

FALL 2015 DHS|OHA CASELOAD FORECAST

Budget Planning and Analysis

Office of Forecasting, Research and Analysis





FALL 2015 DHS OHA
CASELOAD FORECAST

JANUARY 2016

Office of Forecasting,
Research and Analysis

500 Summer Street N.E.

Salem, Oregon 97301

Voice: 503-947-5185

TTY: 503-945-6214

Fax: 503-378-2897

TABLE OF CONTENTS

Executive summary

Introduction..... 5
Forecast environment and risks 6

Department of Human Services

Overview Table 8
Self Sufficiency Programs 9
Child Welfare 15
Vocational Rehabilitation 20
Aging and People with Disabilities 22
Intellectual and Developmental Disabilities 28

Oregon Health Authority

Overview Table 36
Medical Assistance Programs 37
Mental Health 46

Appendix I: Department of Human Services - Caseload History and Definitions

History 50
Definitions 56

Appendix II: Oregon Health Authority - Caseload History and Definitions

History 65
Definitions 72

EXECUTIVE SUMMARY

The **Supplemental Nutrition Assistance Program (SNAP)** Biennial Average Forecast for 2015–17 is 397,404 households, 5.3 percent lower than the Spring 2015 forecast. The forecast average for the 2017–19 biennium is 352,766 households, 11.2 percent lower than the forecast average for 2015–17.

The **Temporary Assistance to Needy Families (TANF)** Biennial Average Forecast for 2015–17 is 24,787 families, 11.6 percent lower than the Spring 2015 forecast. The forecast average for the 2017–19 biennium is 22,242 families, 10.3 percent lower than the forecast average for 2015–17.

The **Child Welfare (CW)** Biennial Average Forecast for 2015-17 is 21,117 children, 0.3 percent lower than the Spring 2015 forecast. The forecast average for the 2017-19 biennium is 21,435 children, 1.5 percent higher than the forecast average for 2015-17.

The **Vocational Rehabilitation (VR)** Biennial Average Forecast for 2015-17 is 10,018 clients, 0.8 percent lower than the Spring 2015 forecast. The forecast average for the 2017-19 biennium is 10,507 clients, 4.9 percent higher than the forecast average for 2015-17.

The total **Aging and People with Disabilities (APD)** Long–Term Care Biennial Average Forecast for 2015-17 is 34,163 clients, 0.3 percent higher than the Spring 2015 forecast. The forecast average for the 2017-19 biennium is 36,486 clients, 6.8 percent higher than the forecast average for 2015-17.

The **Intellectual and Developmental Disabilities (I/DD)** Case Management Biennial Average Forecast for 2015-17 is 25,288 clients, 3.5 percent higher than the Spring 2015 forecast. The forecast average for the 2017-19 biennium is 28,167 clients, 11.4 percent higher than the forecast average for 2015-17.

The total **Health Systems Medicaid (HSM)** Biennial Average Forecast for 2015–17 is 1,131,897 clients, 10.6 percent higher than the Spring 2015 forecast. The forecast average for the 2017–19 biennium is 1,087,715 clients, -3.9 percent lower than the forecast average for 2015–17. Current caseloads are higher than expected due to deferred redeterminations.

The **Mental Health (MH)** Biennial Average Forecast for the 2015–17 biennium is 812 forensic clients. This includes clients who are Guilty Except for Insanity (605 people) and Aid and Assist clients (207 people). The forecast average for the 2017–19 biennium is 809 forensic clients, 0.4 percent lower than 2105-17. Civilly Committed, Previously Mandated, and Never Mandated populations are not being projected this cycle due to changing data systems.

Introduction

This document summarizes the Fall 2015 forecasts of client caseloads for the Oregon Department of Human Services (DHS) and Oregon Health Authority (OHA). The Office of Forecasting, Research and Analysis (OFRA) issues these forecasts semiannually in the spring and fall. DHS caseload forecasts cover the major program areas of Self Sufficiency, Child Welfare, Vocational Rehabilitation, Aging and People with Disabilities, and Intellectual and Developmental Disabilities. OHA caseload forecasts cover the major program areas of Health Systems-Medicaid and Mental Health. Forecasts are used for budgeting and planning and typically extend through the end of the next biennium. Forecasts are developed using a combination of time-series techniques, input-output deterministic models and subject matter expert (SME) input. Forecast accuracy is tracked via monthly reports that compare actual caseload counts to the forecasted caseload and the annual forecast quality report, which compares forecast accuracy across programs over time.¹

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

Forecast environment and risks

Since beginning its recovery from the Great Recession of 2008-09 Oregon has been steadily gaining jobs. Recently, the state has experienced what some have called “full-throttle growth,” with jobs being added at a pace reminiscent of the mid-2000s, a period of rapid growth. By September 2015 there were 48,000 more jobs in the Oregon Economy than in September of 2007. However, this growth was not evenly distributed among economic sectors. In September 2015 there were 24,100 fewer construction jobs (23 percent), and 20,000 fewer durable goods manufacturing jobs (13 percent), than in September 2007. Conversely, there were 38,400 more jobs in health care and social assistance (21 percent) and, 17,900 more jobs in accommodation and food services industries (12 percent).

According to the U.S. Bureau of Labor Statistics, in the third quarter of 2015 103,500 Oregonians said they were working part-time involuntarily (due to economic reasons) and while that number is decreasing, it remains above pre-recession levels. An examination of employment among adults on the Supplemental Nutrition Assistance Program (SNAP) in 2013 and 2014 shows that almost half of them were employed. However, 70 percent of those employed were working less than full time (defined as 30 hours per week or less), and 40 percent were working less than half time. In addition, the most common industries employing SNAP recipients are Food Services, Social Assistance, and Retail Trade, industries that tend to offer low hours, low wages, and limited benefits. This phenomenon is a significant reason why Oregon’s SNAP caseload has remained consistently 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 relatively predictable influence on caseloads. Economic factors can have a dramatic effect on some caseloads, especially during recessions. The most immediate and dramatic effects on caseloads result from policy changes that alter the

pool of eligible clients or the duration of their program eligibility. Sometimes economic factors influence policy changes. For example, a sluggish economy may result in lower tax receipts, which can in turn force spending cuts that may impose or result in eligibility limits for some programs.

The Office of Economic Analysis (OEA) Quarterly Forecasts identify major risks to Oregon’s economy. Some of the major risks listed in the third quarter 2015 edition are:

- The relative weakness of the housing market recovery;
- The drought impacting much of the West Coast and Southwestern U.S;
- Changes in federal timber payments and;
- Global economic challenges in both Europe and Asia.²

Forecasts are based on current practices and policies applied to the expected state of external factors such as demographics and the economy. We do not attempt to anticipate future policy changes. Moreover, the effects of adopted policies that are in the implementation process can be unpredictable and difficult to forecast outcomes. Future policy changes or uncertainty about the implementation of recent policy changes represent major risks to the caseload forecasts.

2. For a complete discussion of risks to Oregon’s economy, see OEA’s most recent forecast: <http://www.oregon.gov/DAS/OEA/docs/economic/forecast0915.pdf>

Department of Human Services

A decorative graphic at the bottom of the page consists of several overlapping, wavy bands. From bottom to top, the colors are a solid dark blue, a gold band with a subtle gradient, a light brown band, a grey band, and a darker brown band. The bands curve upwards from left to right, creating a sense of growth and movement.

Total Department of Human Services Biennial Average Forecast Comparison

	Current Biennium		% Change Between Forecasts	Fall 15 Forecast		% Change Between Biennia
	Spring 15 Forecast	Fall 15 Forecast		2015-17	2017-19	
Self Sufficiency						
Supplemental Nutrition Assistance Program (households)	419,753	397,404	-5.3%	397,404	352,766	-11.2%
Temporary Assistance for Needy Families - Basic and UN (families: cash assistance)	28,050	24,787	-11.6%	24,787	22,242	-10.3%
Child Welfare (children served)						
Adoption Assistance	11,322	11,254	-0.6%	11,254	11,347	0.8%
Guardianship Assistance	1,569	1,618	3.1%	1,618	1,817	12.3%
Out-of-Home Care	6,972	6,958	-0.2%	6,958	6,983	0.4%
Child In-Home	1,314	1,287	-2.1%	1,287	1,288	0.1%
Vocational Rehabilitation Services	10,100	10,018	-0.8%	10,018	10,507	4.9%
Aging and People with Disabilities						
Long-Term Care: In-Home	18,115	18,115	0.0%	18,115	20,134	11.1%
Long-Term Care: Community-Based	11,913	11,874	-0.3%	11,874	12,289	3.5%
Long-Term Care: Nursing Facilities	4,043	4,174	3.2%	4,174	4,063	-2.7%
Intellectual and Developmental Disabilities						
Total Case Management Enrollment	24,438	25,288	3.5%	25,288	28,167	11.4%
Total I/DD Services	18,278	19,150	4.8%	19,150	20,804	8.6%

Self Sufficiency Programs

Supplemental Nutrition Assistance Program (SNAP) — In September 2015 there were 423,293 households (749,388 persons) receiving SNAP benefits, which constitutes approximately 18.7 percent of all Oregonians. The SSP portion of SNAP rose rapidly early in 2009 and continued to grow at a steadily decreasing rate until leveling off in mid-2012. Since June 2012 the caseload has declined by 40,671 households.

The APD SNAP caseload also rose rapidly due to the Great Recession, but now is returning to its traditional, gradual growth pattern. The combined SNAP biennial average forecast for 2015-17 is 397,404 households, 5.3 percent lower than the Spring 2015 forecast. The Fall 2015 Forecast average for the 2017–19 biennium is 352,766 households, 11.2 percent lower than the biennial average forecast for 2015-17.

APD SNAP is in the pilot phase of a policy change that will increase the eligibility period from 12-month to 24-month thereby delaying the redetermination of these clients. 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. This policy change poses a risk to the forecast as it may increase the number of people eligible for APD SNAP.

Starting in 2016, the federal government will reinstate the “Able Bodied Adults without Dependents” or ABAWD rule. The ABAWD rule is a three-month limit to SNAP benefits that applies to non-disabled adults ages 50 and under without dependents. Currently Oregon is operating under an exemption to this rule, but when reinstated, the rule may be applied statewide, or just in Multnomah and Washington Counties. Although it is anticipated that reinstatement of this rule will have only a minor impact on the caseload, it must be considered a risk to the forecast.

In addition to these risks, the SNAP caseload could be affected by the issues described earlier in the “Forecast environment and risks” section.

Temporary Assistance for Needy Families (TANF) — In September 2015 there were 25,324 families receiving TANF benefits. The TANF caseload experienced growth starting in January 2008 until leveling off in mid-2012. After a seasonal increase in the winter of 2012-2013, the caseload began to decline and is currently 11,287 cases below its February 2013 peak.

TANF Reinvestment

House Bill 3535 and House Bill 5026 amended the TANF program to help families transition out of the program. These changes are being referred to as the “TANF Reinvestment.” This reform has broad implications only some of which impact the TANF caseload. The most critical impacts are incorporated into the fall forecast, while other elements that may marginally impact the caseload are considered risks. Note that these changes will produce a “level shift,” moderately increasing the caseload in the months immediately after implementation, after which the caseload will resume its general downward trend through the forecast horizon.

TANF Reinvestment is slated to begin in April 2016 and the elements which were incorporated into this forecast include:

- An increase in the income limit at exit for TANF households who would otherwise exit the program. This is designed to reduce the effect of the so-called “benefits cliff,” the point at which TANF clients are forced off of the program due to rising personal income. At this point, the old program design produced a sudden and significant reduction in the clients’ overall standard of living. Under the new rules, TANF households can remain in the program (at a reduced benefit prorated to their income) up to approximately 60% of the federal poverty limit. This is expected to reduce the monthly number of exits off TANF, there by shifting the overall caseload up slightly.
- Expanding the definition of caretaker relative to allow eligibility for additional relatives who care for children in the absence of a parent. This is expected to lead to a one-time increase in the caseload of approximately 100 families.
- The elimination of deprivation as an eligibility requirement. This is expected to modestly increase the number of monthly entries and decrease the number of exits.

- Creation of a TANF Transition Program. This new program will provide a three month cash payment to households exiting TANF due to employment. This is a new program that is being forecast for the first time. Biennial average caseload values appear for 2015-17 and 2017-19, although the program is currently authorized only for the 2015-17 biennium. If TANF Transition program is not extended beyond the 2015-17 biennium, this caseload will either cease to exist or revert to the previously-authorized Post-TANF program.

Additional elements of the TANF Reinvestment which have not been forecast but are considered risks include:

- An increase in the use of support (beginning July 2016) and stabilization (beginning January 2016) services to prevent families from entering TANF; and
- An increase in client engagement, including intensive client services which focuses on those with extensive barriers to employment (currently ongoing).

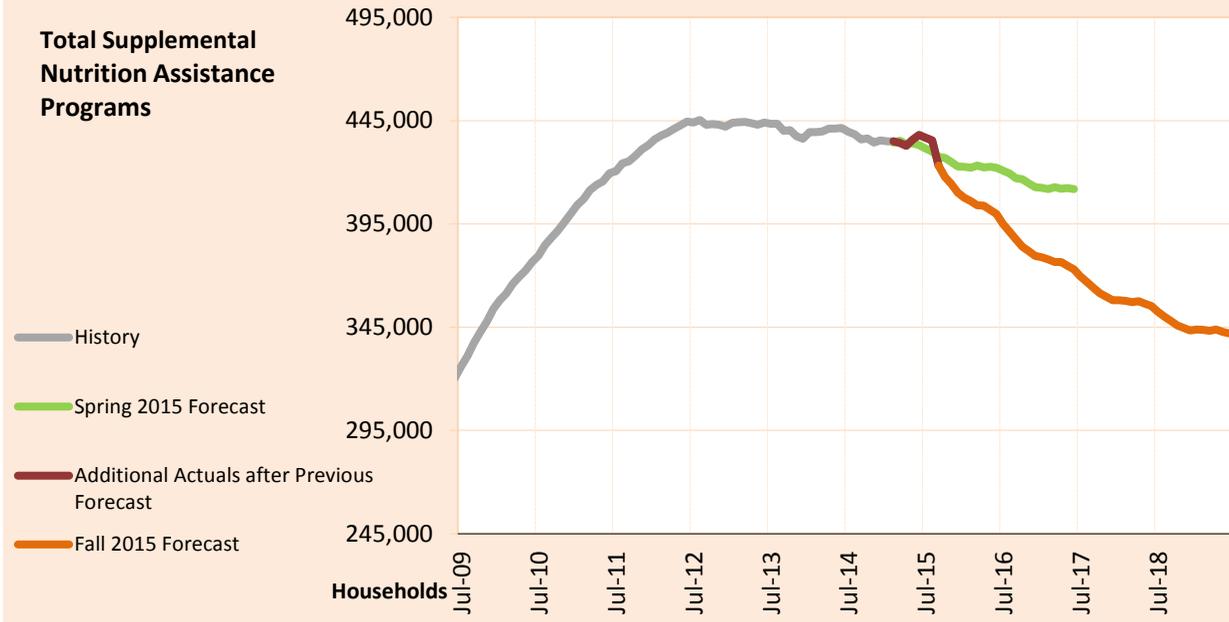
In addition to the risks associated with TANF Reinvestment, the TANF caseload could also be affected by the more general demographic and economic issues described in the “Forecast environment and risks” section of this document.

Despite increases due to TANF reinvestment, the caseload is expected to continue to decline through the forecast horizon, with small seasonal increases during the winter months. The TANF biennial average forecast for 2015–17 is 24,787 families, 11.6 percent lower than the Spring 2015 forecast. The current forecast average for the 2017–19 biennium is 22,242 families, 10.3 percent lower than the forecast for 2015-17.

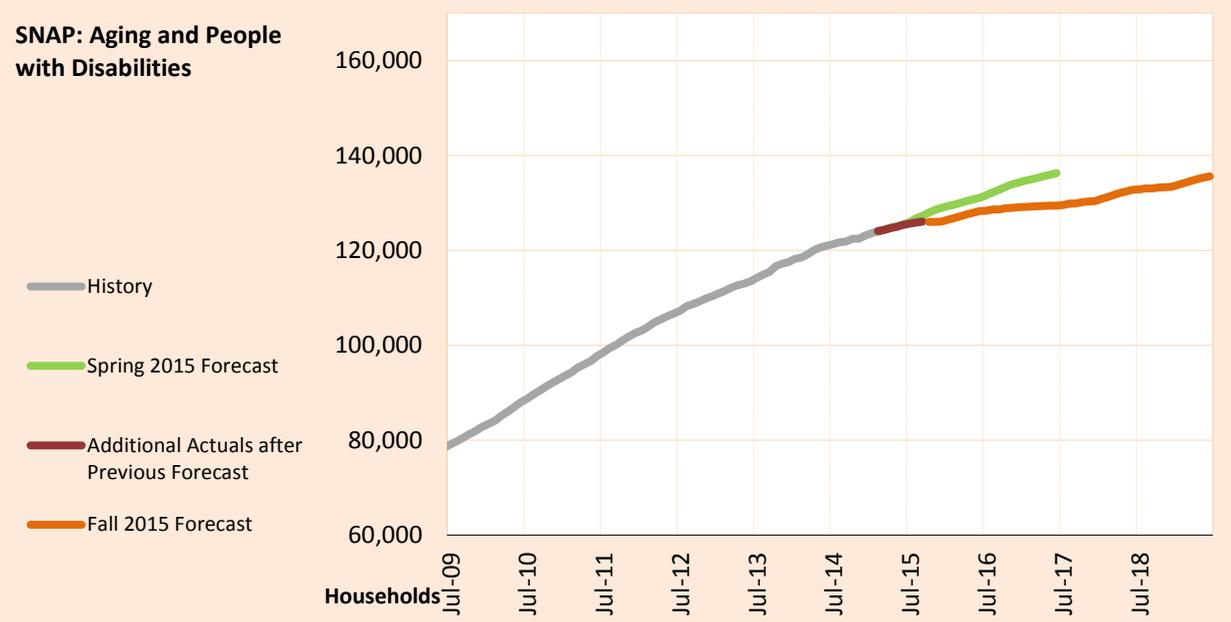
Temporary Assistance for Domestic Violence Survivors (TA-DVS) — This is a relatively small caseload that experiences dramatic seasonal fluctuations. The Fall 2015 forecast for the 2015–17 biennium is 445 families, 4.3 percent lower than the Spring 2015 forecast. The caseload is expected to average 455 families during the 2017–19 biennium, 2.3 percent higher than the forecast for 2015-17.

Pre-SSI - The Fall 2015 forecast for the 2015–17 biennium is 513 families, 9.1 percent higher than the Spring 2015 forecast. The caseload is expected to average 521 families during the 2017–19 biennium, 1.6 percent higher than the forecast for the current biennium.

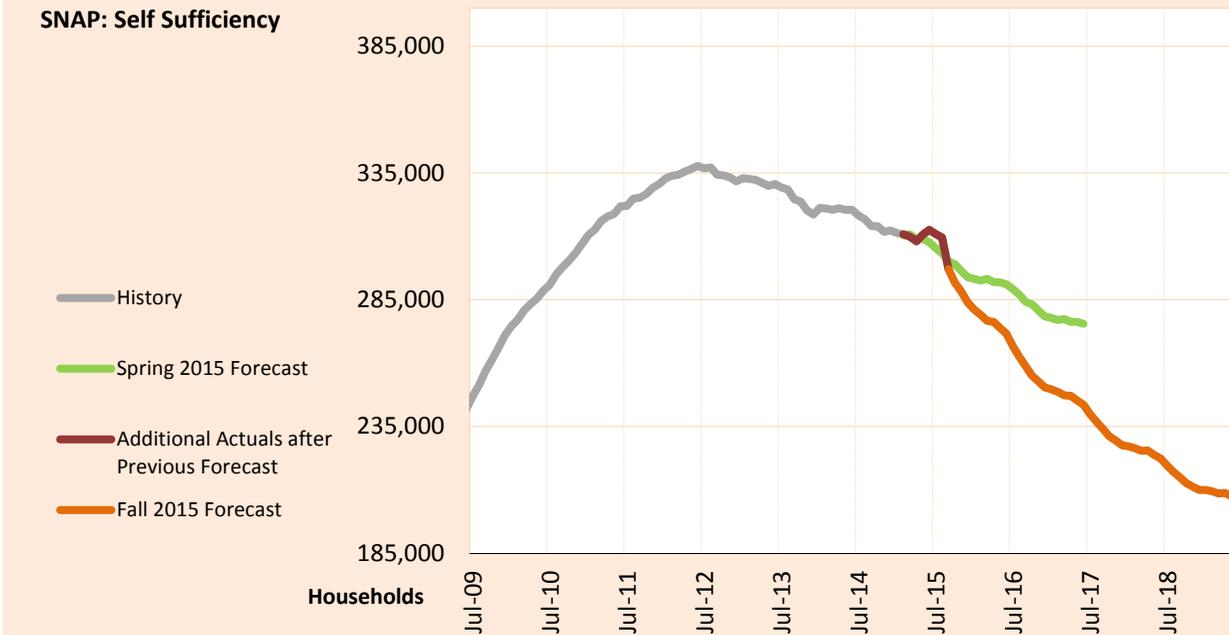
Total Supplemental Nutrition Assistance Programs



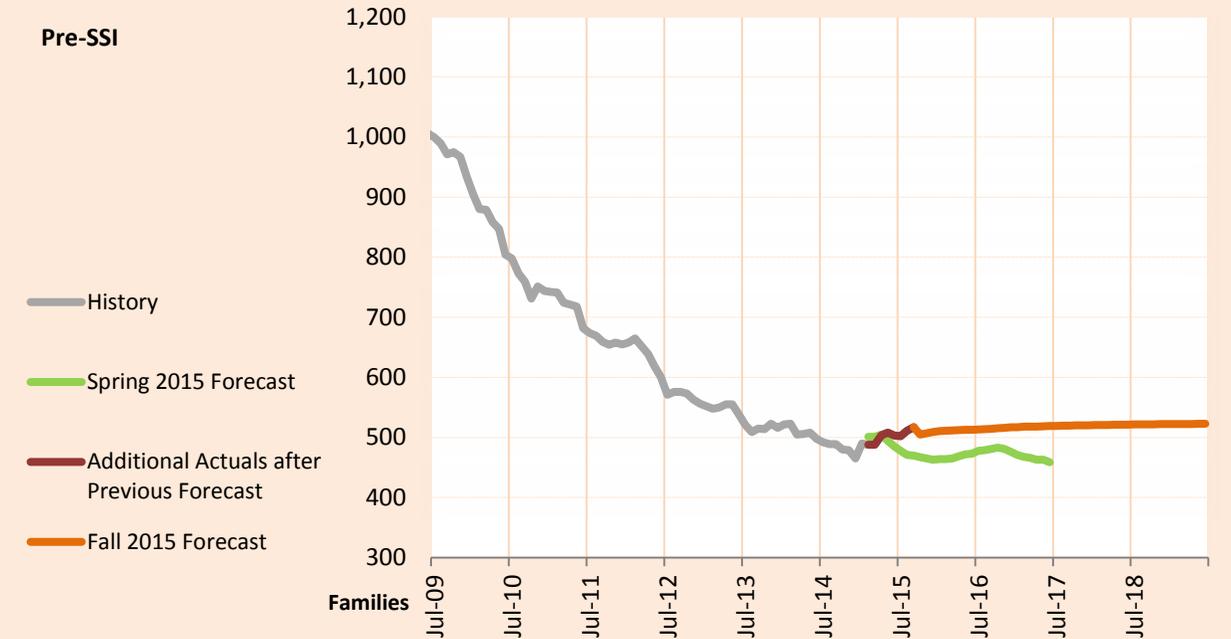
SNAP: Aging and People with Disabilities



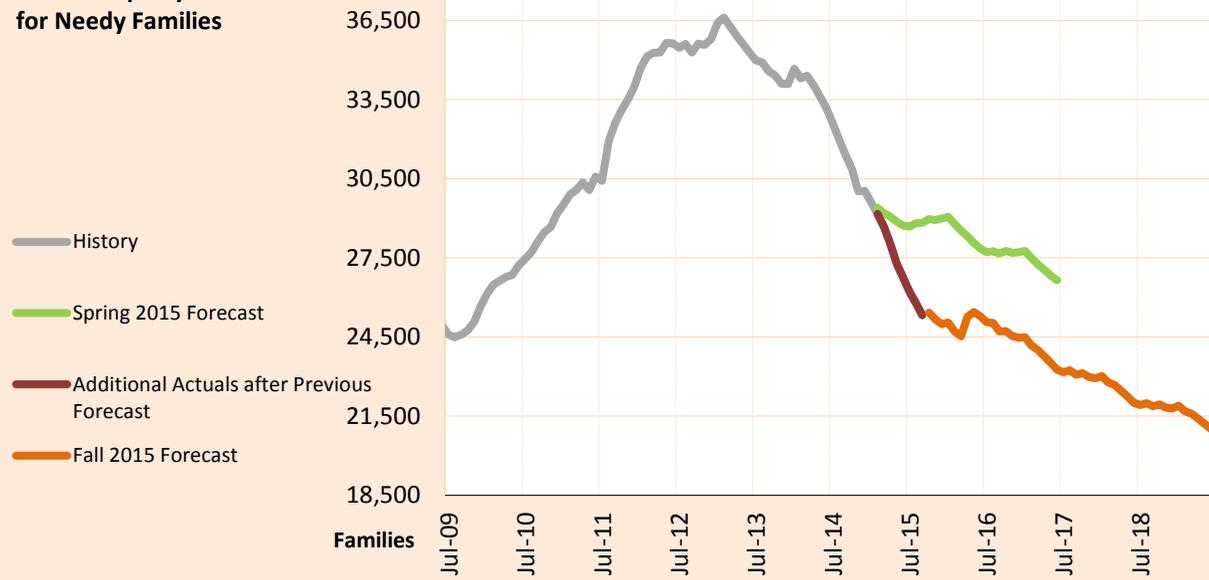
SNAP: Self Sufficiency



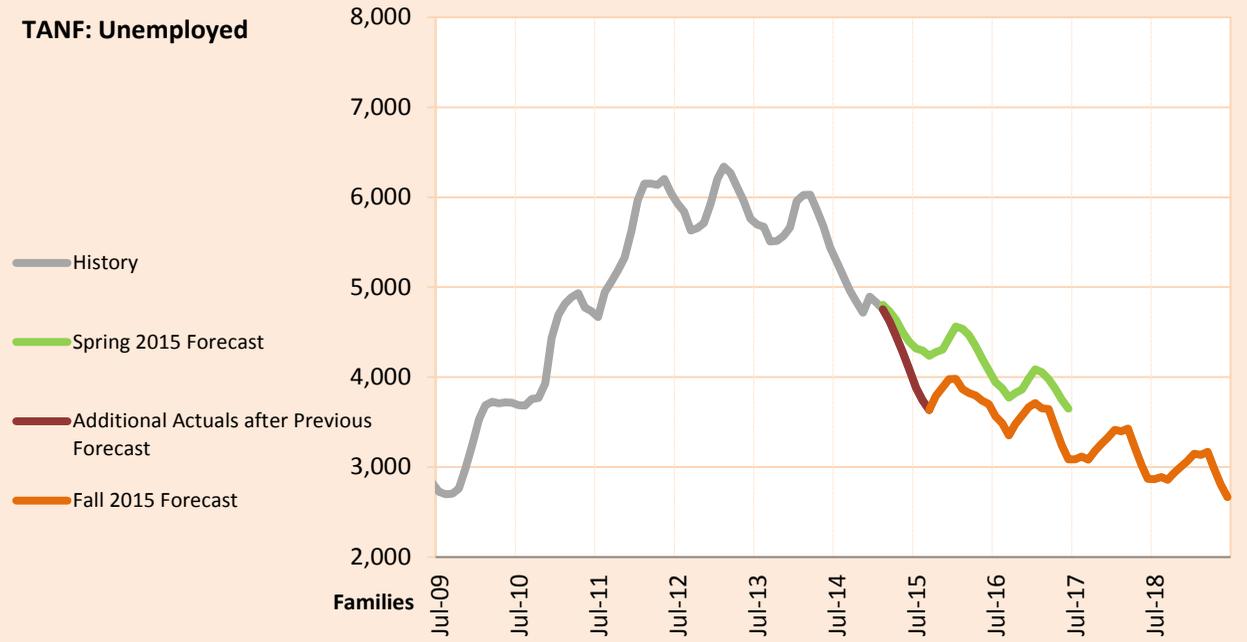
Pre-SSI



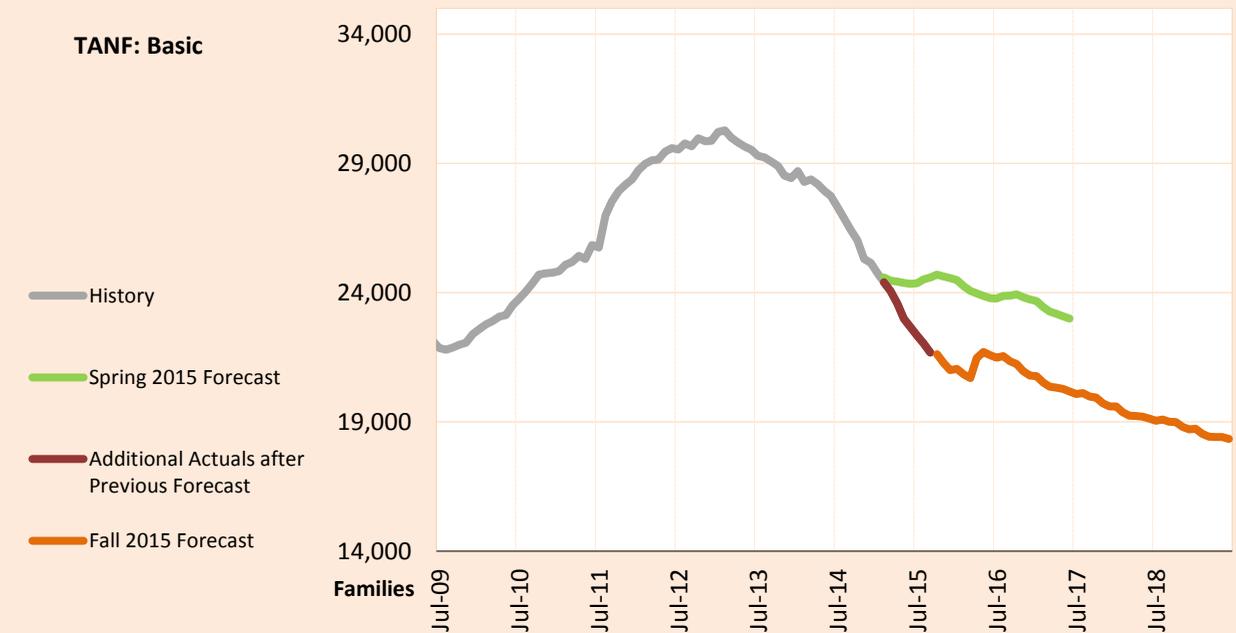
Total Temporary Assistance for Needy Families



