								
In-Home Hourly without SPPC	12,360	12,775	415	3.4%	12,775	14,672	1,897	14.8%
In-Home Agency without SPPC	1,826	1,879	53	2.9%	1,879	2,131	252	13.4%
In-Home Live-In	1,474	922	-552	-37.4%	922	500	-422	-45.8%
In-Home Spousal Pay	103	67	-36	-35.0%	67	66	-1	-1.5%
Independent Choices	459	458	-1	-0.2%	458	587	129	28.2%
Specialized Living	199	198	-1	-0.5%	198	200	2	1.0%
In-Home K Plan Subtotal	16,421	16,299	-122	-0.7%	16,299	18,156	1,857	11.4%
In-Home Hourly with State Plan Personal Care	1,400	1,323	-77	-5.5%	1,323	1,451	128	9.7%
In-Home Agency with State Plan Personal Care	334	337	3	0.9%	337	375	38	11.3%
In-Home non-K Plan Subtotal	1,734	1,660	-74	-4.3%	1,660	1,826	166	10.0%
Total In-Home	18,155	17,959	-196	-1.1%	17,959	19,982	2,023	11.3%
Adult Foster Care	2,878	2,868	-10	-0.3%	2,868	2,831	-37	-1.3%
Assisted Living	4,389	4,361	-28	-0.6%	4,361	4,510	149	3.4%
Contract Residential Care	2,308	2,406	98	4.2%	2,406	2,727	321	13.3%
Regular Residential Care	1,086	1,057	-29	-2.7%	1,057	1,079	22	2.1%
Program of All-Inclusive Care for the Elderly (PACE)	1,173	1,194	21	1.8%	1,194	1,309	115	9.6%
Community-Based Care Subtotal	11,834	11,886	52	0.4%	11,886	12,456	570	4.8%
Basic Nursing Facility Care	3,556	3,571	15	0.4%	3,571	3,459	-112	-3.1%
Complex Medical Add-On	528	575	47	8.9%	575	569	-6	-1.0%
Enhanced Care	55	54	0	0.0%	54	55	1	1.9%
Pediatric Care	45	41	0	0.0%	41	40	-1	-2.4%
Nursing Facilities Subtotal	4,184	4,241	57	1.4%	4,241	4,123	-118	-2.8%
Total Long-Term Care	34,173	34,086	-87	-0.3%	34,086	36,561	2,475	7.3%

Intellectual and Developmental Disabilities (I/DD)

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

Case Management Enrollment

This is an entry-level eligibility, evaluation, and coordination service available to all individuals determined to have intellectual and developmental disabilities, regardless of income level. In 2013-15 Case Management Enrollment averaged 22,459 and is projected to increase to 25,309 or by 12.7 percent in 2015-17. In 2017-19 Case Management biennial average caseload is projected to increase to 28,218 or by 11.5 percent. Enrollment is projected to grow rapidly until most I/DD individuals have enrolled. Research is underway to determine what might be the “natural limit,” where caseload would plateau. Oregon's Office of Developmental Disabilities Services (ODDS) has contracted with Human Services Research Institute (HSRI) to estimate the youth and adult populations likely to seek I/DD services in Oregon through 2019. HSRI estimated demand for I/DD services by applying national prevalence estimates to Oregon's youth and adult populations.

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

Adult Services

Brokerage Enrollment (BE) – Under K Plan, services must be provided to all eligible I/DD clients who wish to be served. In Oregon, adults with I/DD can obtain services through either of two channels: Brokerages or the Community

Developmental Disability Programs (CDDPs). Brokerage demand was expected to grow at the historical rate until reaching the contractual limit of 7,805 brokerage slots – with subsequent growth diverted to the county CDDPs (where most clients would be served in Comprehensive In-Home Services (CIHS)). In reality, Brokerage Enrollment has remained under capacity, while CDDPs have been struggling to keep up with demand. The 2015-17 biennial average forecast for Brokerage Enrollment is 7,659, slightly lower from the Spring 2016 forecast. The forecast for 2017-19 is 7,769, or 1.4 percent higher than 2015-17.

Comprehensive In-Home Services (CIHS) – Due to the K Plan requirement that all eligible clients be served, and the fact that Brokerage capacity is limited, CIHS caseload has grown dramatically since July 2014. While a significant rise was anticipated, the exact timing and magnitude has been difficult to project. CIHS caseload was 312 in mid-2013, 371 in mid-2014, and 1,084 in mid-2015. CIHS is forecast to grow dramatically in both 2015-17 and 2017-19, reaching 1,931 by mid-2017 and 2,482 by mid-2019. The 2015-17 biennial average forecast is 1,569 clients, and the 2017-19 biennial average forecast is 2,229 clients.

24-Hour Residential Care – The 2015-17 biennial average forecast is 2,804, slightly higher than the Spring 2016 forecast. The 2017-19 forecast for is 2,883, which represents a 2.8 percent increase over 2015-17.

Supported Living – The 2015-17 biennial average forecast is 700, which is 2.1 percent lower than the Fall 2015 forecast. The 2017-19 forecast is the same as 2015-17.

I/DD Foster Care – I/DD Foster Care serves both adults and children, with children representing approximately 15 percent of the caseload. The 2015-17 biennial average forecast is 3,169 clients, slightly higher from the Spring 2016 forecast. The 2017-19 forecast is 3,267, which represents a 3.1 percent increase over 2015-17.

Stabilization and Crisis Unit – The Stabilization and Crisis Unit serves both adults and children, with children representing approximately 10.1 percent of the caseload. This caseload is limited by bed capacity and is expected to remain at the current level of 99 for both 2015-17 and 2017-19.

Children Services

In-Home Support for Children (IHSC) – This caseload started growing rapidly in late 2013 as K Plan was implemented. While a rapid and significant rise was anticipated, the exact timing and magnitude has been difficult to project. The caseload was 187 clients in mid-2013; 872 clients in mid-2014; and 2,008 in mid-2015. In-Home Support for Children is forecasted to grow dramatically in both 2015-17 and 2017-19, reaching 3,193 by mid-2017 and 3,681 by mid-2019. The 2015-17 biennial average forecast is 2,696 clients, and the 2017-19 biennial average forecast is 3,484 clients.

Growth in this caseload is primarily due to implementation of the Community First Choice Option (K Plan), which allows individuals eligible for the Oregon Health Plan to receive In-Home services if they have an extended need for assistance with Activities of Daily Living. In addition, the income criteria used for children no longer considers family resources. The forecasted growth for this caseload incorporates assumptions about the historical pattern for children entering Case Management and the percentage of children enrolled in Case Management who will apply for services. However, the K Plan is a significant change and our assumptions may not be correct. For this and other reasons, this caseload was especially complex to forecast and the risk of error is high. For additional information, see the “Risks and Assumptions” section below.

Children Intensive In-Home Services (CIIHS) – This caseload includes Medically Fragile Children Services, Intensive Behavior Programs, and Medically Involved Program. This caseload is limited by capacity and is expected to remain at the level of 412 for both 2015-17 and in 2017-19.

Other Services

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

Based on the old definition (called Employment and Attendant Care Services), caseload averaged 4,166 in 2013-15. The new, more inclusive definition (renamed Employment and Day Support Services) is different enough that comparison to prior forecasts would be misleading.

This forecast projects moderate growth from 2015-17 to 2017-19, reflecting stabilization of the changes being implemented, including an increased focus on early job preparation for qualifying high school students. It is anticipated that these students will graduate from high school with their employment training and/or employment already in place. Using the new caseload definition, the 2015-17 biennial average is 6,304 and the 2017-19 biennial average is 6,425, which represents a 1.9 percent increase over 2015-17.

Transportation – Historically, this caseload included only services paid with state funds, not those using local match funding. In order to provide a more complete picture, the definition of services counted in the Transportation caseload has been expanded to include all of the services previously counted, plus transportation services provided under Plan of Care (e.g. transit passes and non-medical community transportation).

Using the old definition, the 2013-15 Transportation caseload averaged 1,818. The new, more inclusive definition is different enough that comparison to prior forecasts would be misleading.

This forecast projects moderate growth from 2015-17 to 2017-19, reflecting stabilization of the changes being implemented by I/DD employment services biennial average is 6,433, which represents a 3.3 percent increase over 2015-17.

Risks and Assumptions

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

Although the K Plan started in July 2013, initial work began slowly at first and work accelerated in 2014 with most CDDPs experiencing higher caseloads and more requests for services than previous to July 2013. The increase in requests for services and higher caseloads caused some delays in access to service. Many of the CDDPs have recently hired new staff as a result of funding based on the workload model. With additional staff added, this may result in quicker entry of new individuals with I/DD. All of these practical operational changes mean that new service use patterns are not yet stable and may continue to fluctuate for some time. In addition, the estimate may be low if many families who have children with I/DD had never chosen to enroll their children in Case Management.

The increase in people requesting I/DD services has created capacity challenges for CDDPs and their provider networks. To receive funded services, enrollees' Medicaid eligibility must be established, a level of care and assessment completed as well as an Individual Support Plan developed.

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

Comprehensive In-Home Services – Adults can be served through two channels – Brokerages or CDDPs. However, since the brokerages are near capacity, most caseload growth is occurring in the CDDP service known as Comprehensive In-Home Services. Growth in adult caseloads generally comes from children who age into adult services, or previously unserved adults who are newly interested. Since this caseload is growing rapidly and without precedent, the forecast is highly sensitive to the assumptions used to produce it, and the risk of error is higher than usual.

Furthermore, it should be noted that since Brokerage capacity is contractually constrained, contracting changes (e.g., increasing the number of contracted slots, or shifting unutilized seats to brokerages with waiting lists) could shift this growth from Comprehensive In-Home Services back to Brokerage Enrollment.

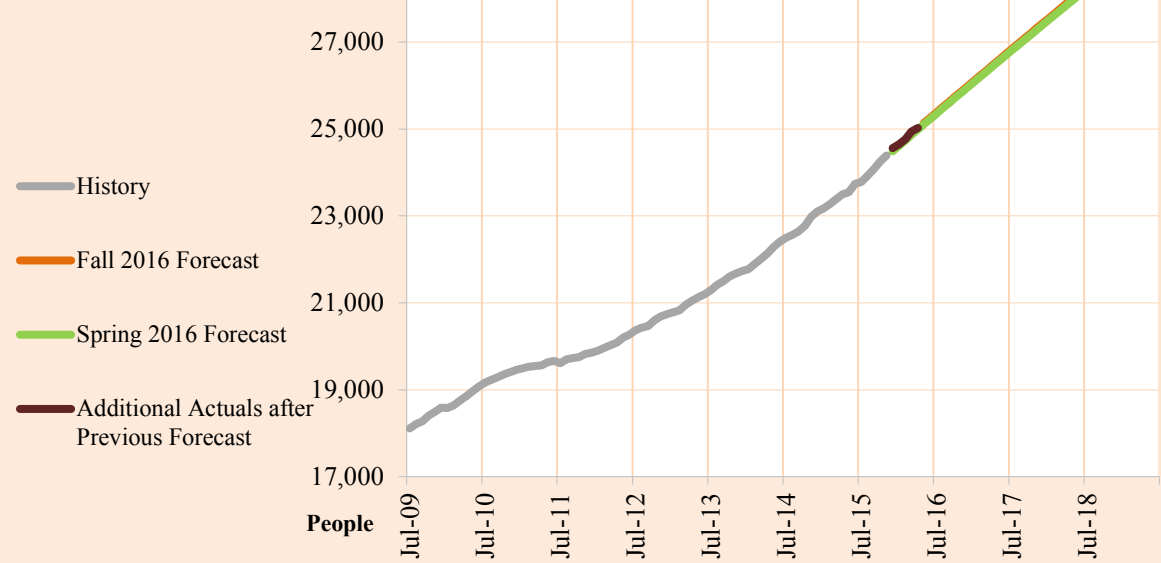
In-Home Support for Children – the K Plan implementation expanded the availability of services for many children. Prior to the implementation of the K Plan children were only able to receive limited in-home services and could only access additional services if they met crisis criteria. A child may now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

Summary of the key assumptions and steps used to project the In-Home Support for Children caseload

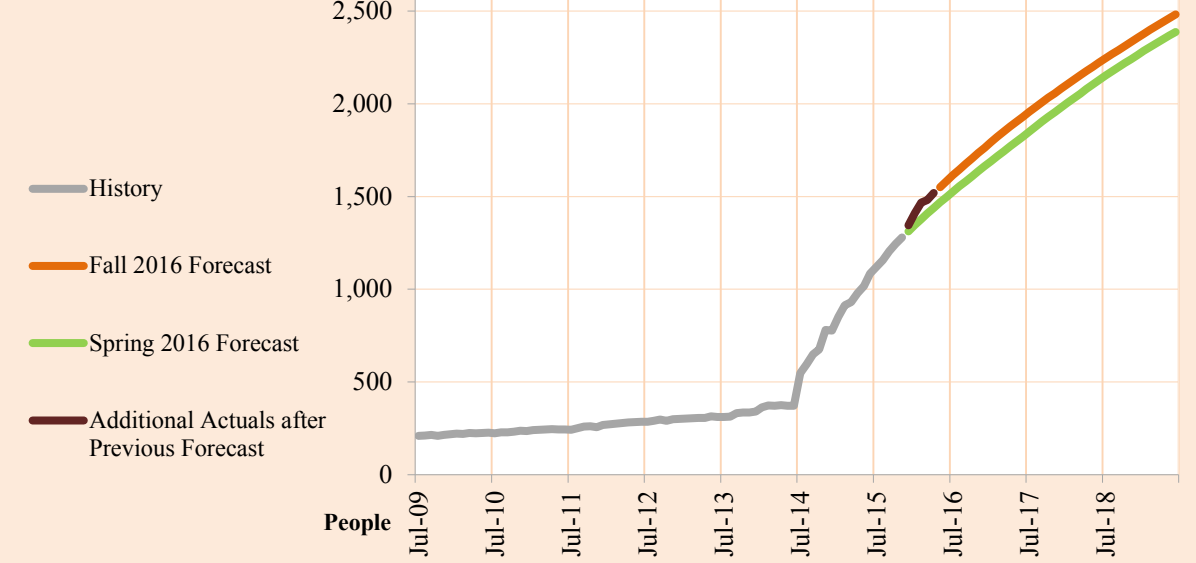
- Case Management enrollees under 18 years of age and not receiving additional I/DD services were used as the basis for estimating new entrants to this caseload.
- Next, the growth projected for Case Management was applied to this caseload as well.
- Then the percentage of children in Case Management and not receiving additional services was gradually reduced from 44 percent to 20 percent over four years.

These assumptions were discussed and debated by the I/DD Caseload Forecast Advisory Committee; then the forecaster made final changes based on personal judgment.

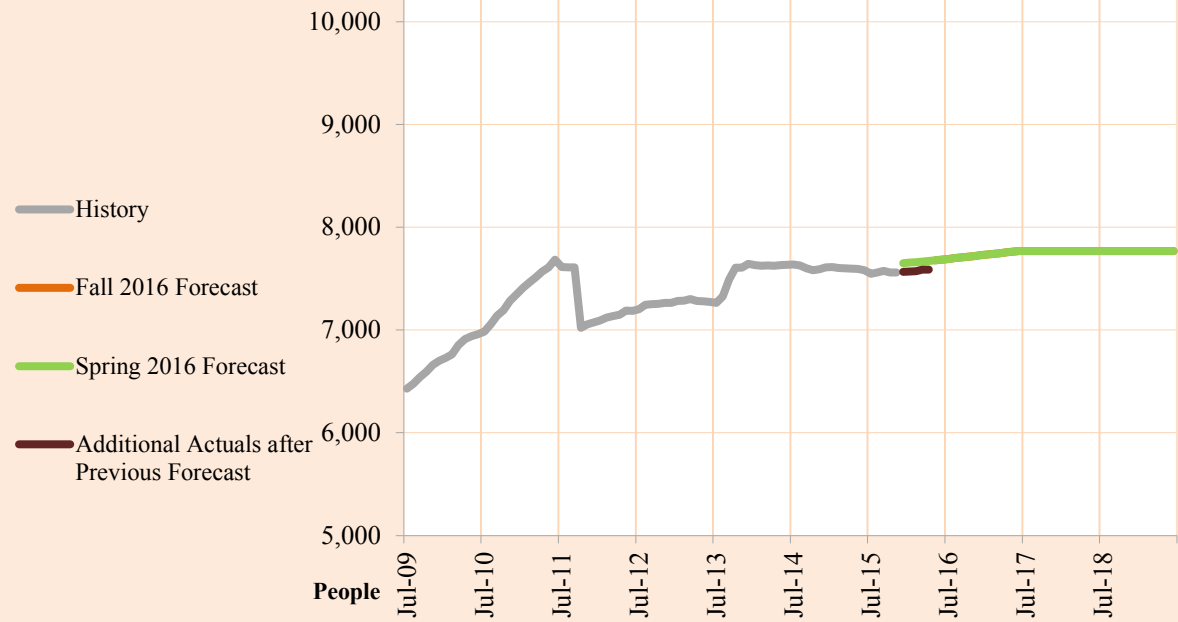
Case Management Enrollment



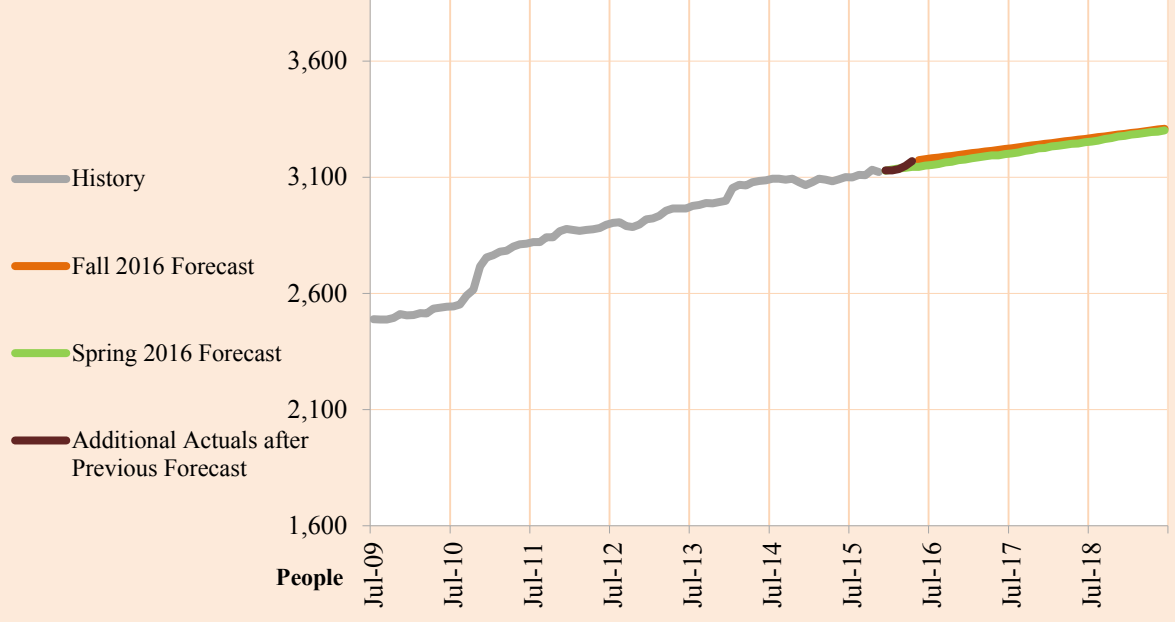
Comprehensive In-Home Services



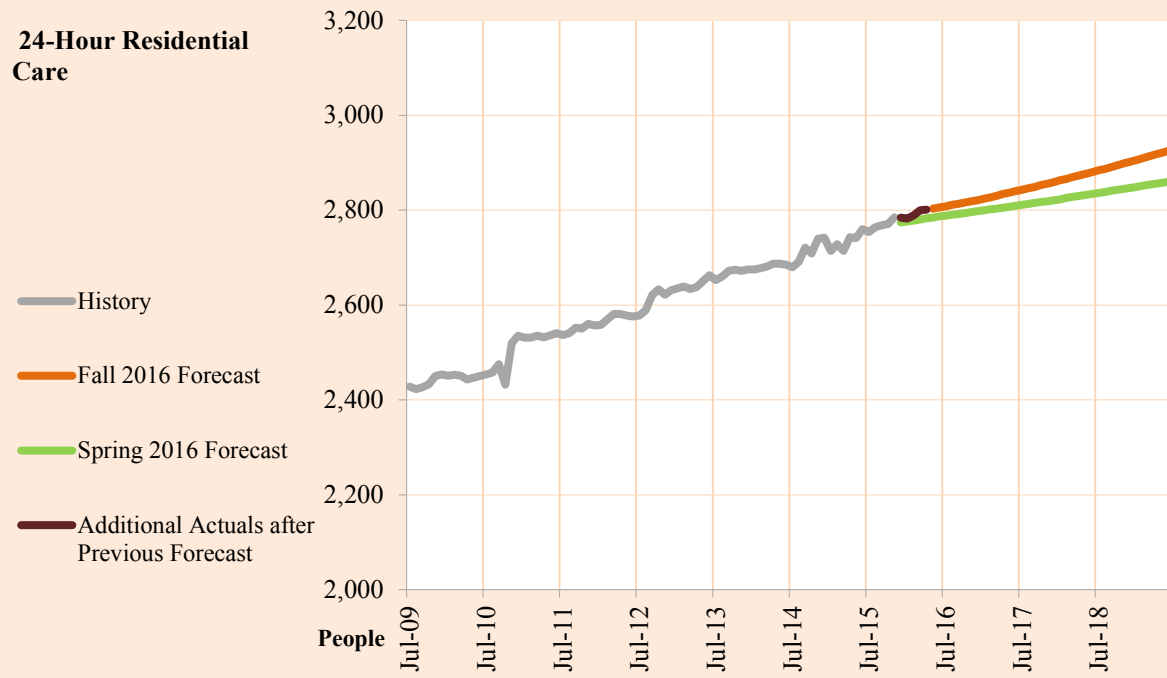
Brokerage Enrollment



I/DD Foster Care



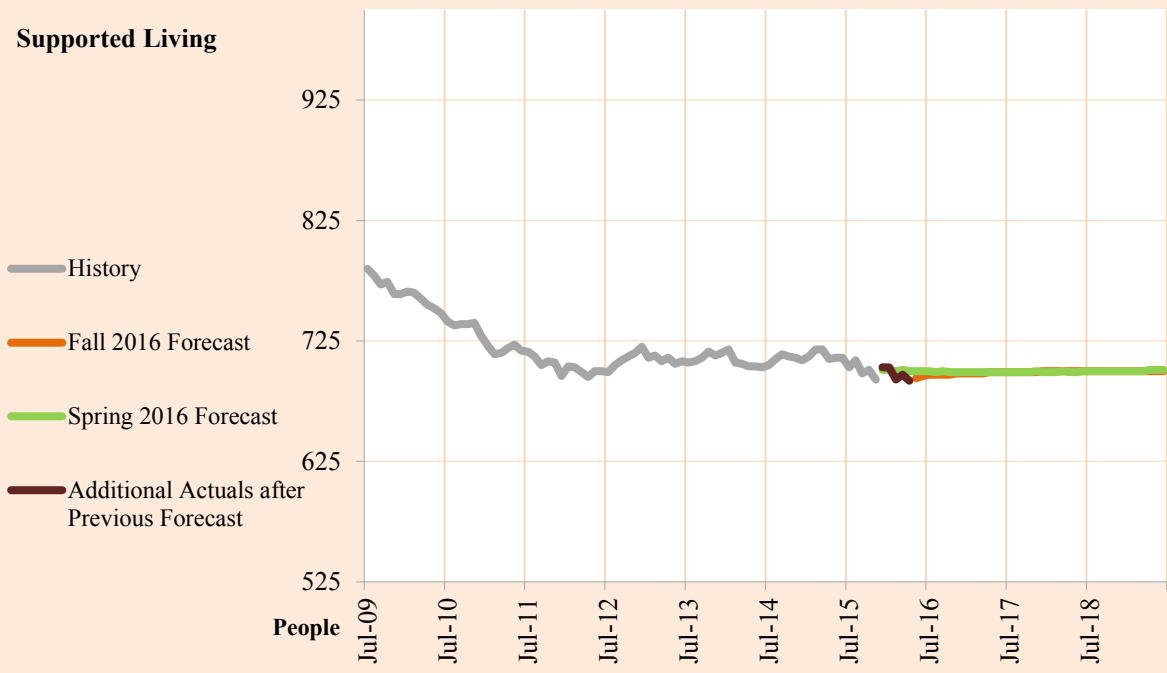
24-Hour Residential Care



Stabilization and Crisis Unit

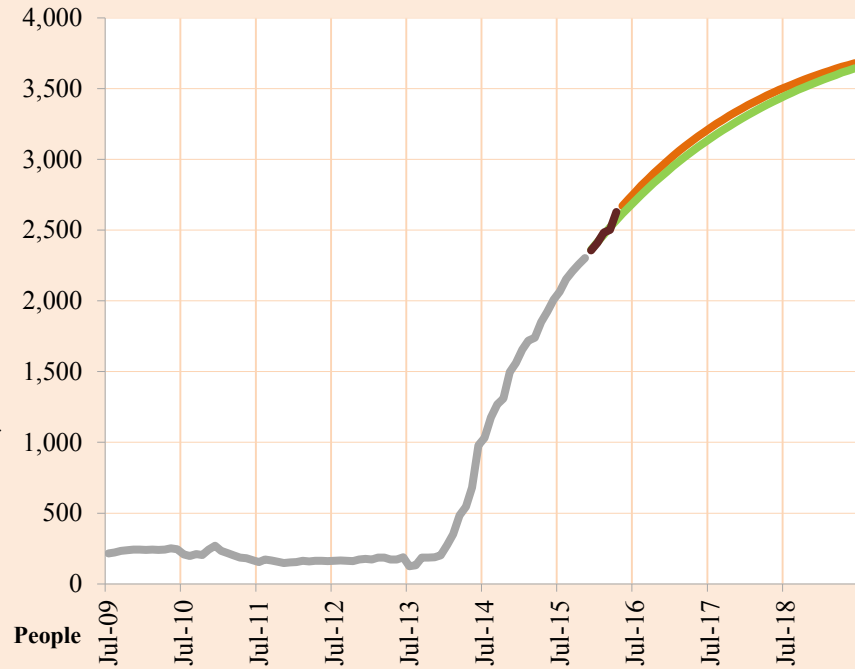


Supported Living



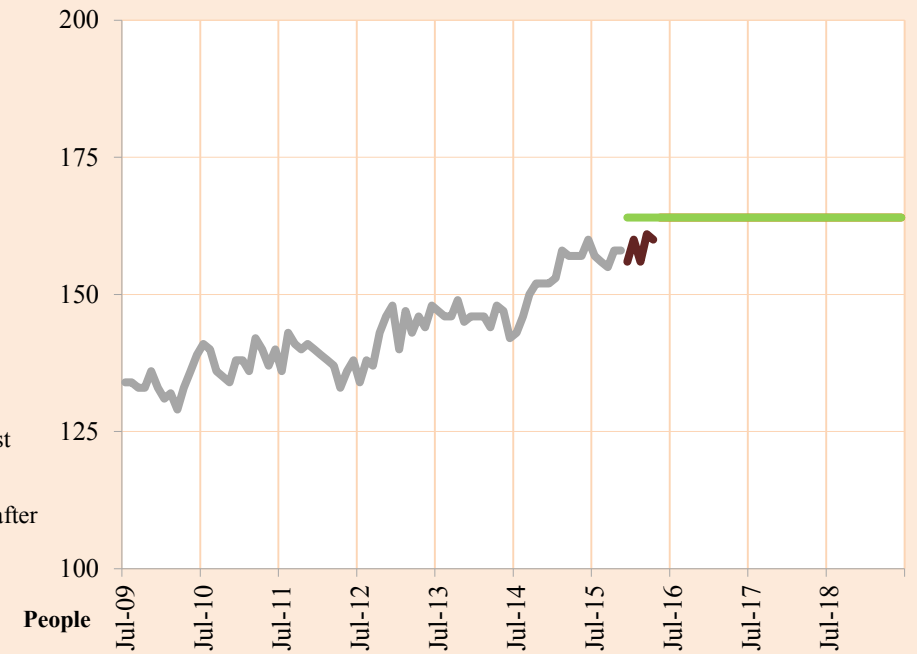
In-Home Support for Children

- History
- Fall 2016 Forecast
- Spring 2016 Forecast
- Additional Actuals after Previous Forecast



Children's Residential Care

- History
- Fall 2016 Forecast
- Spring 2016 Forecast
- Additional Actuals after Previous Forecast

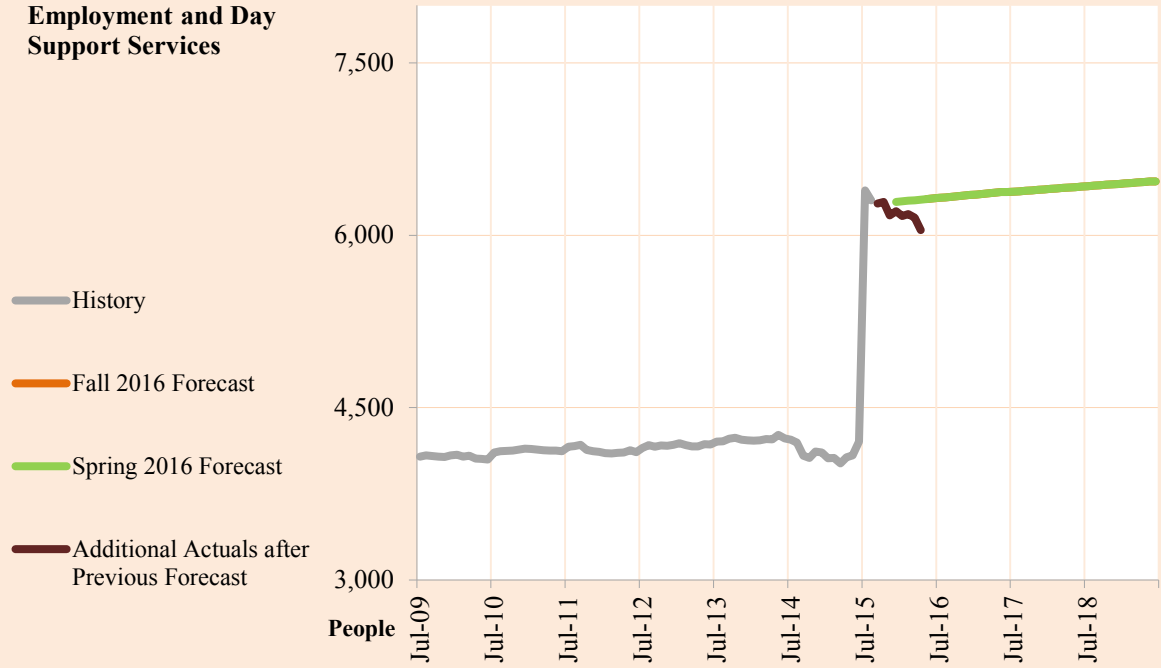


Children's Intensive In-Home Services

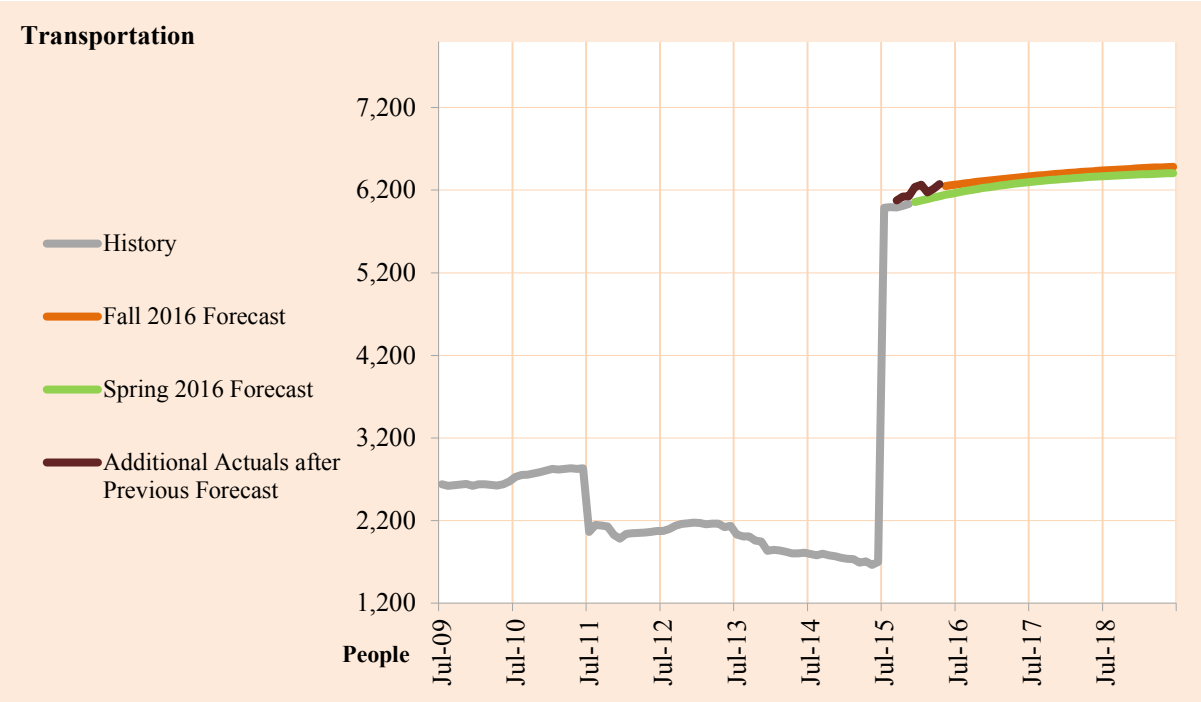
- History
- Fall 2016 Forecast
- Spring 2016 Forecast
- Additional Actuals after Previous Forecast



Employment and Day Support Services



Transportation



Intellectual and Developmental Disabilities Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			% Change Between Forecasts	Fall 2016 Forecast			% Change Between Biennia
	Spring 16 Forecast	Fall 16 Forecast	Change		2015-17	2017-19	Change	
INTELLECTUAL AND DEVELOPMENTAL DISABILITIES								
Total Case Management Enrollment ¹	25,281	25,309	28	0.1%	25,309	28,218	2,909	11.5%
Adult								
Brokerage Enrollment	7,676	7,659	-17	-0.2%	7,659	7,769	110	1.4%
Comprehensive In-Home Services ²	1,499	1,569	70	4.7%	1,569	2,229	660	42.1%
I/DD Foster Care ³	3,154	3,169	15	0.5%	3,169	3,267	98	3.1%
24 hrs Residential Care	2,787	2,804	0	0.6%	2,804	2,883	79	2.8%
Supported Living	700	698	-2	-0.3%	698	700	2	0.3%
Stabilization and Crisis Unit ³	104	99	0	-4.8%	99	99	0	0.0%
Children								
In-Home Support for Children ²	2,654	2,696	42	1.6%	2,696	3,484	788	29.2%
Children Intensive In-Home Services	404	398	-6	-1.5%	398	412	14	3.5%
Children Residential Care	163	162	-1	-0.6%	162	166	4	2.5%
Total I/DD Services	19,141	19,254	113	0.6%	19,254	21,009	1,755	9.1%
Other I/DD Services								
Employment & Day Support Activities	6,302	6,304	2	0.0%	6,304	6,425	121	1.9%
Transportation	6,151	6,230	79	1.3%	6,230	6,433	203	3.3%

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

2. Caseloads for both Comprehensive In-Home Services and In-Home Support for Children are rising significantly due to implementation of K Plan.

3. Foster Care and the Stabilization and Crisis Unit serve both adults and children: (I/DD FC - 83% / 17%; SACU - 89% / 11% respectively).

Oregon Health Authority

Total Oregon Health Authority Biennial Average Forecast Comparison

	2015-17 Biennium			% Change Between Forecasts	Fall 2016 Forecast			% Change Between Biennia
	Spring 2016 Forecast	Fall 16 Forecast	Change		2015-17	2017-19	Change	
Medical Assistance								
OHP Plus								
ACA Adults	418,438	409,098	-9,340	-2.2%	409,098	355,149	-43,555	-10.4%
Aid to the Blind & Disabled	82,045	82,008	-37	0.0%	82,008	84,313	2,305	2.8%
Children's Health Insurance Program (CHIP)	60,485	61,706	1,221	2.0%	61,706	57,587	-4,119	-6.7%
Children's Medicaid	345,519	342,797	-2,722	-0.8%	342,797	336,831	-5,966	-1.7%
Foster, Substitute & Adoption Care	19,573	19,689	116	4.2%	19,689	20,215	526	2.7%
Old Age Assistance	41,872	42,338	466	0.6%	42,338	46,763	4,425	10.5%
Parent/Caretaker Relative	64,601	68,770	4,169	1.1%	68,770	68,273	-497	-0.7%
Pregnant Women	15,964	16,639	675	6.5%	16,639	13,530	-3,109	-18.7%
Total OHP Plus	1,048,498	1,043,045	-5,453	-0.5%	1,043,045	982,661	-60,384	-5.8%
Other Medical Assistance Total	73,016	73,765	749	1.0%	73,765	74,384	619	0.8%
Total Medical Assistance	1,121,514	1,116,810	-4,704	-0.4%	1,116,810	1,057,045	-59,765	-5.4%
Mental Health ¹								
Under Commitment								
Total Forensic Care	828	859	31	3.7%	859	861	2	0.2%
Civilly Committed	948	975	27	2.8%	975	921	-54	-5.5%
Previously Committed	2,548	2,567	19	0.7%	2,567	2,543	-24	-0.9%
Never Committed	41,101	41,244	143	0.3%	41,244	43,198	1,954	4.7%
Total Served	45,425	45,645	220	0.5%	45,645	47,523	1,878	4.1%

1. Numbers reported represent adults only.

Health Systems Medicaid (HSM)

Since 2008, the primary drivers of the Medicaid caseload growth 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.
- Implementation of Patient Protection and Affordable Care Act (ACA) in January of 2014.

Taken together these three factors drove the total Medicaid caseload from approximately 408,000 clients prior to the recession to about 1,009,000 clients in January 2014, for a net increase of 601,000 clients or 147 percent. As of April 2016, the Medicaid caseload was 1,162,147 and the preliminary estimate for July 2016 is 1,117,367. For the past few years, the average caseloads were higher due to some delays in planned redeterminations, but since the redetermination work resumed in February 2016 the caseloads have been consistently declining. In general, the caseloads will continue to decline thru the forecast horizon as long as the economy remains in the current state and there are no further delays in the planned redeterminations.

ACA Adults – Since the redeterminations resumed in March 2016, the ACA Adult caseload has been steadily declining. The most recent preliminary estimate for July 2016 shows 410,731 clients on this caseload, down by roughly 38,000 compared to March 2016 count of 448,823. The caseload is expected to drop to 367,582 by the end of 2015-17 biennium and will account for about 36.9 percent of the total OHP caseload. The caseload is expected to continue declining at a slower pace through 2017-19 biennium as well.

Parent/Caretaker Relative – Although the improving economy puts downward pressure on this caseload, the inflow from ACA Adults, as a result of redeterminations, caused the caseload to grow. The most recent preliminary estimate for July 2016 shows 74,689 clients on this caseload, up by 6,604

compared to March 2016 count of 68,085. However, the current forecast does not project inflow to continue at that pace. The caseload is expected to drop to 70,608 by the end of 2015-17 biennium and will account for about 7.1 percent of the total OHP caseload. Similar to the previous caseload, this caseload is also expected to continue declining through 2017-19 biennium.

Pregnant Women – As of April 2016 there were 17,786 women on this caseload. The caseload has been declining steadily in the past few months as redeterminations were resumed. The caseload is expected to drop to 13,912 by the end of 2015-17 biennium and will account for 1.4 percent of the total OHP Plus caseload.

Children's Medicaid – Since redeterminations resumed in March 2016, this caseload has been steadily declining. The most recent preliminary estimate for July 2016 shows 337,543 clients on this caseload, down by 23,731 compared to March 2016 count of 361,274. The forecast predicts a small period of growth for this caseload this winter, when fewer redeterminations are planned and higher inflow of new clients is expected due to open enrollment. Overall, the caseload is expected to stay flat for the forecast horizon. By the end of 2015-17 biennium there will be 337,796 clients on this caseload and it will account for about 33.9 percent of the total OHP caseload.

Children's Health Insurance Program (CHIP) – As of April 2016 there were 63,280 children on this caseload. The caseload has been declining steadily in the past few months as redeterminations were resumed. The caseload is expected to drop to 58,892 by the end of 2015-17 biennium and will account for 5.9 percent of the total OHP Plus caseload.

Foster, Substitute Care & Adoption Assistance – As of April 2016 there were 19,576 children on this caseload. This caseload is growing and will continue to grow slowly through the forecast horizon. By the end of 2015-17 biennium there will be 20,004 clients on this caseload and it will account for 2.0 percent of the total OHP caseload.

Aid to the Blind and Disabled (ABAD) – As of April 2016 there were 81,387 clients on this caseload. Historically this caseload grew steadily. The ACA reform had a profound impact on this caseload. First, the availability of health insurance to low income adults (ACA Adults caseload) and, second, the availability of K-Plan (access to long term care without having to obtain a federal designation of disability) negatively impacted the demand for this caseload. Despite the declining trend immediately following the ACA implementation, there was always a consensus among the experts that the caseload will start growing again although at a more moderate growth rate. The most recent data proves that point. The caseload is expected to grow to 83,213 by the end of 2015-17 biennium and will account for 8.3 percent of the total OHP Plus caseload.

Old Age Assistance (OAA) – There were 41,768 clients on this caseload as of April 2016. The caseload is projected to grow steadily through the foreseeable future. This caseload is driven by population dynamics as well as economic conditions. Oregon’s elderly population is projected to increase by roughly 4 percent per year. The caseload is expected to be 44,618 by the end of 2015-17 biennium and will account for 4.5 percent of the total OHP Plus caseload.

Other Medical Assistance Programs

Citizen-Alien Waived Emergent Medical - Regular (CAWEMR) – Since the redeterminations resumed in March 2016, this caseload has been steadily declining. The most recent preliminary estimate for July 2016 shows 43,861 clients on this caseload, down by 7,561 compared to the March 2016 count of 51,422. The caseload is expected to grow slightly to 44,849 by the end of 2015-17 biennium and will account for about 61.5 percent of Other Medicaid caseload.