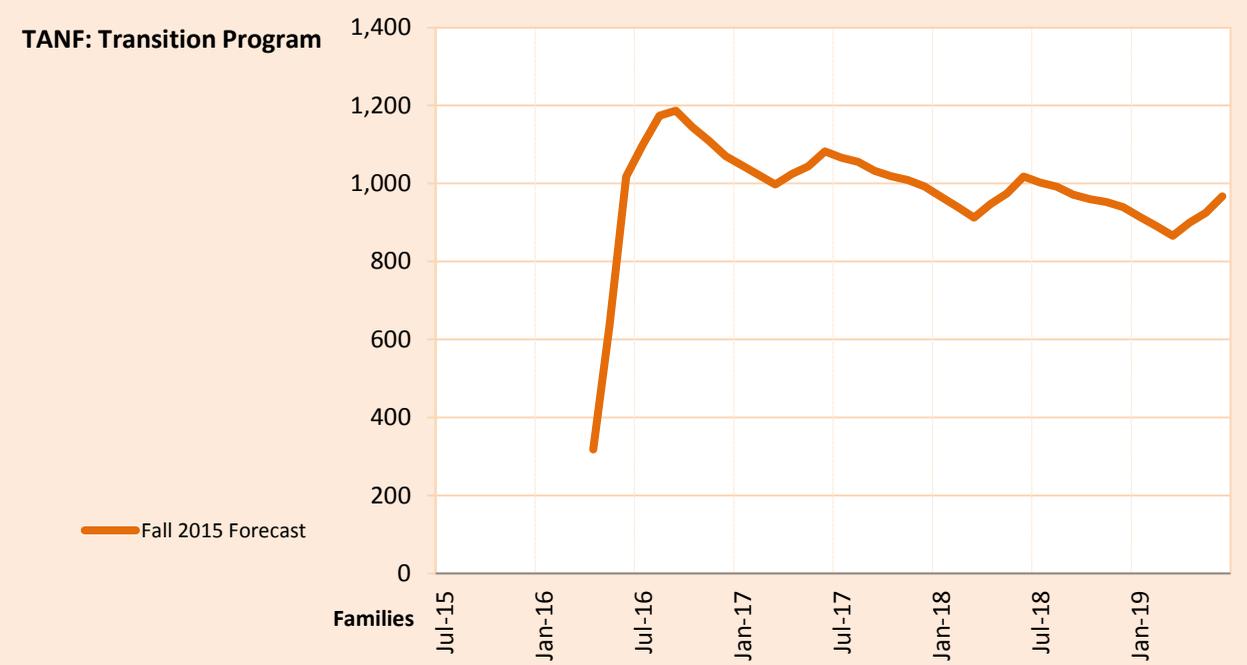
TANF: Unemployed



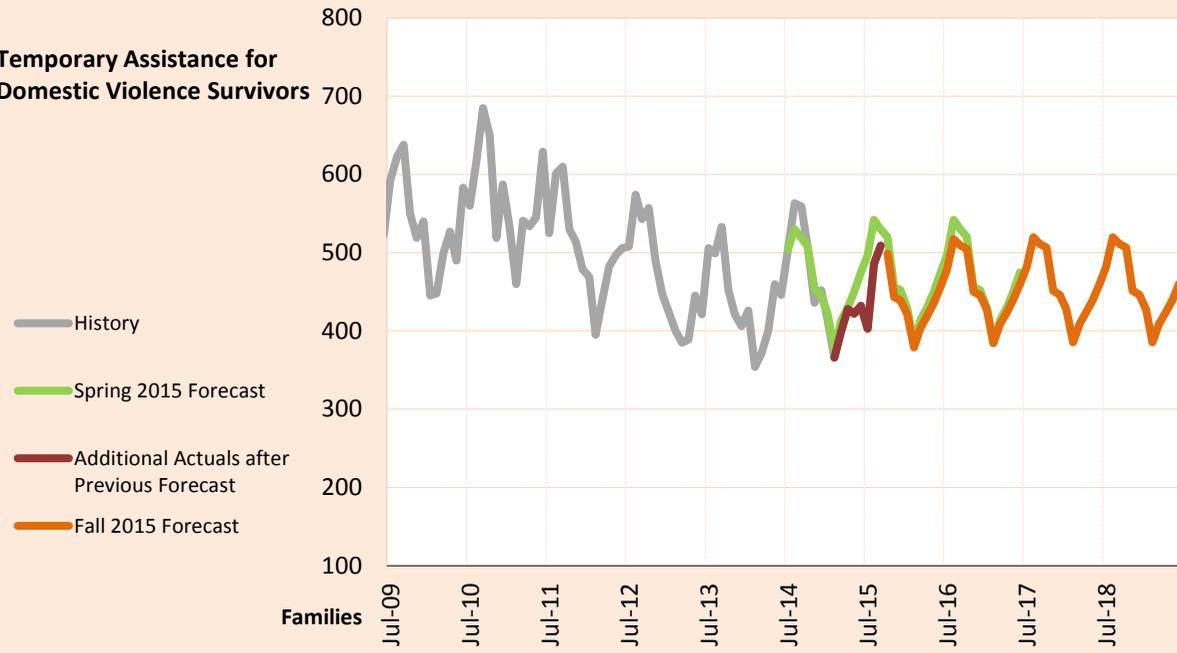
TANF: Basic



TANF: Transition Program



Temporary Assistance for Domestic Violence Survivors



Self Sufficiency Biennial Average Forecast comparison

	Current Biennium		% Change Between Forecasts	Fall 15 Forecast		% Change Between Biennia
	Spring 2015 Forecast	Fall 15 Forecast		2015-17	2017-19	
Supplemental Nutrition Assistance Program (households)						
Children, Adults and Families	288,149	269,515	-6.5%	269,515	220,296	-18.3%
Aging and People with Disabilities	131,604	127,890	-2.8%	127,890	132,470	3.6%
Total SNAP	419,753	397,404	-5.3%	397,404	352,766	-11.2%
Temporary Assistance for Needy Families (families: cash/grants)						
Basic	23,937	21,132	-11.7%	21,132	19,161	-9.3%
UN	4,113	3,655	-11.1%	3,655	3,081	-15.7%
Total TANF	28,050	24,787	-11.6%	24,787	22,242	-10.3%
TANF Transition ¹	-	998	NA	998	967	-3.1%
Pre-SSI (families)	470	513	9.1%	513	521	1.6%
Temporary Assistance for Domestic Violence Survivors (families)	465	445	-4.3%	445	455	2.3%

1. TANF Transition is a new program whose forecast appears here for the first time. The program begins in April 2016. The forecasted biennial average calculation is for the 15 months from April 2016-June 2017 rather than for the entire biennium. An average for the 2017-19 biennium also appears, although the program is currently authorized for the 2015-17 biennium only. If TANF Transition is not extended beyond the 2015-17 biennium, this caseload will either end or revert to the previously-authorized Post-TANF program.

Child Welfare

DHS implemented a new Child Welfare computer system (OR-KIDS) in August 2011. This explains the gaps in the forecast graphs, as several months of data were not collected during the transition process. Data definitions for some of these caseloads continue to evolve.

Adoption Assistance – This caseload has exhibited slow to moderate growth since early 2012. Caseload numbers following the Spring 2015 forecast were about 0.3 percent lower than was forecasted. Virtually all intakes are from paid foster care; thus decreases to the foster care caseload will have subsequent impacts on this caseload. The caseload is expected to average 11,254 for the 2015-17 biennium, 0.6 percent lower than the Spring 2015 forecast. The caseload is expected to average 11,347 over the 2017-19 biennium, 0.8 percent higher than the biennial average forecast for 2015-17.

Guardianship Assistance – This caseload has exhibited steady, fairly rapid growth for its entire history. The caseload grew 6 percent between October 2014 and May 2015. Current policies are in place to shorten the length of time to permanency, so we expect continued increases to this caseload as children move out of foster care. The Fall 2015 forecast reflects this expected growth. The caseload is expected to average 1,618 for the 2015-17 biennium, 3.1 percent higher than the Spring 2015 forecast. The caseload is expected to average 1,817 over the 2017-19 biennium, 12.3 percent higher than the biennial average forecast for 2015-17.

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 15.9 percent drop between 2010 and 2015, declining from 8,434 children in October 2010 to 7,089 children in May 2015. During this period, the number of children supervised in home also declined, as well as the percentage of in-home children who transferred into foster care. Many initiatives 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 grown slightly, 1.4 percent from February to May 2015. The caseload is expected to level off in the forecast horizon.

The caseload is expected to average 6,958 for the 2015-17 biennium, 0.2 percent lower than the Spring 2015 forecast. The caseload is expected to average 6,983 over the 2017-19 biennium, 0.4 percent higher than the biennial average forecast for 2015-17.

Child-In-Home — Since implementation of the OR-Kids data system, this caseload has exhibited an almost continuous decline. The caseload decreased 45 percent from 2,306 in December 2011 to 1,267 in May 2015. A workgroup has been revising the definition of children served in-home, and recently the caseload leveled off. The caseload is expected to average 1,287 for the 2015-17 biennium, 2.1 percent lower than the Spring 2015 forecast. The caseload is expected to average 1,288 over the 2017-19 biennium, 0.1 percent higher than the biennial average forecast for 2015-17.

Risks

Risks to this forecast include expansion of differential response, a program designed to reduce the use of foster care in favor of supervising children in their homes. The number of counties using the alternate track, engaging more families in prevention, will continue to increase. Children may not end up with a case plan, and as such, will not get counted in any of the Child Welfare caseloads.

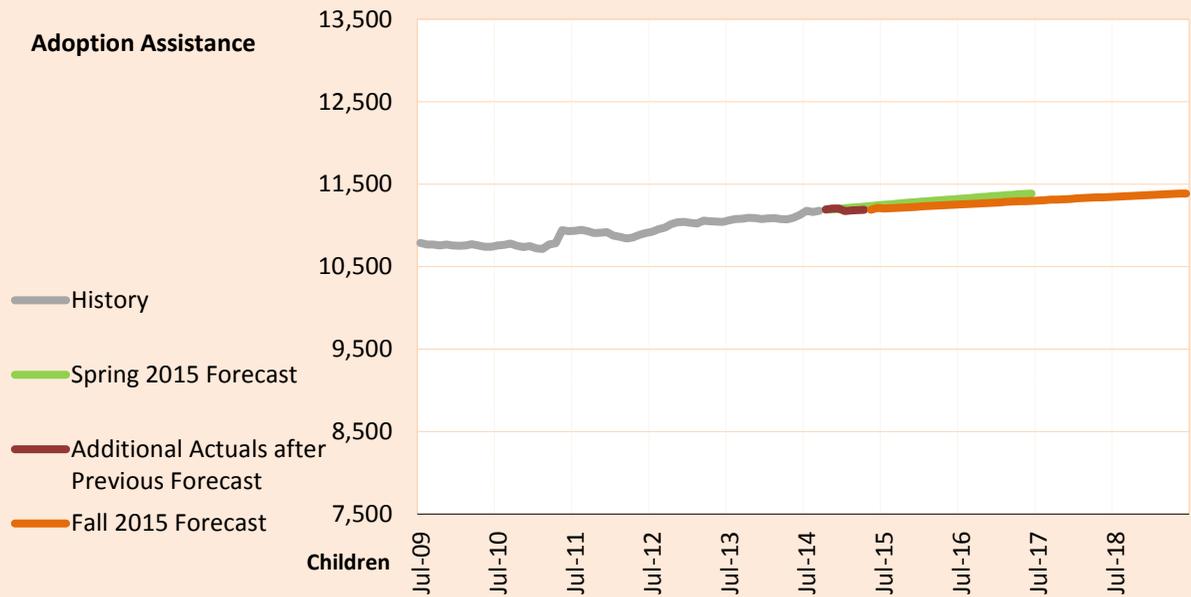
The Adoption Assistance caseload may increase as Another Planned Permanent Living Arrangement (APPLA) plans are terminated. This will occur over a year, beginning September 15, 2015. As each plan comes up for its annual court hearing, it is expected that ten percent of the children will change out of Out of Home Care and transition into Adoption Assistance or Guardianship Assistance.

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.

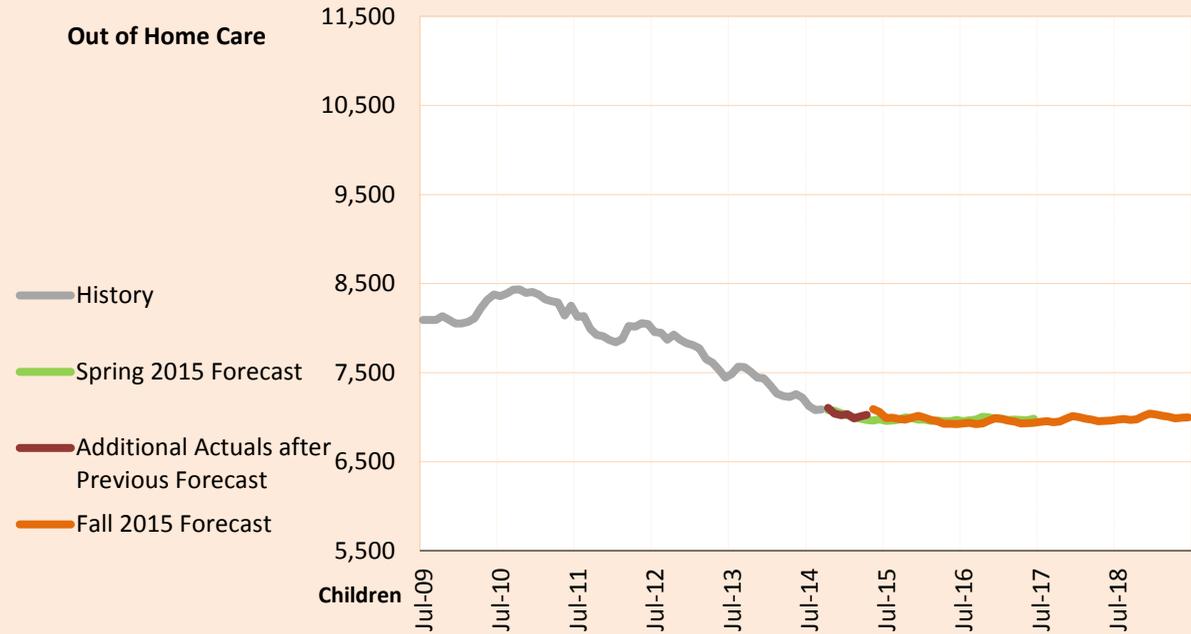
The Child in Home data are still being re-worked. The initial safety plan data need to be entered into OR-Kids, and there is the expectation that more children will be captured in the Child in Home caseload. Additionally, as counties use the alternate track, Child in Home will slowly increase.

Another risk is the influence of over-due or unclosed assessments; if not entered in the system, Child in Home numbers could be affected. Finally, as counties use the alternate track, assessments will increase.

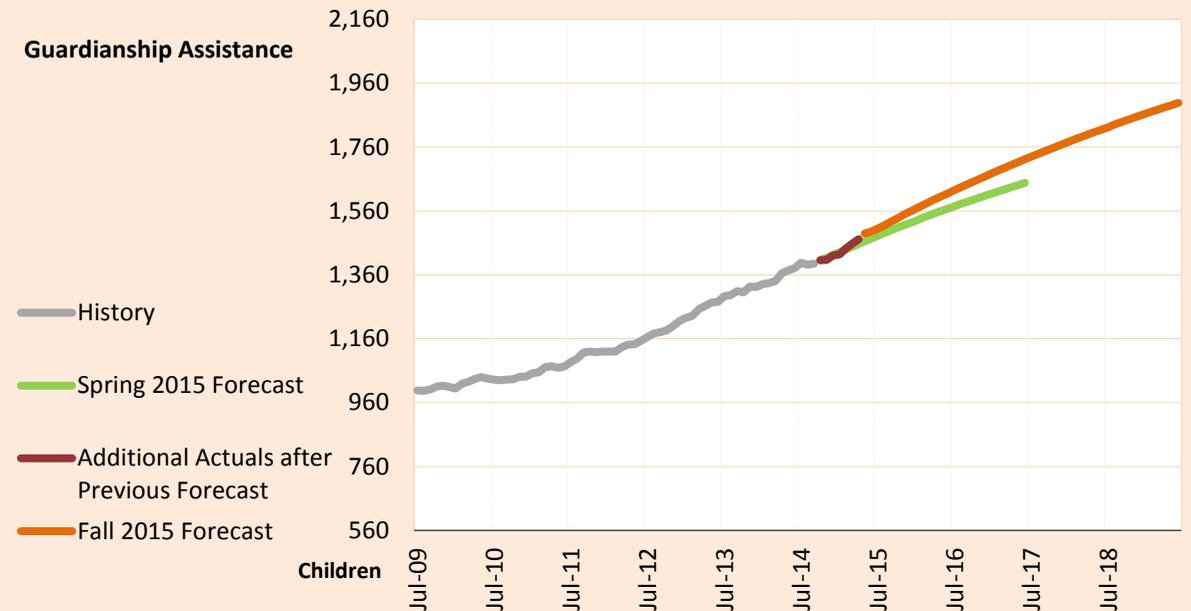
Adoption Assistance



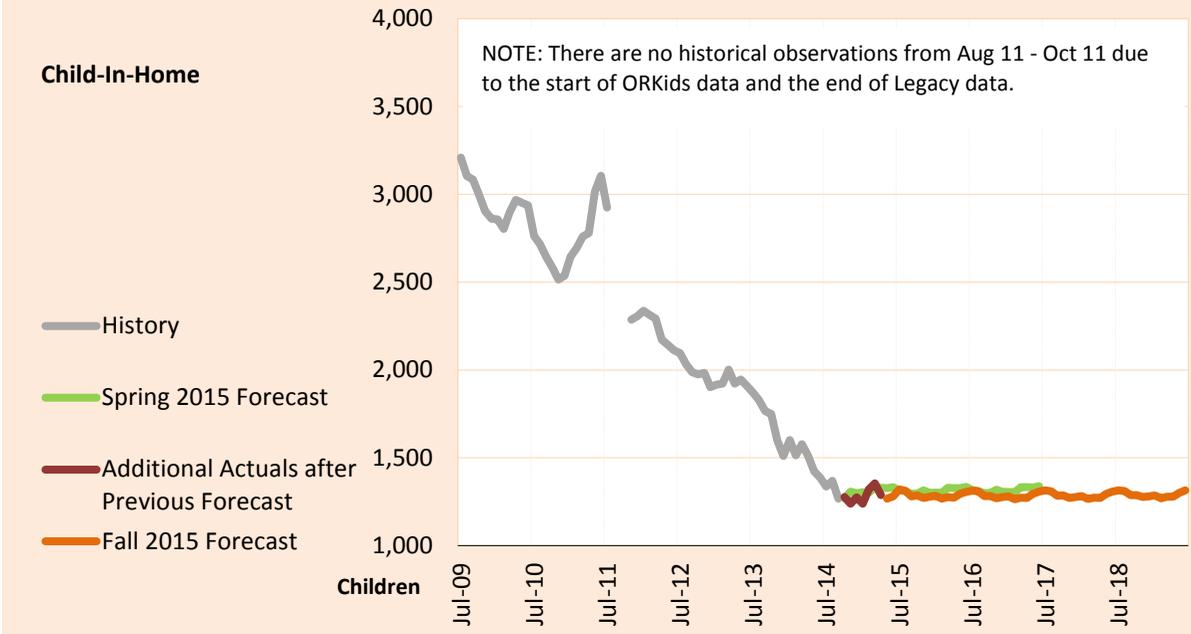
Out of Home Care

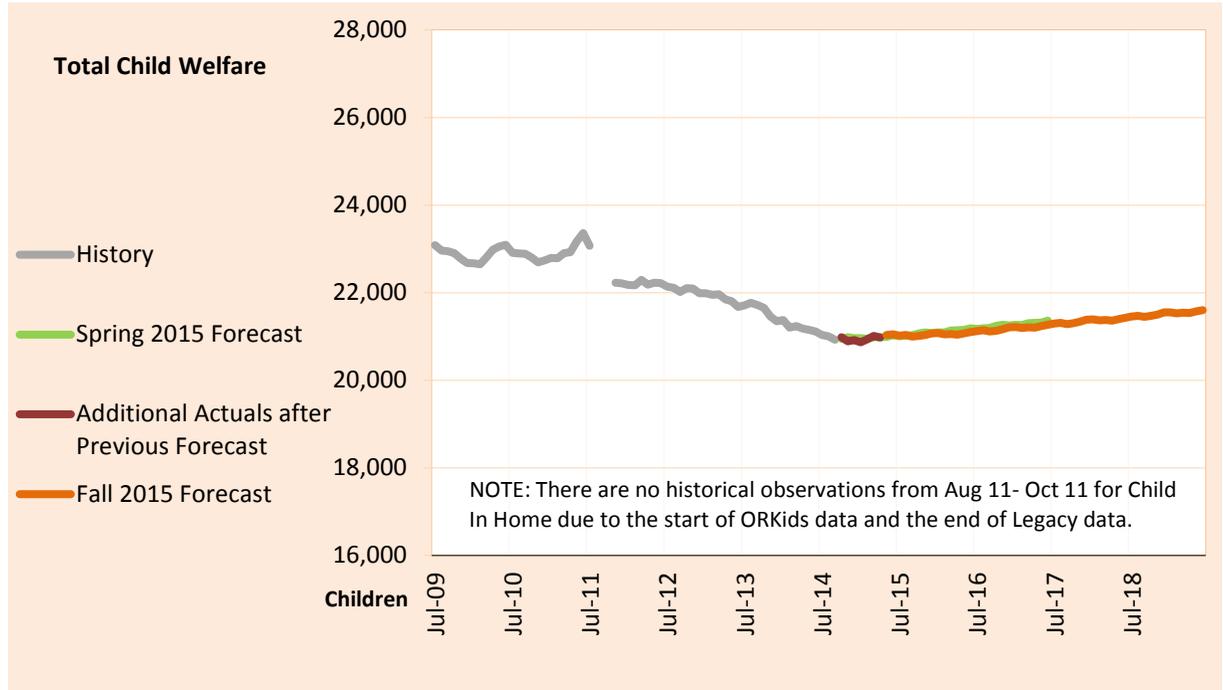


Guardianship Assistance



Child-In-Home





Child Welfare Biennial Average Forecast comparison

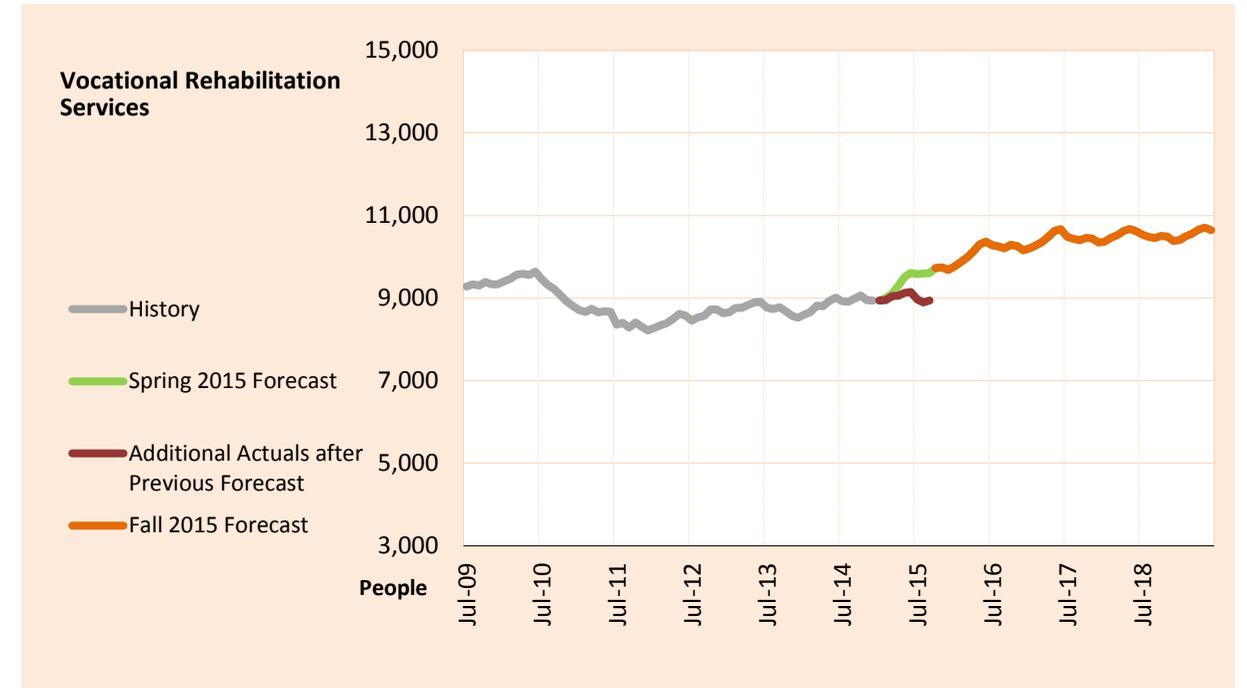
	Current Biennium		% Change Between Forecasts	Fall 15 Forecast		% Change Between Biennia
	Spring 15 Forecast	Fall 15 Forecast		2015-17	2017-19	
Adoption Assistance	11,322	11,254	-0.6%	11,254	11,347	0.8%
Guardianship Assistance	1,569	1,618	3.1%	1,618	1,817	12.3%
Out-of-Home Care	6,972	6,958	-0.2%	6,958	6,983	0.4%
Child In-Home	1,314	1,287	-2.1%	1,287	1,288	0.1%
Total Child Welfare	21,177	21,117	-0.3%	21,117	21,435	1.5%

Vocational Rehabilitation

From 2006 through 2008 the VR caseload averaged 9,100 clients. In 2009, budget reductions caused the program to operate under an order of selection, a means of prioritizing clients when demand for services exceeds program capacity. As a result, in 2009 VR served an average of 6,000 clients. Since then, VR has avoided placing clients on the waiting list and the caseload has averaged 8,700 clients over the past three years.

This caseload is expected to average 10,018 clients in the 2015–17 biennium, 0.6 percent lower than the Spring 2015 forecast, but 12.9 percent higher than 2013–15. The biennial average forecast for 2017–19 is 10,507, 4.9 percent higher than 2015-17. Executive Order 15-01 requires DHS to serve an average of 800 additional clients each year through FY 2022, an increase that was factored into the Spring 2015 forecast. Although actual caseload has been lower than anticipated in that forecast, program staff believes the variance is primarily caused by delays that have caused a backlog in ODDS client processing and which will eventually resolve itself.

Risks include the effects of Executive Order 15-01, the outcome of the Disability Rights Oregon lawsuit, and a possible Order of Selection. The Workforce Innovation and Opportunity Act (PL 113-128) was signed into law in July 2014 and is scheduled to take effect July 1, 2015. This new federal law as well as the other identified risks may lead to significant changes in the VR program over the next several years.



Vocational Rehabilitation Services Biennial Average Forecast comparison

	Current Biennium		% Change Between Forecasts	Fall 15 Forecast		% Change Between Biennia
	Spring 15 Forecast	Fall 15 Forecast		2015-17	2017-19	
Total receiving service	10,100	10,018	-0.8%	10,018	10,507	4.9%

Aging and People with Disabilities

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

Over the last thirteen years, the Total Long-Term Care (LTC) caseload has varied from a high of 31,500 in November 2002 to a low of 25,900 in May 2008; with slightly over half of that decline occurring between November 2002 and June 2003 when the LTC eligibility rules were modified to cover only clients in Service Priority Levels 1 to 13. From 2008 to 2013 the caseload grew by only 2.7 percent a year, despite a serious recession and significant growth in the number of Oregon seniors. However, in late 2013 the caseload growth rose to 6.9 percent a year due to factors such as the implementation of K Plan, expansion of Medicaid, and various changes made by APD to make in-home care more attractive. How long this new trend will continue before it slows is not yet clear.

Total Long-Term Care — A total of 32,706 clients received long-term care services in June 2014. The Fall 2015 biennial average forecast for 2015-17 is 34,163 clients, 0.3 percent higher than the Spring 2015 forecast. The forecast for 2017-19 is 6.8 percent higher than 2015-17.

The LTC forecast is divided into three major categories: In-Home, Community-Based Care (CBC), and Nursing Facilities. Most of the increase forecasted for Total LTC between 2015-17 and 2017-19 is in In-Home Care which 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. Community-Based Care is still forecasted to grow, although the growth rate has been reduced slightly to reflect the anticipated shift toward In-Home Care services. Community-Based Care will continue to be a stable placement choice for many LTC clients because they are 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 hospitalizations.