Qualified Medicare Beneficiary (QMB) – There were 23,921 clients on this caseload as of April 2016. This caseload is expected to be 25,715 by the end of 2015-17 biennium and will account for about 35.3 percent of Other Medicaid caseload. This caseload has grown consistently since January of 2009 and is expected to continue growing through the forecast horizon.

Breast and Cervical Cancer Treatment Program (BCCTP) – There were 362 clients on this caseload as of April 2016. This caseload is expected to be 286 by the end of 2015-17 biennium and will account for about 0.4 percent of Other Medicaid caseload. This caseload is forecast to continue declining since ACA has reduced the number of uninsured adults who might qualify for the program.

Medicare Part A/B Premium Assistance Programs

Medicare Part-A Premium Assistance – There were 6,468 clients on this caseload as of April 2016. This caseload is expected to grow through the foreseeable future, and is expected to be 6,714 by the end of 2015-17 biennium.

Medicare Part-B Premium Assistance – There were 116,938 clients on this caseload as of April 2016. This caseload is projected to continue growing steadily, similar to the OAA and QMB caseloads. It is expected to be 124,297 by the end of 2015-17 biennium. Twenty-eight percent of those receiving Medicare Part-BA assistance are in OAA caseload; 27 percent are in ABAD; 20 percent are in QMB; and most of the remaining 25 percent are not in any of the forecasted Medicaid caseloads.

Risks and Assumptions

Implementation of the ACA continues to create uncertainty and forecast risk. The biggest known risks for the current forecast are:

- Deferred redeterminations.
- Next phase of Oregon Eligibility (ONE) system implementation.
- Volatility of historical data.

The first major risk arises from temporary changes made to eligibility redetermination practices. Since the implementation of ACA, the scheduled redeterminations have been delayed a few times:

- Oct-2013 thru Sep-2014, scheduled redeterminations were delayed in order to focus resources on ACA reform and the inflow of newly eligible adults and children.

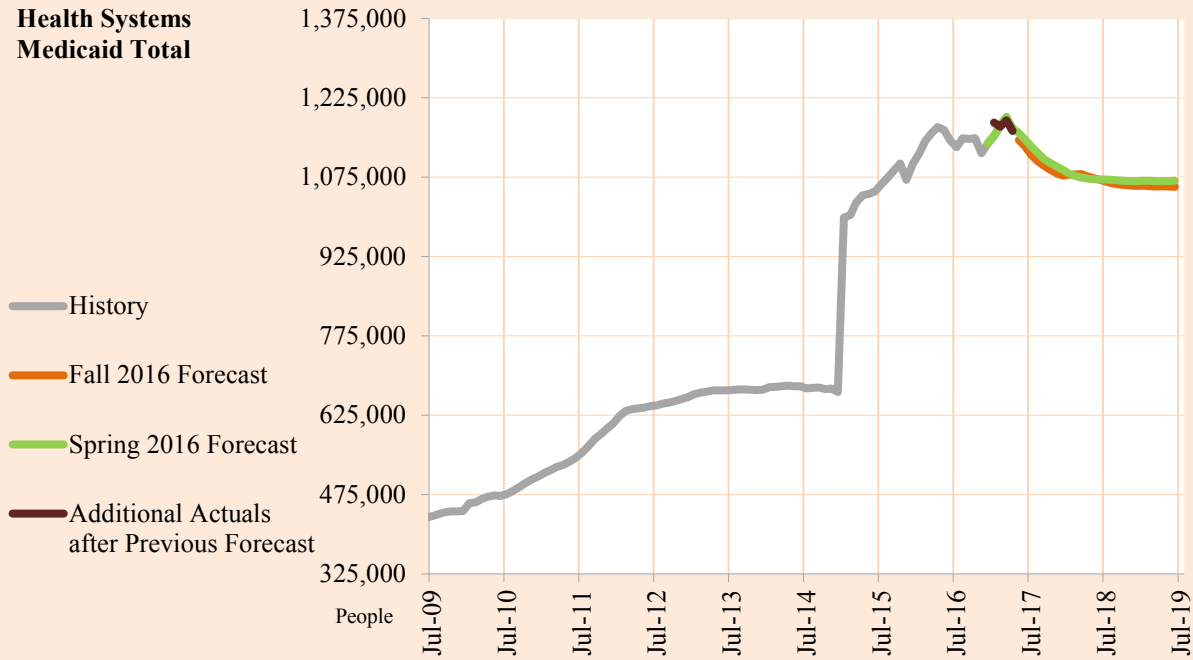
- Dec-2014 thru Mar-2015, scheduled redeterminations were delayed due to issues with Cover Oregon system and consequent challenges with the upcoming open enrollment period.
- Dec-2015 thru Feb-2016, scheduled redeterminations were delayed in order to focus resources on the transition to Oregon's new eligibility system – ONE.

As of March 2016, the scheduled redeterminations have been resumed and the transition to ONE is on schedule. There will be a brief slowing of redeterminations this Fall as OHA moves forward with the next phase of ONE implementation. To the extent possible, the Fall 2016 forecast incorporates the impact and consequences of anticipated changes to redeterminations. However, because operational details can change, this remains a major risk to our current forecast.

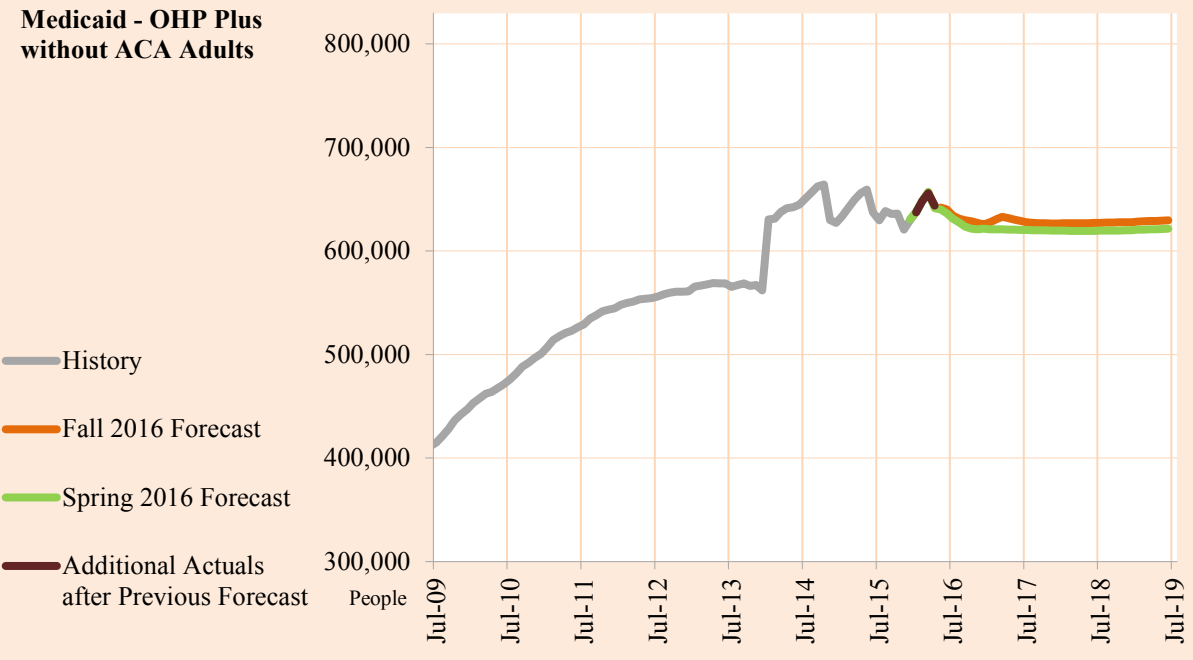
The second major risk is associated with the last phase of the ONE system implementation. In this phase OHA intends to fully launch ONE and make it directly available to Oregonians so they can access the application process themselves. So far, the implementation of ONE overall has been going smoothly, but nevertheless, system changes are tricky and there could be technical setbacks that could in turn cause delays in redeterminations and other issues.

The third major risk is associated with volatility of post-ACA data, which results in wide confidence intervals and could result in high forecast errors. The delays in redeterminations resulted in periods of caseload growth and consequent decline, which makes it very challenging to detect the true trends. Additionally, this had some profound consequences on all of the underlying model components – survival curves (used to predict leavers), new client flow, and transfer rates between caseloads. As the migration to ONE is complete (in early 2017) and there are more delays and disruptions to the ongoing renewal processes, the data will start to improve, however it might take an additional year until new patterns are established.

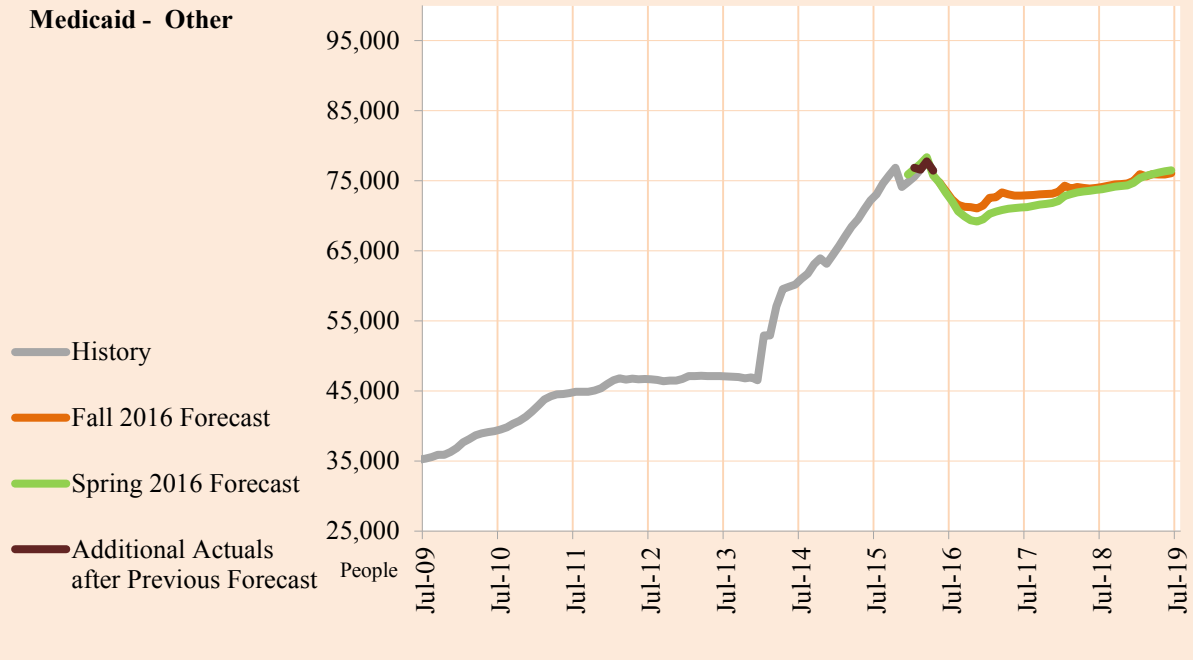
**Health Systems
Medicaid Total**



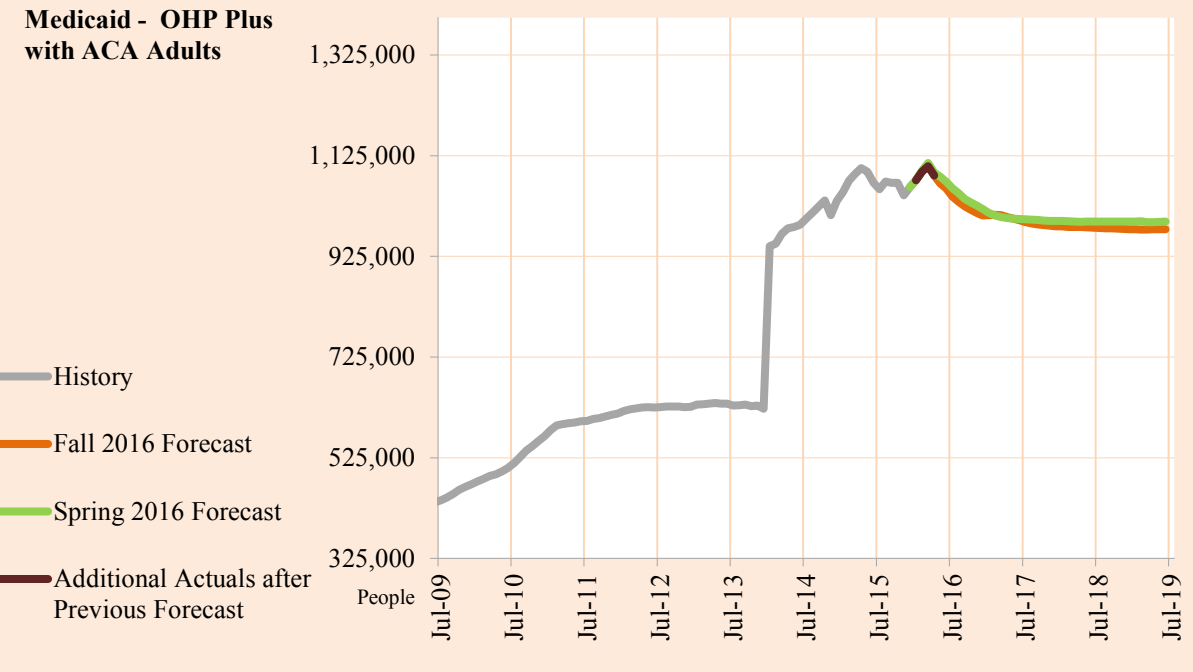
**Medicaid - OHP Plus
without ACA Adults**



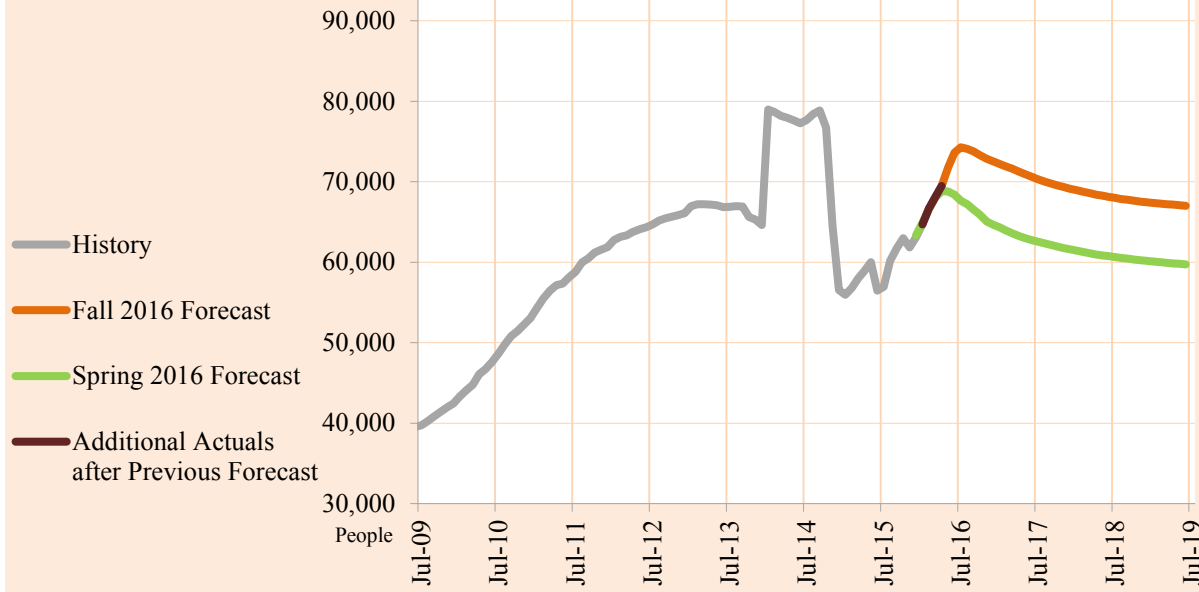
Medicaid - Other



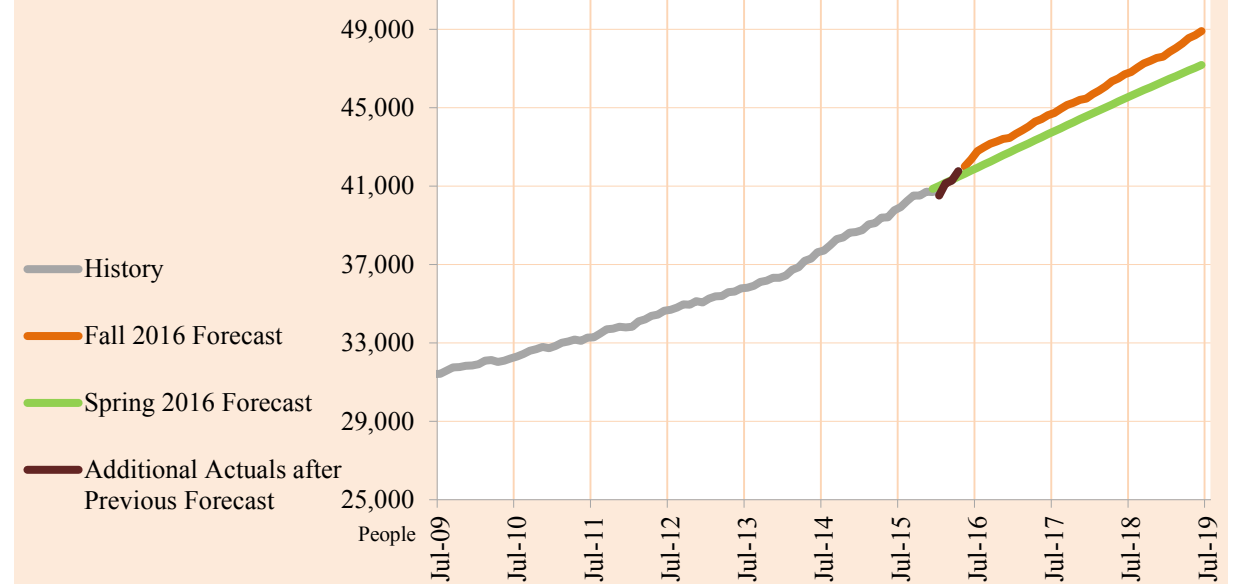
**Medicaid - OHP Plus
with ACA Adults**



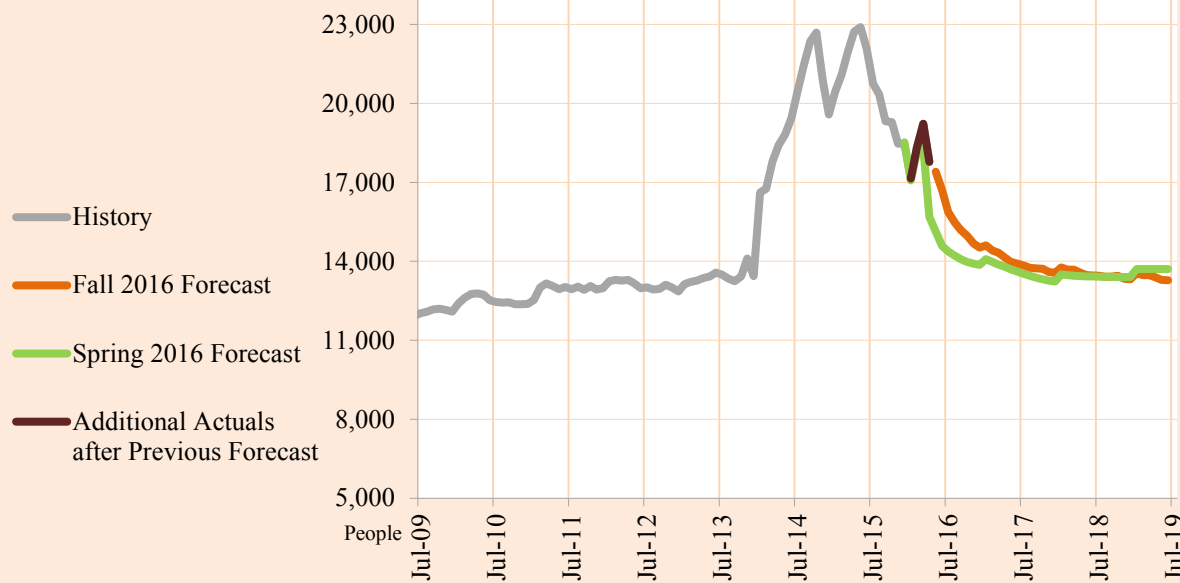
**OHP Plus:
Parent/Caretaker Relative**



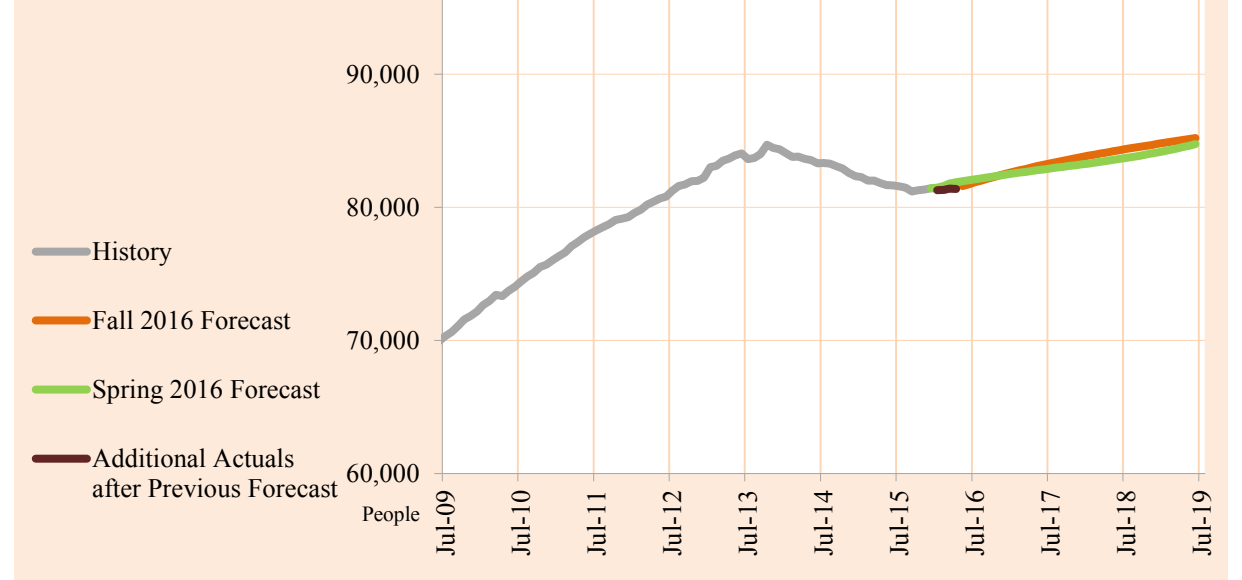
OHP Plus: Old Age Assistance



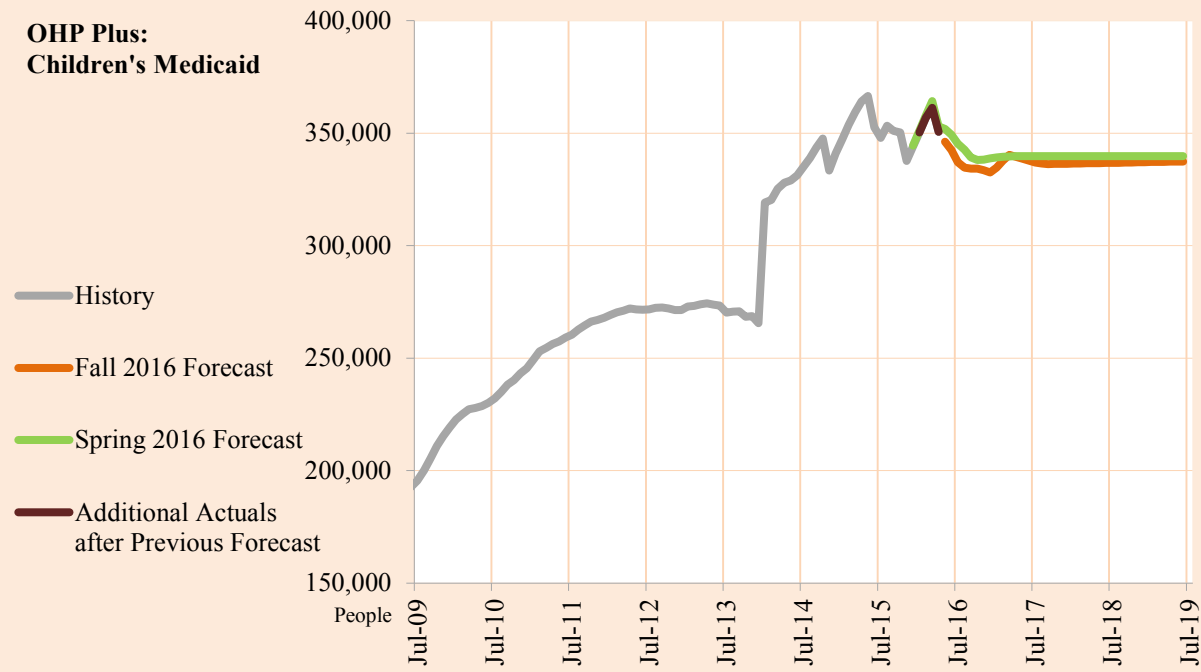
OHP Plus: Pregnant Woman Program



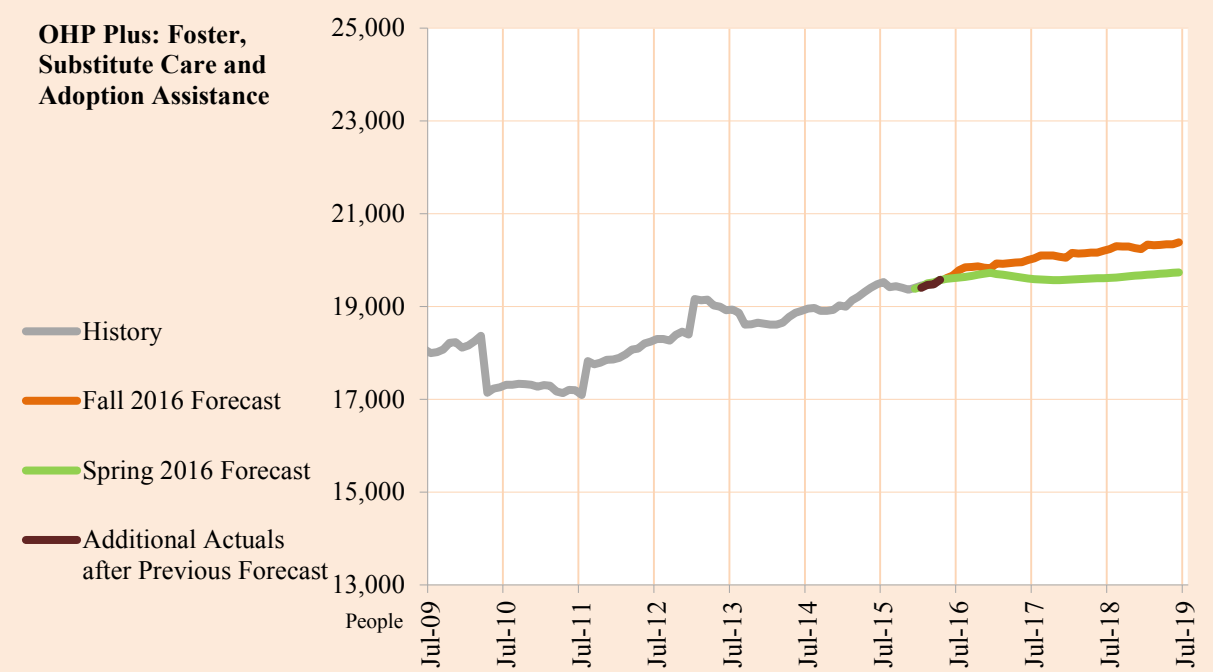
OHP Plus: Aid to the Blind and Disabled



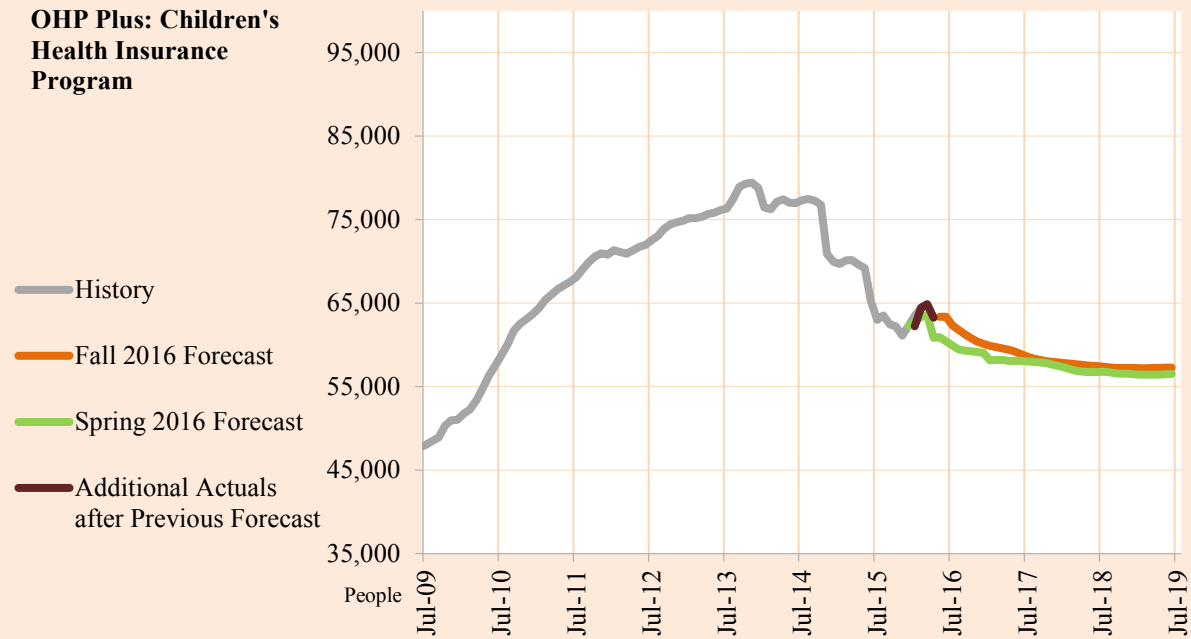
**OHP Plus:
Children's Medicaid**



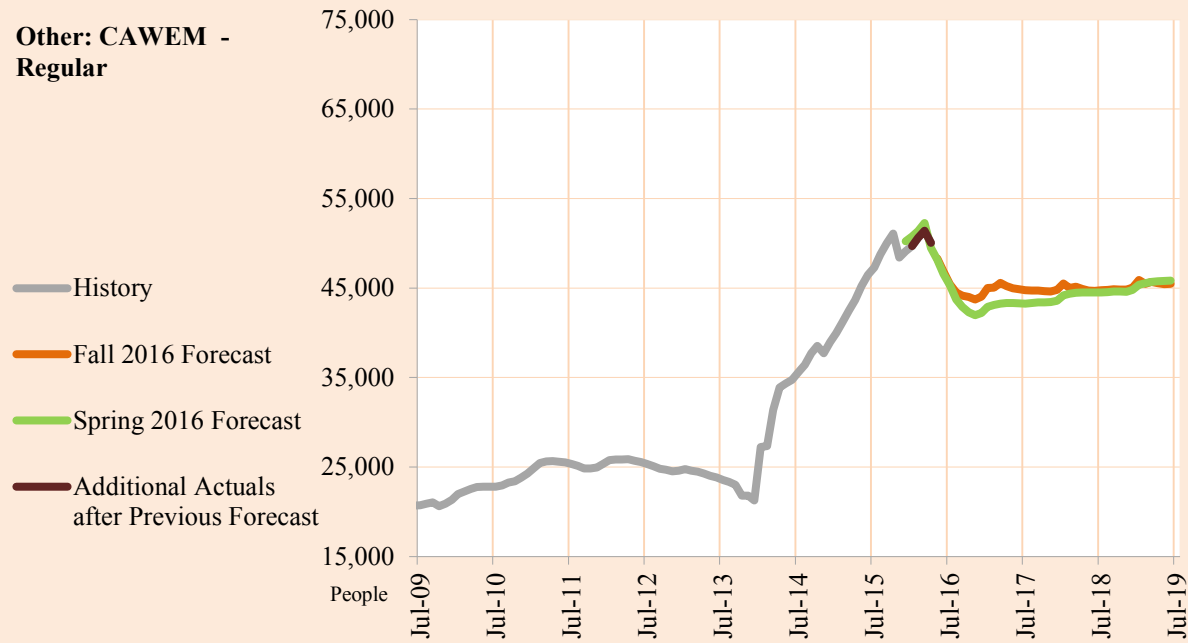
**OHP Plus: Foster,
Substitute Care and
Adoption Assistance**



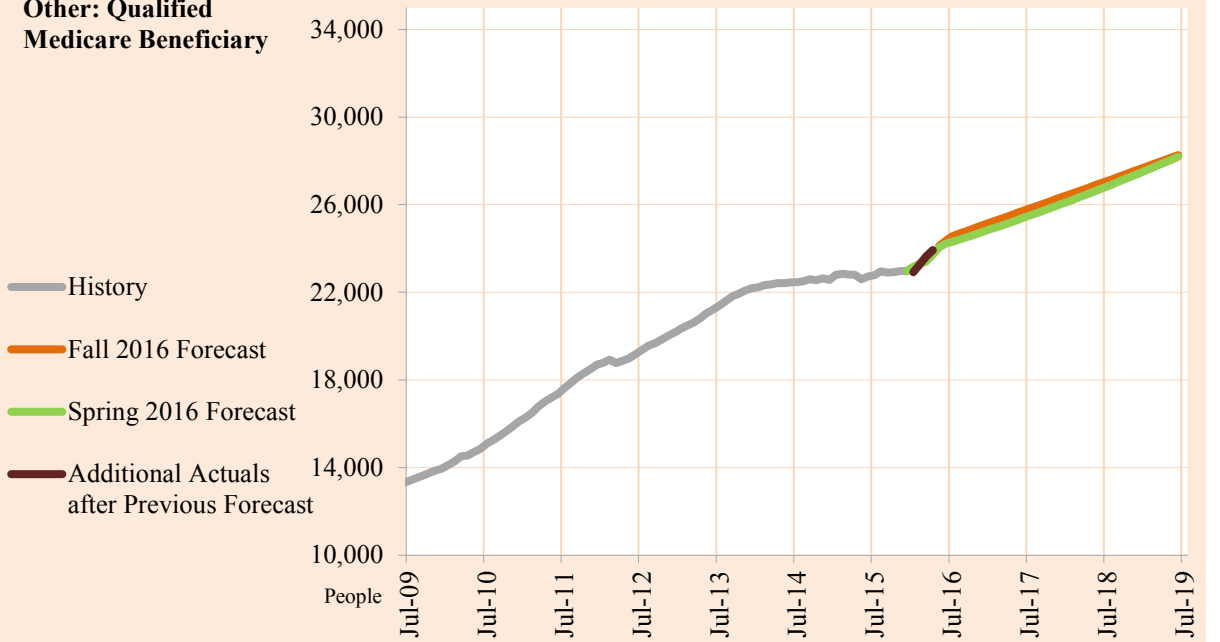
**OHP Plus: Children's
Health Insurance
Program**



Other: CAWEM - Regular



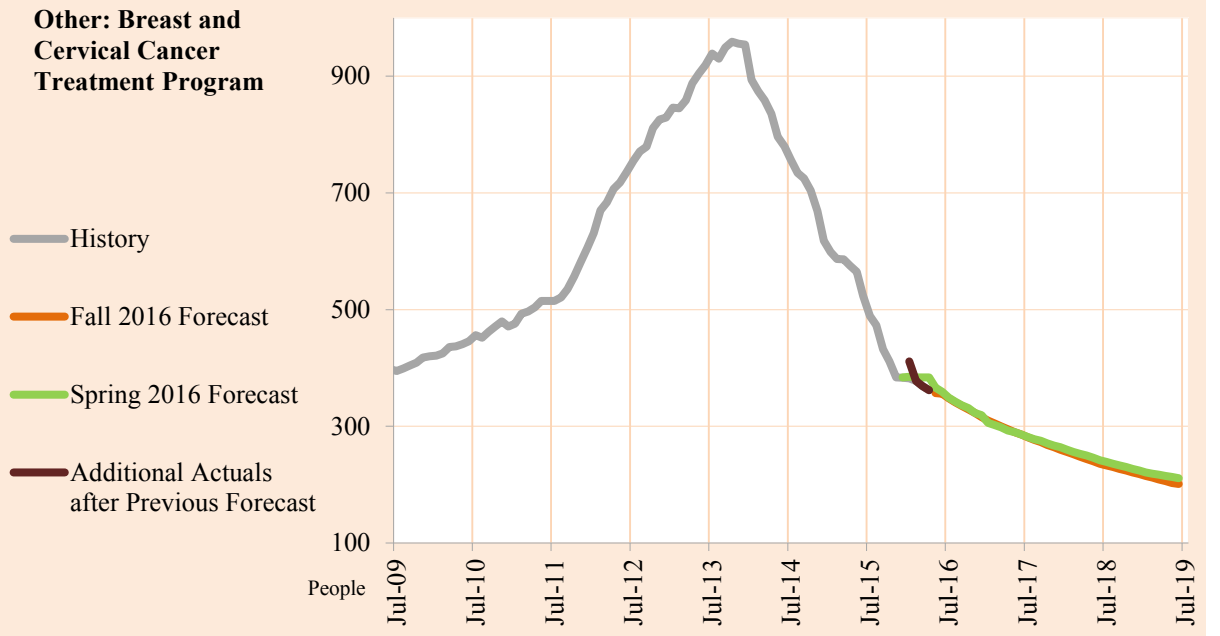
Other: Qualified Medicare Beneficiary



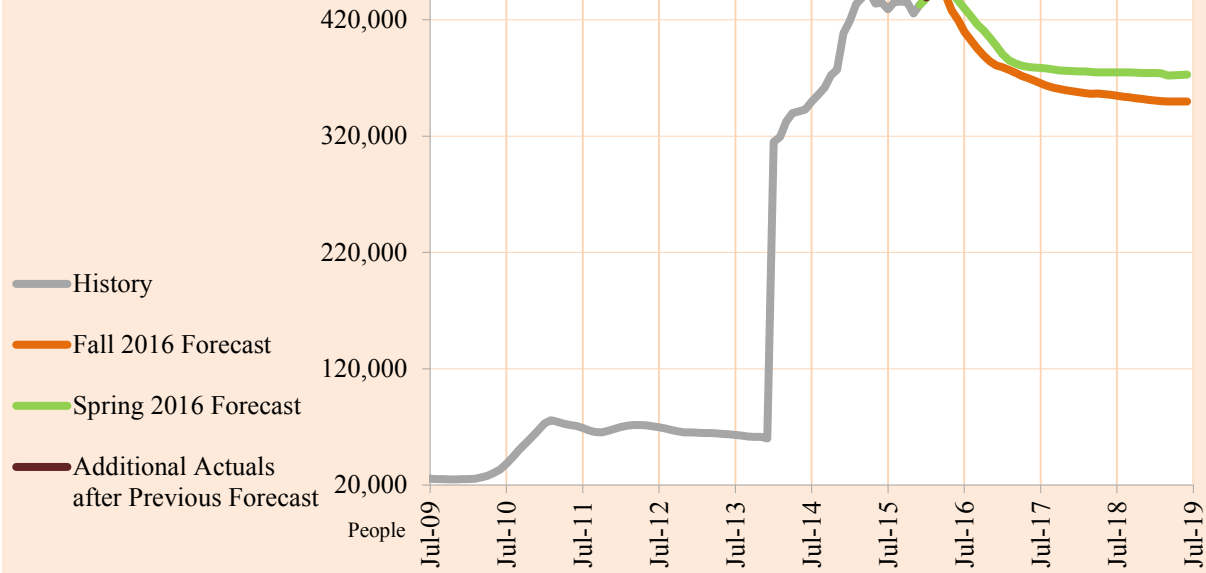
Other: CAWEM - Prenatal



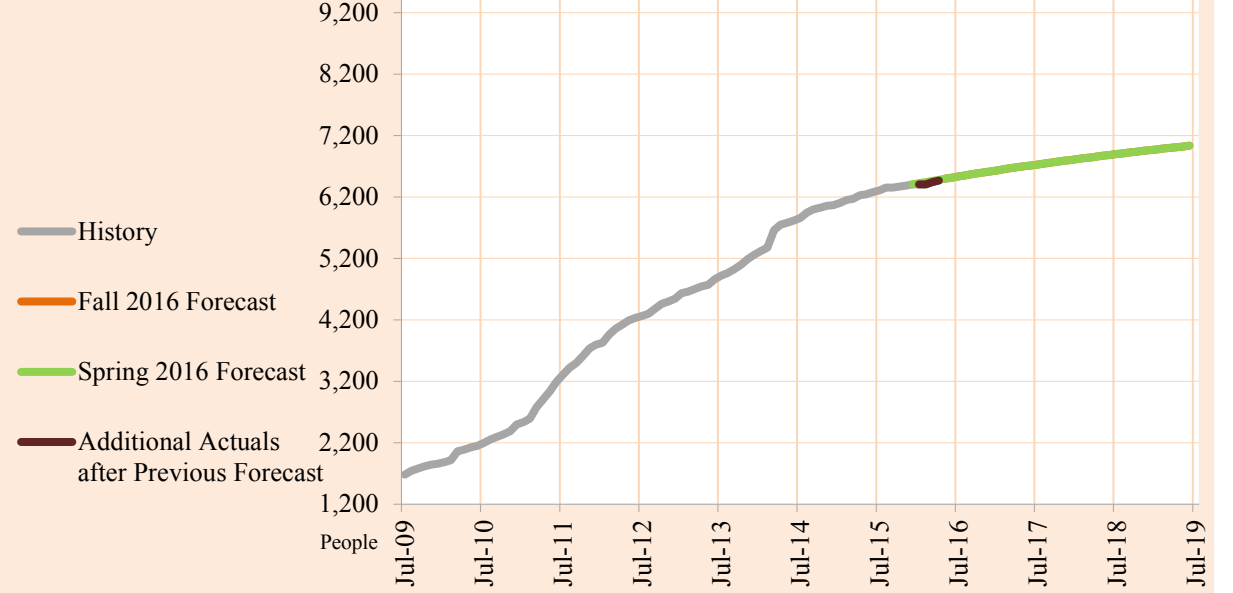
Other: Breast and Cervical Cancer Treatment Program