Although Medicaid reimbursement rates continue to lag behind private market rates,

low housing prices and slow home sales continue to impact the flow of private pay clients, thus making Medicaid clients more attractive than they might otherwise be to CBC providers.

In-Home Care — In June 2015, 16,720 clients received In-Home Care, which accounted for 51.1 percent of Total LTC at that time. The Fall 2015 biennial average forecast for 2015-17 remain the same as the Spring 2015 forecast -- 18,115 clients. The forecast for 2017-19 is expected to be 11.1 percent higher than 2015-17. By June 2019 In-Home Care is forecasted to be 55.8 percent of Total LTC.

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

Community-Based Care (CBC) — In June 2015, 11,696 clients received Community-Based Care, which accounted for 35.8 percent of Total LTC at that time. The Fall 2015 biennial average forecast for 2015-17 is 11,874 clients, 0.3 percent lower than the Spring 2015 forecast. The forecast for 2017-19 is expected to be 3.5 percent higher than 2015-17. By June 2019 Community-Based Care is forecasted to be 33.4 percent of Total LTC.

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

Several factors may be contributing to the recent decline in AFC caseload: policy changes that make In-Home Care more attractive may reduce demand for foster care; providers apparently consider the current reimbursement rate inadequate and often request exception rates – but the exception approval process is cumbersome; workforce unionization has made the relationship between workers and providers more adversarial; and capacity may be declining as individual providers retire without a replacement.

Nursing Facility Care (NFC) — In June 2015, 4,290 clients received Nursing Facility Care, which accounted for 13.1 percent of Total LTC at that time. The Fall 2015 biennial average forecast for 2015-17 is 4,174 clients, about 3.2 percent higher than the Spring 2015 forecast. The forecast for 2017-19 is expected to be 2.7 percent lower than 2015-17. By June 2019 Nursing Facility Care is forecasted to be 10.8 percent of Total LTC.

ACA Long-Term Care

Beginning in January 2014, a new population of individuals became eligible for LTC under the Affordable Care Act (ACA). Although clients eligible due to ACA may be referred to as “MAGI Medicaid” (because their financial eligibility is determined based on the Modified Adjusted Gross Income or “MAGI” from their federal income tax statement), future LTC forecasts will refer to these clients as “ACA LTC.” ACA LTC clients (aged 18-64 with income under 138 percent of FPL) who meet the requisite institutional Level of Care (LOC) for a hospital, skilled nursing facility or intermediate care facility may receive long-term care nursing facility, community-based facility or In-Home services.

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.

Risk 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 which are still not fully resolved.

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 choose to extend Medicaid coverage (including long-term care) to a significantly larger pool of low income adults. To qualify for LTC under the HCBS Waiver, clients had to meet four criteria: 1) be assessed as needing the requisite Level of Care, 2) be over 65 years old or have an official determination of disability, 3) have income below 300 percent of SSI (roughly 2.25 times FPL), and 4) have very limited assets. However, under K Plan, clients only need to meet two criteria: 1) be assessed as needing the requisite Level of Care, and 2) have income below 138 percent of FPL. Note that although the HCBS Waiver allows clients to have a higher income, K Plan has no asset limits and no need for clients to be over 65 or officially determined disabled. K Plan’s reduced requirements may also open the door for clients whose needs are relatively short in duration (e.g. as short as six months).

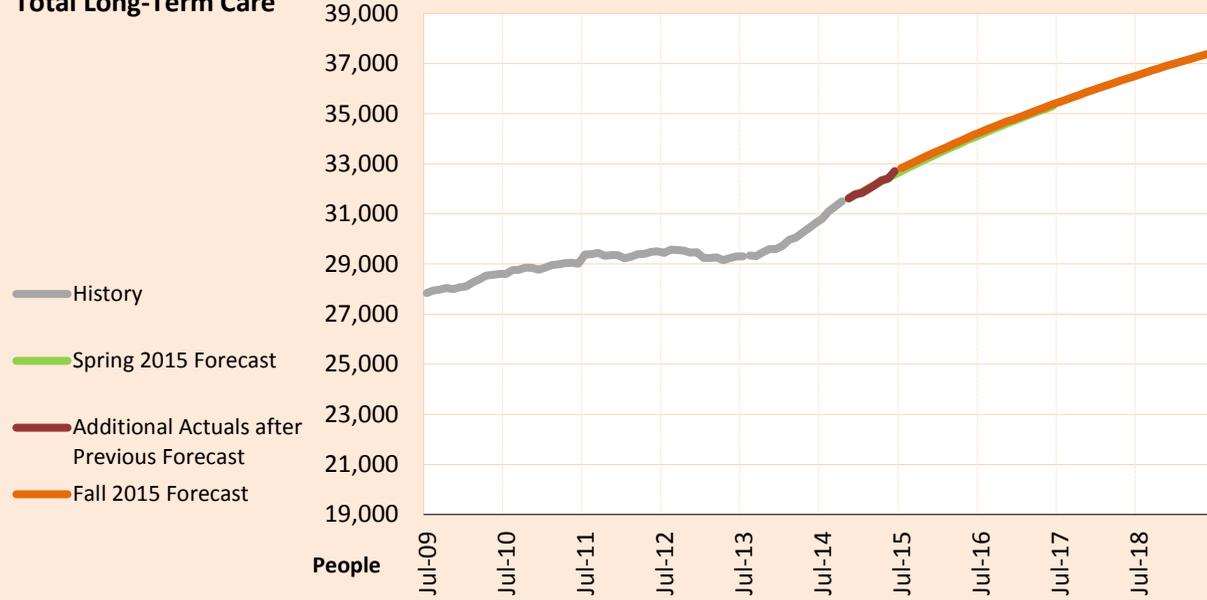
Recent changes in the pattern of new clients entering long-term care indicates that ACA (the combined effects of K Plan and Medicaid expansion) is contributing to long-term care caseload growth. What is not yet clear is whether it will be a one-time level shift or a new, on-going pattern of growth.

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 may save money in the future, changes that make In-Home Care more attractive could save money (by leading clients to choose lower cost services) or increase costs (by making accepting assistance more attractive).

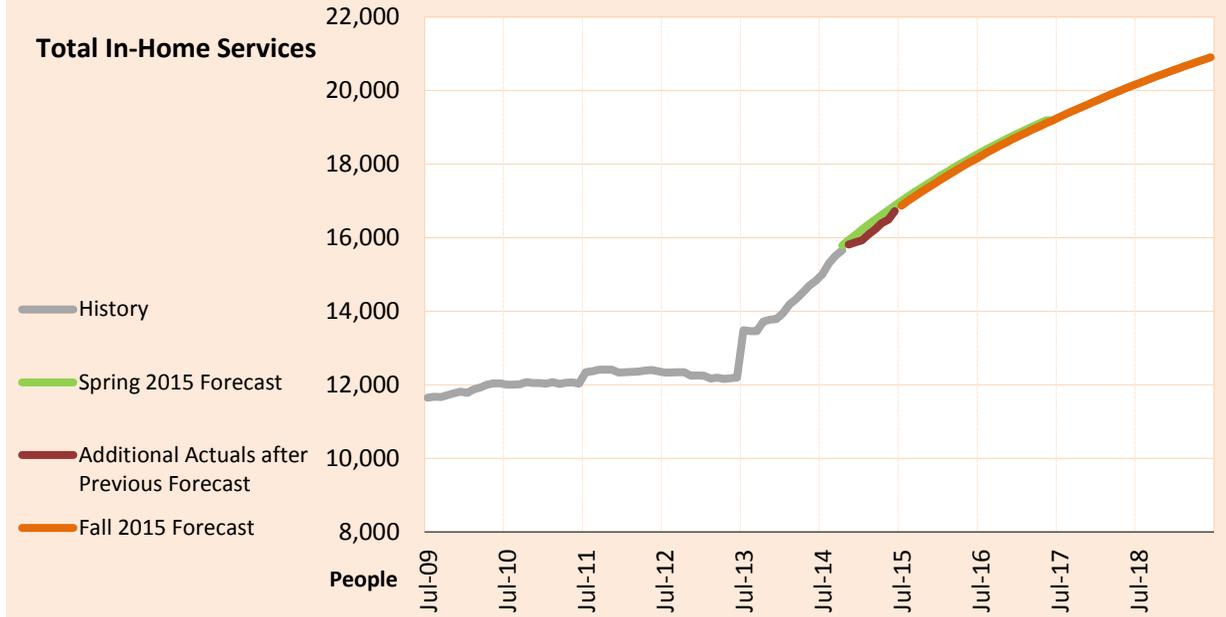
Oregon Demographic Shift: In addition to internal policy and program related changes, external change such as demographic shifts in Oregon's population also pose a risk to the forecast's accuracy (e.g. more seniors living longer, or the financial or physical health of those seniors). The shift toward the elderly population as a percentage of the total is a risk to the forecast. Elderly Oregonians are among the fastest growing segments of the state population. Oregonians with multiple chronic conditions in the 85+ age group also risk depleting their resources. If they do, then they will likely become eligible for the DHS Medicaid and Long-Term Care programs.

Oregon House Bill 2216: Another factor that could eventually impact LTC caseloads is Oregon HB 2216, passed in 2013, which calls for a reduction in the overall Long-Term Care bed capacity by 1,500 by December 31, 2015.

Total Long-Term Care



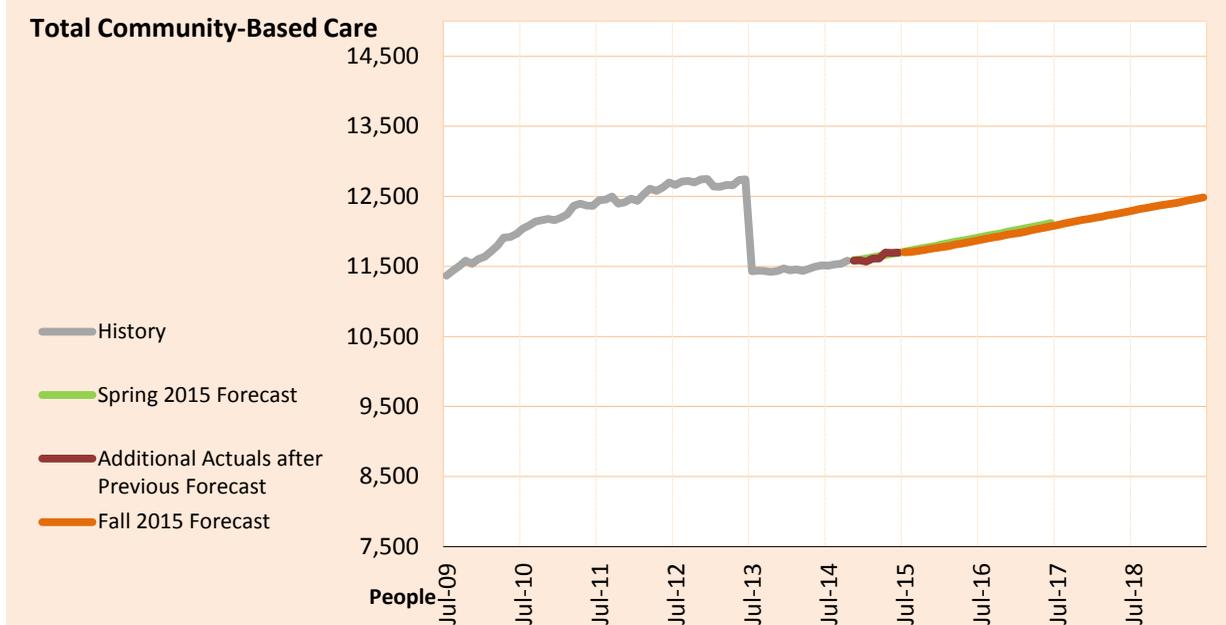
Total In-Home Services

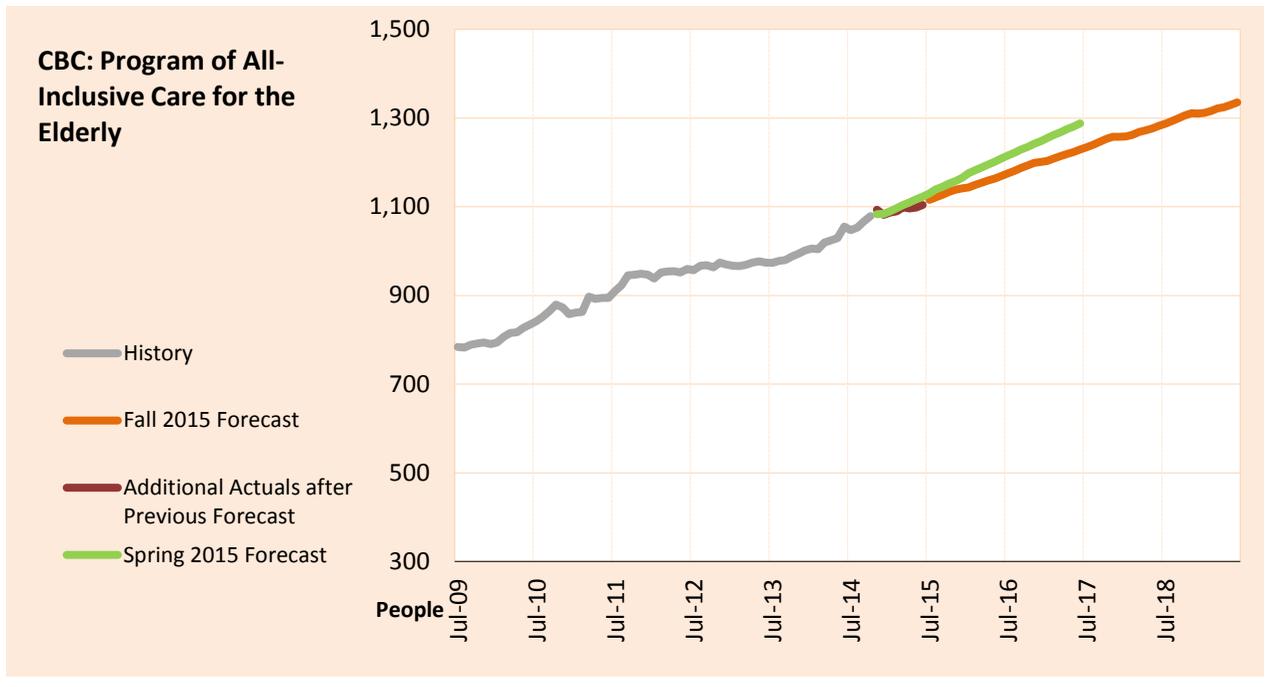
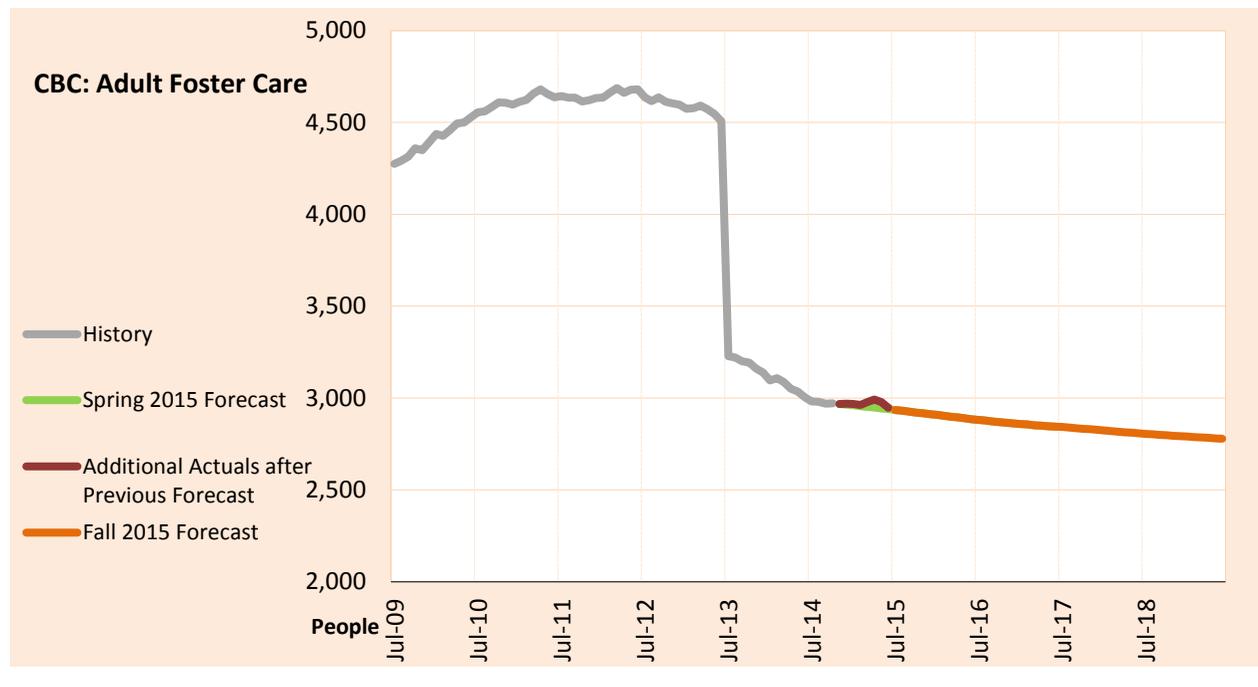
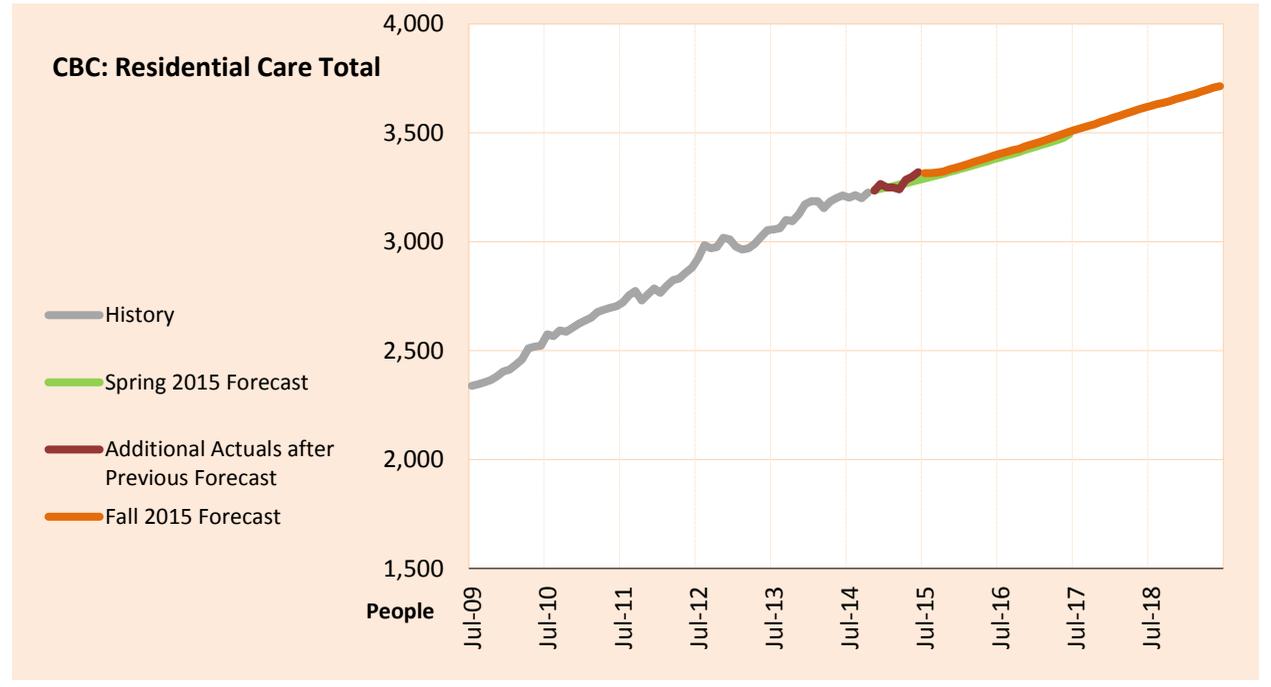
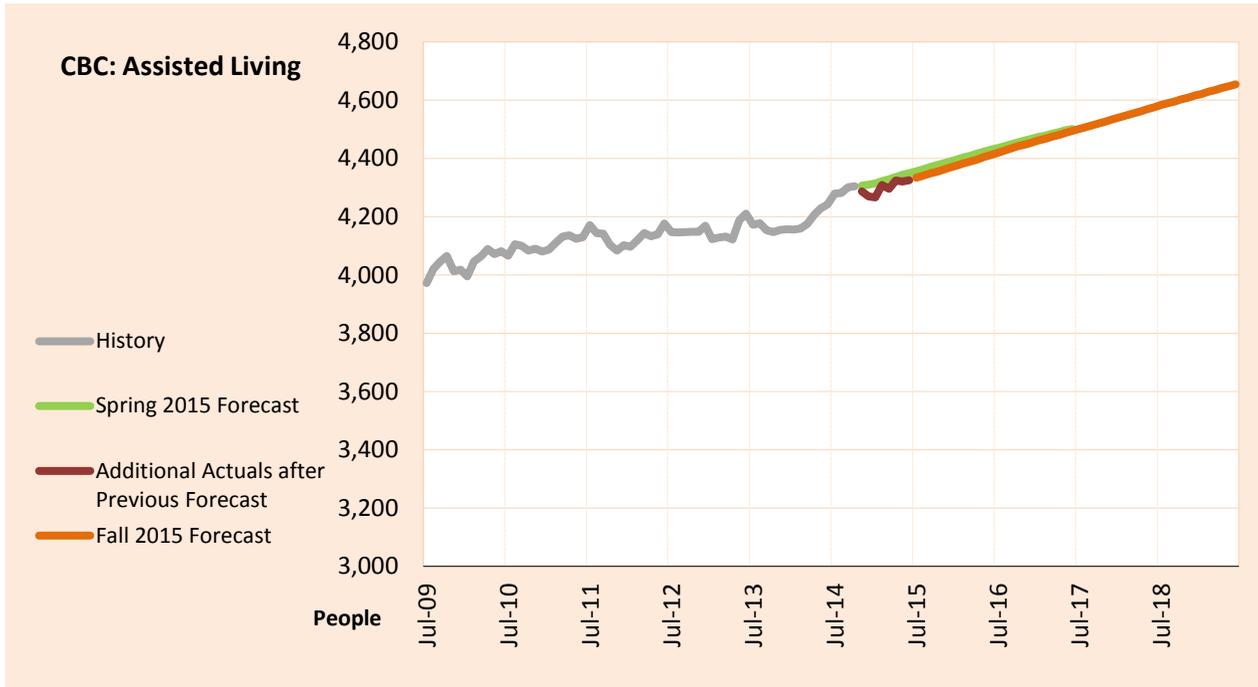


Total Nursing Facility Care



Total Community-Based Care





Aging and People with Disabilities Biennial Average Forecast comparison

	Current Biennium		% Change Between Forecasts	Fall 15 Forecast		% Change Between Biennia
	Spring 15 Forecast	Fall 15 Forecast		2015-17	2017-19	
In-Home Hourly without SPPC	11,514	11,514	0.0%	11,514	12,802	11.2%
In-Home Agency without SPPC	1,920	1,920	0.0%	1,920	2,135	11.2%
In-Home Live-In	2,194	2,194	0.0%	2,194	2,439	11.2%
In-Home Spousal Pay	113	113	0.0%	113	125	10.6%
Independent Choices (J Plan)	345	345	0.0%	345	390	13.0%
Specialized Living	187	187	0.0%	187	195	4.3%
In-Home K Plan Subtotal	16,273	16,273	0.0%	16,273	18,086	11.1%
In-Home Hourly with State Plan Personal Care	1,459	1,459	0.0%	1,459	1,622	11.2%
In-Home Agency with State Plan Personal Care	383	383	0.0%	383	426	11.2%
In-Home Non-K Plan Subtotal	1,842	1,842	0.0%	1,842	2,048	11.2%
Total In-Home	18,115	18,115	0.0%	18,115	20,134	11.1%
Assisted Living	4,432	4,415	-0.4%	4,415	4,579	3.7%
Adult Foster Care	2,886	2,886	0.0%	2,886	2,808	-2.7%
Contract Residential Care	2,329	2,317	-0.5%	2,317	2,521	8.8%
Regular Residential Care	1,055	1,083	2.7%	1,083	1,095	1.1%
Program of All-Inclusive Care for the Elderly (PACE)	1,211	1,173	-3.1%	1,173	1,286	9.6%
Community-Based Care Subtotal	11,913	11,874	-0.3%	11,874	12,289	3.5%
Basic Nursing Facility Care	3,421	3,540	3.5%	3,540	3,444	-2.7%
Complex Medical Add-On	522	534	2.3%	534	519	-2.8%
Enhanced Care	55	55	0.0%	55	55	0.0%
Pediatric Care	45	45	0.0%	45	45	0.0%
Nursing Facilities Subtotal	4,043	4,174	3.2%	4,174	4,063	-2.7%
Total Long-Term Care	34,071	34,163	0.3%	34,163	36,486	6.8%

Intellectual and Developmental Disabilities

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

Case Management Enrollment is an entry-level eligibility, evaluation, and coordination service available to all individuals determined to have intellectual and developmental disabilities, regardless of income level. Case Management Enrollment averaged 22,459 in 2013-15, but is forecast to average 25,288 in 2015-17 (12.6 percent higher than the prior biennium) and 28,167 in 2017-19 (11.4 percent higher than 2015-17). Enrollment is projected to grow rapidly until most I/DD individuals have enrolled. Research is underway to determine what to expect as a “natural limit.”

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

Adult Services include:

Brokerage Enrollment — Under K Plan, services must be provided to all eligible I/DD clients who wish to be served. In Oregon, I/DD adults can obtain services through either of two channels: Brokerages or the Community Development Disability Programs (CDDPs). For three forecast cycles (Fall 2013 to Fall 2014) Brokerage demand was projected 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, however, Brokerage Enrollment has continued to hover in the low 7,600’s, and CDDPs have been struggling to keep up with demand. The biennial average forecast for Brokerage Enrollment in 2015-17 is 7,691, unchanged from the Spring 2015 forecast. The forecast for 2017-19 is 7,769, 1.0 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. Historically, 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. The biennial average forecast for 2015-17 is 1,473 clients, 26.5 percent higher than the Spring 2015 forecast. The forecast for 2017-19 is 2,120 clients, 43.9 percent higher than 2015-17.

24-Hour Residential Care — The biennial average forecast for 2015-17 is 2,787, 0.1 percent lower than the Spring 2015 forecast. The forecast for 2017-19 is 2,835, 1.7 percent higher than 2015-17.

Supported Living — The biennial average forecast for 2015-17 is 715, 0.1 percent lower than the Spring 2015 forecast. The forecast for 2017-19 is 721, 0.8 percent higher than 2015-17.

I/DD Foster Care — I/DD Foster Care serves both adults and children, with children representing approximately 17 percent of the caseload. The biennial average forecast for 2015-17 is 3,153 clients, 1.3 percent lower than the Spring 2015 forecast. The forecast for 2017-19 is 3,254, 3.2 percent higher than 2015-17.

Stabilization and Crisis Unit — The Stabilization and Crisis Unit serves both adults and children, with children representing approximately 11 percent of the caseload. This caseload is limited by bed capacity and is expected to remain at the current level of 104 through 2015-17 and 2017-19.

Children's Services:

In-Home Support for Children - 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. Historically 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 projected to continue rising rapidly throughout the forecast horizon, reaching 3,118 by mid-2017, and 3,644 by mid-2019. The biennial average forecast for 2015-17 is 2,652 clients, 29.9 percent higher than the Spring 2015 forecast. The forecast for 2017-19 is 3,425, 29.1 percent higher than 2015-17.

Growth in this caseload is primarily due to the implementation of the Community First Choice Option (K Plan), which allows for individuals eligible for the Oregon Health Plan to receive in home services. In addition, children may also become eligible for Medicaid services based on having a disability (meeting SSI standards), while not accounting for family resources. Not known, however, is the number of children who are currently enrolled in /DD services and not currently receiving K Plan services who will request them in the future, nor the number of children in Oregon not currently enrolled in services who will now apply. 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 - 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 current level of 411 through 2015-17, rising to 412 in 2017-19.

Children Residential Care - This caseload is forecast to grow very slightly from 2013-15 due to the addition of 16 new beds between March 2014 and March 2015, as well as an additional 4 beds in November 2015. The biennial average forecast is 164 for both 2015-17 and 2017-19.

Other Services:

Employment and Attendant Care 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 Day Support Activities) caseload averaged 4,159 in 2013-15. The new, more inclusive definition (renamed Employment and Attendant Care Services) is different enough that comparison to prior forecasts would be misleading.

This forecast projects only moderate growth from 2015-17 to 2017-19 to reflect the transition and 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 biennial average for 2015-17 is 6,322. The biennial average for 2017-19 is 6,425, 1.6 percent higher than 2015-17.

Transportation — In order to better reflect recent program changes and to present a more complete picture of I/DD transportation services, the definition of what is counted in the Transportation caseload has been revised. Historically, this caseload included only services paid with state funds, not those using local match funding. However, recent changes to I/DD employment services mean more clients are being served by local match programs, leading to a progressively less complete picture of transportation services actually provided. 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 as well as transportation services provided under Plan of Care (e.g. transit passes and non-medical community transportation).

Using the old definition, the Transportation caseload averaged 1,815 in 2013-15. The new, more inclusive definition is different enough that comparison to prior forecasts would be misleading.

This forecast projects only moderate growth from 2015-17 to 2017-19 to reflect the transition and stabilization of the changes being implemented by I/DD employment services (which is the primary use for non-medical transportation). Using the new caseload definition, the biennial average for 2015-17 is 5,968. The biennial average for 2017-19 is 6,116, 2.5 percent higher than 2015-17.