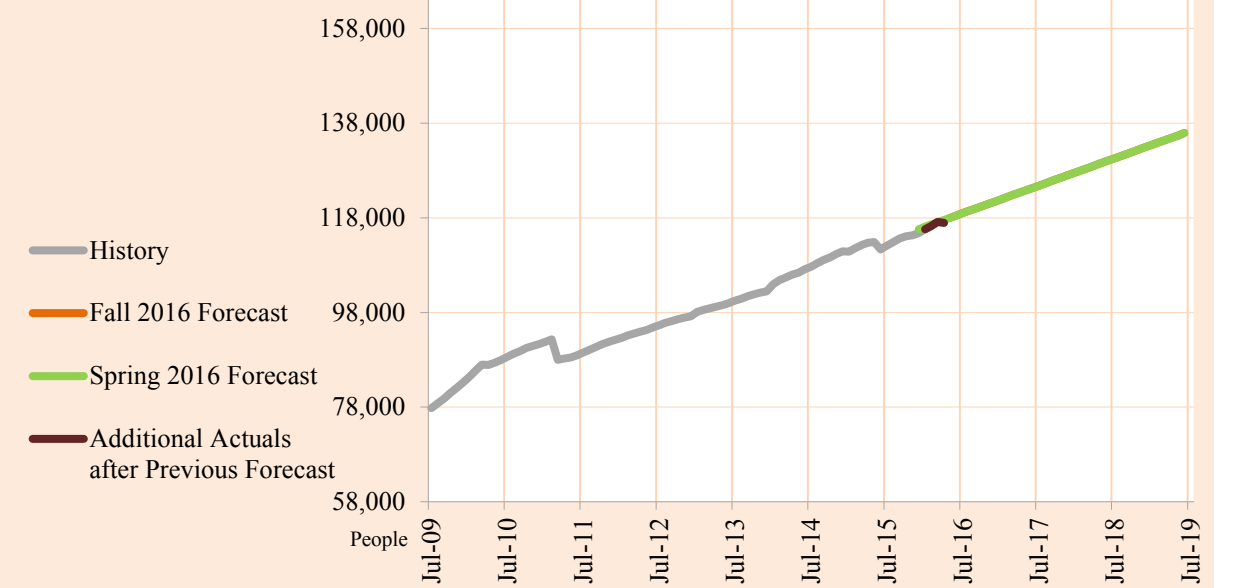
**OHP Plus: ACA
Adults Only**



**Medicare Buy-In:
Part A**



**Medicare Buy-In:
Part B**



Health Systems Medicaid Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			% Change Between Forecasts	Fall 2016 Forecast			% Change Between Biennia
	Spring 16 Forecast	Fall 16 Forecast	Change		2015-17	2017-19	Change	
MEDICAL ASSISTANCE								
OHP Plus								
ACA Adults	418,438	409,098	-9,340	-2.2%	409,098	355,149	-43,555	-10.4%
Aid to the Blind & Disabled	82,045	82,008	-37	0.0%	82,008	84,313	2,305	2.8%
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Foster, Substitute & Adoption Care	19,573	19,689	116	0.6%	19,689	20,215	526	2.7%
Old Age Assistance	41,872	42,338	466	1.1%	42,338	46,763	4,425	10.5%
Parent/Caretaker Relative	64,601	68,770	4,169	6.5%	68,770	68,273	-497	-0.7%
Pregnant Women	15,964	16,639	675	4.2%	16,639	13,530	-3,109	-18.7%
Total OHP Plus	1,048,498	1,043,045	-5,453	-0.5%	1,043,045	982,661	-60,384	-5.8%
Other Medical Assistance								
Breast & Cervical Cancer Treatment Program	359	356	-3	-0.8%	356	237	-119	-33.4%
Citizen-Alien Waived Emergent Medical - Prenatal	2,257	2,168	-89	-3.9%	2,168	2,075	-93	-4.3%
Citizen-Alien Waived Emergent Medical - Regular	46,339	47,007	668	1.4%	47,007	45,036	-1,971	-4.2%
Qualified Medicare Beneficiary	24,061	24,234	173	0.7%	24,234	27,036	2,802	11.6%
Other Subtotal	73,016	73,765	749	1.0%	73,765	74,384	619	0.8%
Total Medical Assistance	1,121,514	1,116,810	-4,704	-0.4%	1,116,810	1,057,045	-59,765	-5.4%
Medicare Part A	6,522	6,518	-4	-0.1%	6,518	6,888	370	5.7%
Medicare Part B	118,626	118,532	-94	-0.1%	118,532	130,332	11,800	10.0%

Mental Health (MH)

This forecast includes adults who are receiving mental health services from the Oregon Health Authority. For budgeting purposes, the Mental Health caseload is divided between Mandated and Non-Mandated populations. Oregon law requires Mandated populations, including criminally and civilly committed patients, to receive mental health services. There are three Mandated populations: (1) Aid and Assist, served at the State Hospital; (2) Guilty Except for Insanity (GEI), served at the State Hospital and in the community; and (3) Civilly Committed, also served at both the State Hospital and in the community. The Non-Mandated populations include two groups: (1) Previously Committed individuals, served mostly in the community; and (2) Never Committed individuals, also served mostly in the community. Due to data system changes, the Civilly Committed, Previously Committed, and Never Committed populations were not forecast during the Fall 2015 forecast cycle. As service providers have become more consistent in their use of the Measures and Outcomes Tracking System (MOTS), data for these populations have continued to be refined.

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

Total Mandated Mental Health Services

The mandated caseload encompasses the committed caseload (Aid and Assist, GEI, and Civilly Committed clients). The 2015-17 biennial average forecast is 1,834 clients. The 2017-19 biennial average is 1,782 clients, which is 2.8 percent lower than the 2015-17 biennial average. As with all MH categories forecasted in this report, the Mandated population includes only adults.

Total Forensic Mental Health Services

The forensic caseload encompasses the Aid and Assist and GEI clients. The 2015-17 biennial average forecast is 859 clients. The 2017-19 biennial average is 861 clients, which is 0.2 percent higher than the 2015-17 biennial average.

Aid and Assist – This caseload exhibited steady growth throughout 2013, 2014, 2015 and into 2016. Aid and Assist currently counts only clients served at the State Hospital. As MH moves toward mobile forensic evaluation teams, Aid and Assist in the State Hospital will likely decrease, but the timing is unknown. The total number served may continue to increase, but we will be unable to forecast that number unless community Aid and Assist data are also tracked and available for analysis. The 2015-17 biennial average forecast is 260 clients. The 2017-19 biennial average is 271 clients, which is 4.2 percent higher than the 2015-17 biennial average forecast.

Guilty Except for Insanity (GEI) – These clients are under the jurisdiction of the Psychiatric Security Review Board and State Hospital Review Panel. Nationally, violent crimes are down despite population growth. For the past several years the Total GEI caseload in Oregon has steadily declined. The 2015-17 biennial average forecast is 599. The 2017-19 biennial average is 590, which is 1.5 percent lower than the 2015-17 biennial average forecast.

Civil Commitments – This caseload has been subject to several data system changes, rendering conclusions about caseload trends variable. For the past two years the caseload has been declining. This may be due in part to the expansion of Medicaid. It is also possible that new investments are helping to reduce this caseload. The 2015-17 biennial average forecast is 975 clients. The 2017-19 biennial average is 921 clients, which is 5.5 percent lower than the 2015-17 biennial average.

Previously Committed – This caseload captures clients receiving mental health services that had been civilly or criminally committed at some time since the year 2000.

About 80 percent of these clients are served in non-residential settings, and the rest are served in residential settings, the State Hospital, or Acute Care hospital settings. The 2015-17 biennial average forecast is 2,567 clients. The 2017-19 biennial average is 2,543 clients, which is 0.9 percent lower than the 2015-17 biennial average.

Never Committed – This caseload captures clients receiving mental health services that have not been civilly or criminally committed since the year 2000. More than 99 percent of these clients are served in non-residential settings. The 2015-17 biennial average forecast is 41,244 clients. The 2017-19 biennial average is 43,198 clients, which is 4.7 percent higher than the 2015-17 biennial average.

Risks and Assumptions

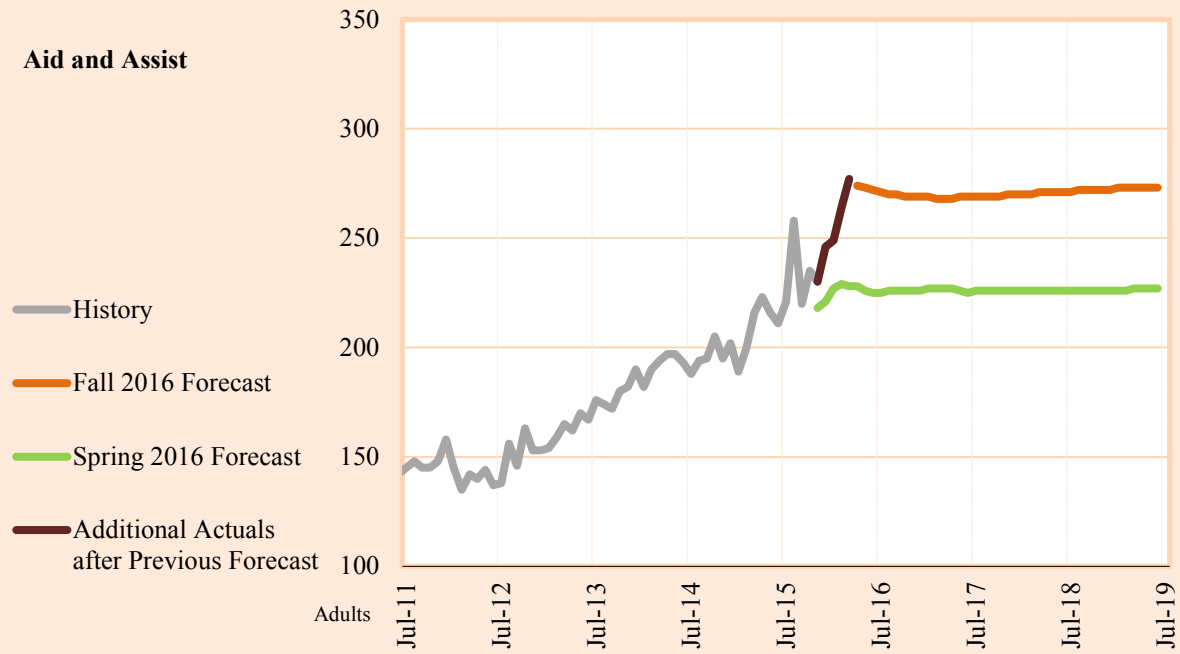
The Aid and Assist caseload may be impacted by community level efforts to keep people out of the State Hospital. In particular, misdemeanor admissions have decreased in Marion County, and this may spread to other counties. Additionally, program leadership is promoting the idea that Aid and Assist can be provided locally, not just at the Oregon State Hospital. Resource development is under way, and funding is going to high-utilizing areas. To the extent this idea gains traction, caseload would under count the actual number served since data are not currently available for Aid and Assist clients served outside the State Hospital.

The Aid and Assist caseload is subject to variation at the county level. For example, differences in police training as well as local judges can affect the Aid and Assist caseload at the Oregon State Hospital.

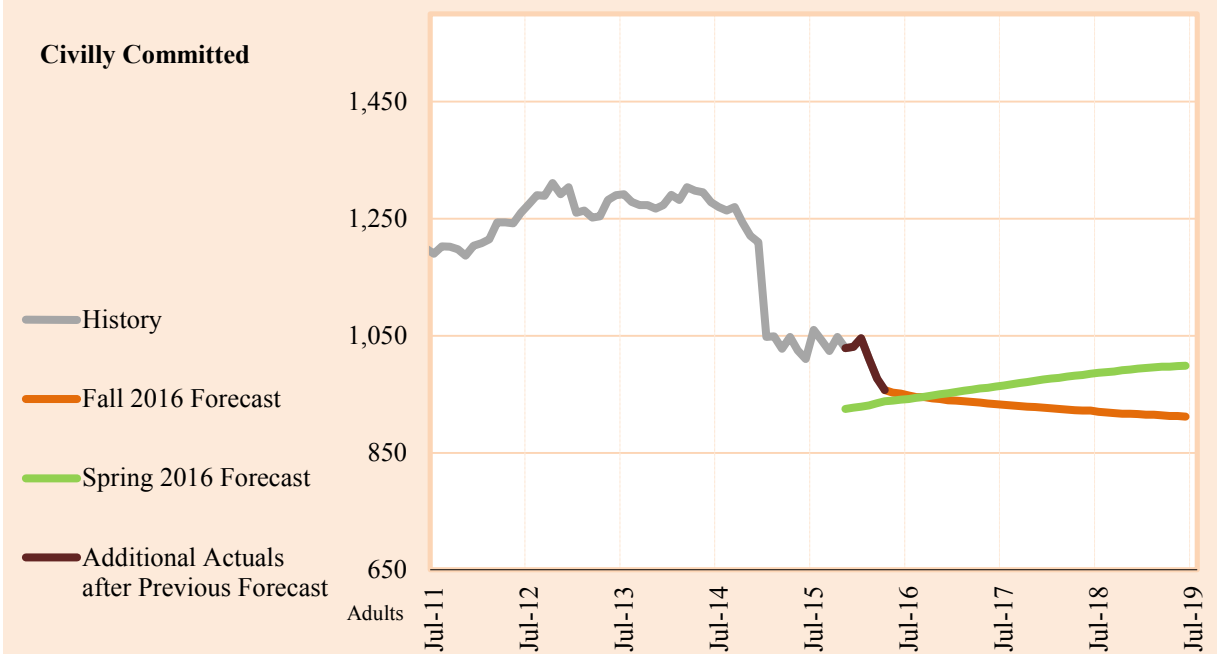
The Guilty Except for Insanity caseload is subject to review by the Psychiatric Security Review Board and/or the State Hospital Review Panel. When clients are released by the Board/Panel prior to their end of jurisdiction date, the caseload is driven down. Based on end of jurisdiction date alone, January and March of 2017 are expected to have above normal numbers ending jurisdiction.