Risks and Assumptions

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

Although 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 which may result in speeding up the entry of new I/DD clients. All of these practical operational changes mean that new service use patterns are not yet stable and may continue to fluctuate for some time. It should also be noted that there may be families with I/DD children who, having not previously enrolled in Case Management, were not represented in the original pool of eligible children used to estimate the forecast.

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 that is, Comprehensive In-Home Services (for adults) and the In-Home Support for Children.

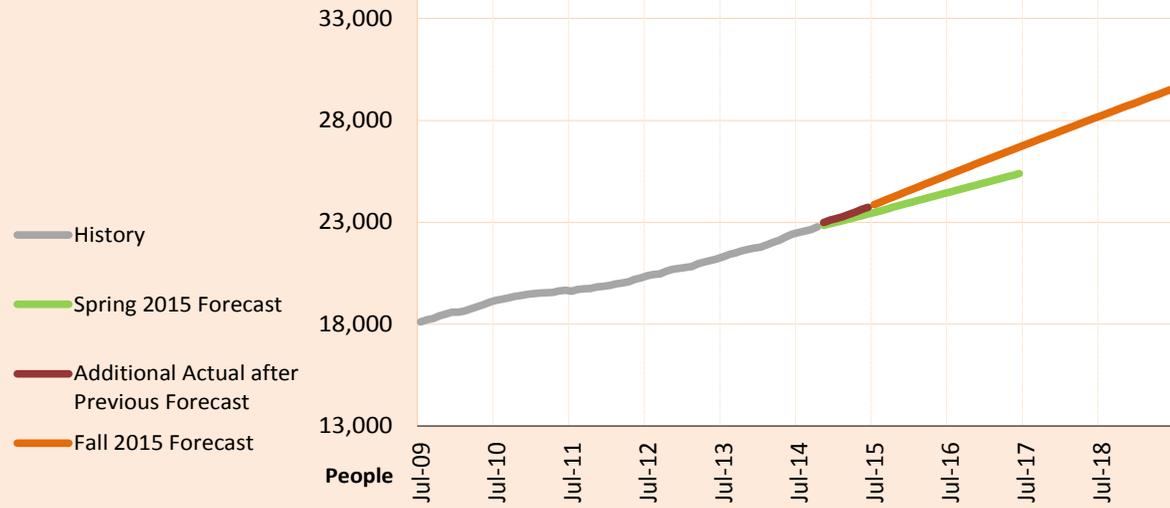
Comprehensive In-Home Services — Adults have a choice to receive their case management supports through one of two case management programs – Brokerages or CDDPs. However, since the brokerages are close to capacity, most growth in the adult caseload will continue to occur in the CDDP service known as Comprehensive In-Home Services. Growth in adult caseloads may come from children who age into the adult caseloads, or previously unserved adults who are either newly eligible or newly interested. It should be noted that since Brokerage capacity is contractually constrained, contract changes (such as increasing the number of contracted slots, or shifting unutilized seats to brokerages with waiting lists) could impact both Brokerage Enrollment and Comprehensive In-Home Service caseloads.

In-Home Support for Children — 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. Now a child may access significant in-home supports 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, additional children may become eligible for Medicaid services based on having a disability (meeting SSI standards), while not accounting for family financial resources, and entering the Oregon's comprehensive waiver; this also contributes to the number of children who are able to access in-home services through the K Plan .

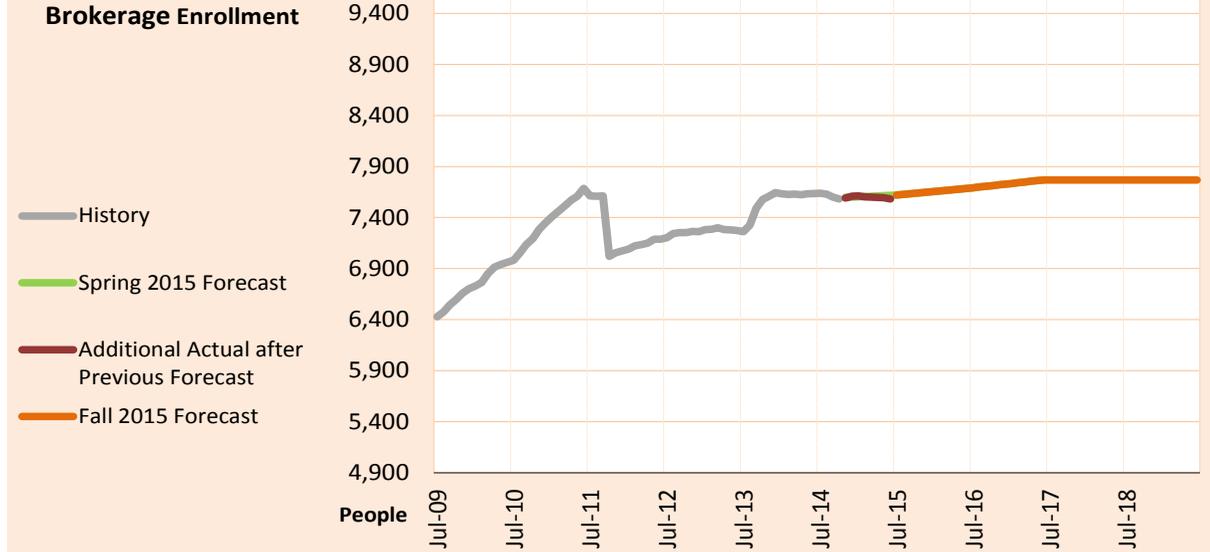
Prior to K Plan, In-Home Support for Children averaged fewer than 200 children receiving supports. The caseload has grown to 2,008 by June 2015, and is projected to exceed 3,000 by June of 2017.

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.

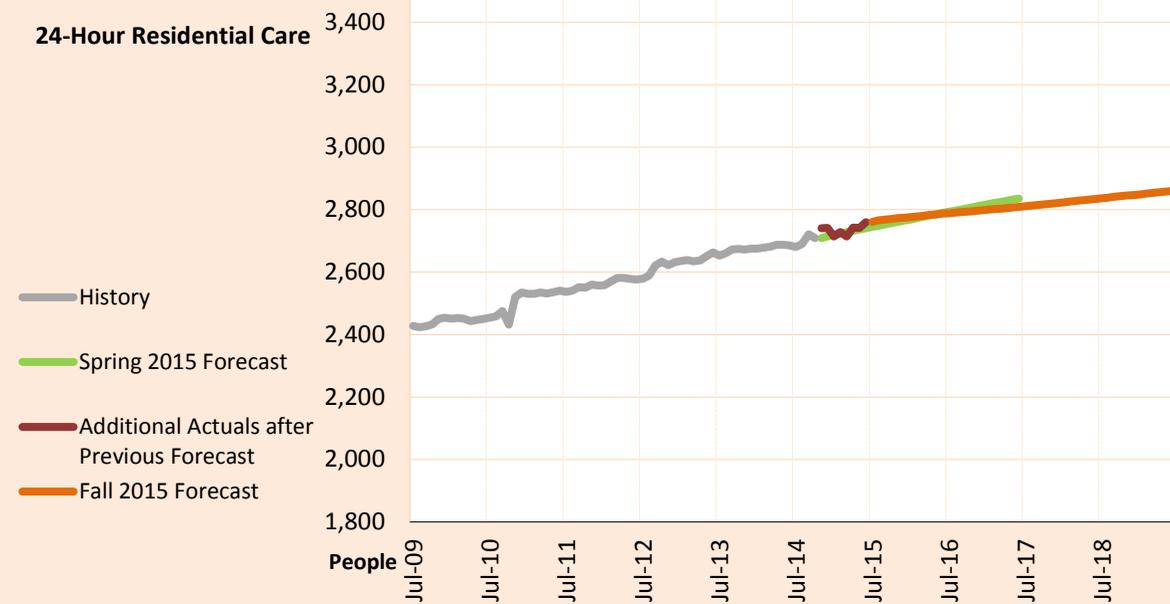
Case Management Enrollment



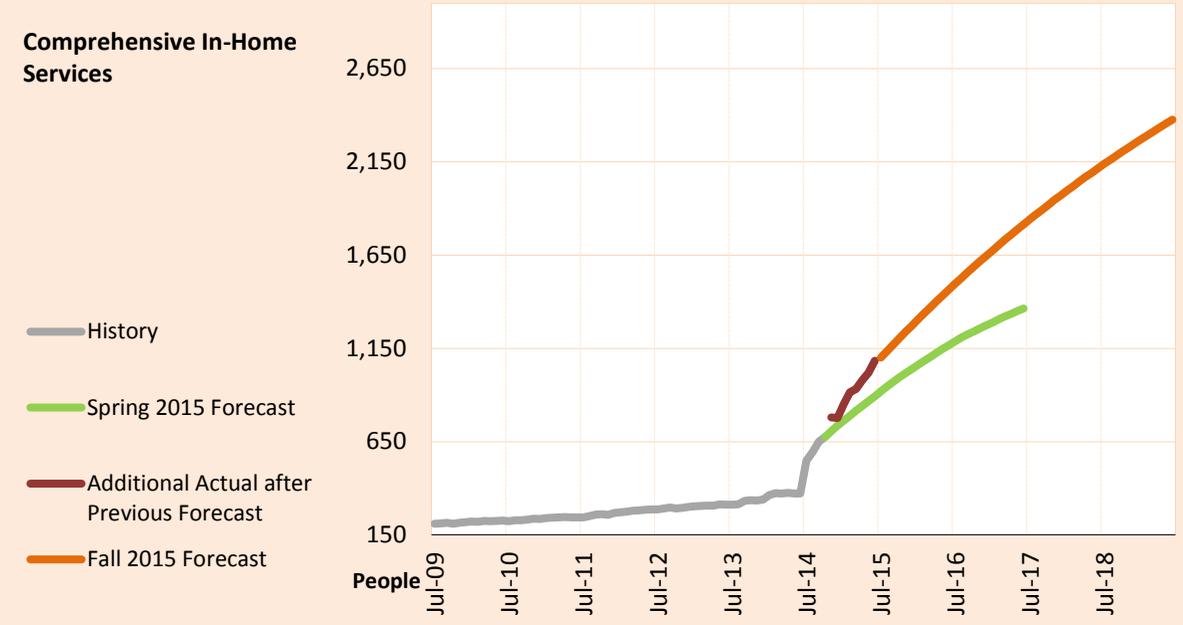
Brokerage Enrollment



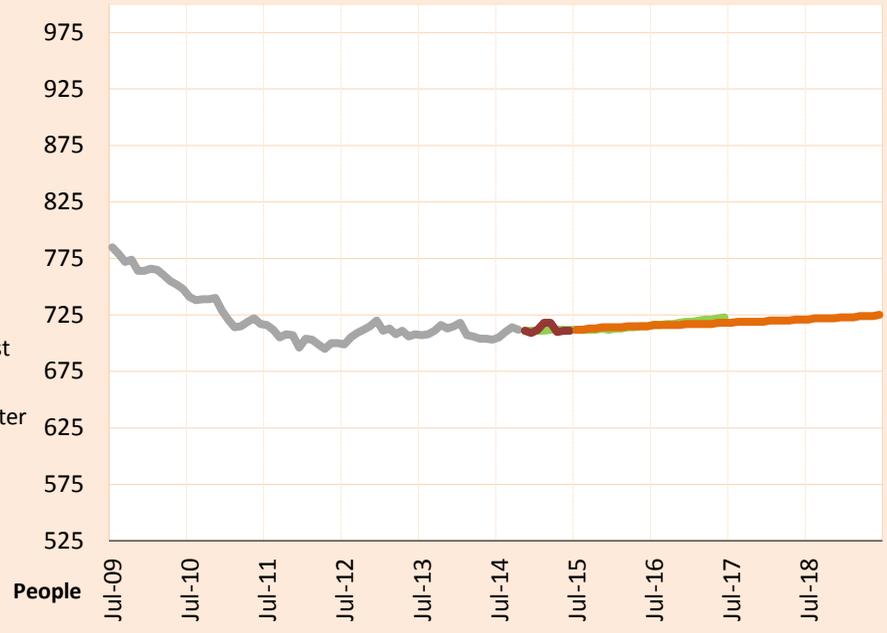
24-Hour Residential Care



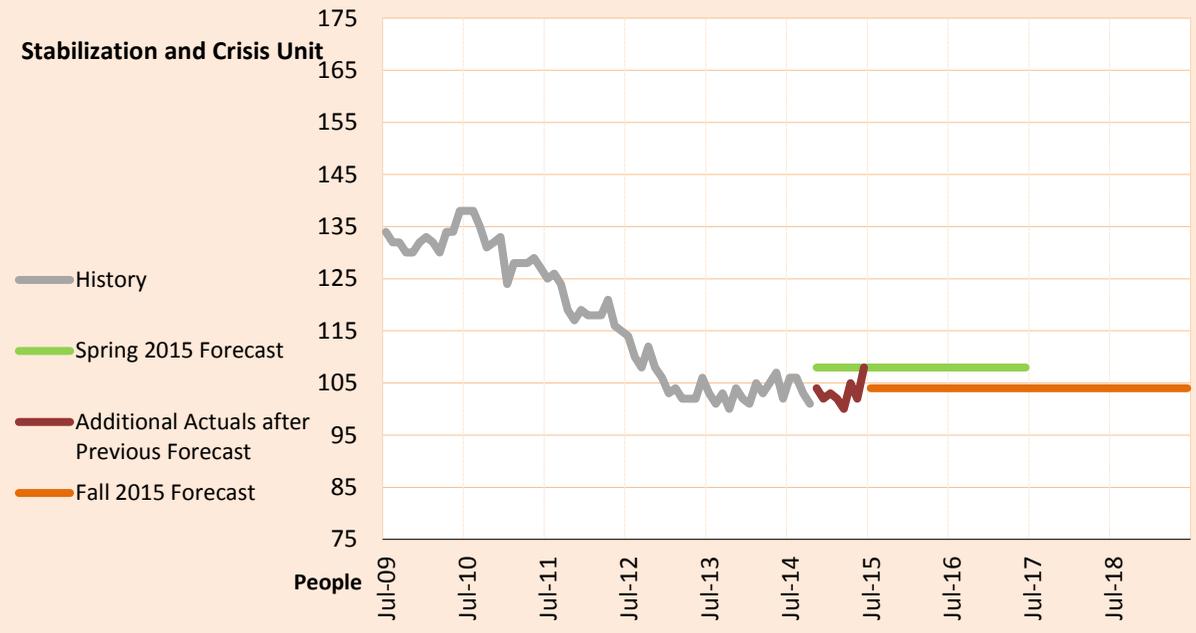
Comprehensive In-Home Services



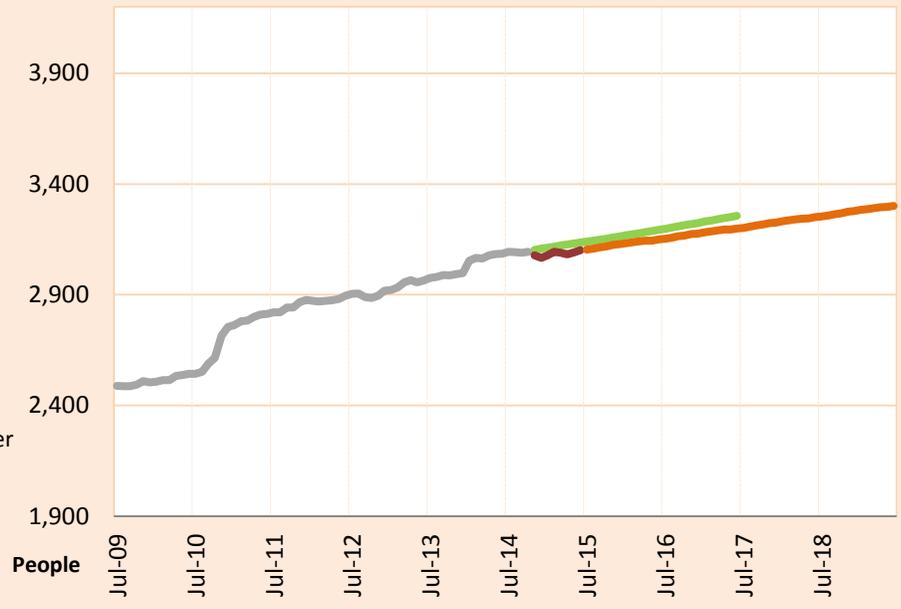
Supported Living



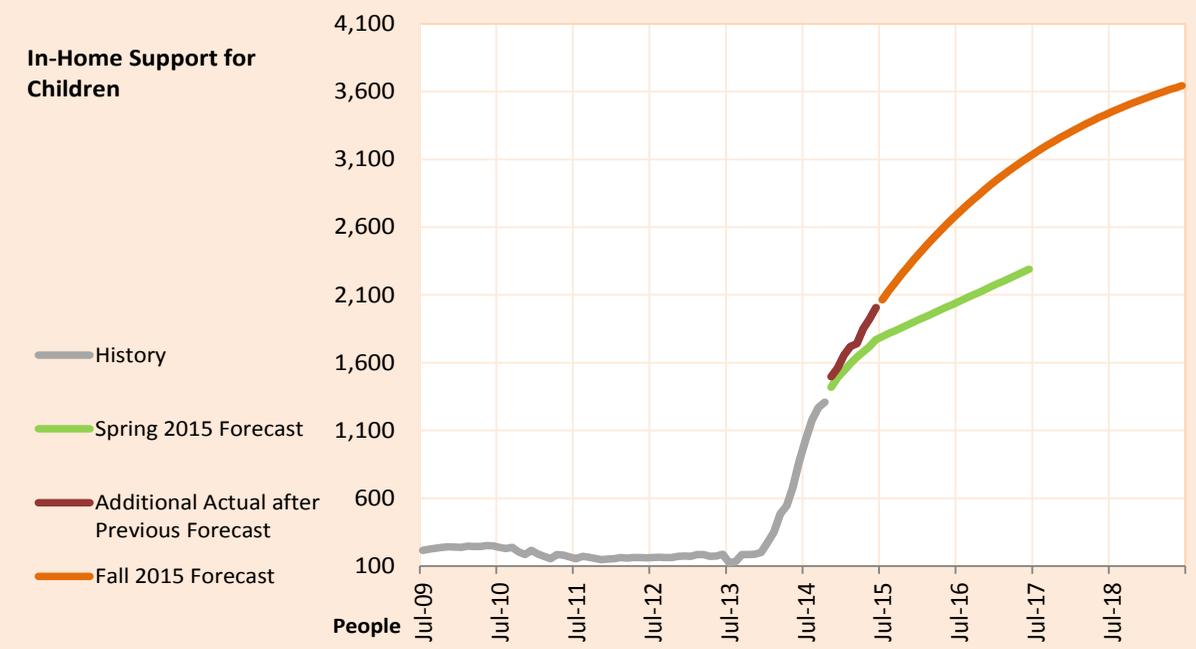
Stabilization and Crisis Unit

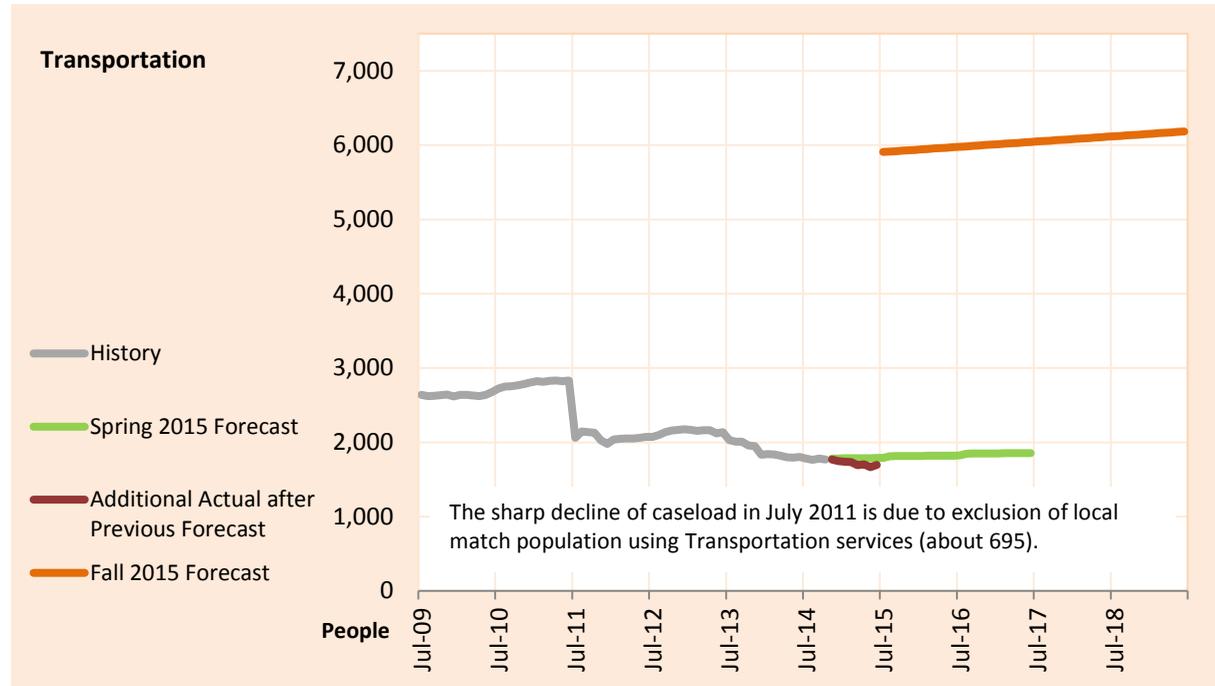
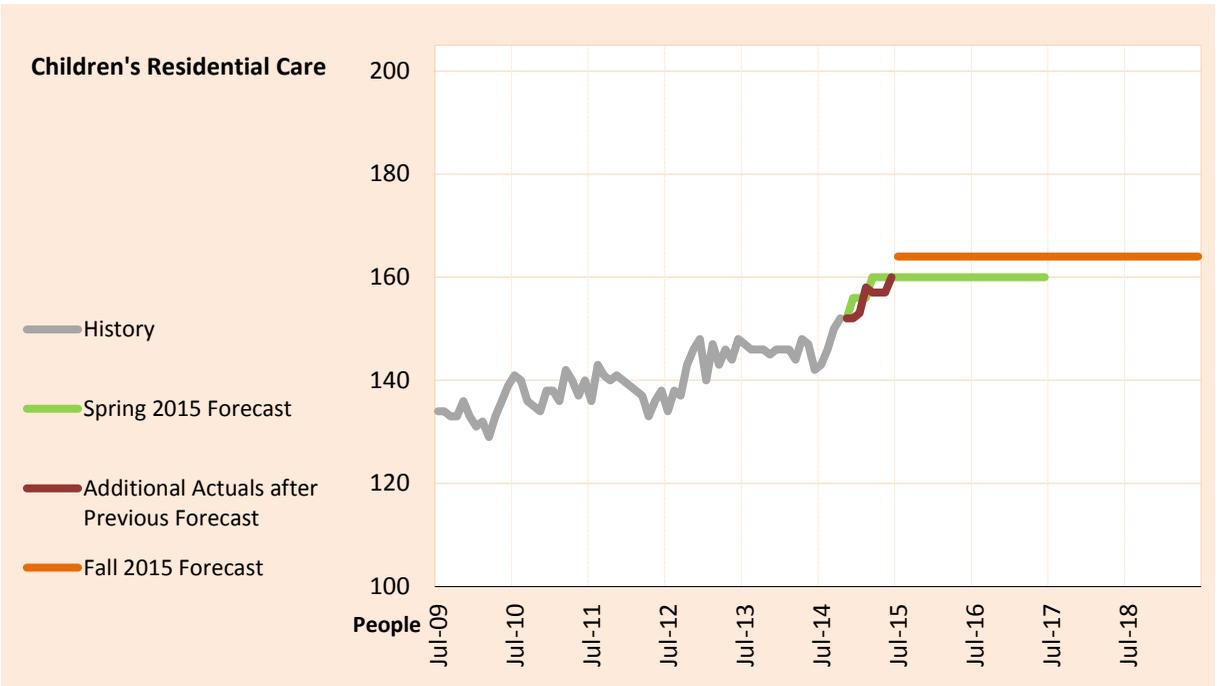
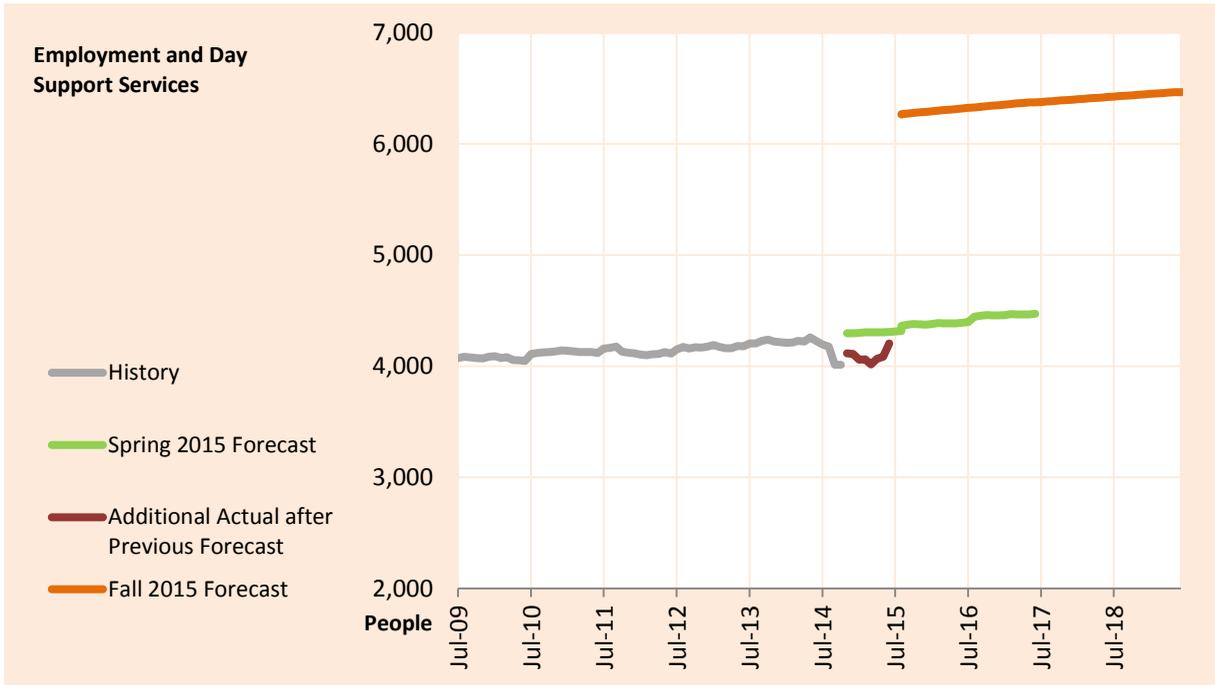
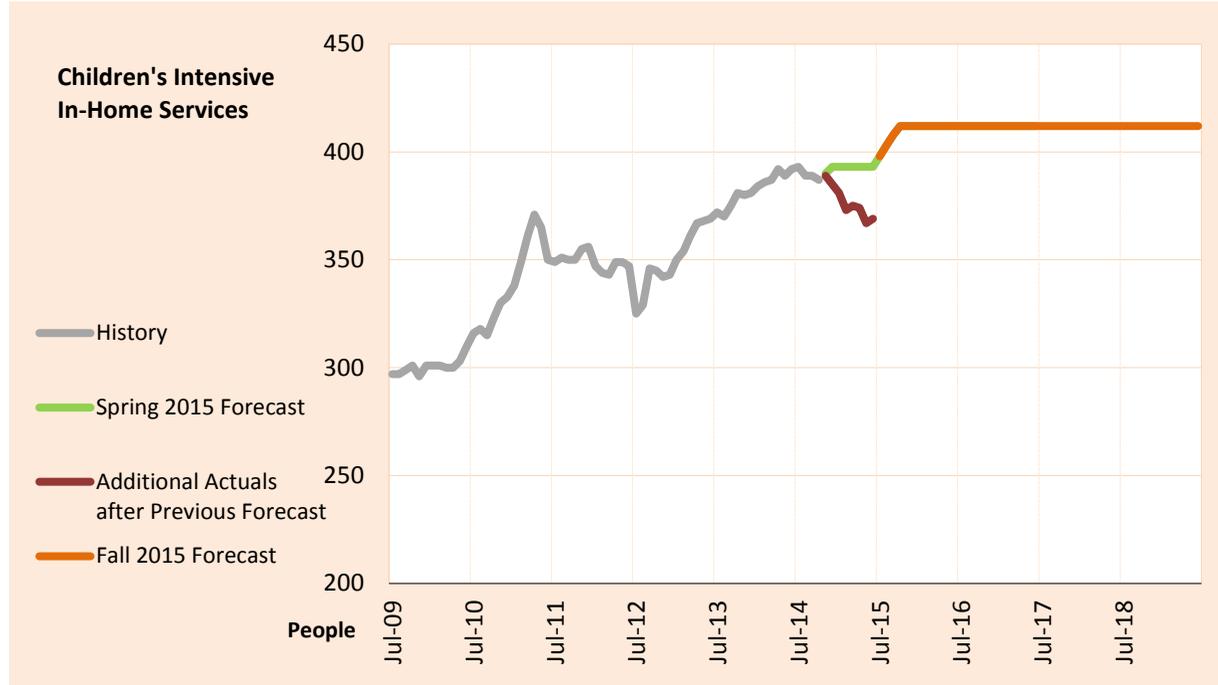


I/DD Foster Care



In-Home Support for Children





Intellectual and Developmental Disabilities Biennial Average Forecast comparison

	Current Biennium		% Change Between Forecasts	Fall 15 Forecast		% Change Between Biennia
	Spring 15 Forecast	Fall 15 Forecast		2015-17	2017-19	
Total Case Management Enrollment¹	24,438	25,288	3.5%	25,288	28,167	11.4%
Adult						
Brokerage Enrollment	7,691	7,691	0.0%	7,691	7,769	1.0%
24-Hour Residential Care	2,791	2,787	-0.1%	2,787	2,835	1.7%
Supported Living	716	715	-0.1%	715	721	0.8%
Comprehensive In-Home Services ²	1,164	1,473	26.5%	1,473	2,120	43.9%
I/DD Foster Care ³	3,196	3,153	-1.3%	3,153	3,254	3.2%
Stabilization and Crisis Unit ³	108	104	-3.7%	104	104	0.0%
Children						
In-Home Support for Children ²	2,041	2,652	29.9%	2,652	3,425	29.1%
Children Intensive In-Home Support	411	411	0.0%	411	412	0.2%
Children Residential Care	160	164	2.5%	164	164	0.0%
Total I/DD Services	18,278	19,150	4.8%	19,150	20,804	8.6%
Other DD Services						
Employment & Day Support Activities	4,416	6,322	43.2%	6,322	6,425	1.6%
Transportation	1,833	5,968	225.6%	5,968	6,116	2.5%

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 expected to increase significantly due to the 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

	Current Biennium		% Change Between Forecasts	Fall 15 Forecast		% Change Between Biennia
	Spring 15 Forecast	Fall 15 Forecast		2015-17	2017-19	
Medical Assistance Programs						
OHP Plus						
ACA Adults	369,083	423,677	14.8%	423,677	395,906	-6.6%
Parents/Caretaker Relative	48,607	57,850	19.0%	57,850	50,668	-12.4%
Old Age Assistance	41,969	42,009	0.1%	42,009	45,668	8.7%
Pregnant Woman Program	15,431	15,612	1.2%	15,612	13,965	-10.5%
Aid to the Blind & Disabled	84,192	81,558	-3.1%	81,558	83,289	2.1%
Children's Medicaid Program	316,500	346,569	9.5%	346,569	333,883	-3.7%
Children's Health Insurance Program	66,063	62,631	-5.2%	62,631	59,752	-4.6%
Foster, Substitute & Adoption Care	18,753	19,631	4.7%	19,631	20,145	2.6%
Total OHP Plus	960,598	1,049,537	9.3%	1,049,537	1,003,276	-4.4%
Total Other Medical Assistance Programs	63,002	82,360	30.7%	82,360	84,440	2.5%
Total Medical Assistance Programs	1,023,600	1,131,897	10.6%	1,131,897	1,087,716	-3.9%
Mental Health¹						
Aid & Assist	203	207	2.0%	207	208	0.5%
Guilty Except for Insanity (GEI)	625	605	-3.2%	605	601	-0.7%
Total Forensic	828	812	-1.9%	812	809	-0.4%

1. Several data systems changes occurred following the Spring 2015 forecast 1) CPMS ended and 2) providers have been continuing to transition to utilization of the MOTS system. Consequently, the Civilly Committed, Previously Mandated, and Never Mandated caseload categories are incomplete at this time. In the future, when providers become more consistent in their use of the new MOTS system, we will be able to resume providing caseload numbers for all Mental Health categories.

Health Systems Medicaid (HSM)

Medicaid caseloads have increased significantly since 2008 due to a variety of factors including: the recent recession (December 2007 through June 2009), implementation of the Healthy Kids Initiative in July 2009, and the Patient Protection and Affordable Care Act of 2010 (ACA) in January 2014. Taken together these three factors drove the total medical assistance caseload from about 408,000 clients prior to the recession to about 1,009,000 clients in January 2014, for a net increase of 601,000 clients (147 percent increase). The caseload continued to grow throughout most of 2014 and 2015 due to deferred redeterminations, reaching 1,144,314 by June 2015. The Fall 2015 forecast predicts caseload will continue to grow and will reach the highest point of 1,217,163 total clients by March 2016. Once redeterminations are resumed in March 2016, the caseload will start to decline and is expected to drop to 1,093,310 by November 2016.

ACA Adults –

The ACA Adults caseload is expected to peak at 483,713 in March 2016. If implementation of the new ONE eligibility system goes as planned and redeterminations are resumed as scheduled, closures will resume in April 2016, and the caseload is expected to drop to 391,500 by November 2016 and to grow slowly thereafter. Once leveled out, this caseload will account for about 39 percent of the total OHP Plus caseload.

Parent/Caretaker Relative –

The Parent/Caretaker Relative caseload declined over the past year - going from 78,842 people in September 2014 to 56,449 people in June 2015. The most significant factors driving this decline are: 1) the economic recovery, 2) resumed redeterminations, and 3) the availability of ACA Adults coverage. This caseload is expected to grow to 65,550 by March 2016 as the renewals are delayed, after which it will start declining again. This caseload is expected to be 54,500 in December of 2016 and to account for about 5.4 percent of the total OHP Plus caseload.

Pregnant Women -

The Pregnant Women caseload has been higher than expected, averaging about 21,500 from July 2014 to June 2015. Several technical issues were recently identified as factors contributing to the high pregnant women caseload. Due to the high cost of this group,

the Oregon Health Authority is planning to complete redeterminations for this caseload by the end of 2015 despite the fact that redeterminations for most other caseloads will be temporarily deferred. This caseload is expected to drop to 14,425 by January of 2016. By December of 2016 the caseload is expected to account for 1.4 percent of the total OHP Plus caseload.

Children's Medicaid

The Children's Medicaid caseload has averaged about 348,600 from July 2014 to June 2015. This forecast projects the caseload will peak at 357,000 in March 2016, then as redeterminations begin again it will start to decline. This caseload is expected to be 343,050 in December of 2016 and account for about 34 percent of the total OHP Plus caseload.

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program is projected to include 61,050 children in December 2016 and to account for 6 percent of the total OHP Plus caseload.

Foster, Substitute Care & Adoption Assistance

The Foster, Substitute Care & Adoption Assistance program is forecasted to include 19,675 clients in December of 2016 and to account for 1.9 percent of the total OHP Plus caseload. Current estimates are for this caseload to remain relatively stable, growing at a slow pace through the forecast horizon.

Aid to the Blind and Disabled (ABAD)

The ABAD caseload was 84,697 clients in October 2013, but only 81,652 in June 2015, an overall decline of more than 3,000 clients. Historically this caseload has grown consistently. However following ACA, including implementation of the K-Plan option for long-term care services, this caseload has begun to decline. Clients now have access to medical and long term care service without having to obtain a federal determination of disability. The impact is rather dramatic, while past forecasts predicted a lower growth rate for this population, a negative growth rate was not expected. Given the uncertainty with ACA redeterminations and possible future backlog of transfers, this forecast projects that the caseload will continue to decline until redeterminations are resumed in March of 2016.

Then as redeterminations take effect, this forecast projects slow growth rate through the forecast horizon. The caseload is expected to be 81,800 by December 2016 and to account for 8 percent of the total OHP Plus caseload.

Old Age Assistance (OAA)

The Old Age Assistance caseload is projected to be 42,900 by December 2016 and to account for 4.2 percent of the total OHP caseload. This caseload is driven by population dynamics as well as economic conditions. Oregon's elderly population is projected to increase by roughly 4 percent per year. This caseload is forecast to grow steadily through the foreseeable future.

Other Medical Assistance Programs

Citizen-Alien Waived Emergent Medical - Regular (CAWEMR) has grown rapidly since the implementation of ACA expansion. It was 21,278 in December of 2013 and 46,465 in June of 2015, for an overall increase of more than 25,000 in 18 months. Factors contributing to this growth include:

1. Expansion of coverage due to ACA reform. CAWEM eligibility uses the same rules as Medicaid except for the citizenship/residency requirement. Consequently, when Medicaid expanded due to ACA, this category expanded as well (both for adults up to 138 percent of FPL and children with family incomes of 200-300 percent of FPL). However, there are differences in the uptake curves between OHP and CAWEM caseloads. CAWEM caseload experienced relatively steady, even growth, while OHP grew rapidly at the outset due to Fast Track enrollment and extensive news coverage/publicity.
2. Presumptive eligibility. This policy, implemented in January of 2014, allows hospitals to provide service to patients who appear to meet the eligibility criteria for either OHP or CAWEM. This contributed to the inflow of clients to the CAWEM caseload.
3. Low exit rates due to changes in redeterminations and new MAGI based eligibility determinations.

The current forecast predicts this caseload will continue growing thru March 2016, after

which it is expected to decline slowly. The CAWEM caseload is expected to be 56,700 in December of 2016 and to account for 70.1 percent of Other Medicaid caseload.

Citizen-Alien Waived Emergent Medical Plus (CAWEMP) expanded statewide in October of 2013. This program provides full benefits to pregnant CAWEM women. This caseload had 1,213 women in September of 2013 and had tripled to 2,488 by June of 2015. This caseload has been impacted by the same technical issues as the Pregnant Women caseload, and should be impacted by the same corrective actions. The caseload is expected to drop to 2,190 by January of 2016 and to account for 2.6 percent of Other Medicaid caseload.

Qualified Medicare Beneficiary (QMB)

The Qualified Medicare Beneficiary caseload is expected to be 24,800 clients by December 2016 and to account for 29.5 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)

Breast and Cervical Cancer Treatment Program is expected to have 275 clients in December 2016 and to account for 0.3 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.

Risks and Assumptions

ACA implementation is still creating a lot of uncertainty and forecast risk. The biggest known risks for the current forecast are:

1. Deferred redeterminations,
2. Implementation of the new OHP eligibility and enrollment system – Oregon Eligibility (ONE), and
3. Data quality.

The first major risk arises from temporary changes made to eligibility redetermination practices. Typically, a client is enrolled for a six or twelve-month period, and at the end of that coverage the case is scheduled for a review, and a new determination is made whether the person is 1) still eligible for coverage in the same group, 2) eligible for cov-

erage in a different group, or 3) no longer eligible for coverage. Most of the redeterminations for 2014 and the first 3 months of 2015 were deferred.

This resulted in caseload accumulation. The Oregon Health Authority tried to complete all of the deferred redeterminations between April and October 2015. However, working with multiple eligibility systems created technical challenges that resulted in some people who needed a redetermination not being successfully processed. OHA requested and received a CMS waiver to pause OHP renewals from November 2015 thru January 2016 in order to focus on implementation of the ONE system and to manage the large volume of applications anticipated during open enrollment. CMS also approved spreading the resulting catch up work throughout 2016 in an effort to balance monthly volumes.

The Fall 2015 forecast incorporates the impact of the deferred redeterminations. However, operational details continue to change and data is limited, therefore - high variations should be expected.

The second major risk is associated with implementation of ONE. This new system is modeled after Kentucky's basic system. Problems with implementation of Cover Oregon as a single portal for purchasing health insurance and enrolling in OHP created many technical challenges for the forecast. Successful implementation of ONE will be crucial in resolving current data issues. While OHA is doing everything possible to assure timely and seamless migration, system implementation presents a real risk to the current forecast due to the following factors:

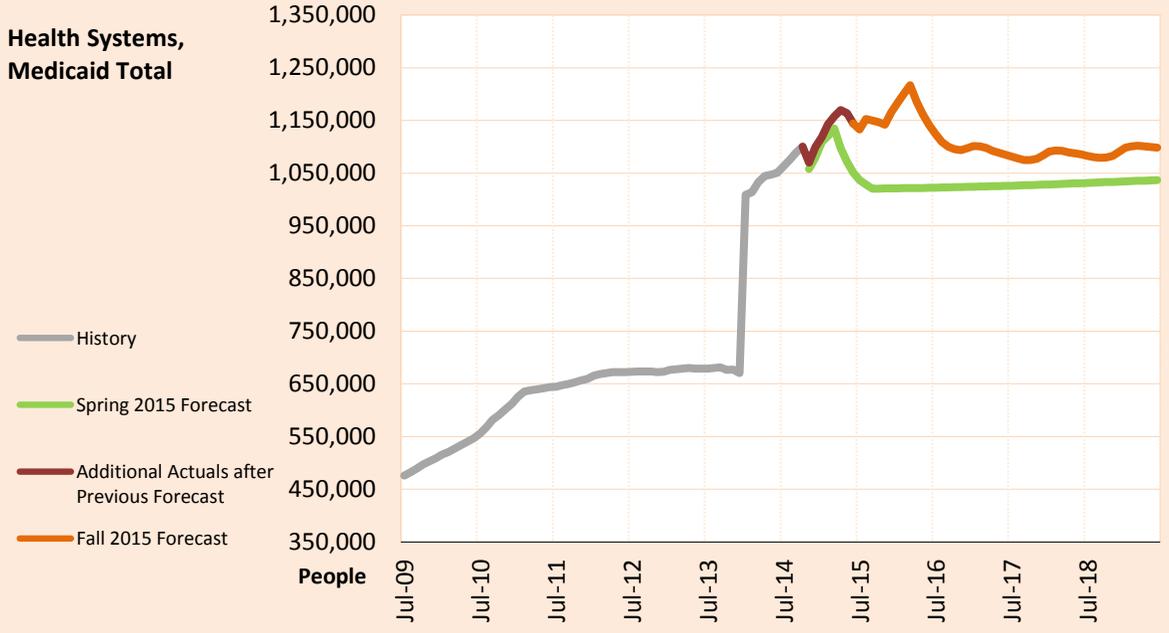
1. This project is labor intensive and relies on the same resources used to process renewals – if more time needed, redeterminations might be further delayed.
2. In the event that implementation does not go as planned, there might be additional delays or data quality issues.

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

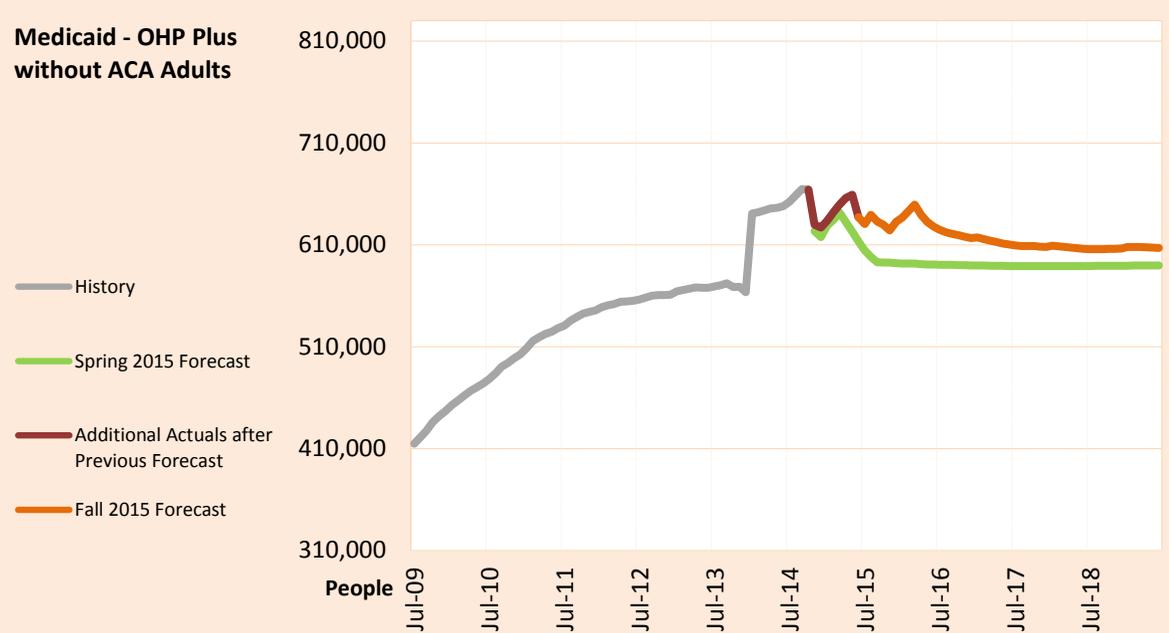
Below is a summary of how each components was impacted.

1. Exits were disrupted by deferred redeterminations.
2. Transfers were impacted by creation of the new ACA Adults caseload, as well as reorganization of some existing caseloads with the ACA requirements for MAGI determination. In addition, deferred redeterminations disrupted transfer patterns because most transfers occur at the time of eligibility redetermination.
3. New clients were impacted by creation of the new ACA Adults caseload, since individuals enrolled as ACA Adults may no longer need services they would have used in the past (e.g. Breast & Cervical Cancer Treatment Program, Aid to the Blind & Disabled), or will enter as transfers rather than as new clients (e.g. Pregnant Women, Parent/Caretaker Relative). Additionally, deferred redeterminations disrupted new client patterns by reducing "churn". That is, since redeterminations were not required, fewer people dropped off caseloads temporarily (30-90 days) due to incomplete paperwork.

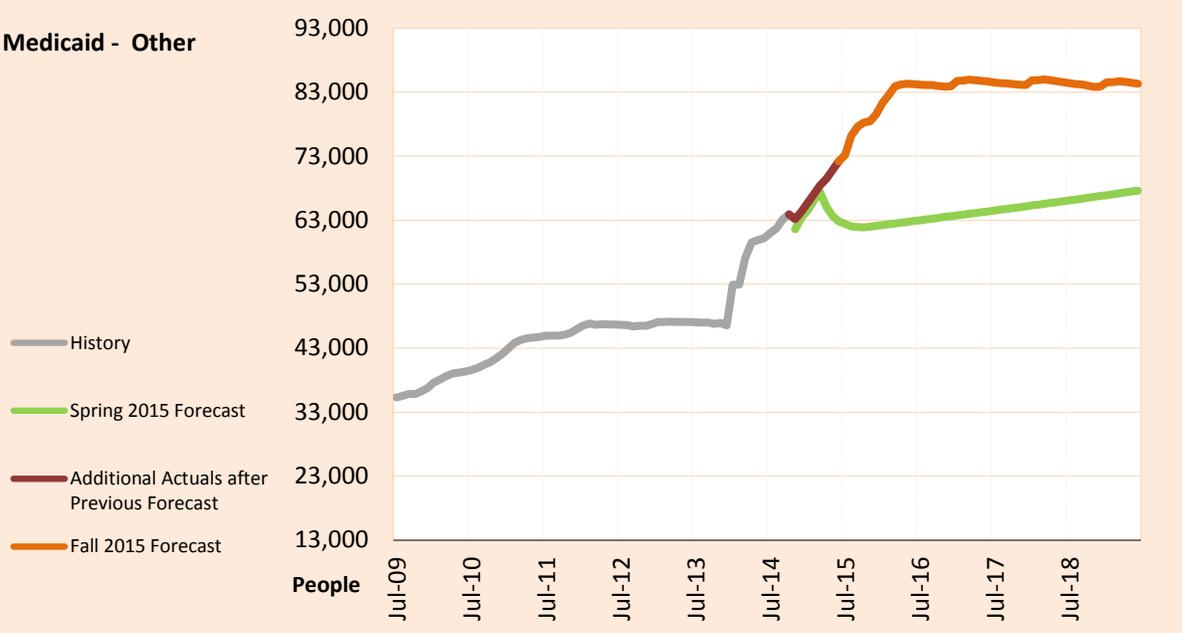
Health Systems, Medicaid Total



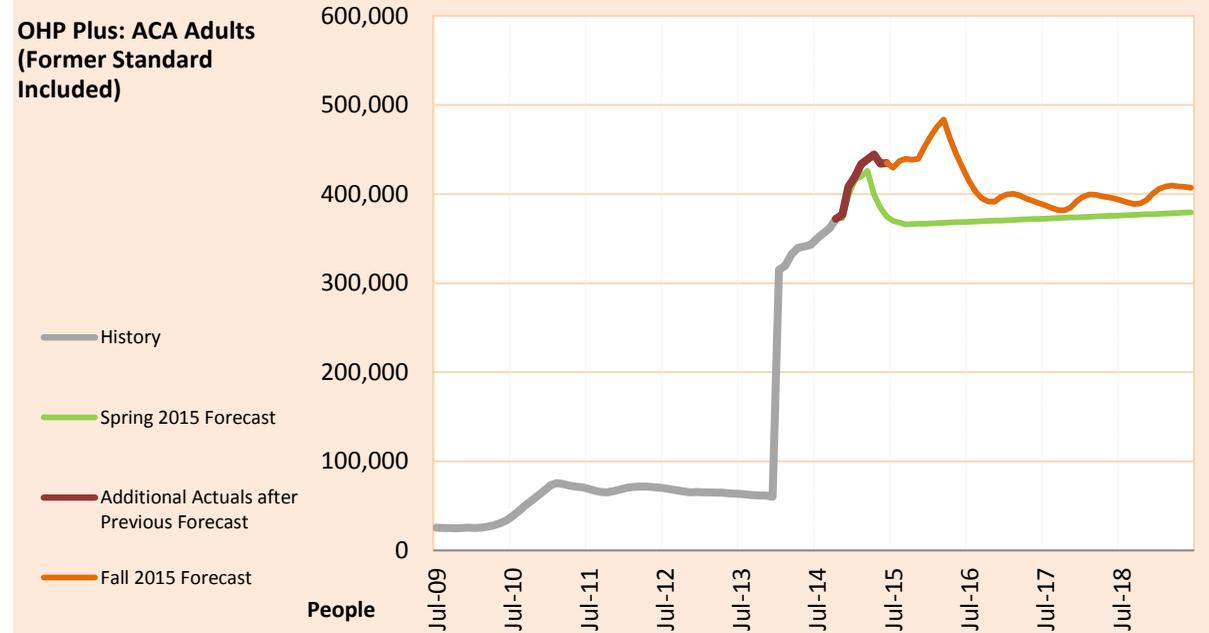
Medicaid - OHP Plus without ACA Adults



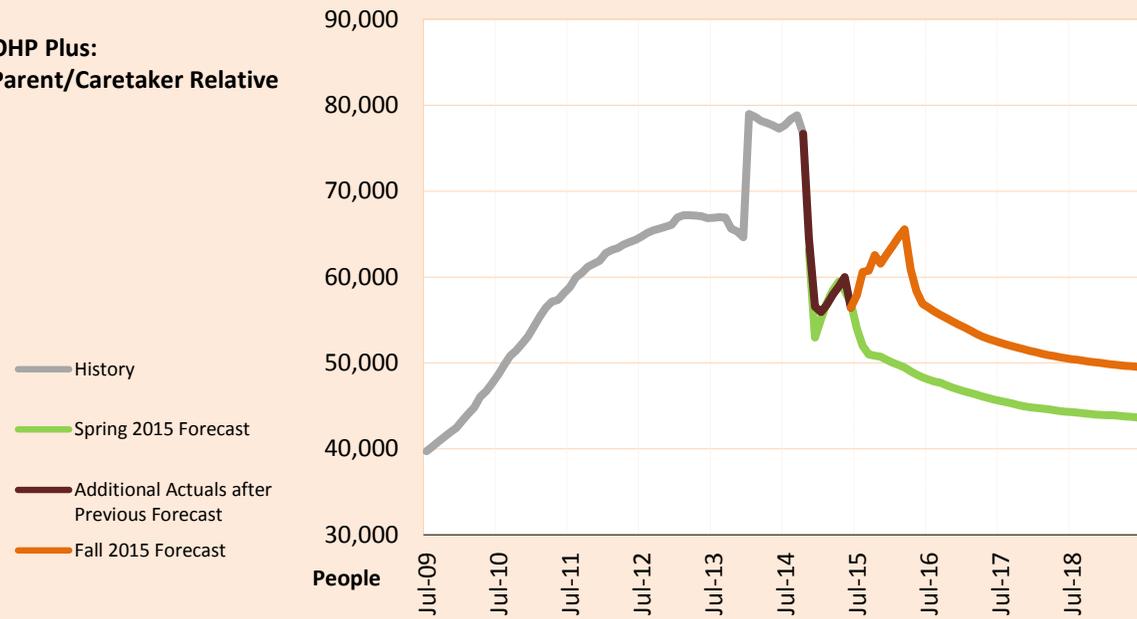
Medicaid - Other



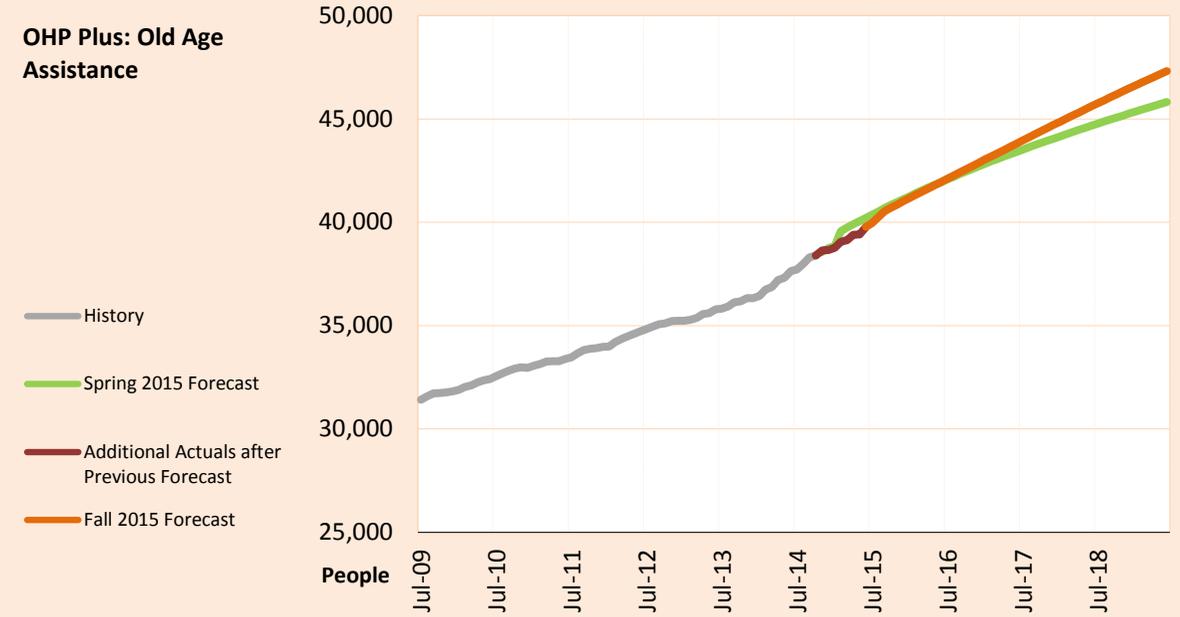
OHP Plus: ACA Adults (Former Standard Included)