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

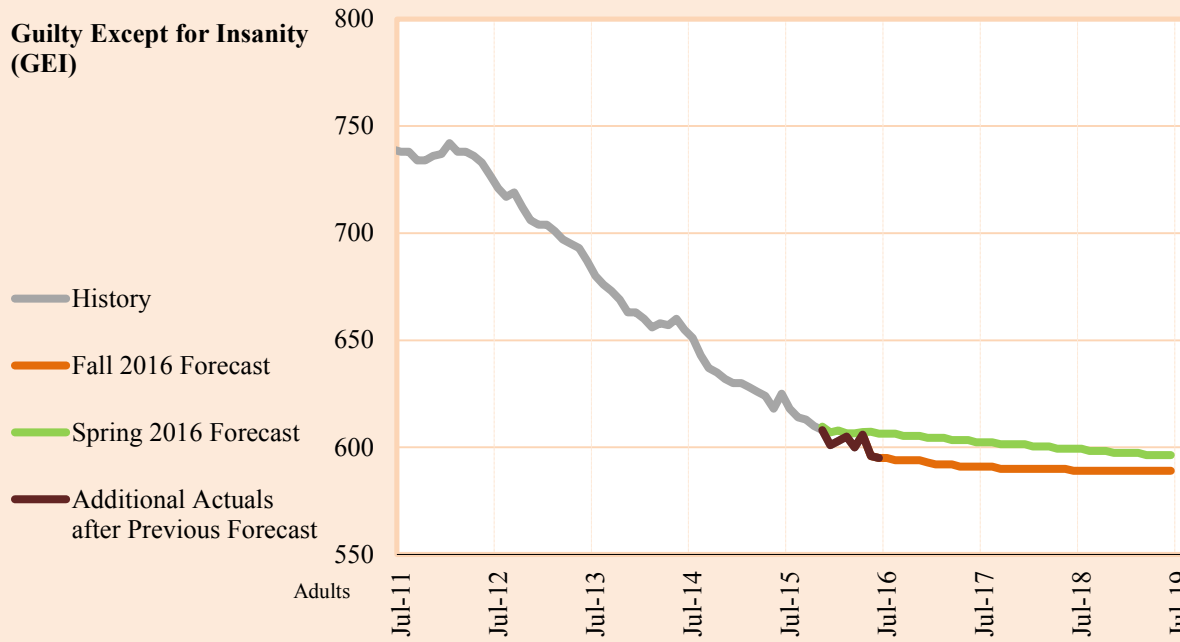
Aid and Assist



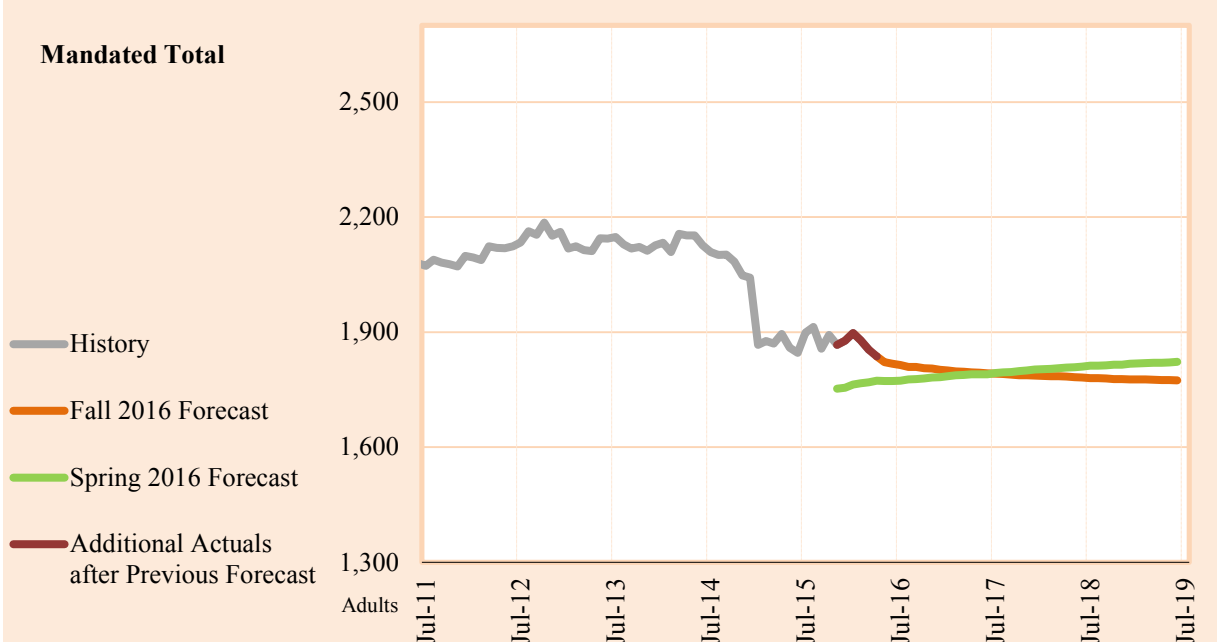
Civily Committed

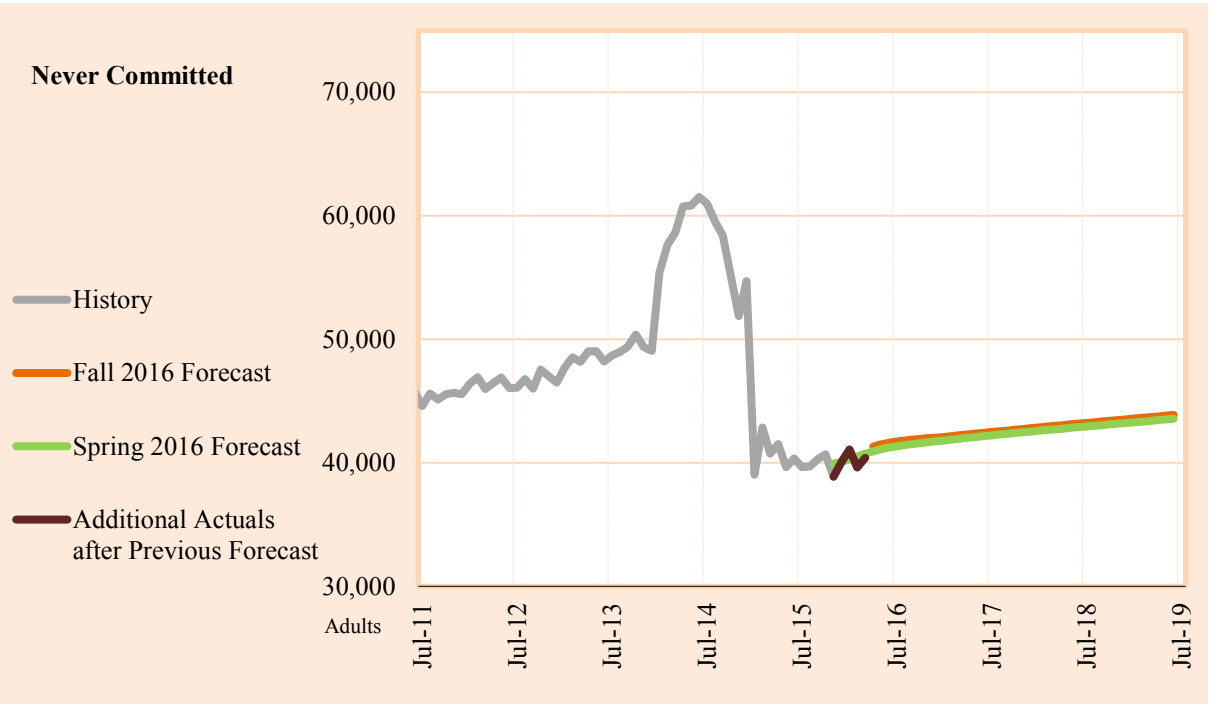
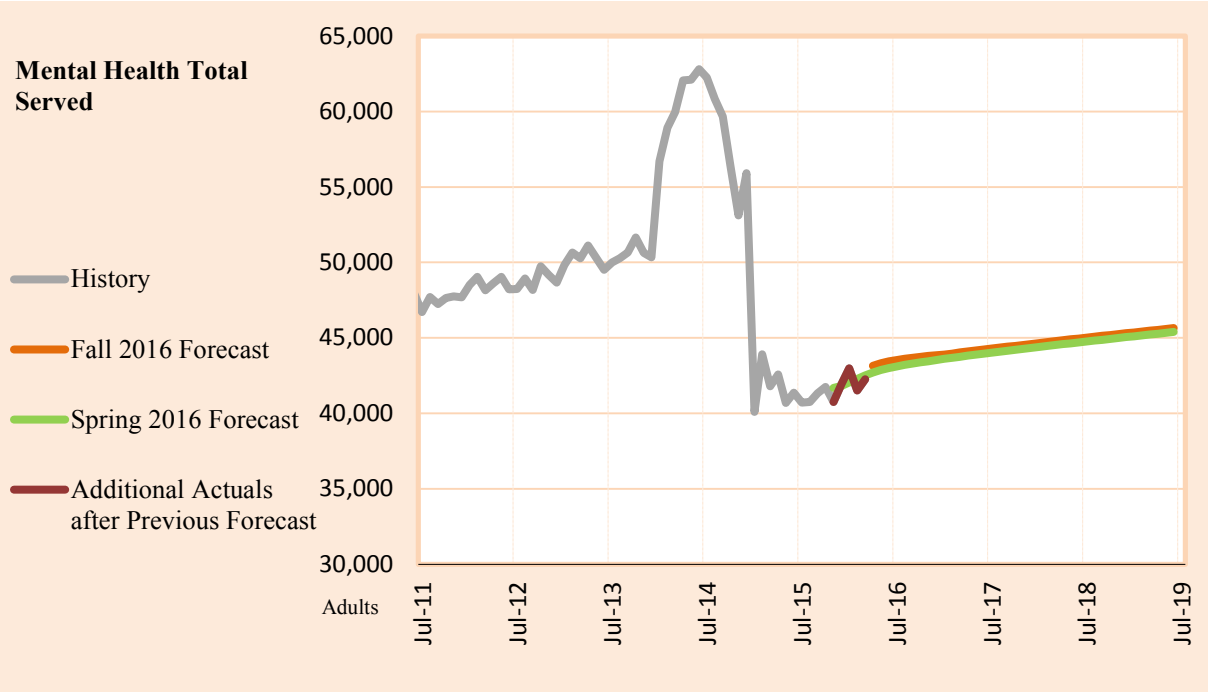


Guilty Except for Insanity (GEI)



Mandated Total





Mental Health Biennial Average Forecast Comparison

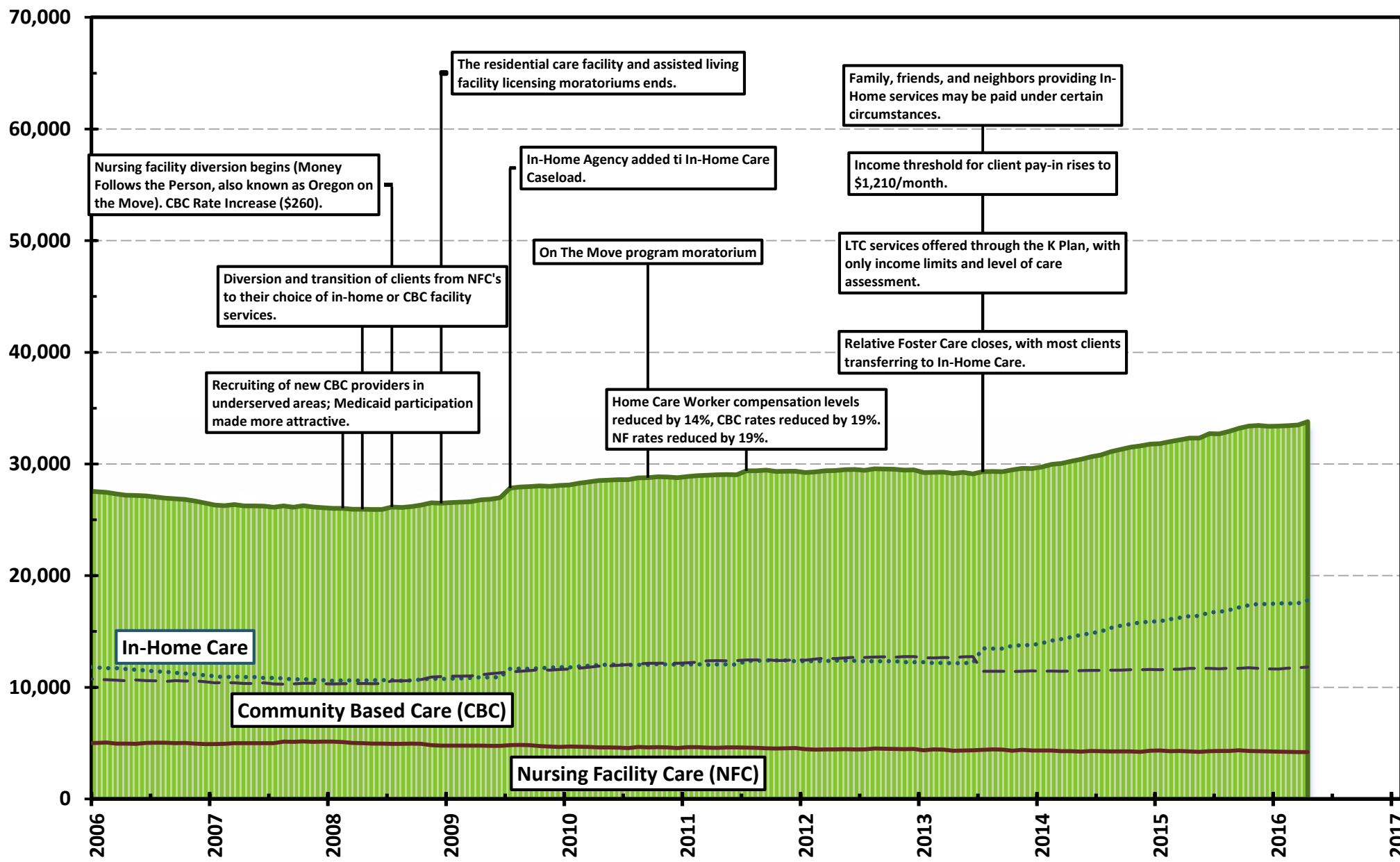
Biennial Averages	2015-17 Biennium			% Change Between Forecasts	Fall 2016 Forecast			% Change Between Biennia
	Spring 16 Forecast	Fall 16 Forecast	Change		2015-17	2017-19	Change	
MENTAL HEALTH ¹								
Under Commitment								
Aid and Assist	221	260	39	17.6%	260	271	11	4.2%
Guilty Except for Insanity (GEI)	607	599	-8	-1.3%	599	590	-9	-1.5%
Total Forensic Care	828	859	31	3.7%	859	861	2	0.2%
Civilly Committed	948	975	27	2.8%	975	921	-54	-5.5%
Previously Committed	2,548	2,567	19	0.7%	2,567	2,543	-24	-0.9%
Never Committed	41,101	41,244	143	0.3%	41,244	43,198	1,954	4.7%
Total Served	45,425	45,645	220	0.5%	45,645	47,523	1,878	4.1%

1. Numbers reported represent adults only.

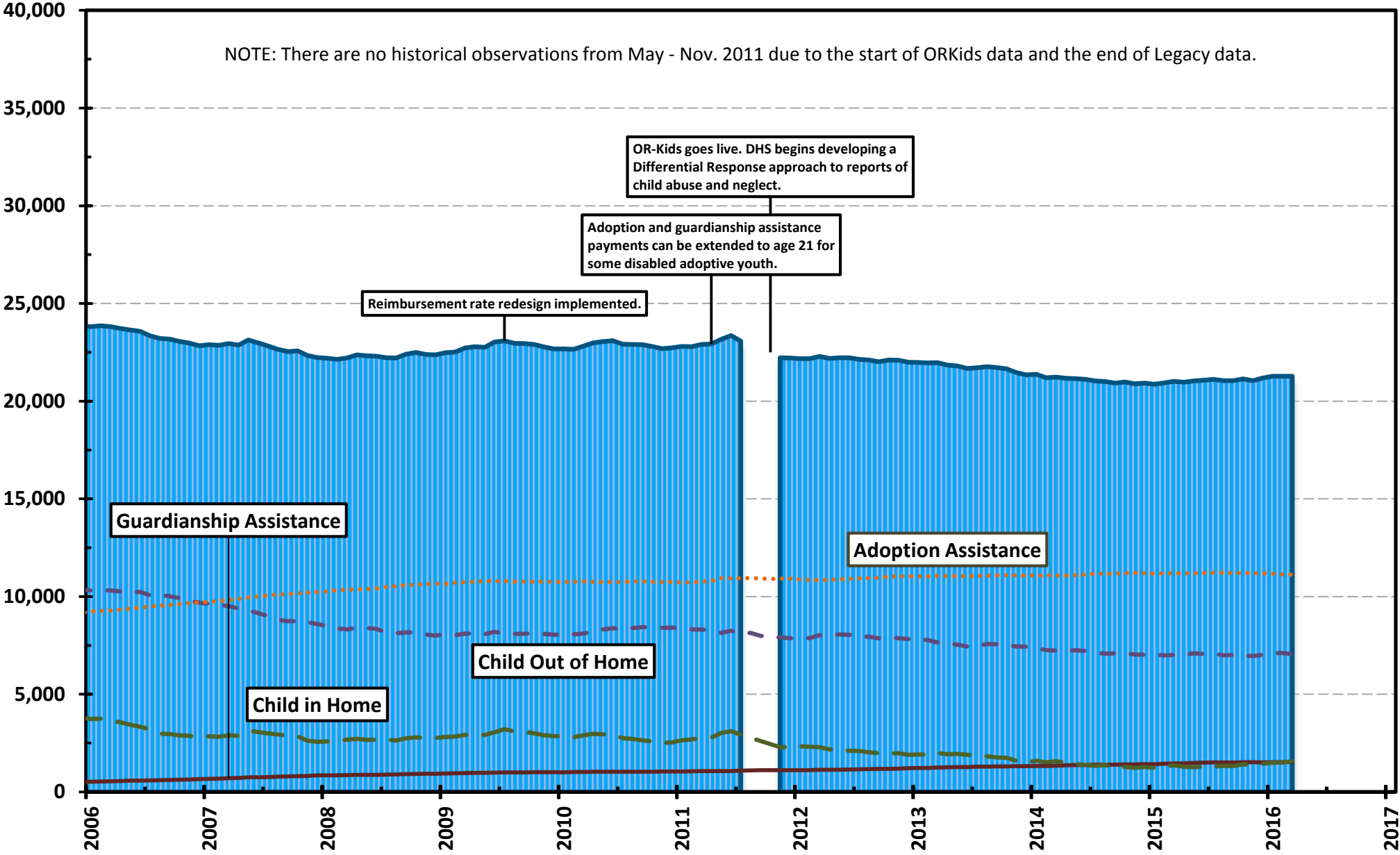
Appendix I

DHS Caseload History & Definitions

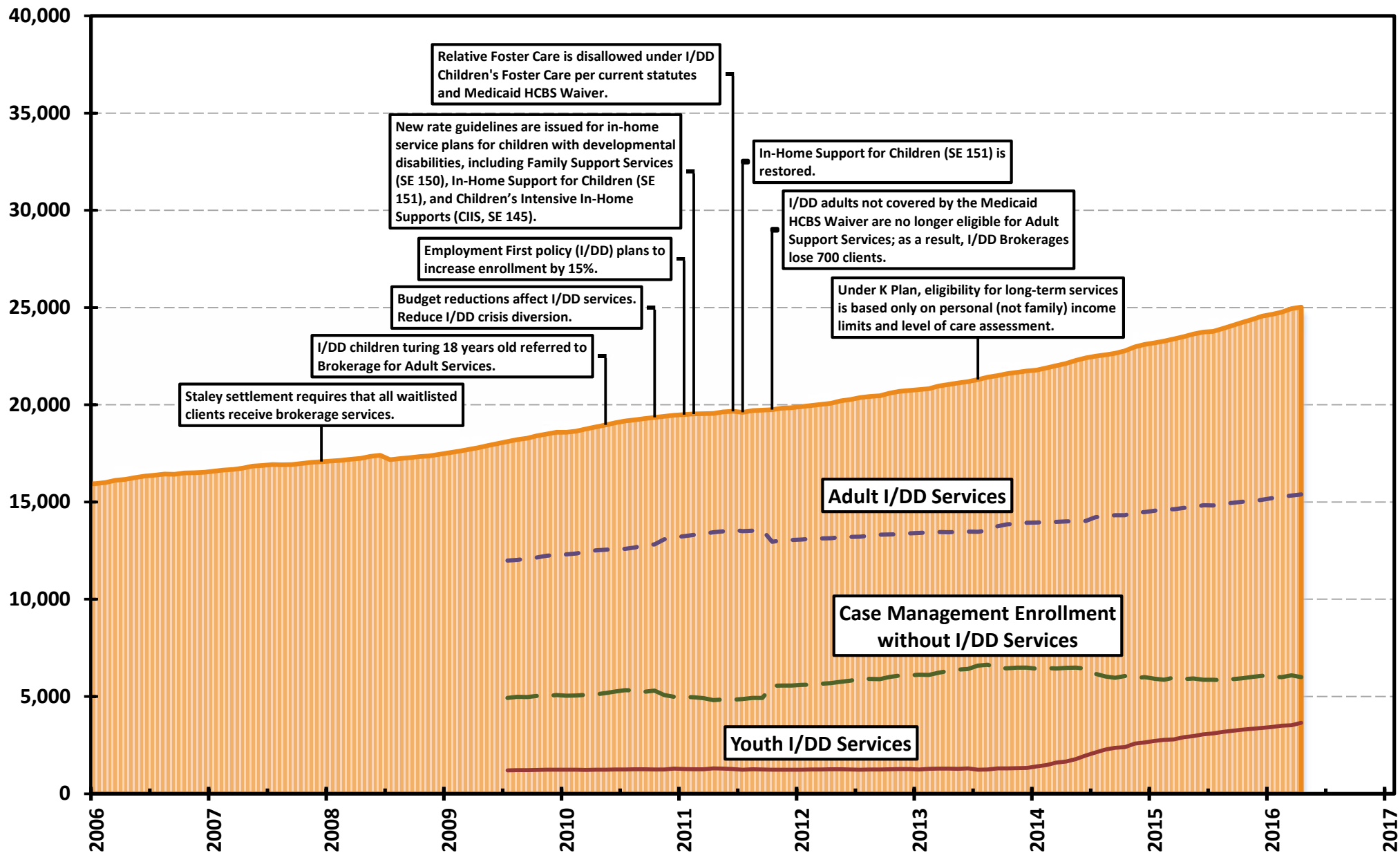
Aging and People with Disabilities (APD) Caseload



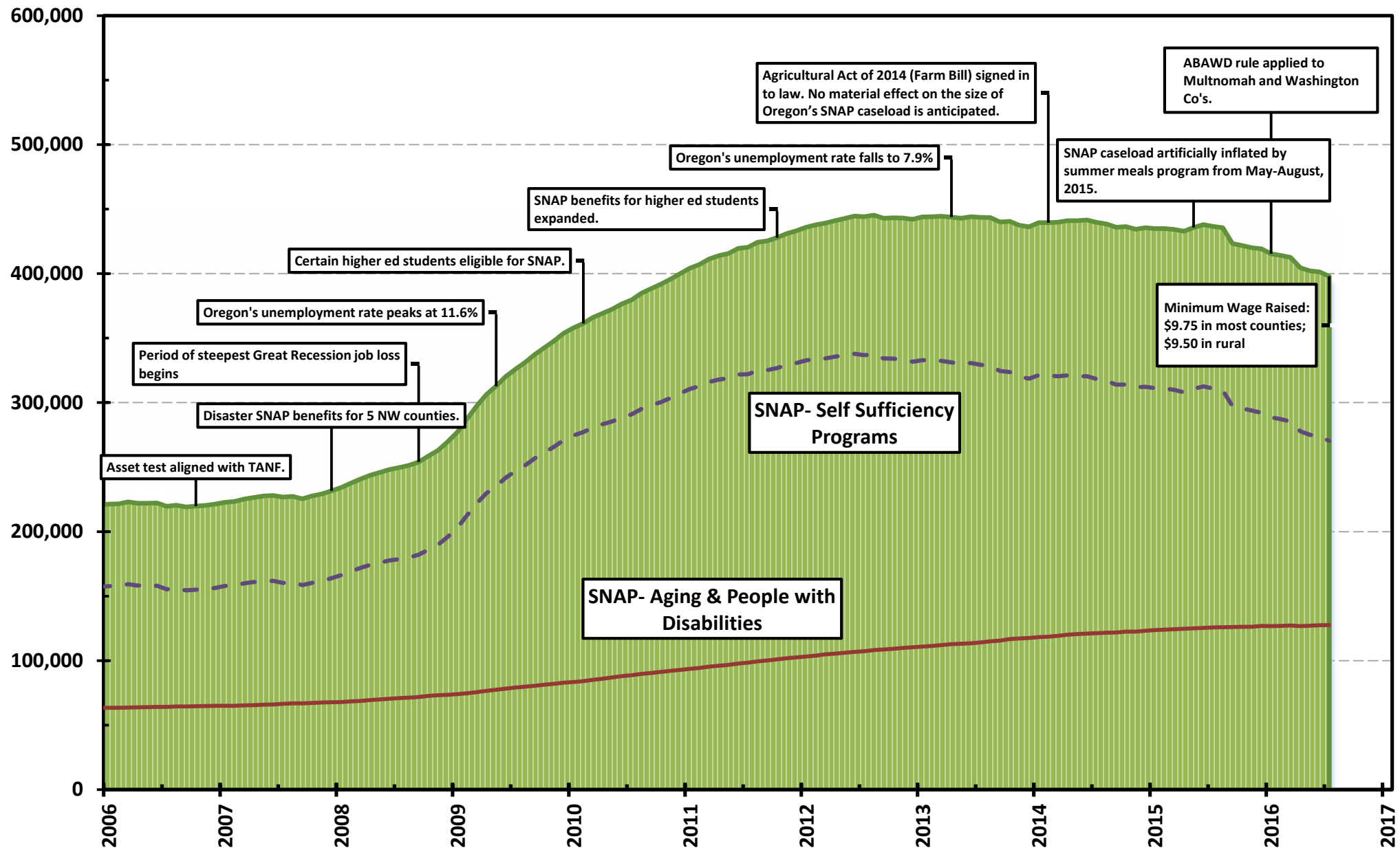
Child Welfare (CW) Caseload



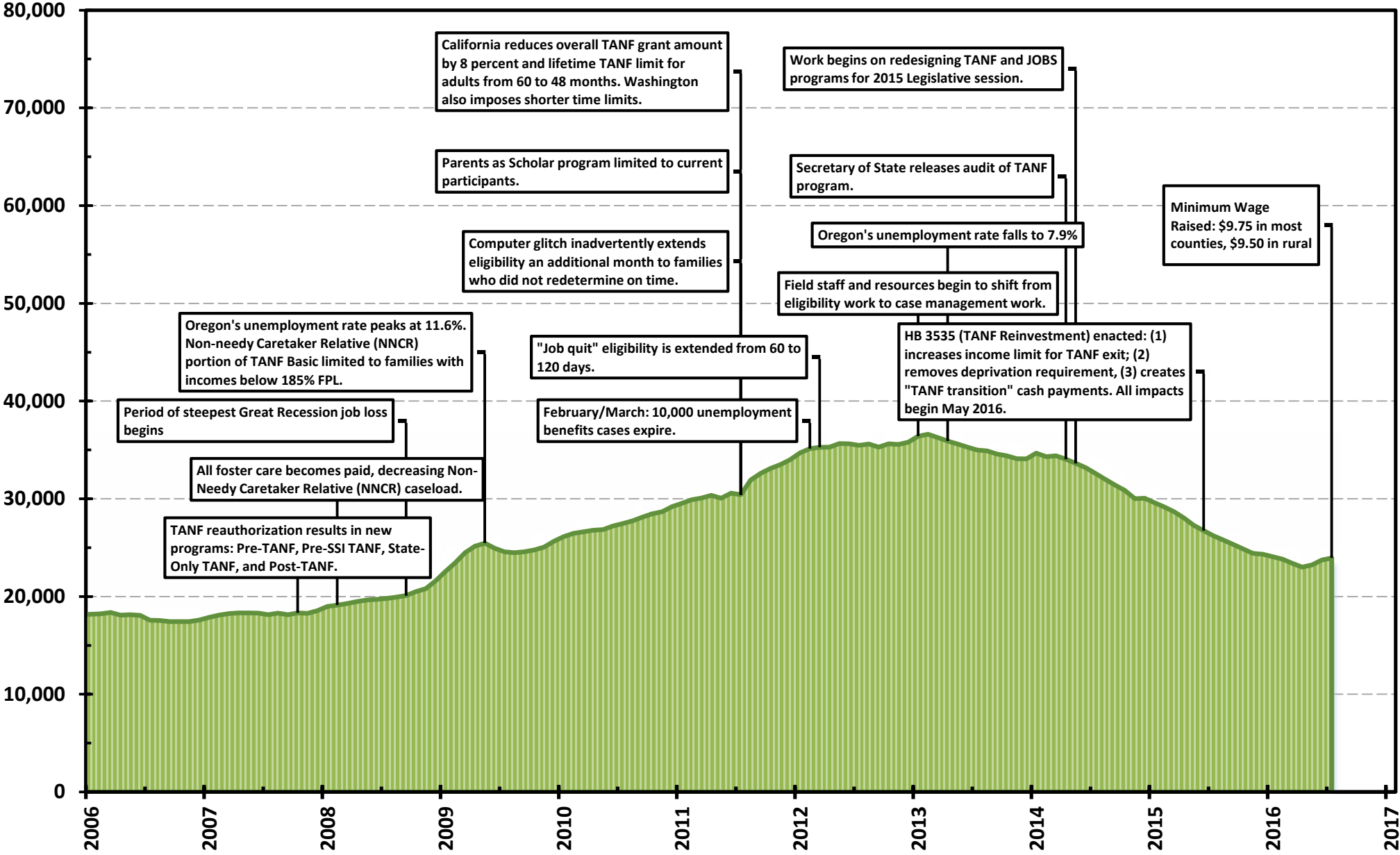
Intellectual & Developmental Disabilities (I/DD): Case Management Enrollment