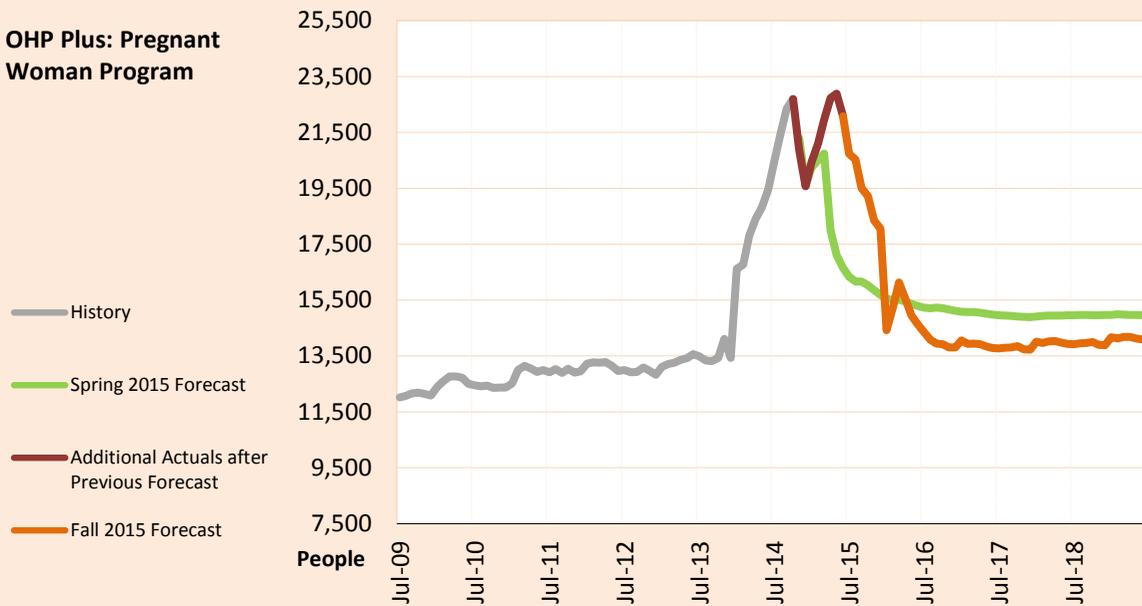
**OHP Plus:
Parent/Caretaker Relative**



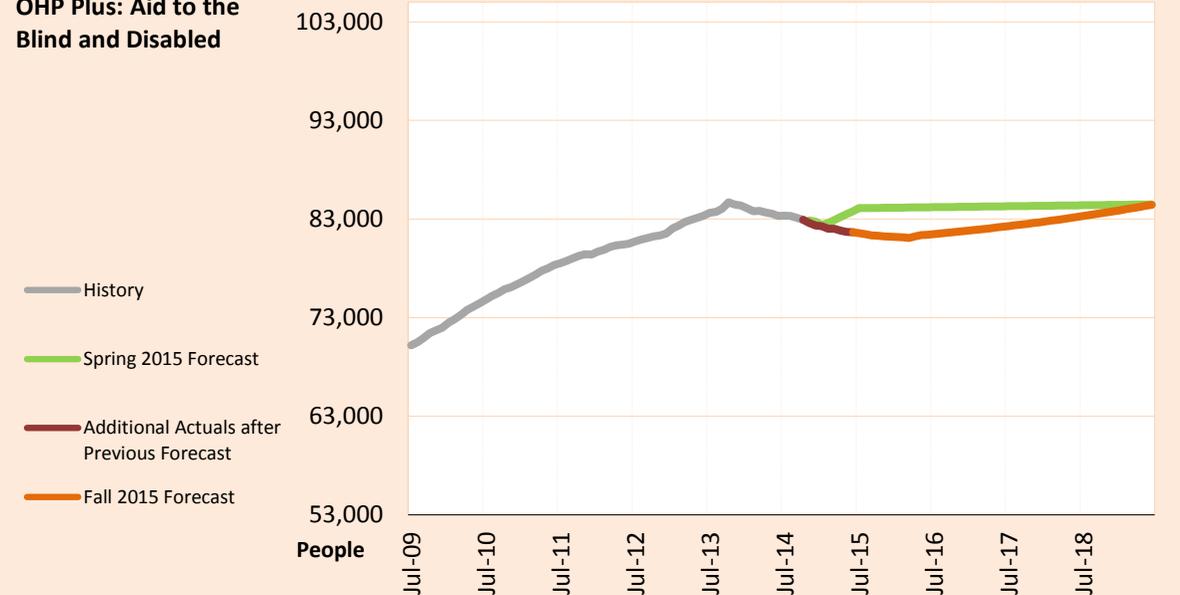
OHP Plus: Old Age Assistance



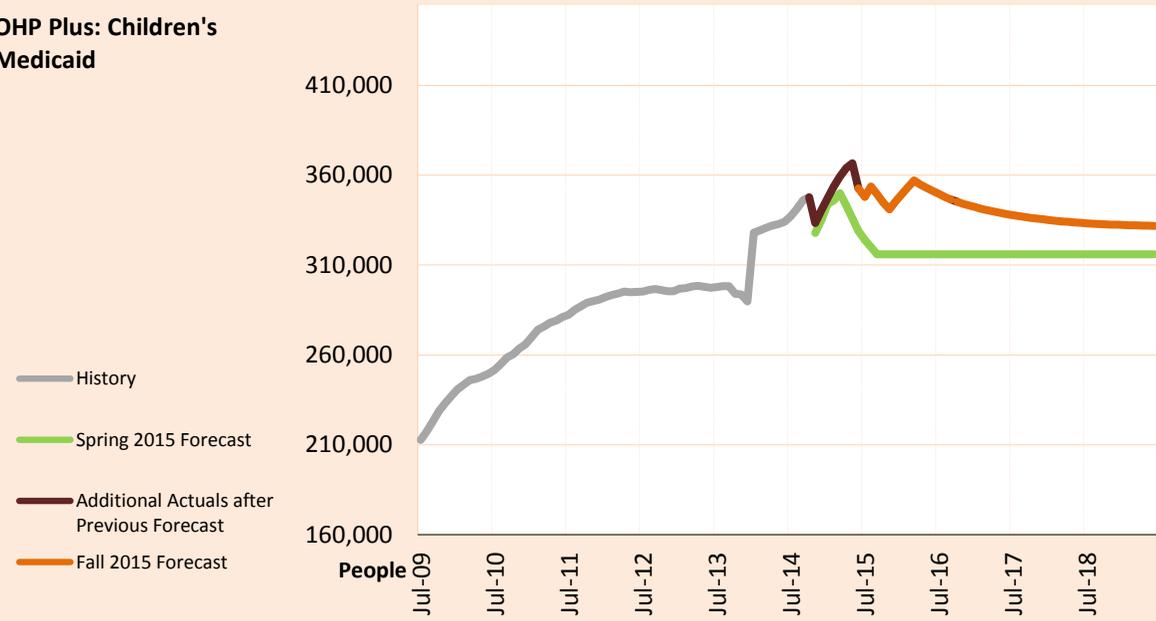
OHP Plus: Pregnant Woman Program



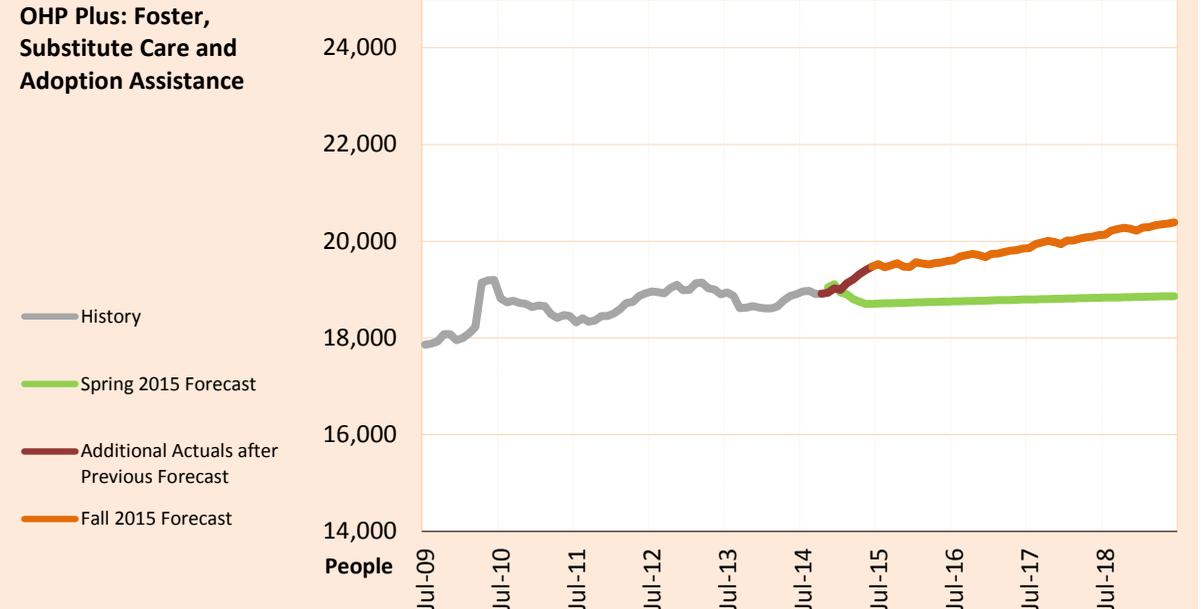
OHP Plus: Aid to the Blind and Disabled



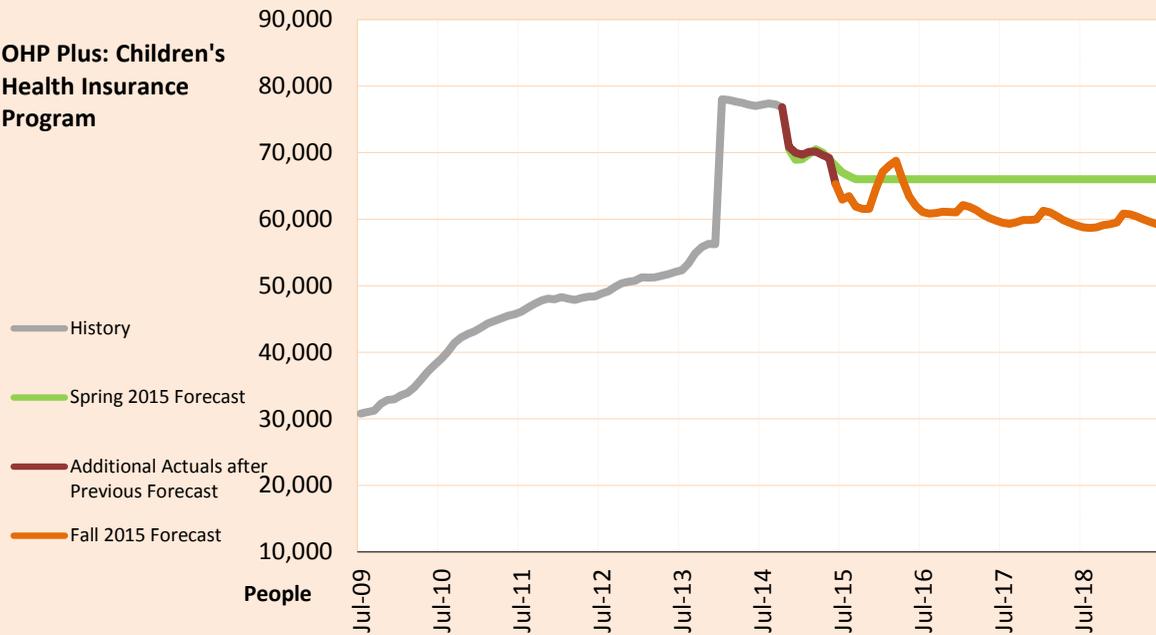
OHP Plus: Children's Medicaid



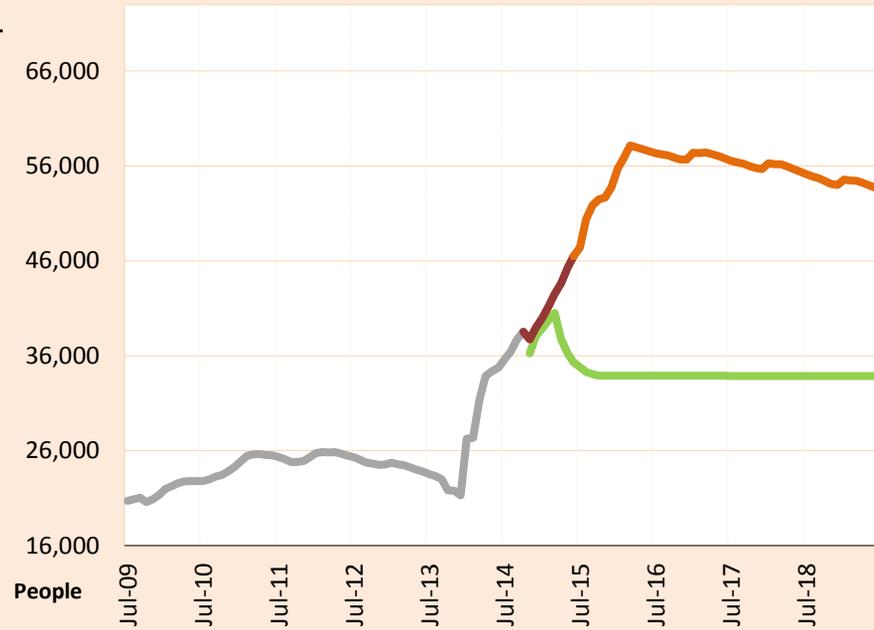
OHP Plus: Foster, Substitute Care and Adoption Assistance



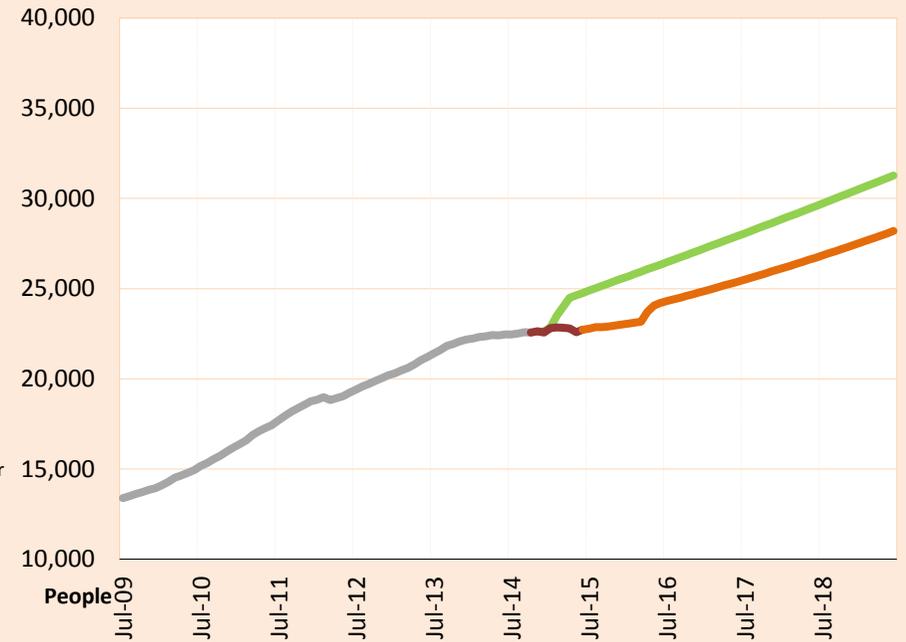
OHP Plus: Children's Health Insurance Program



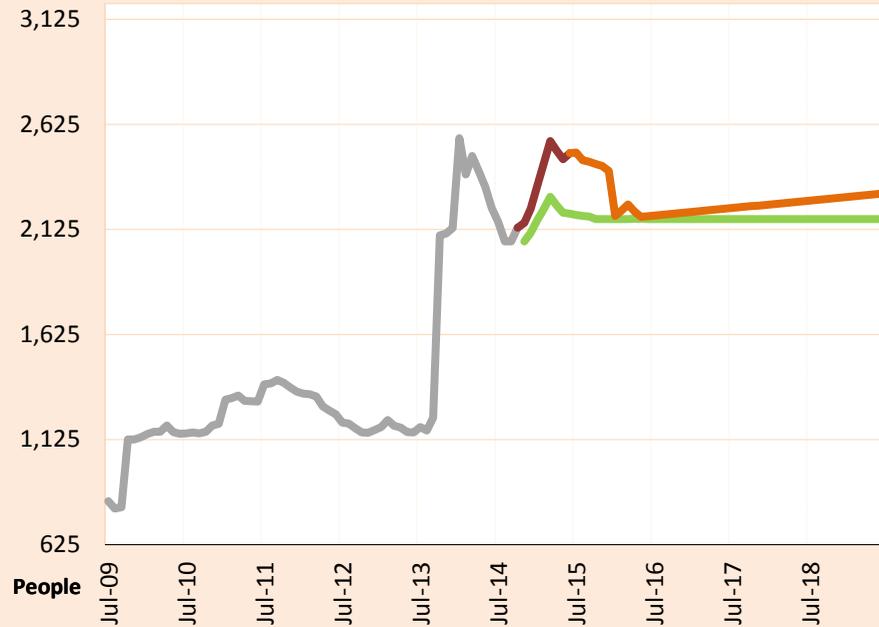
Other: CAWEM - Regular



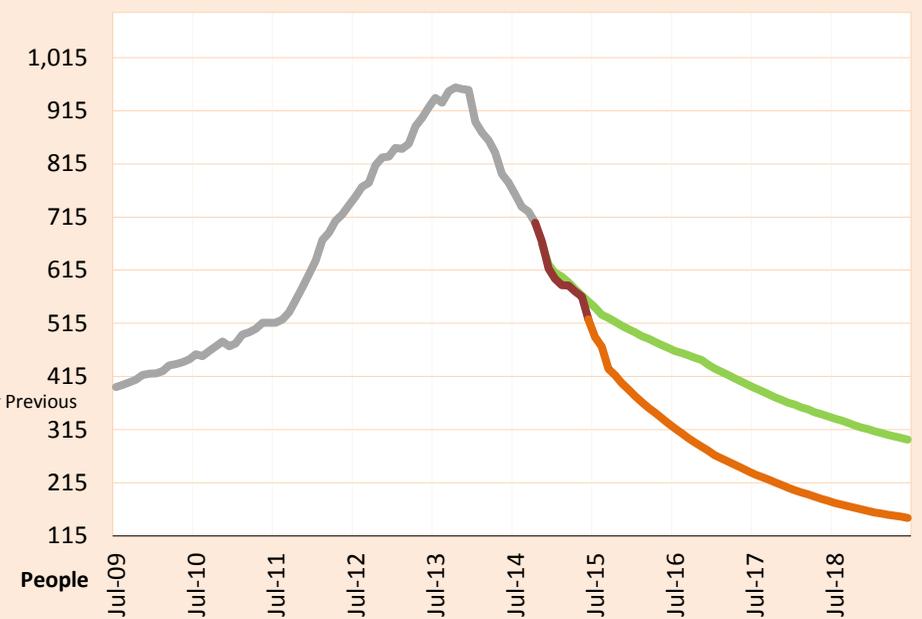
Other: Qualified Medicare Beneficiary



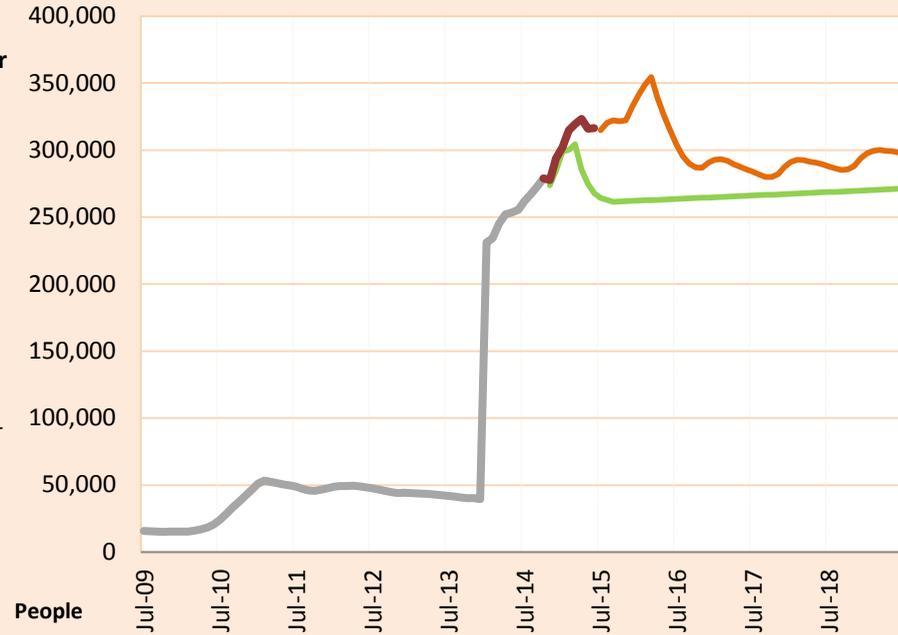
Other: CAWEM - Prenatal



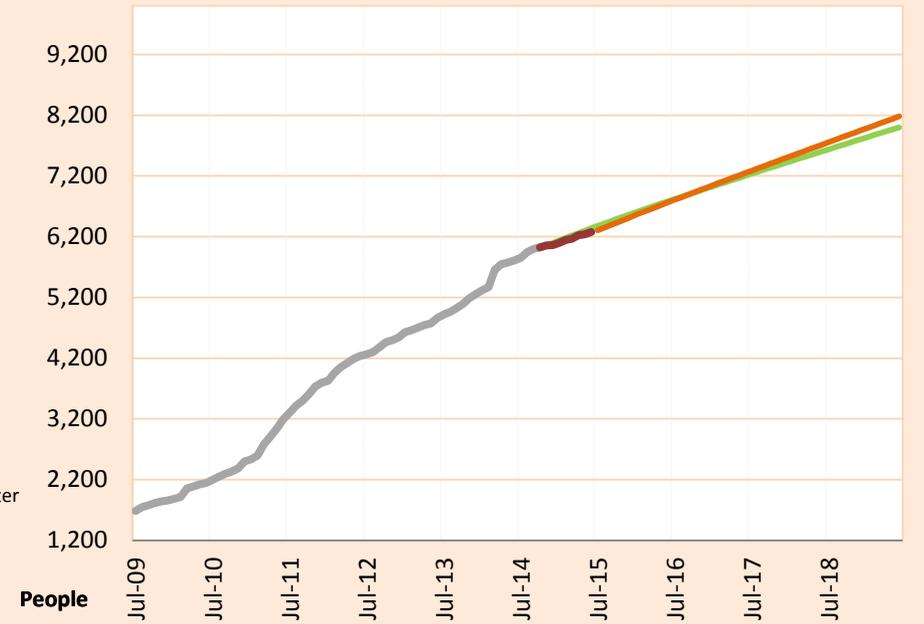
Other: Breast and Cervical Cancer Treatment Program



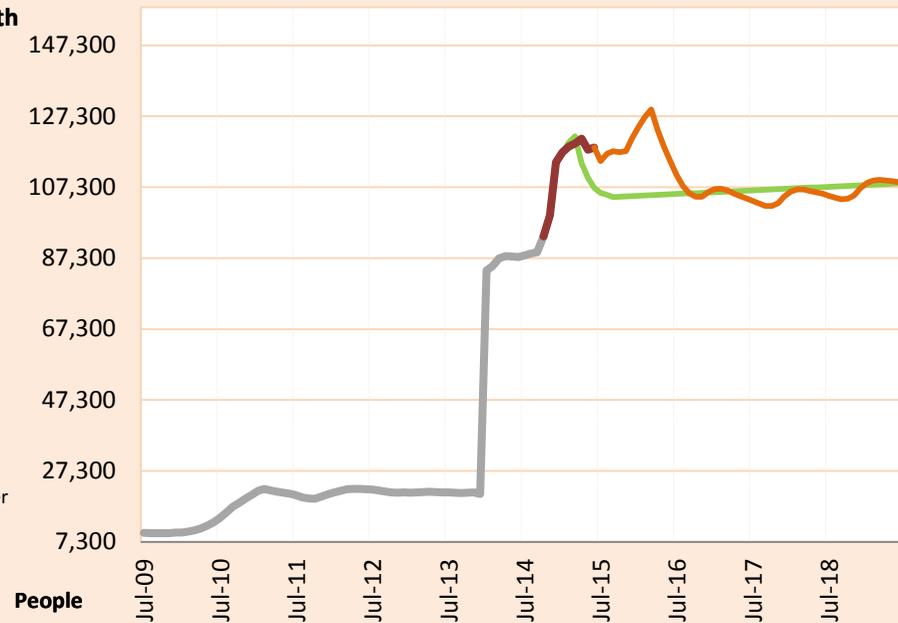
OHP Plus: ACA Adults without Children (Former Standard: Adults & Couples Included)



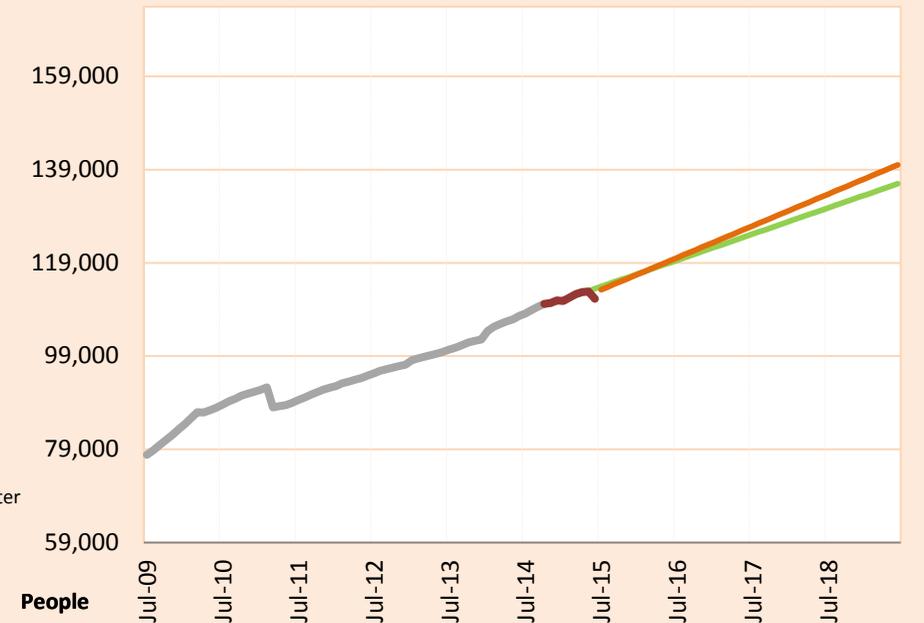
Medicare Buy-In: Part A



OHP Plus: ACA Adults with Children (Former Standard: Families Included)



Medicare Buy-In: Part B



Health Systems Medicaid Biennial Average Forecast comparison

	Current Biennium		% Change Between Forecasts	Fall 15 Forecast		% Change Between Biennia
	Spring 15 Forecast	Fall 15 Forecast		2015-17	2017-19	
OHP Plus						
ACA Adults with children	105,429	113,162	7.3%	113,162	105,745	-6.6%
ACA Adults without children	263,654	310,515	17.8%	310,515	290,161	-6.6%
Total ACA Adults	369,083	423,677	14.8%	423,677	395,906	-6.6%
Parent/Caretaker Relative	48,607	57,850	19.0%	57,850	50,668	-12.4%
Old Age Assistance	41,969	42,009	0.1%	42,009	45,668	8.7%
Pregnant Woman Program	15,431	15,612	1.2%	15,612	13,965	-10.5%
Children's Medicaid Program	316,500	346,569	9.5%	346,569	333,883	-3.7%
Children's Health Insurance Program (CHIP)	66,063	62,631	-5.2%	62,631	59,752	-4.6%
Foster, Substitute & Adoption Care	18,753	19,631	4.7%	19,631	20,145	2.6%
Aid to the Blind & Disabled	84,192	81,558	-3.1%	81,558	83,289	2.1%
Total OHP Plus	960,598	1,049,537	9.3%	1,049,537	1,003,276	-4.4%
Other Medical Assistance Programs						
Citizen-Alien Waived Emergent Medical - Regular	33,955	55,729	64.1%	55,729	55,194	-1.0%
Citizen-Alien Waived Emergent Medical - Prenatal	2,177	2,266	4.1%	2,266	2,262	-0.2%
Qualified Medicare Beneficiary	26,402	24,032	-9.0%	24,032	26,801	11.5%
Breast & Cervical Cancer Treatment Program	468	333	-28.8%	333	183	-45.0%
Other Subtotal	63,002	82,360	30.7%	82,360	84,440	2.5%
Total Medical Assistance Programs	1,023,600	1,131,897	10.6%	1,131,897	1,087,716	-3.9%
Medicare Part A	6,798	6,784	-0.2%	6,784	7,737	14.0%
Medicare Part B	119,319	119,805	0.4%	119,805	133,485	11.4%

Mental Health

This forecast includes clients who are criminally committed and are required to receive mental health services by Oregon law. These two populations are: (1) Aid and Assist, served at the State Hospital; and (2) Guilty Except for Insanity (GEI), served at the State Hospital and in the community. Data for three other forecast groups (Civilly Committed, Previously Mandated, and Never Mandated) are incomplete at this time, due to data system changes. In the future, when providers become more consistent in their use of the Measures and Outcomes Tracking System (known as MOTS), we will be able to resume providing caseload numbers for all Mental Health categories. Information on these categories is still available in the glossary.

Aid and Assist and GEI are mandated mental health services. These are provided through community programs, including residential care, and the Oregon State Hospital system. Community programs provide outpatient services including intervention, therapy, case management, child and adolescent day treatment, crisis, and pre-commitment services. The state hospitals provide 24-hour supervised care to people with the most severe mental health disorders.

Total Forensic Mental Health Services — The forensic caseload encompasses the Aid and Assist and GEI clients. The biennial average forecast for 2015-17 is 812 clients. The 2017-19 biennial average is 809 clients, 0.4 percent lower than 2015-17 biennial average.

Aid and Assist — This caseload exhibited steady growth throughout 2013 and into 2014. The Fall 2015 biennial average forecast for 2015-17 is 207 clients. As mobile forensic evaluation teams become more common, Aid and Assist in the State Hospital will likely decrease, but the timing of this is unknown. Although the numbers in the State Hospital will decrease, the number served will increase, so it will be important to track them in the community. The 2017-19 biennial average is 208 clients, 0.5 percent higher than the biennial average forecast for 2015-17.

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 Fall 2015 biennial average forecast

for 2015-17 is 605. The 2017-19 biennial average is 601, 0.7 percent lower than the biennial average forecast for 2015-17.

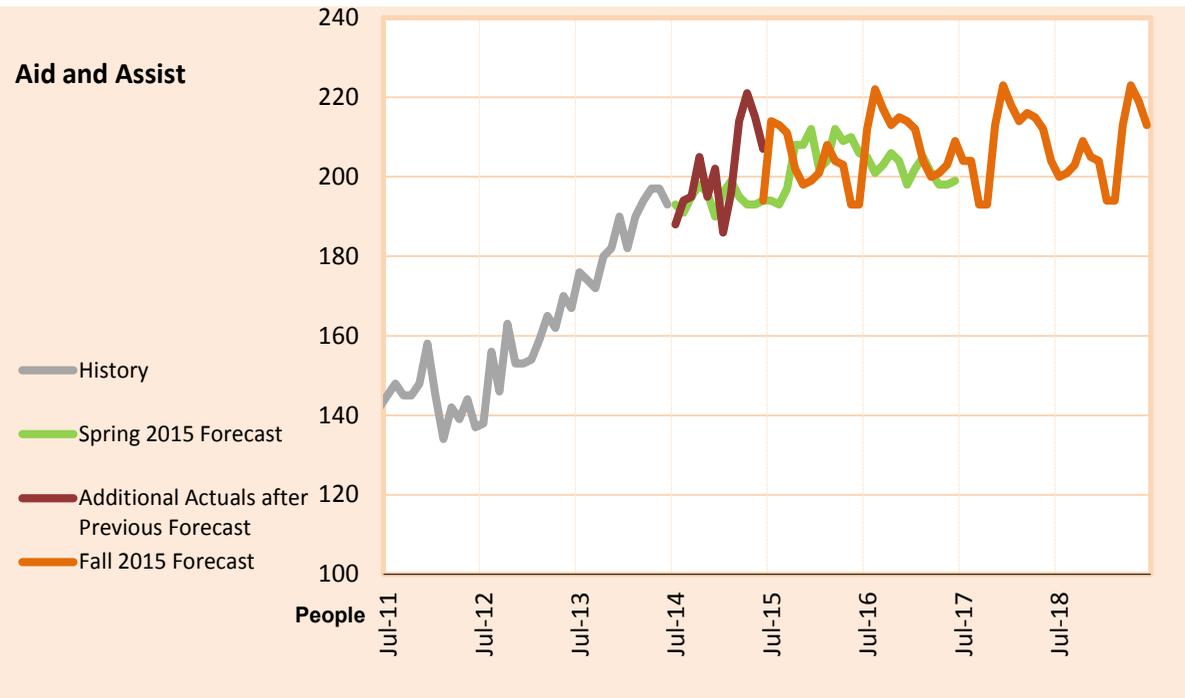
Risks and Assumptions

These forecasts were developed using common statistical methods based on month-to-month changes in caseload history. External factors such as population growth or program policies did not influence the forecast except to the degree they influence historical trends. Therefore, the base forecast assumption is that current trends will continue unchanged through the forecast horizon of June 2019.

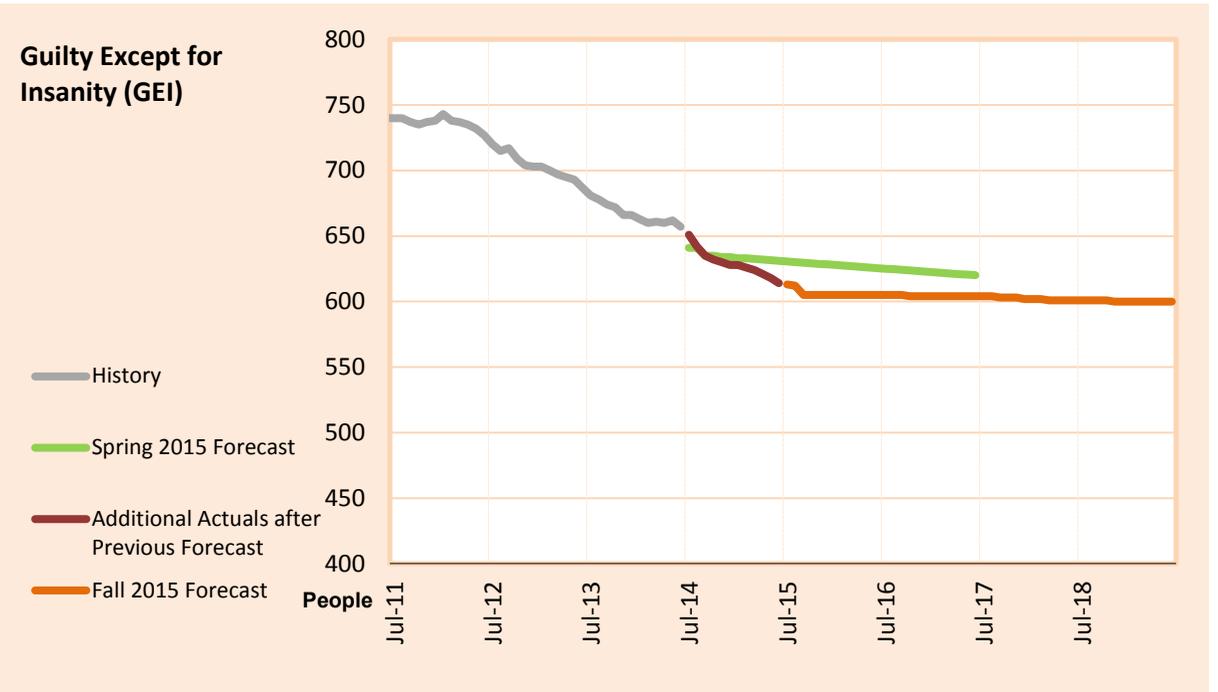
The Aid and Assist caseload may be impacted by community level efforts to keep people out of the State Hospital. In particular, misdemeanor admissions have significantly decreased in Marion County, and this may spread to other counties. In addition, program leadership is promoting the idea that Aid and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

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.

Aid and Assist



Guilty Except for Insanity (GEI)



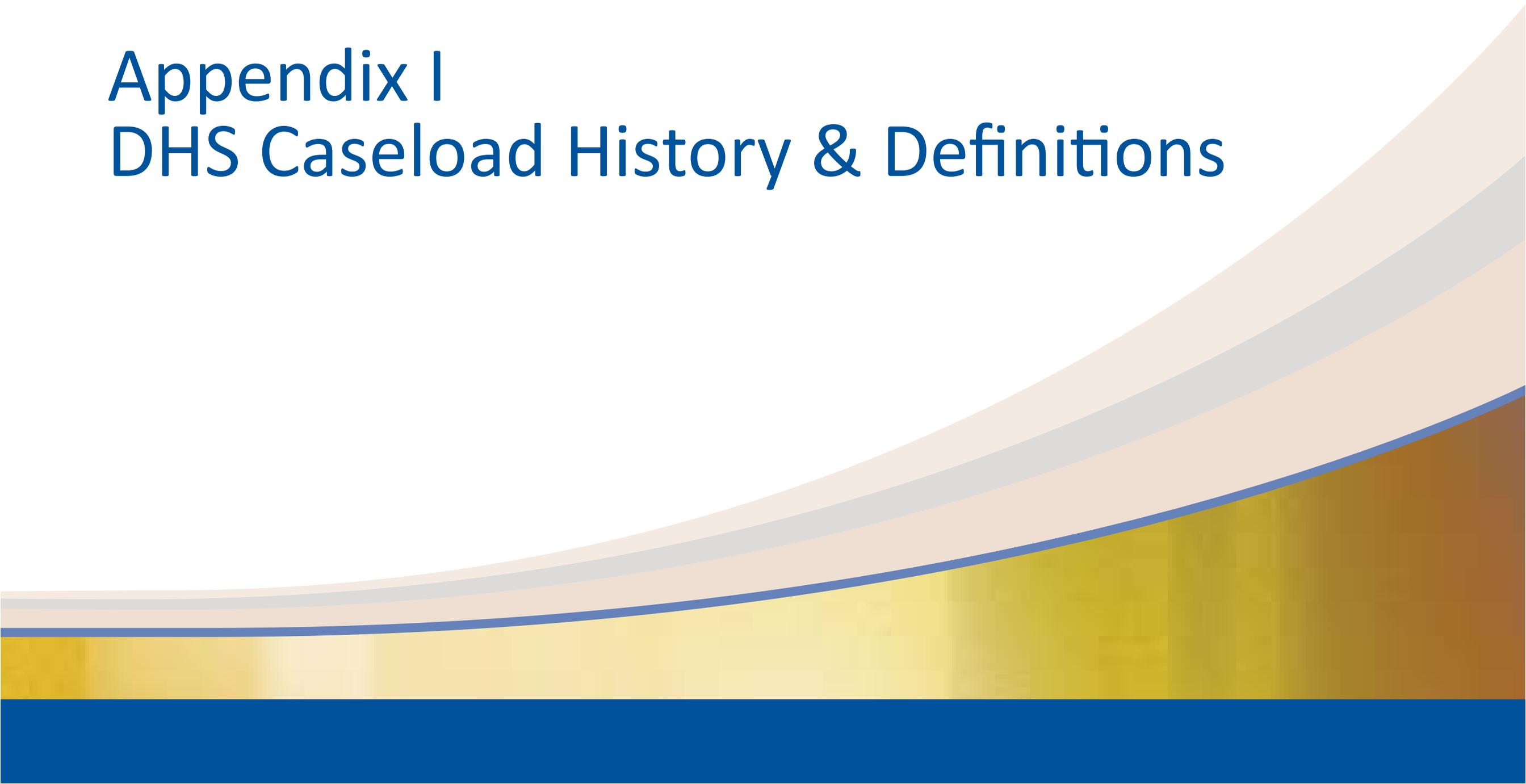
Mental Health Biennial Average Forecast comparison¹

	Current Biennium		% Change Between Forecasts	Fall 15 Forecast		% Change Between Biennia
	Spring 15 Forecast	Fall 15 Forecast		2015-17	2017-19	
Under Commitment						
Aid and Assist	203	207	2.0%	207	208	0.5%
Guilty Except for Insanity (GEI)	625	605	-3.2%	605	601	-0.7%
Total Forensic	828	812	-1.9%	812	809	-0.4%

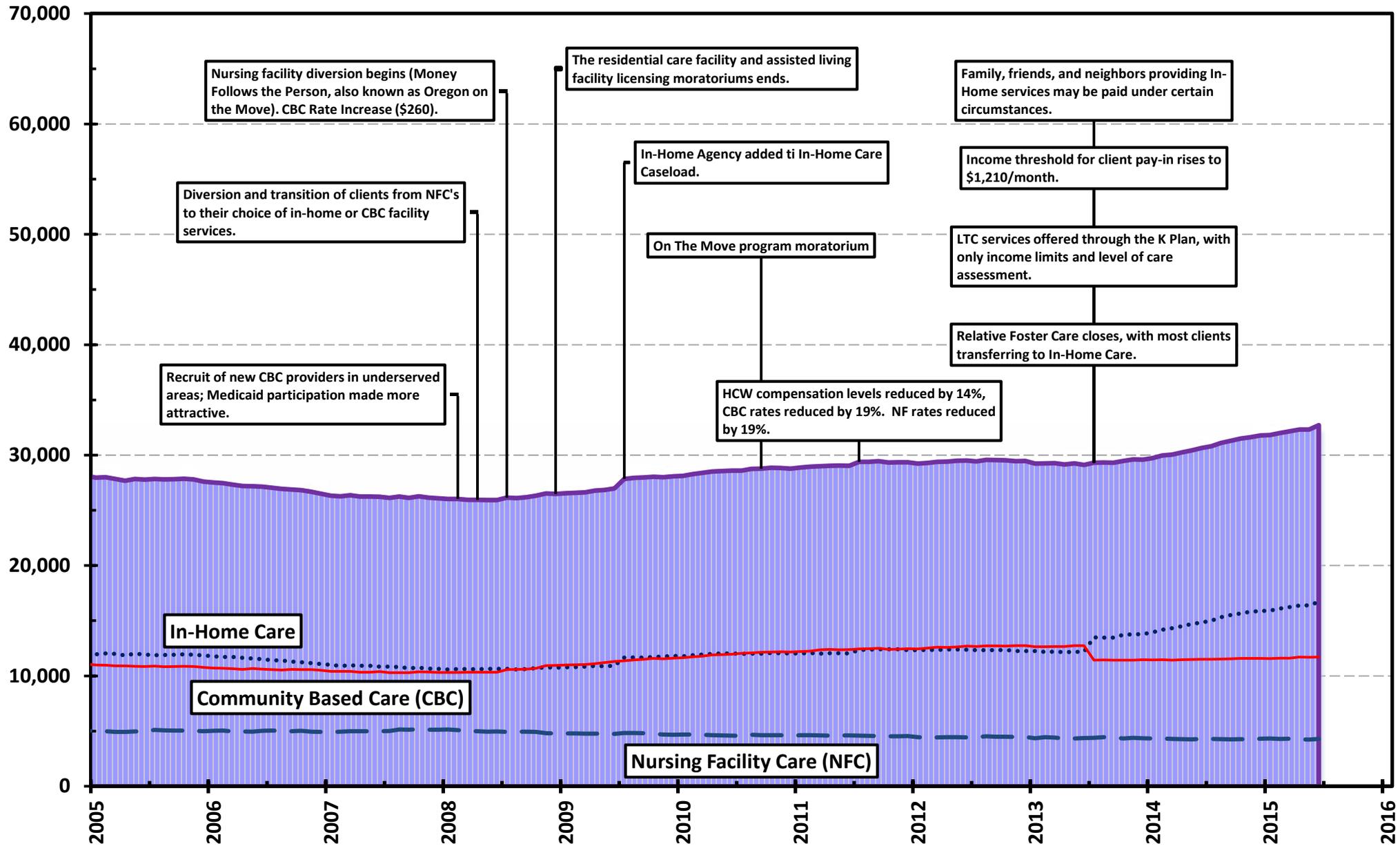
1. Several data system changes occurred following the Spring 2015 forecast: 1) CPMS ended, and 2) providers have been continuing to transition to utilization of the MOTS system. Consequently, the Civilly Committed, Previously Mandated, and Never Mandated caseload categories are incomplete at this time. In the future, when providers become more consistent in their use of the new MOTS system, we will be able to resume providing caseload numbers for all Mental Health categories.

Appendix I

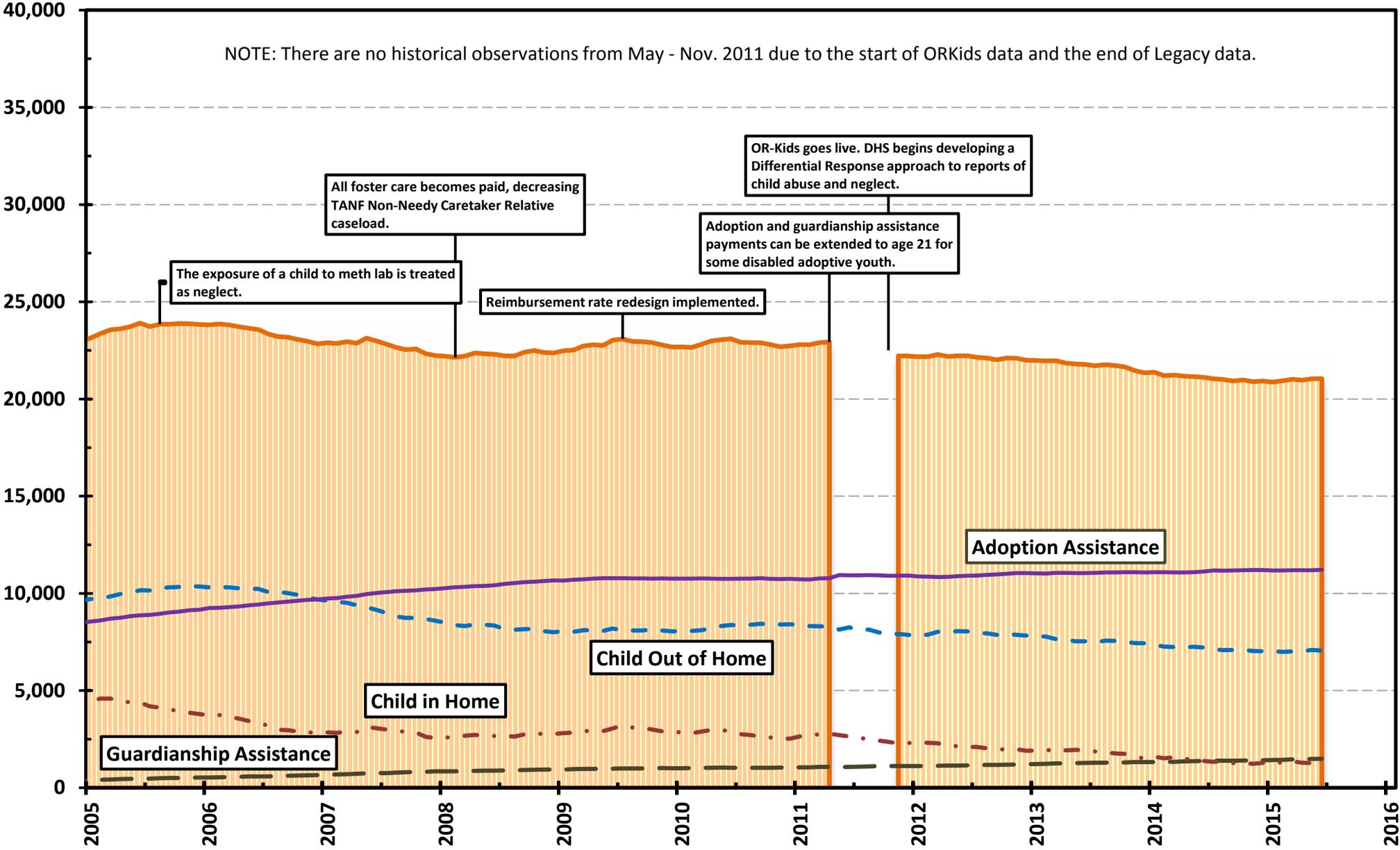
DHS Caseload History & Definitions



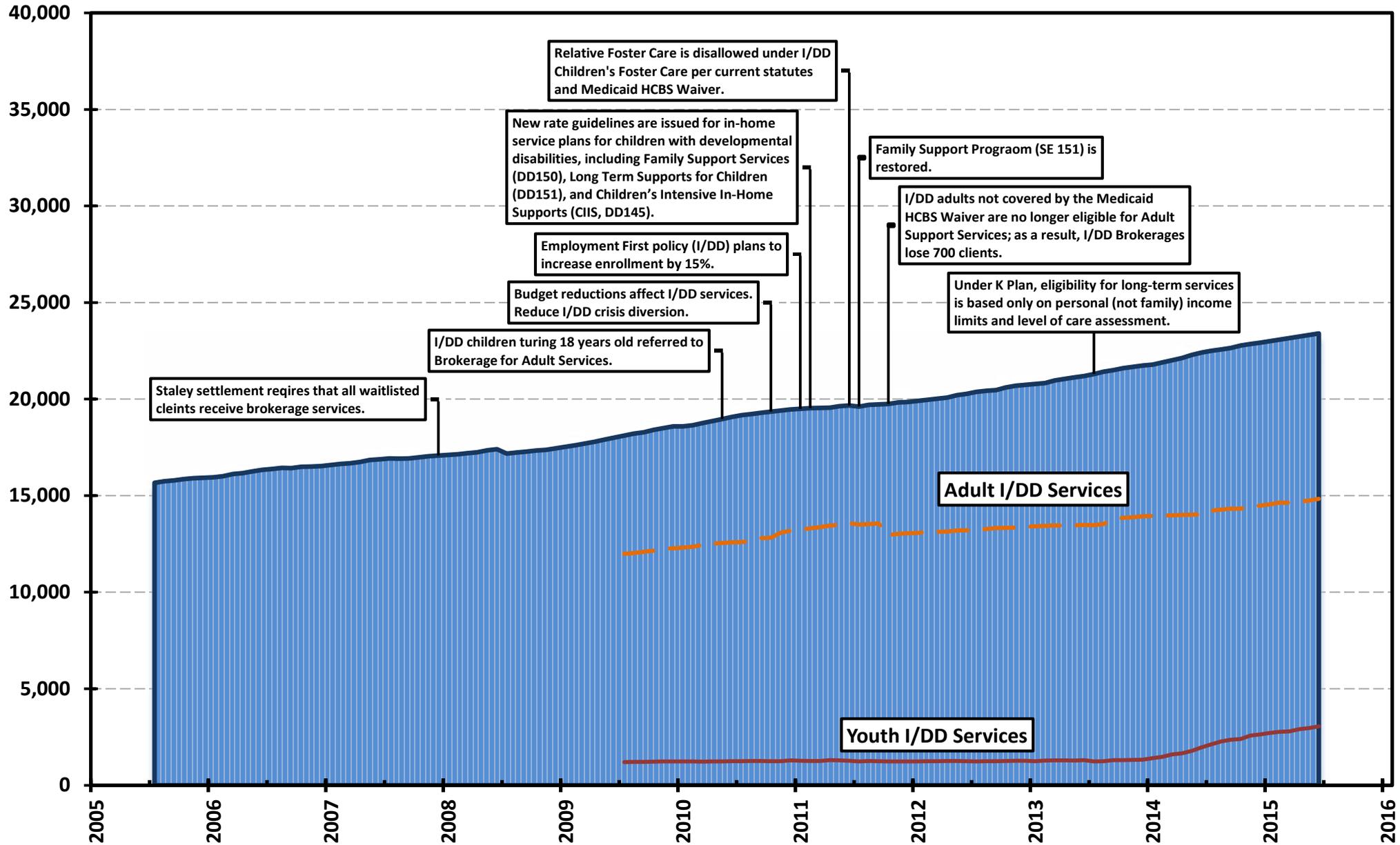
Aging and People with Disabilities (APD) Caseload



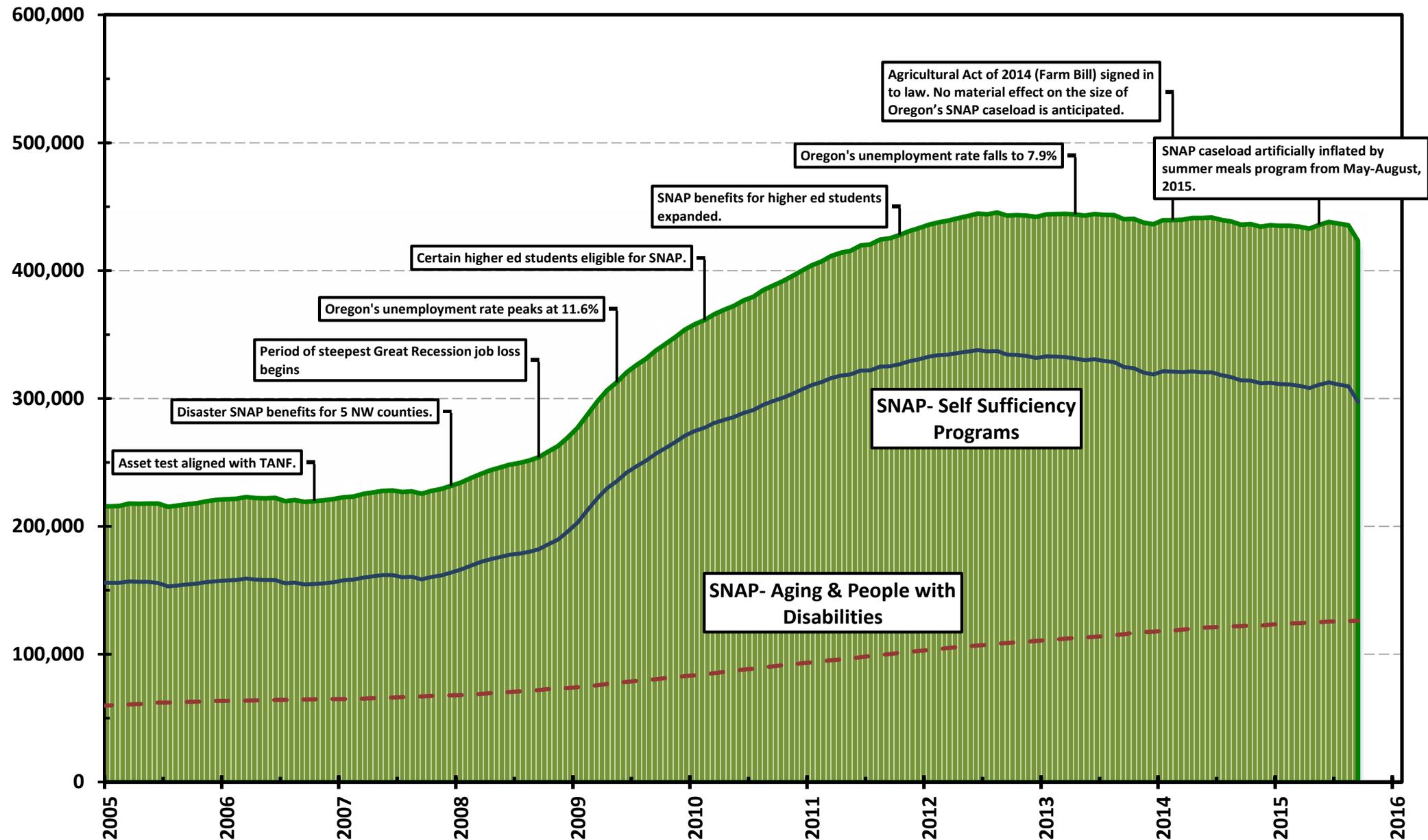
Child Welfare (CW) Caseload



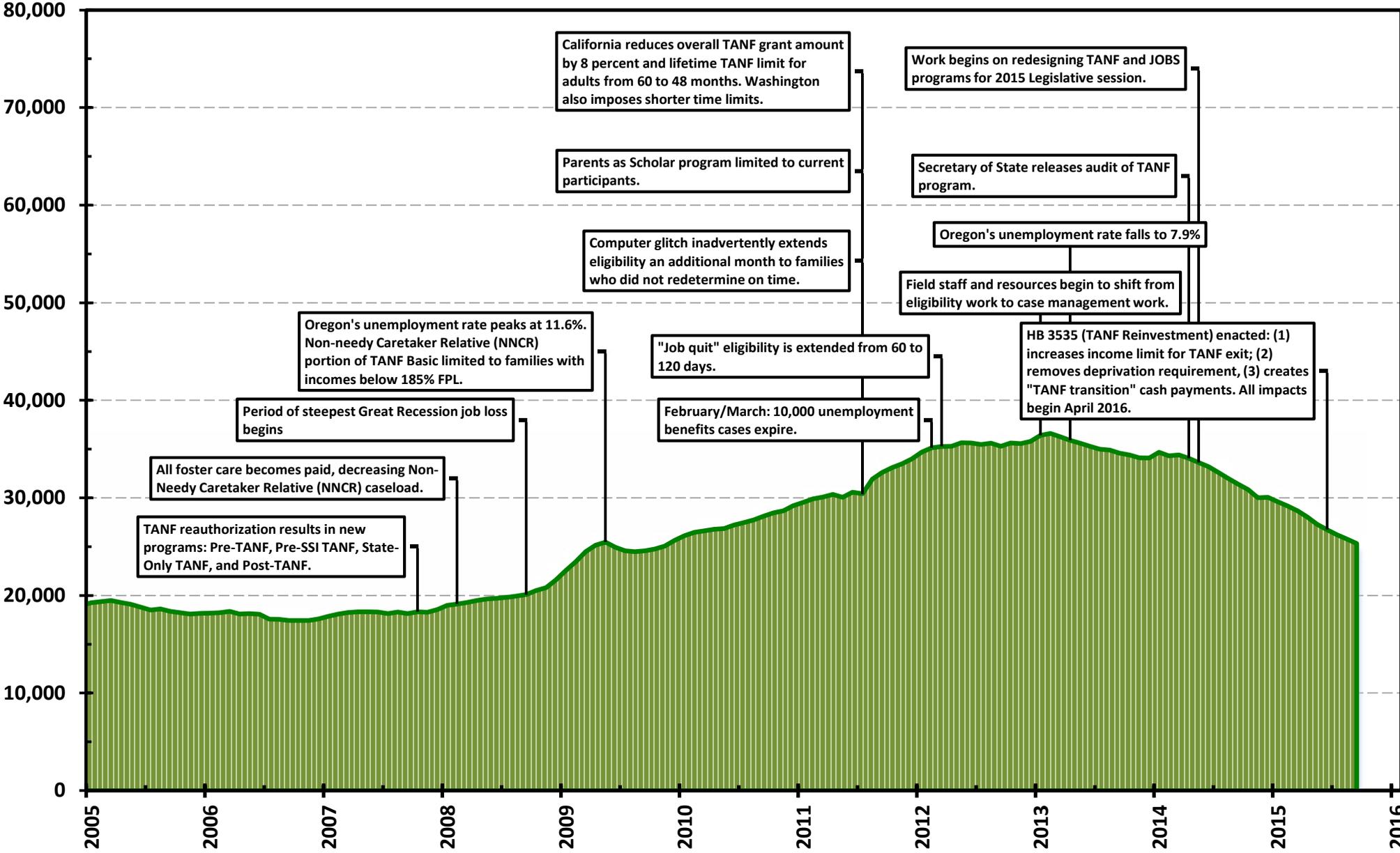
Intellectual & Developmental Disabilities (I/DD): Case Management Enrollment



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



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



Federal Poverty Level (FPL)

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

2015 Poverty Guidelines for Oregon

Person in Family/ Household	Poverty Guidelines
1	\$11,770
2	\$15,930
3	\$20,090
4	\$24,250
5	\$28,410
6	\$32,570
7	\$36,730
8	\$40,890

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

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. The SPPC does not require level of care determination while K plan and waiver services require that a person is determined to meet the level of care criteria.

COMMUNITY-BASED CARE (CBC)

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

Assisted Living Facilities

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

Adult Foster Care

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

Residential Care Facilities

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

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

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

NURSING FACILITIES (NFC)

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

Basic Care

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

Complex Medical Add-On

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

Enhanced Care

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

Pediatric Care

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

CHILD WELFARE

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

The Child Welfare caseload is an unduplicated count of children served in the various programs listed below. A child can be counted only once during a month, and if there is participation in more than one of the programs listed below, they are counted in only one group. The groups are listed below in order of this counting priority.

Adoption Assistance

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

Guardianship Assistance

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

Out-of-Home Care

Out-of-Home Care programs provide a safe, temporary home for abused or neglected children who cannot remain safely in their homes. Children in the program are placed with relatives, foster families, or in residential treatment care settings. The program

aims to reunite children with their parents. Out-of-Home Care services can include financial support and/or medical help for costs associated with the child's needs.

Child-In-Home

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

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (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

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

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

Adult services include:

Brokerage Enrollment

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

24-Hour Residential Care

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

Supported Living

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

Comprehensive In-Home Services (CIHS)

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

I/DD Foster Care

Foster Care provides 24-hour care, supervision, provision of room and board, and assistance with activities of daily living for both adults and children (approximately 82 percent and 18 percent respectively).

Stabilization and Crisis Unit

Stabilization and Crisis Unit (previously called State Operated Community Programs) offers safety net services and support to the most vulnerable, intensive, medically and behaviorally challenged I/DD clients when no other community based option is available to them. The program serves both adults and children (approximately 89 percent and 11 percent respectively).

Children's Services include:

In-Home Support for Children

In-Home Support for Children (also called Long-Term Support) provides services to individuals under the age of 18 in the family home.

Children Intensive In-Home Services

Children Intensive In-Home Services cares for children with intensive medical or behavioral needs in their own homes. This caseload is composed of three distinct groups: Medically Fragile Children Services, Intensive Behavior Program, and Medically Involved Programs.

Children Residential Care

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

Children Proctor Care (discontinued December 31, 2013)

This program was ended and clients were transferred to other caseloads – primarily to I/DD Foster Care and other children services including In-Home Support.