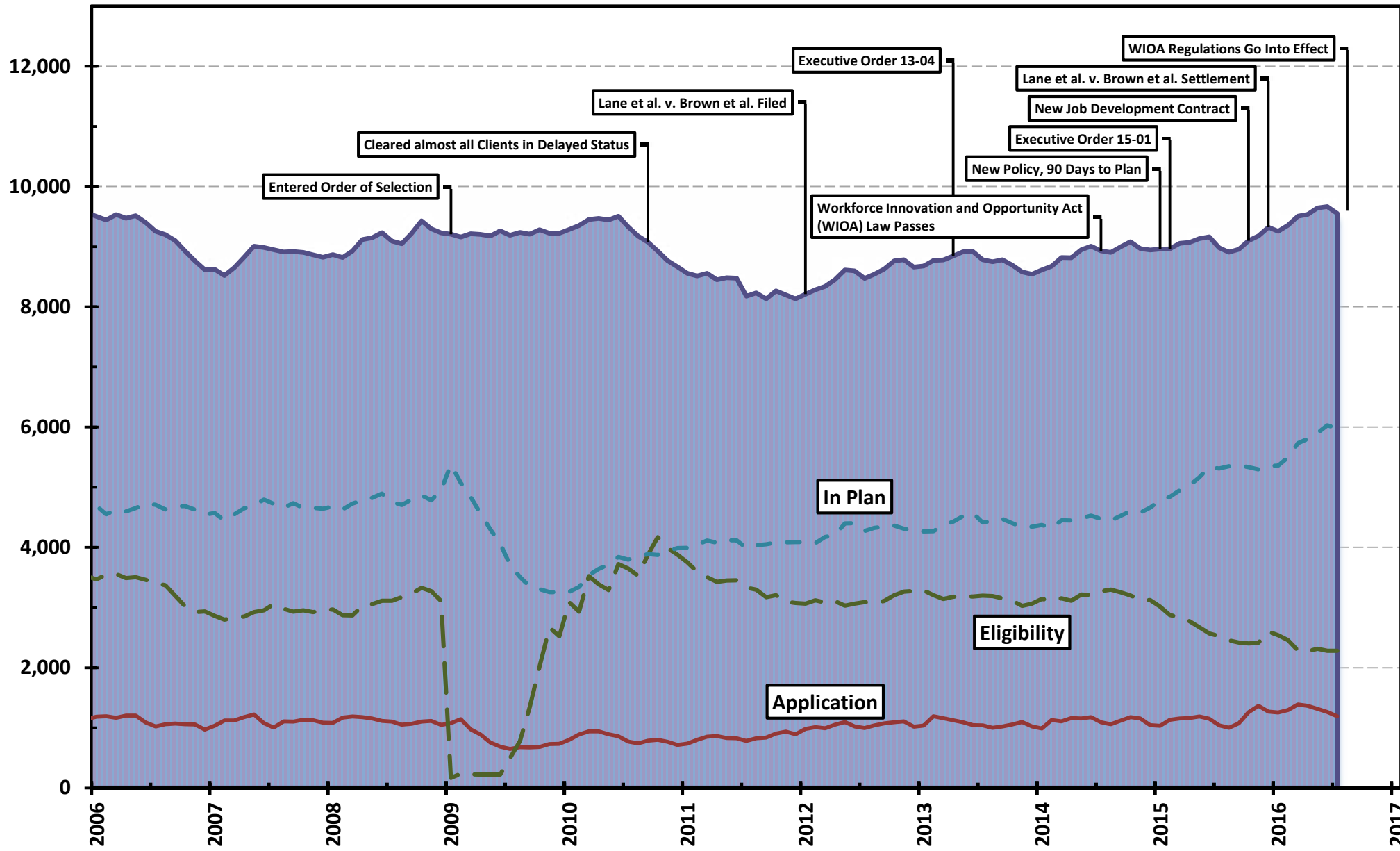
Self Sufficiency Programs (SSP): Supplemental Nutrition Assistance Program (SNAP) Caseload



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



Vocational Rehabilitation



DHS CASELOAD DEFINITIONS

Federal Poverty Level (FPL)

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

2016 Poverty Guidelines for Oregon

Person in family/ household	Poverty Guideline
1	\$11,880
2	\$16,020
3	\$20,160
4	\$24,300
5	\$28,440
6	\$32,580
7	\$36,730
8	\$40,890

Aging and People with Disabilities (APD)

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

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

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

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

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

In-Home Programs

In-Home programs provide personal services that help people stay in their homes when they need assistance with Activities of Daily Living (ADL).

In-Home Hourly

In-Home Hourly caseload includes clients who hire hourly workers to assist them in meeting their ADL needs and other common household tasks.

In-Home Agency

In-Home Agency is an alternative way to purchase in-home care. Under this program, clients contract with an agency for the services they need, and those services are delivered in the client's own home by an employee of the agency. Screening and scheduling are often simpler when working with an agency.

Live-In

Live-In Provider caseload includes clients who hire a live-in home care worker to provide 24-hour care.

Spousal Pay

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

Independent Choices

Independent Choices allows clients more control in the way they receive their in-home services. Under this program, clients decide for themselves which services they will purchase, but are also required to keep financial records of the services they've purchased.

Specialized Living

Specialized Living provides care in a home-like setting for clients with specialized needs (such as quadriplegics or clients with acquired brain injuries). These clients are eligible for a live-in attendant, but because of their special needs, cannot live independently or be served in other Community-Based Care facilities.

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

State Plan Personal Care services are available to people who are eligible for Medicaid, but not eligible for waived services. Services supplement the individual's own personal abilities and resources, but are limited to assistance with Activities of Daily Living and Instrumental Activities of Daily Living.

Community Based Care (CBC)

Community-Based Care caseload includes clients receiving services in licensed, community-based residential settings. Services include assistance with ADLs, medication oversight, and social activities. Services can also include nursing and behavioral supports to meet complex needs.

Assisted Living Facilities

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

Adult Foster Care

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

Residential Care Facilities

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

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

PACE is a capitated Medicare/Medicaid program providing all-inclusive care. Seniors served in this program live in a variety of care settings. PACE is responsible for coordinating their clients’ acute health and long-term care needs.

Nursing Facilities (NF)

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

Basic Care

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

Complex Medical Add-On

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

Enhanced Care

Enhanced Care clients have difficult to manage behavioral issues such as self-endangering behaviors, physical aggression, intrusiveness, intractable psychiatric symptoms, or problematic medication needs that require special care in Nursing Facilities. Some of these clients are also served in community-based care facilities.

Pediatric Care

Pediatric Care clients are children under 21 who receive nursing care in pediatric nursing facility units.

Child Welfare (CW)

Child Welfare programs oversee the safety of children who have been abused or neglected. The Child Protective Services (CPS) program investigates reports of child abuse or neglect. If abuse or neglect is founded, caseworkers prepare an action plan and provide case management to ensure safety for the child using the strengths of the family.

The Child Welfare caseload is an unduplicated count of children served in the various programs listed below. A child is counted only once during a month. For children participating in more than one CW program within a month, they are counted in the program highest on the list below:

Adoption Assistance

Adoption Assistance coordinates and supervises adoption for children in foster care who cannot return safely to the care of their biological parents. Adoption Assistance services can include financial and/or medical help with the costs associated with the adoptive child's needs.

Guardianship Assistance

Guardianship Assistance helps remove financial barriers for individuals who provide a permanent home for children who would otherwise be in Foster Care. Guardianship allows an alternative plan to adoption. Guardianship Assistance services can include financial support for costs associated with the needs of the child (similar to a Foster Care payment).

Out of Home Care

Out of Home Care programs provide a safe, temporary home for abused or neglected children who cannot remain safely in their homes. Children in the program are placed with relatives, foster families, or in residential treatment care settings. The program aims to reunite children with their parents. Out of Home Care services can include financial support and/or medical help for costs associated with the child's needs.

Child In-Home

In-Home Services provide support and safety monitoring services to prevent placement of children in Foster Care and to support reunification with the parents after Foster Care. Caseworkers oversee services and monitor in-home safety plans for children. In-Home Services can include financial support for costs associated with the safety, permanence, and well-being of children, and outside resources to help meet those needs.

Intellectual and Developmental Disabilities (I/DD)

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

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

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

Case Management Enrollment

Case Management Enrollment provides entry-level eligibility evaluation and coordination services.

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

Adult services

Brokerage Enrollment

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

24-Hour Residential Care

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

Supported Living

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

Comprehensive In-Home Services

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

I/DD Foster Care

Foster Care provides 24-hour care, supervision, provision of room and board, and assistance with activities of daily living for both adults and children (approximately 84 percent and 16 percent respectively).

Stabilization and Crisis Unit

Stabilization and Crisis Unit (previously called State Operated Community Programs) offers safety net services and support to the most vulnerable, intensive, medically and behaviorally challenged I/DD clients when no other community based option is available to them. The program serves both adults and children (approximately 88 percent and 12 percent respectively).

Children's services

In-Home Support for Children

In-Home Support for Children provides services to individuals under the age of 18 in the family home.

Children Intensive In-Home Services

Children Intensive In-Home Services cares for children with intensive medical or behavioral needs in their own homes.

This caseload is composed of three distinct groups: Medically Fragile Children Services, Intensive Behavior Program, and Medically Involved Programs.

Children Residential Care

Children Residential Care provides 24-hour care, supervision, training, and support services to individuals under the age of 18 in neighborhood homes other than the family home or foster care.

Other I/DD services

Employment and Day Support Activities

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

Transportation

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

Self Sufficiency Programs (SSP)

Self Sufficiency programs provide assistance for low-income families to help them become healthy, safe, and economically independent. With the exception of SNAP, self-sufficiency program caseloads count the number of families receiving program benefits within the month. In the SNAP program, caseloads count the number of households receiving the benefit within the month.

Supplemental Nutrition Assistance Program (SNAP)

As of October 1, 2008, the new name for the federal Food Stamp Program is the Supplemental Nutrition Assistance Program (SNAP). Oregon began using the new name on January 1, 2010.

SNAP benefits improve the health and well-being of low-income individuals by providing them a means to meet their nutritional needs. Recipients use SNAP benefits to buy food.

To be eligible for SNAP benefits, applicants provide proof of household composition (living in same dwelling, purchase food and prepare meals together) and have assets and income within program limits. The maximum income limit is 185 percent of Federal Poverty Level (FPL), however most recipients qualify below 130 percent of FPL.

The SNAP forecast includes two caseloads – APD and SSP. Households entering the program through the Self Sufficiency Programs (SSP) are classified as SSP households, while those entering the program through Aging and People with Disabilities (APD) are classified as APD households. The two caseloads share eligibility guidelines and benefits amounts.

Temporary Assistance for Needy Families (TANF)

The Temporary Assistance for Needy Families (TANF) program provides case management and cash assistance to very poor families with minor children. The goal of the program is to reduce the number of families living in poverty through employment services and community resources.

Recipients must meet basic TANF asset requirements (including a \$2,500 - \$10,000 resource limit and income less than 40 percent of FPL) to be eligible for the program. They must also meet non-financial eligibility requirements including dependent children in the case, Oregon residence, citizenship status, parental school attendance, pursuing assets, and pursuing treatment for drug abuse or mental health as needed. As of April 2016 proof of deprivation (death, absence, incapacity, or unemployment of a parent) will no longer be a requirement of TANF enrollment.

The **TANF Basic** program includes one-parent families and two-parent families where at least one parent is unable to care for children, or families headed by an adult relative who is not considered financially needy.

The **TANF UN** program includes families where both parents are able to care for their children, but both are unemployed or underemployed.

TANF Employment Payments (EP) are available to those families exiting TANF due to employment. Transition payments are for three months only. TANF EP is currently authorized for the 2015-17 biennium.

Pre-SSI

The State Family Pre-SSI/SSDI (SFPSS) program provides cash assistance, case management, and professional level support to TANF-eligible adults and their family in pursuing Supplemental Security Income (SSI) and Supplemental Security Disability Income (SSDI). To be eligible for Pre-SSI, the adult must be found eligible for a TANF grant and must have severe physical or mental impairment(s) that has been assessed and determined to meet the program impairment criteria by the program's disability analyst.

Temporary Assistance to Domestic Violence Survivors (TA-DVS)

The TA-DVS program supports domestic violence survivors by providing temporary financial assistance to flee domestic violence. TA-DVS payments can be issued to meet the family's needs for shelter, food, medical care, relocation, stabilization, or to promote safety or independence from the abuser.

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

Vocational Rehabilitation (VR)

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

VR services involve four stages, each of which are now being forecast:

Application

Clients in the Application stage have completed an application for VR services.

Eligibility

Clients in the Eligibility stage have been determined eligible for VR services and are developing a plan for employment.

In Plan

Clients who are In Plan are receiving VR services. After employment and if all is going well, a case is normally closed after 90 days.

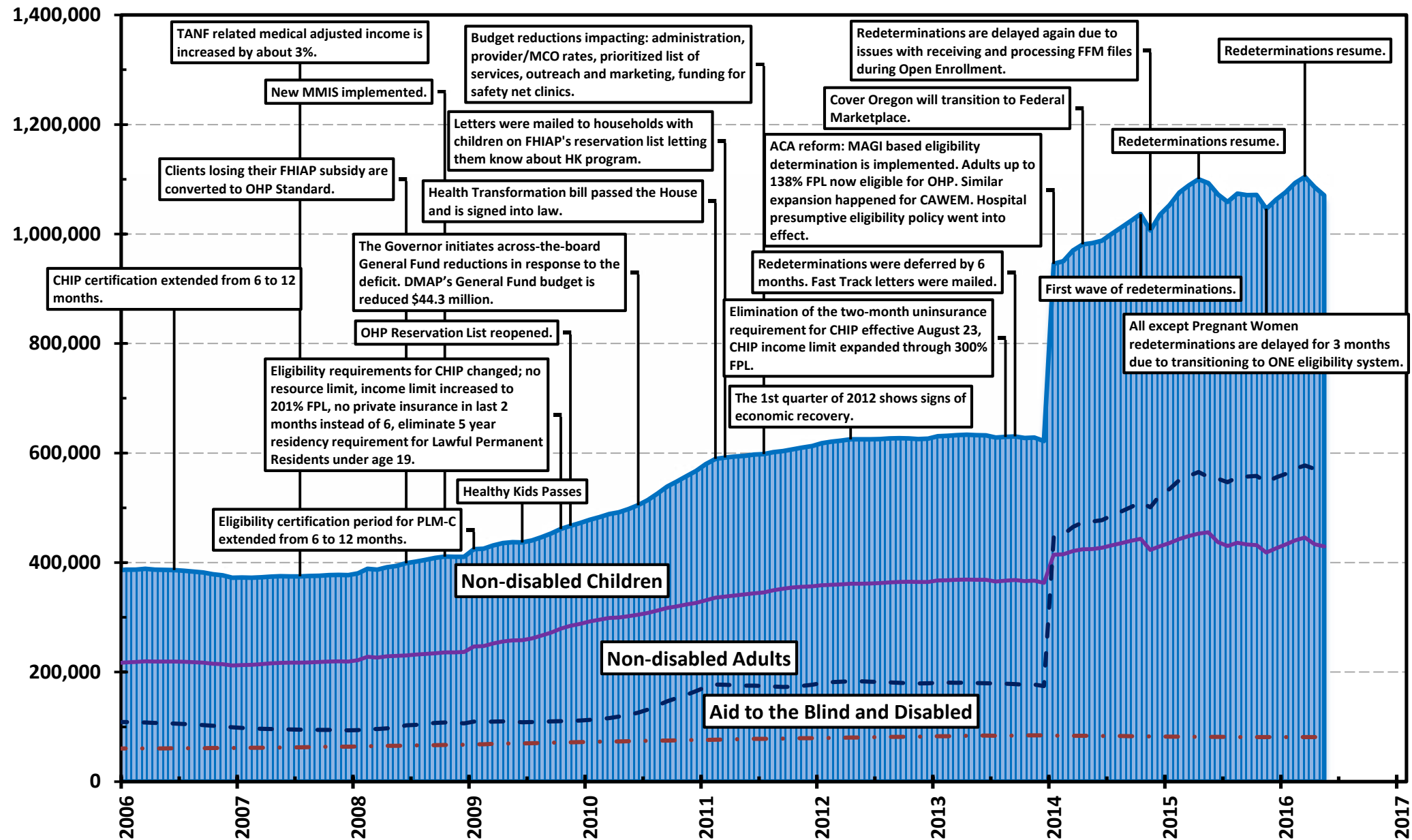
Post-Employment Services

Clients can receive Post-Employment Services after employment if they need help keeping their job or advancing within it. Also, if they need assistance re-obtaining their job if it is lost.

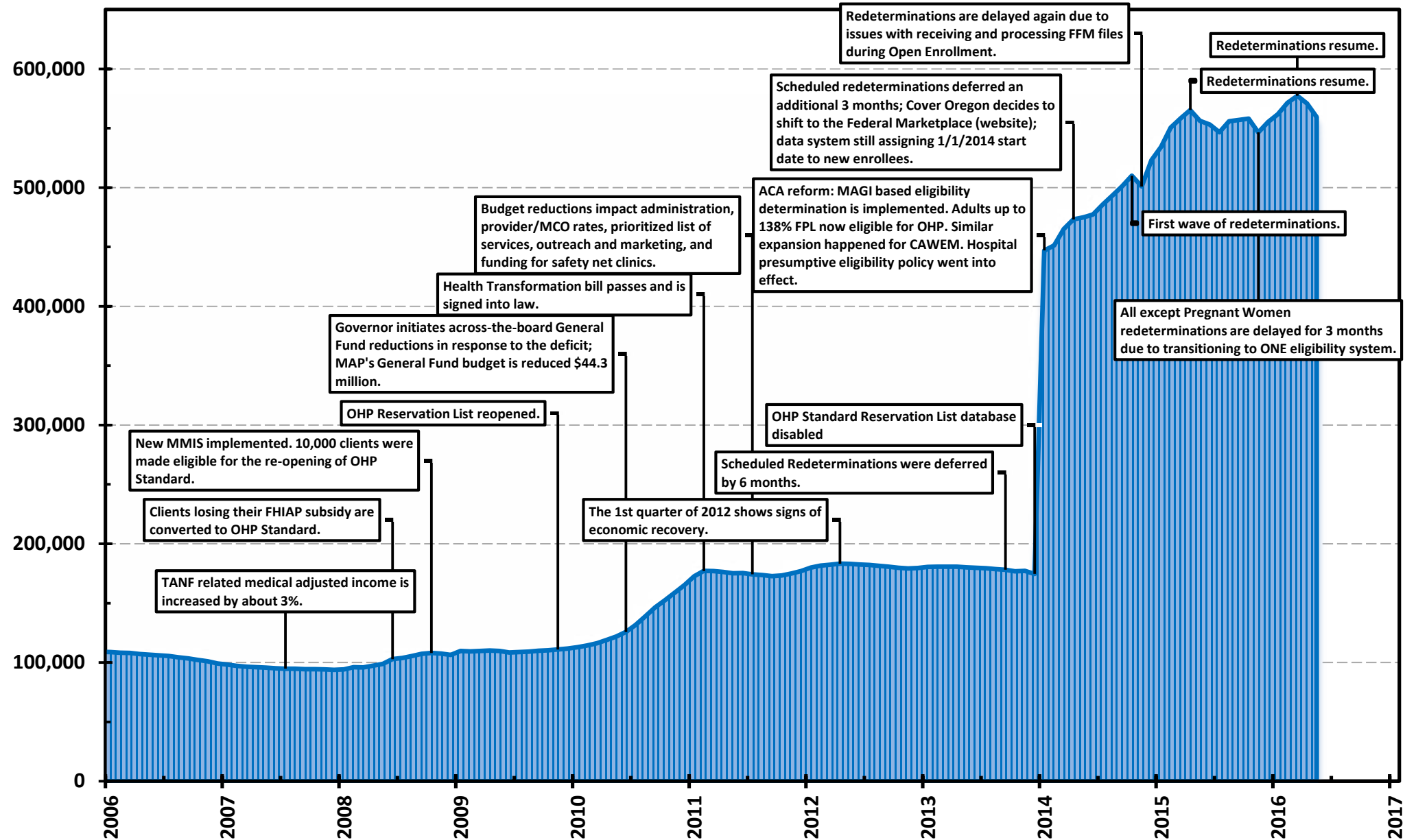
Appendix II

OHA Caseload History & Definitions

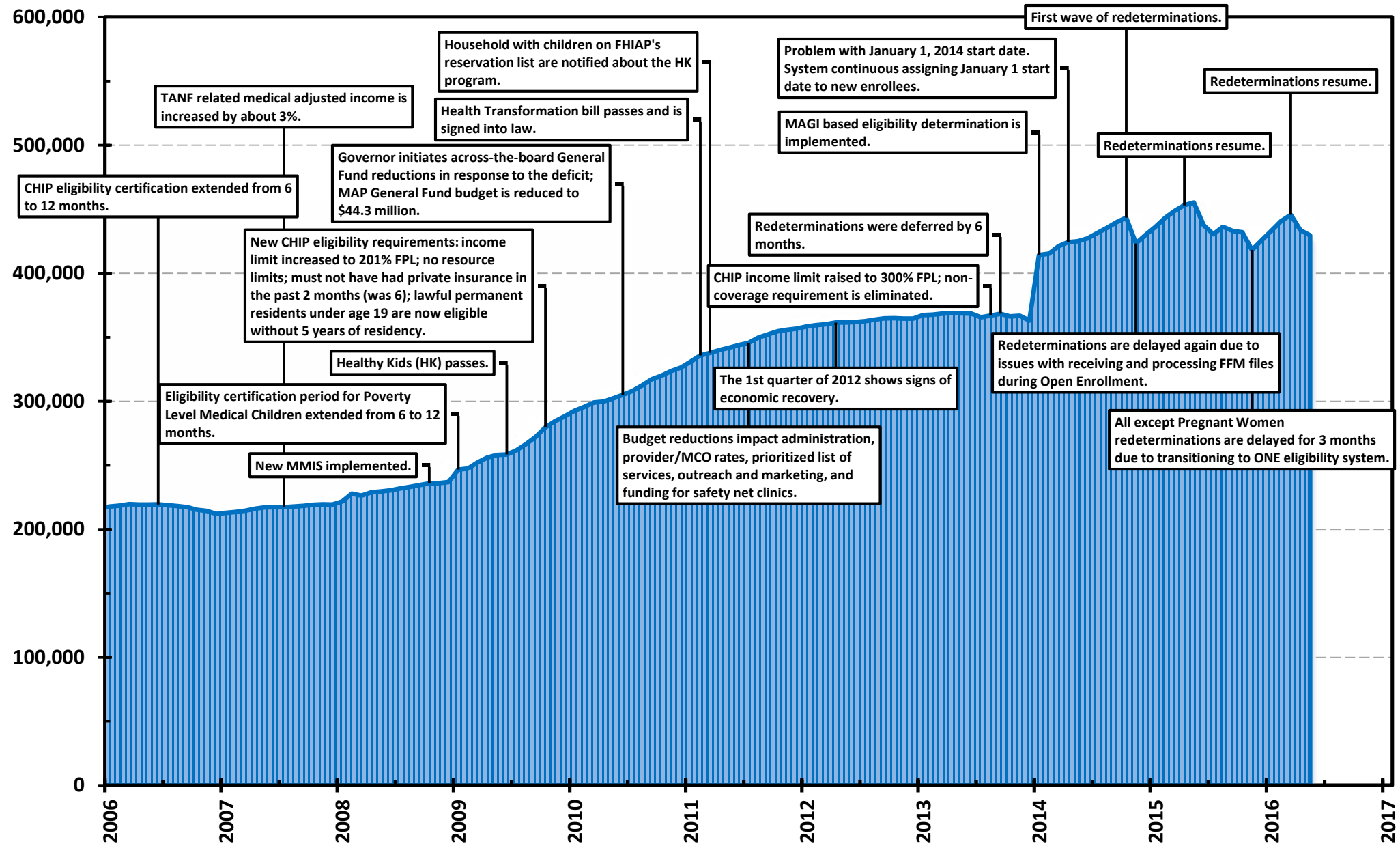
Health Systems - Medicaid, Total Oregon Health Plan - Plus and Standard



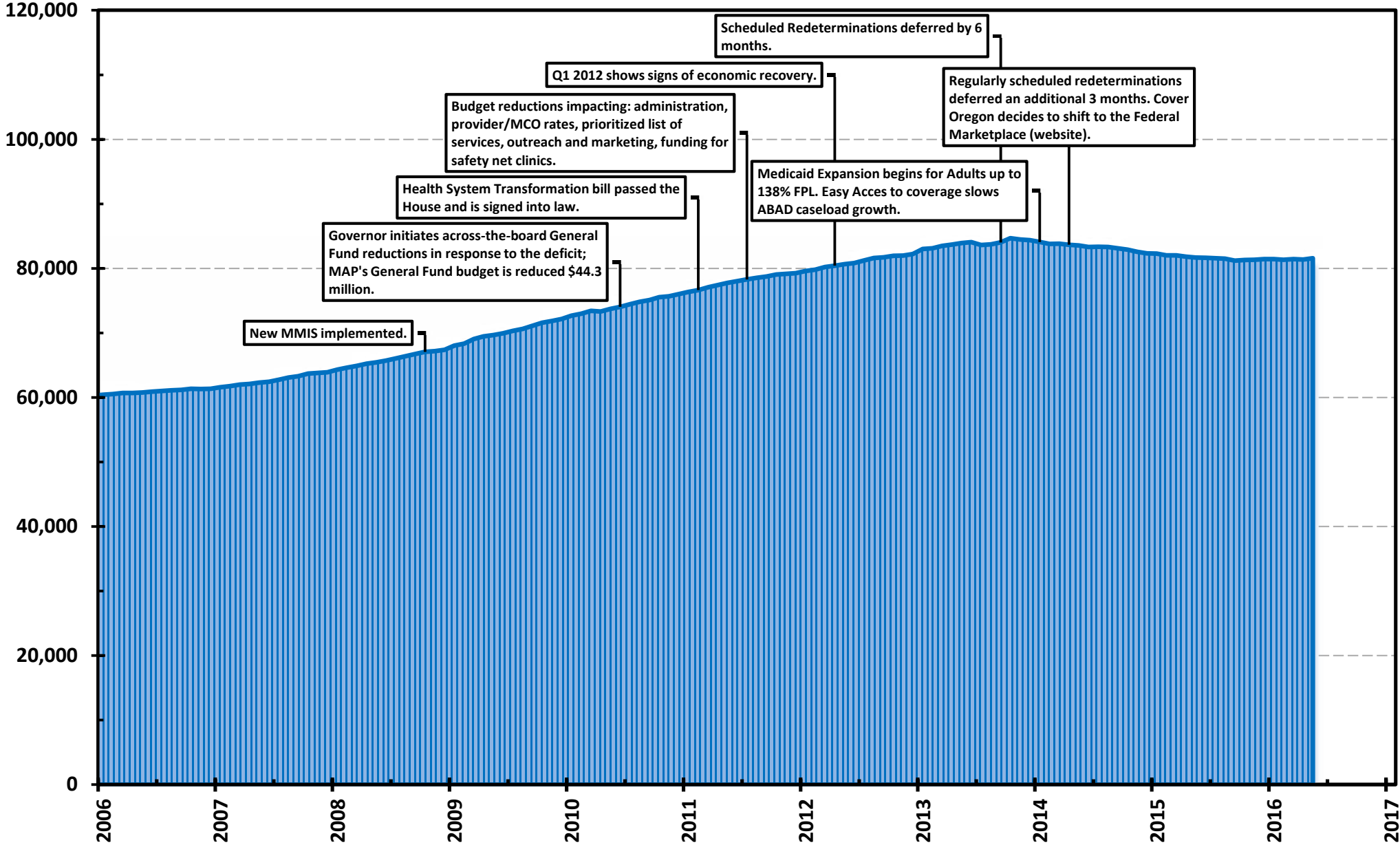
Health Systems - Medicaid, Non-Disabled Adults



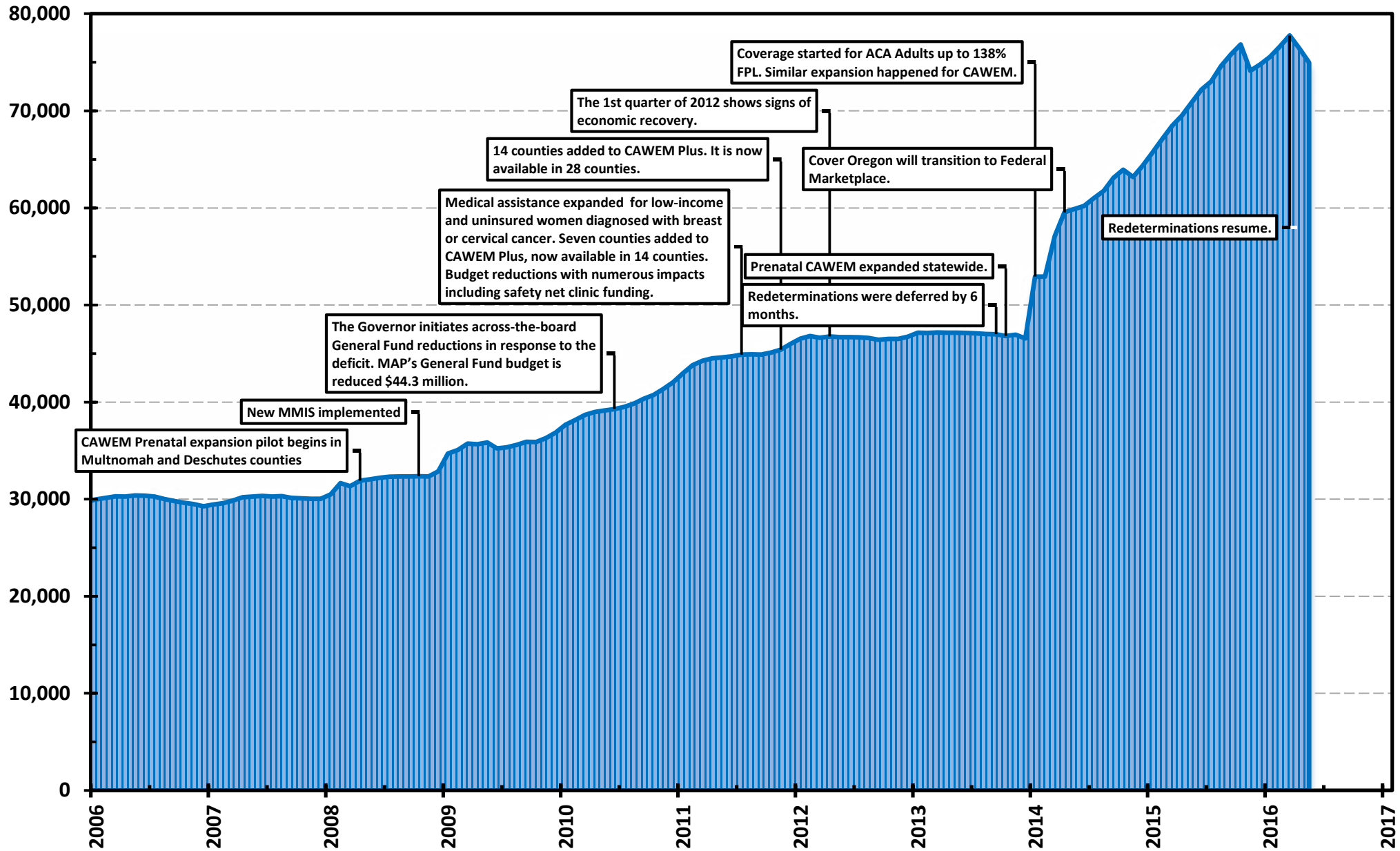
Health Systems - Medicaid, Non-Disabled Children



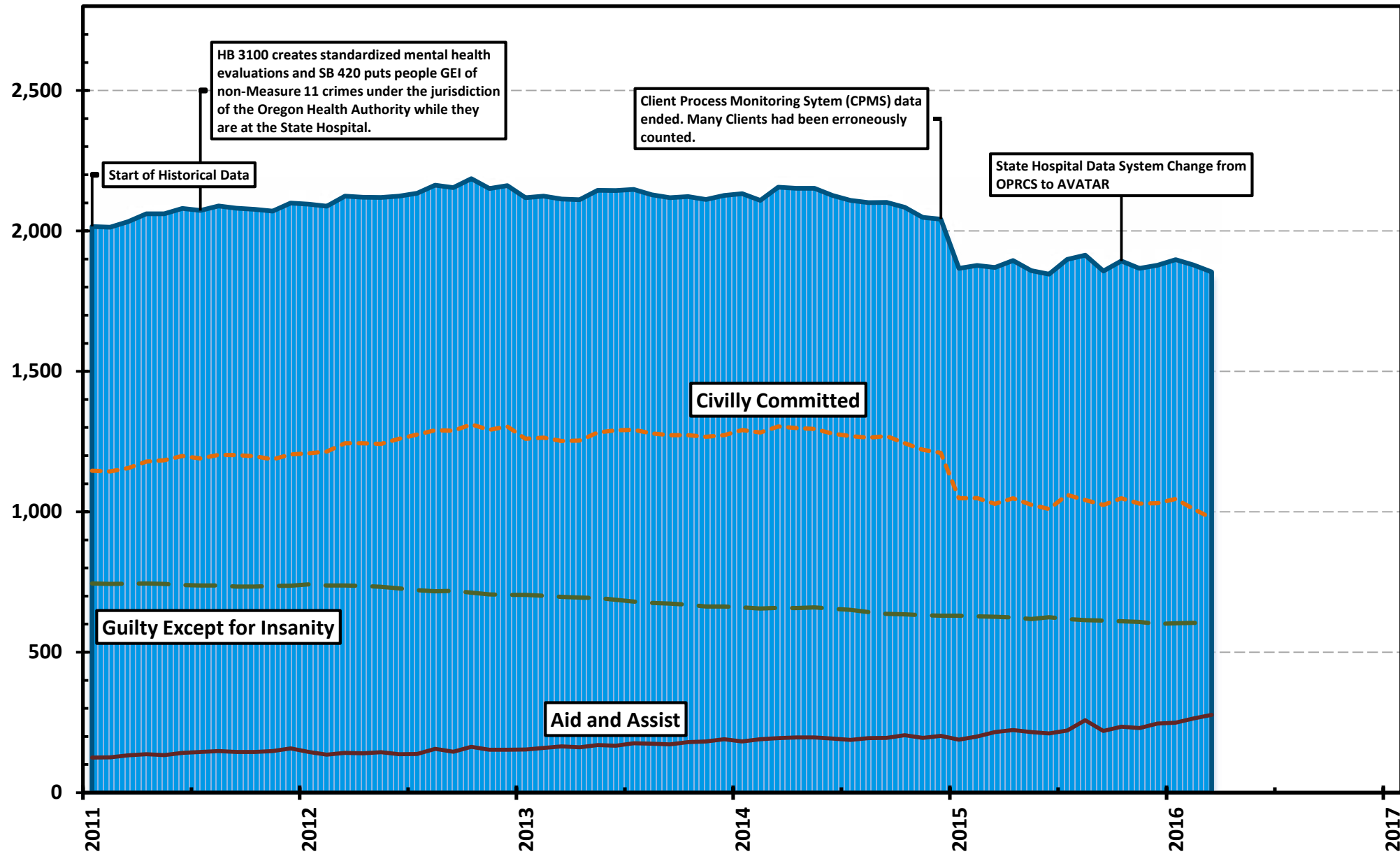
Health Systems - Medicaid, Aid to the Blind and Disabled



Health Systems - Medicaid Other



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



OHA CASELOAD DEFINITIONS

Federal Poverty Level (FPL)

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Health Systems - Medicaid (HSM)

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

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

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

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 adults and children who are eligible under Medicaid or CHIP rules. The new ACA Adults caseload also receives this benefit package.

ACA Adults

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

Pregnant Women

This is the new name for Poverty Level Medical Women (PLMW).

This program provides medical coverage to pregnant women with income levels up to 185 percent of the FPL. Coverage is extended for 60 days after childbirth.

Parent/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)

Clients from this caseload were transferred to two other caseloads: adults were transferred into Parent/Caretaker Relative caseload and children - into Children's Medicaid caseload.

Children's Medicaid

The Children's Medicaid 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). 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.

Poverty Level Medical Children (PLMC)

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

Children's Health Insurance Program (CHIP)

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 Care and Adoption Assistance

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

Aid to the Blind and Disabled Program (ABAD)

Aid to the Blind and Disabled provides medical coverage through Medicaid to individuals who are blind or disabled and eligible for federal Supplemental Security Income (SSI). The income limit is 100 percent of the SSI level (roughly 75 percent of FPL), unless the client also meets long-term care criteria, in which case the income limit rises to 300 percent of SSI (roughly 225 percent of FPL).

Old Age Assistance (OAA)

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

OHP Standard Benefit Package (discontinued December 31, 2013)

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

Other Medicaid (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.
- Plus (CAWEM CX) which also covers all pre-natal medical services (plus up to 2 months postpartum).

Qualified Medicare Beneficiary (QMB)

Qualified Medicare Beneficiary clients meet the criteria for both Medicare and Medicaid participation. Clients in this caseload have incomes from 100 percent of SSI (roughly 75 percent of FPL) to 100 percent of FPL, and do not meet the criteria for medical covered long-term care services. OHA pays for any Medicare Part A and Part B premiums as well as any applicable Medicare coinsurance and/or deductible not exceeding the Department's fee schedule.

Breast and Cervical Cancer Treatment Program (BCCTP)

Historically, BCCTP provided medical benefits for women diagnosed with breast or cervical cancer through the Breast and Cervical Cancer Program administered by Public Health through county health departments and tribal health clinics. Effective January 1, 2012, women do not need to be enrolled for screening through the Breast and Cervical Cancer Program in order to access BCCTP. After determining eligibility, the client receives full OHP Plus benefits. Clients are eligible until reaching the age of 65, obtaining other coverage, or ending treatment. This program is available for both citizens and non-citizens/aliens.

Medicare Part A/B Premium Assistance Programs

Medicare Part-A Premium Assistance

Medicare Part A covers *inpatient services*, such as inpatient stays and emergency visits. It is free for Medicare eligible individuals except for those who don't have sufficient work history. Thus, **Medicare Part-A Premium Assistance Program** is a subsidiary program offered by HSM to help low-income individuals (under 100 percent of FPL) to pay for the premiums when free Medicare coverage is not available due to insufficient work history.

Medicare Part B Premium Assistance

Medicare Part B coverage is for outpatient services, such as routine check-ups and physical therapy. Medicare eligible individuals have an option to subscribe, but they are required to pay a premium. **Medicare Part B Premium Assistance Program** offered by HSM is a subsidiary program available to low-income individuals (under 133 percent of FPL) and it pays for the premiums.

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

Mental Health (MH)

The Mental Health program provides prevention and treatment options for clients with mental illnesses.

The MH caseload forecast is the total number of adult clients receiving government paid mental health services per month. MH provides both Mandated and Non-Mandated mental health services, some of which are residential.

Total Mandated Population

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 for psychiatric assessment and treatment until they are fit to stand trial. "Fitness to Proceed" means that the client is able to assist the attorney and stand trial.

Guilty Except for Insanity (GEI)

Clients in GEI caseloads have been found "guilty except for insanity" of a crime by a court. 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. OHA is required by Oregon law to provide treatment and supervision for these individuals, either in the community or in a State Hospital. Clients in this caseload receive a full range of counseling, medication, skills training and supports to assist their progress toward recovery.

Civil Commitment

This caseload includes 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

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.

Never Committed

The Never Committed caseload includes people who have never been either civilly or criminally committed but who are receiving mental health services either in the community or in a residential setting. About 99 percent of these clients are served in non-residential settings. Clients in the State Hospital are of a voluntary or voluntary by guardian status.



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.