Other I/DD Services include:

Employment and Day Support Activities

Employment and Day Support Activities are out-of-home employment or community training services and related supports, provided to individuals aged 18 or older, to improve the individuals' productivity, independence and integration in the community. Changes to this category are anticipated in the near future.

Transportation

Transportation services are state-paid public or private transportation provided to individuals with intellectual and developmental disabilities.

Crisis Services

Crisis Services offer temporary out-of-home placement services to I/DD adults and children.

SELF SUFFICIENCY PROGRAMS (SSP)

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

Supplemental Nutrition Assistance Program (SNAP)

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

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

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

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

Temporary Assistance to Needy Families (TANF)

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

Recipients must meet basic TANF asset requirements (including a \$2,500 - \$10,000

resource limit and income less than 40 percent of FPL) to be eligible for the program. They must also meet non-financial eligibility requirements including dependent children in the case, Oregon residence, citizenship status, parental school attendance, pursuing assets, deprivation (death, absence, incapacity, or unemployment of a parent) and pursuing treatment for drug abuse or mental health as needed.

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

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

Pre-SSI

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

Temporary Assistance to Domestic Violence Survivors (TA-DVS)

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

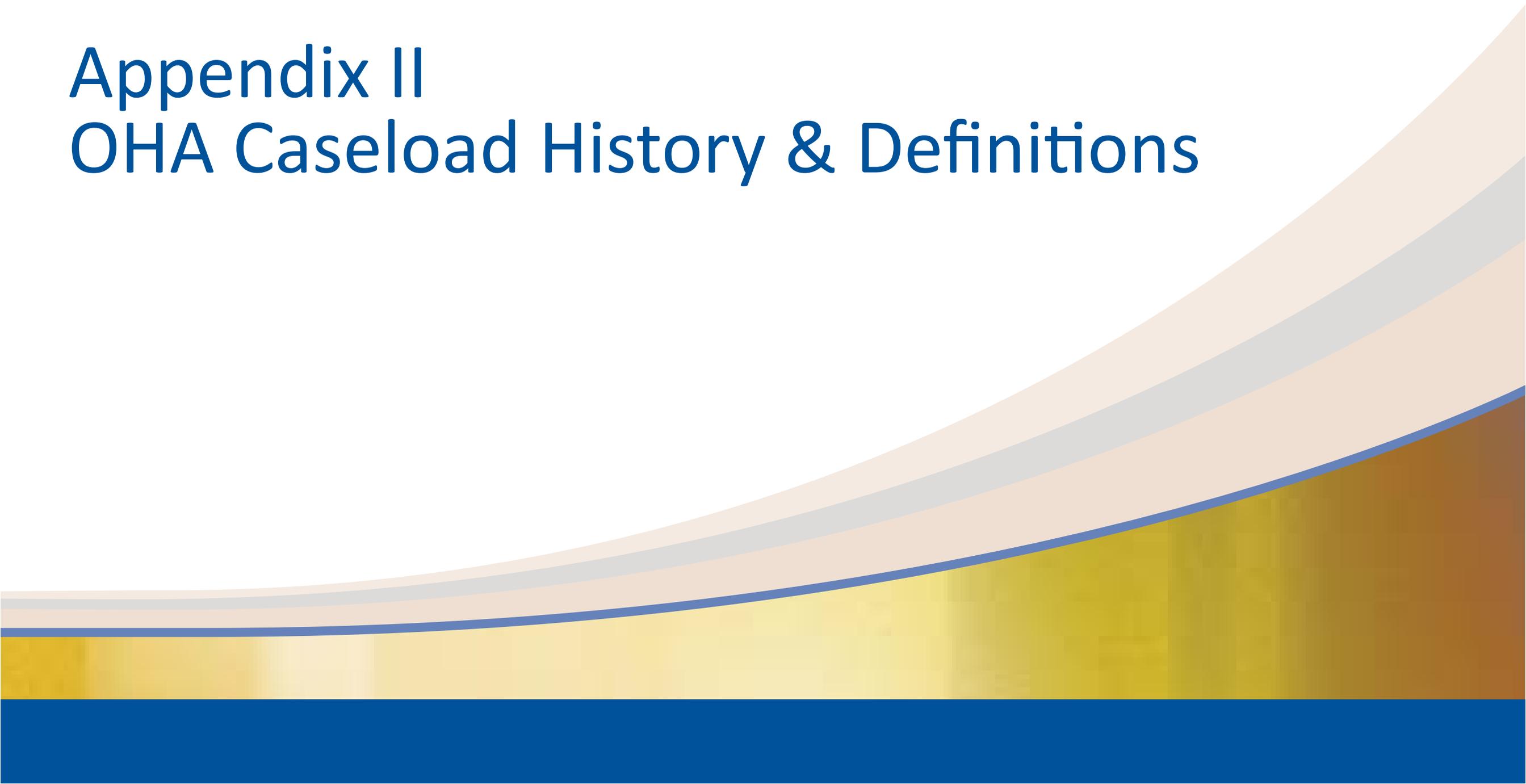
To be eligible for TA-DVS, a survivor must have a current or future risk of domestic violence; be a pregnant woman, or a parent or relative caring for a minor child; and must have income not exceeding TANF limits (40 percent of FPL) TA-DVS only considers income on hand that is available to meet emergency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

VOCATIONAL REHABILITATION (VR)

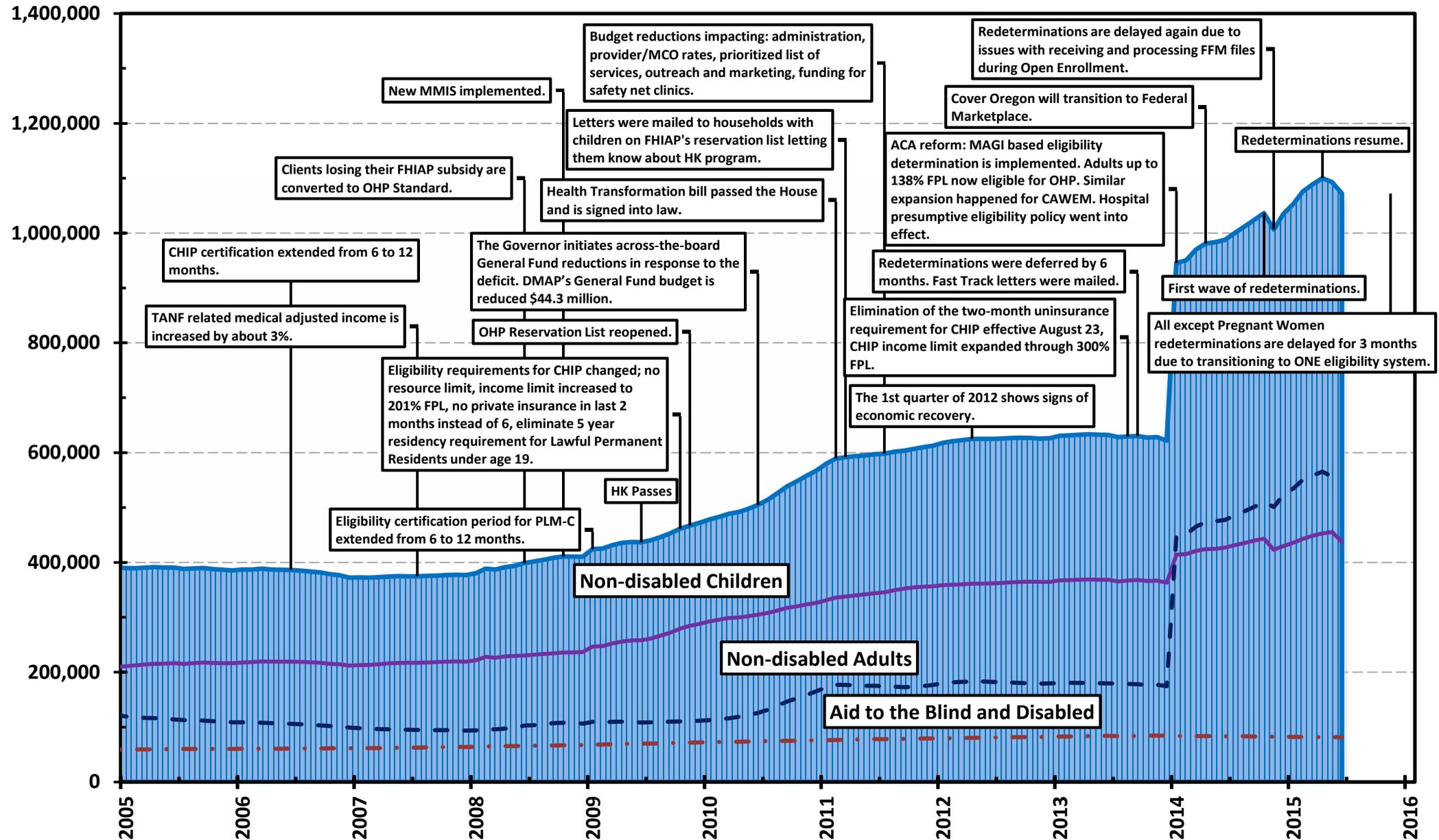
Vocational Rehabilitation (VR) Services assess, plan, and coordinate vocational rehabilitation services for people who have physical or mental disabilities and need assistance to obtain and retain employment that matches their skills, potential, and interest. Services are provided through local Vocational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

Appendix II

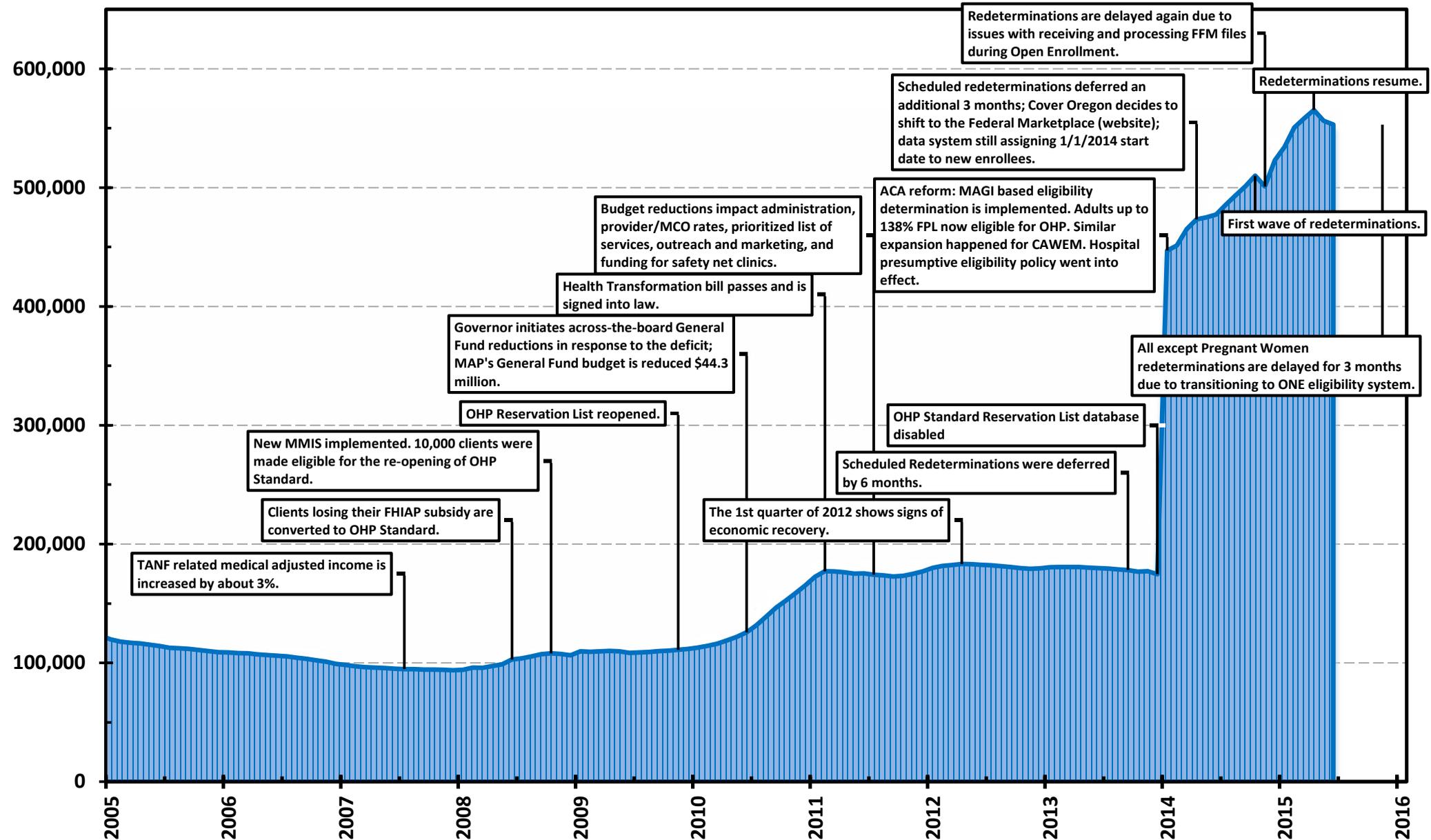
OHA Caseload History & Definitions



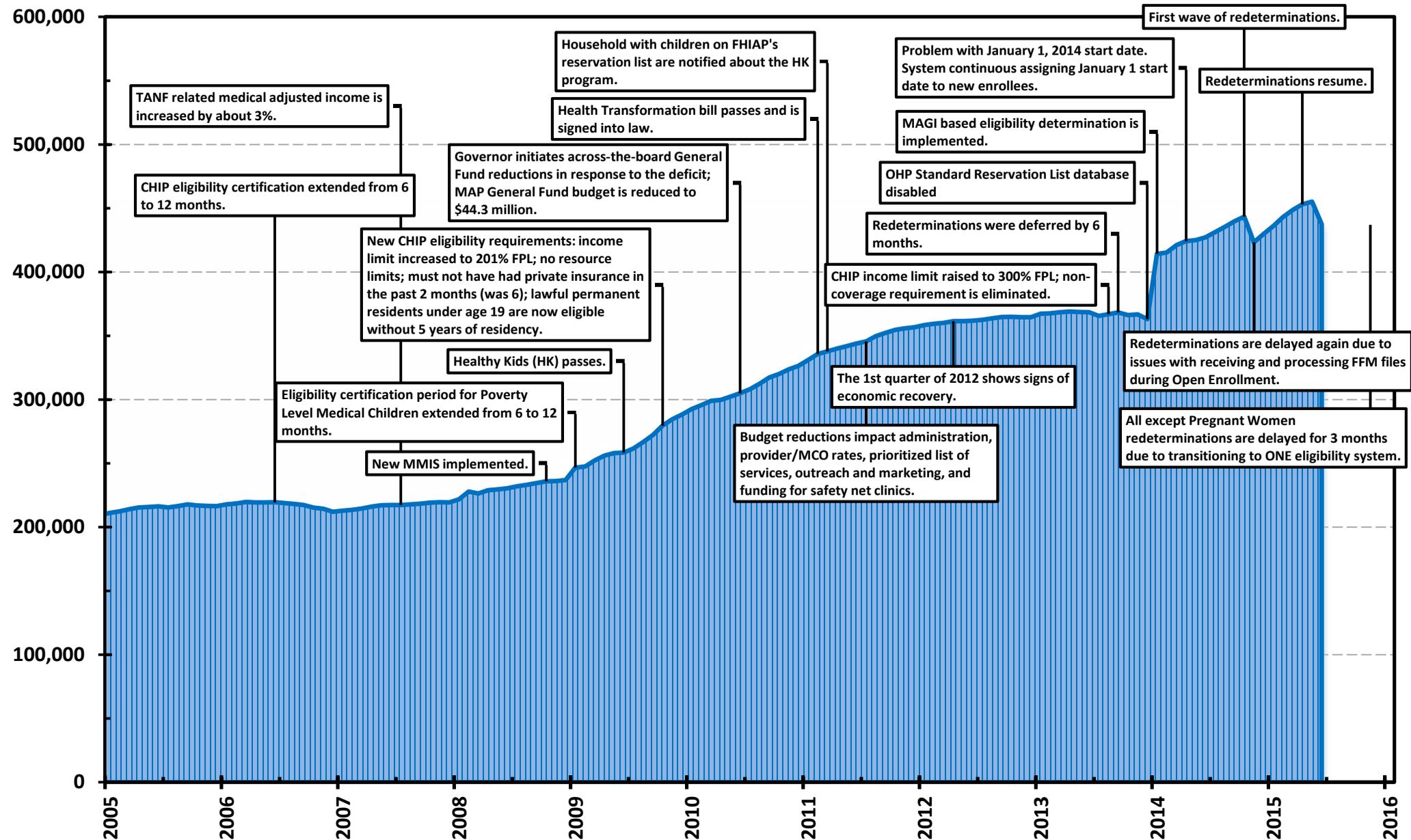
Health Systems - Medicaid, Total Oregon Health Plan - Plus and Standard



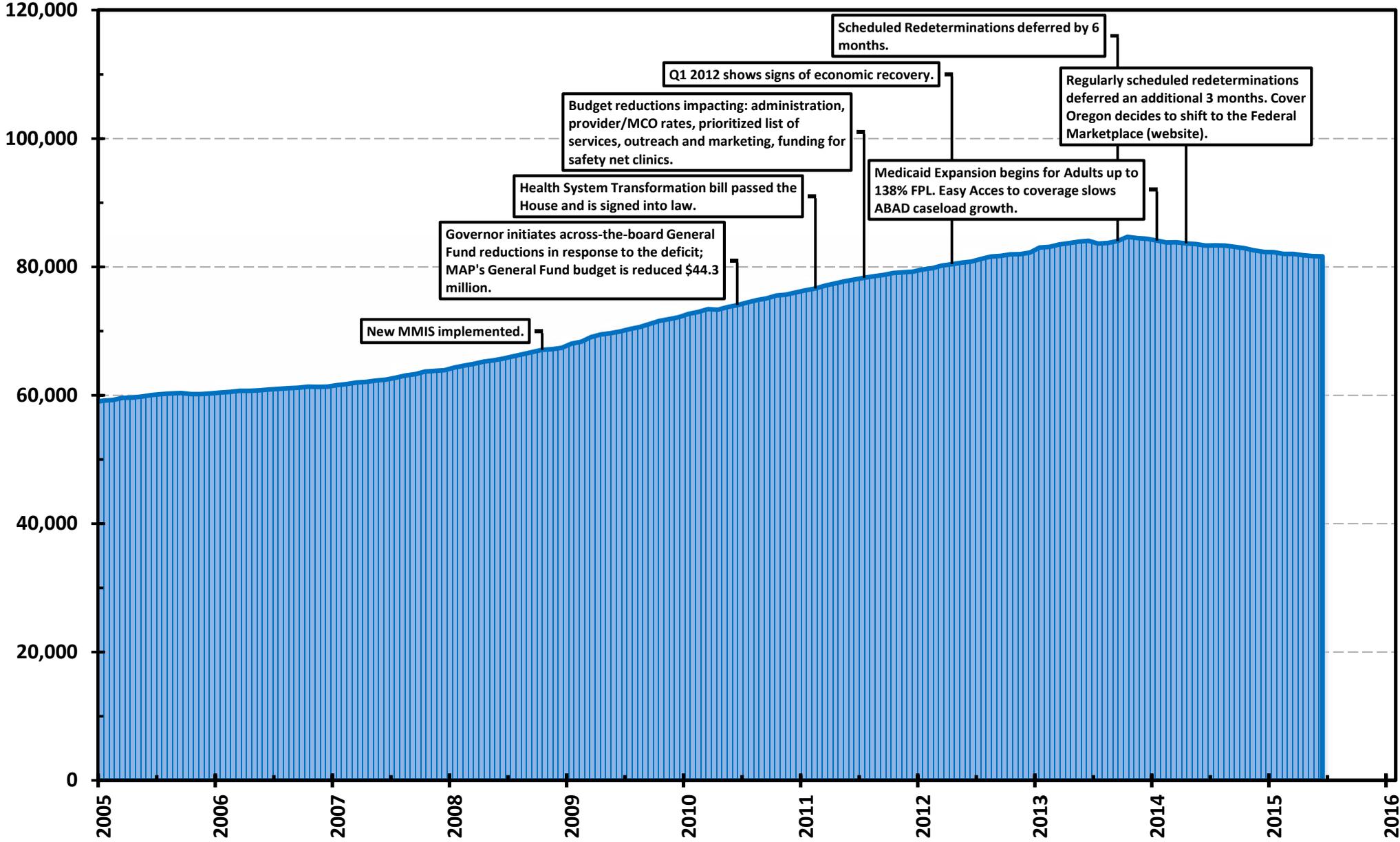
Health Systems - Medicaid, Non-Disabled Adults



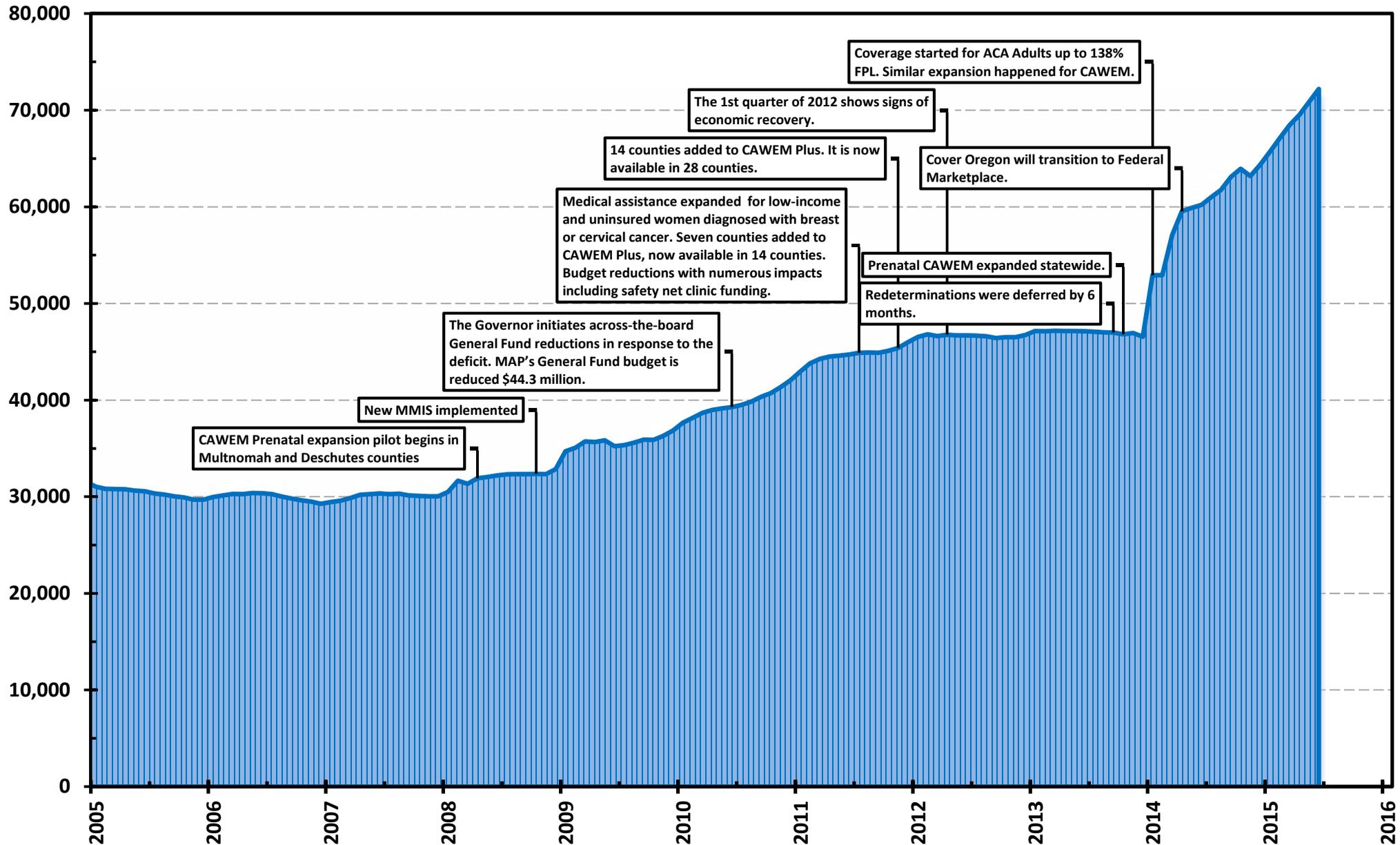
Health Systems - Medicaid, Non-Disabled Children



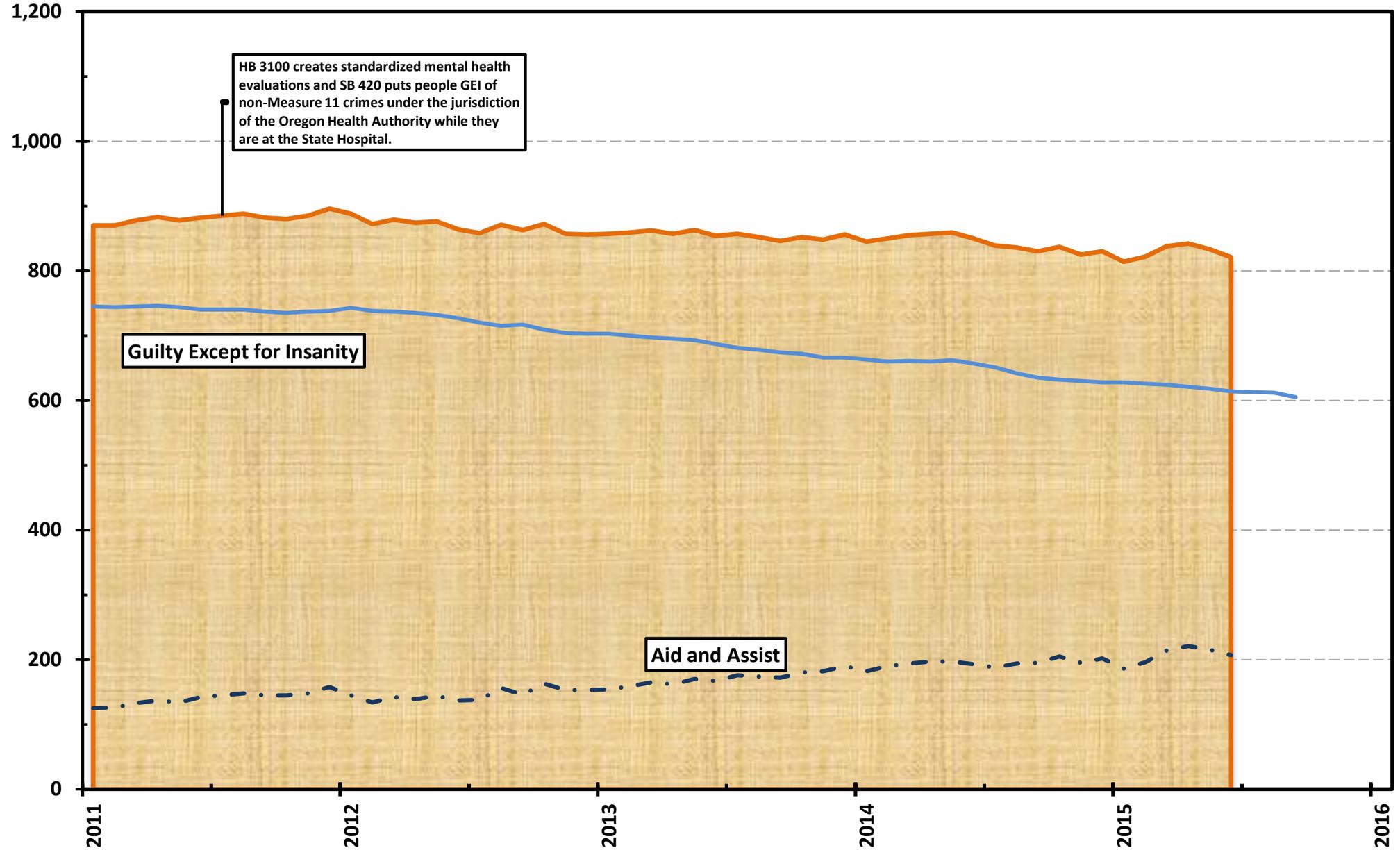
Health Systems - Medicaid, Aid to the Blind and Disabled



Health Systems - Medicaid, Other



Mental Health (MH): Total Forensic Mental Health Caseload



Federal Poverty Level (FPL)

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

2015 Poverty Guidelines for Oregon

Persons in Family/ Household	Poverty guideline
1	\$11,770
2	\$15,930
3	\$20,090
4	\$24,250
5	\$28,410
6	\$32,570
7	\$36,730
8	\$40,890

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

HEALTH SYSTEMS MEDICAID (HSM)

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

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

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

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

OHP Plus Benefit Package

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

ACA Adults

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

Pregnant Woman Program

This is the new name for Poverty Level Medical Women (PLMW). The Pregnant Woman Program provides medical coverage to Pregnant Woman with income levels

up to 185 percent of the FPL. Coverage is extended for 60 days after childbirth.

Parent/Caretaker Relative

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

Temporary Assistance for Needy Families (TANF)

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

Children's Medicaid Program

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

Poverty Level Medical Children (PLMC)

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

Children's Health Insurance Program (CHIP)

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

Foster, Substitute, and Adoption Care

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

Aid to the Blind and Disabled Program (ABAD)

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

Old Age Assistance (OAA)

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

OHP Standard Benefit Package (discontinued December 31, 2013)

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

Other Medical Assistance Programs (Non-OHP Benefit Packages)

Citizen/Alien Waived Emergent Medical (CAWEM)

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

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

Qualified Medicare Beneficiary (QMB)

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

Breast and Cervical Cancer Treatment Program (BCCTP)

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

Medicare Part A and Medicare Part B

Low income Oregonians who are eligible for Medicare are also eligible for benefits from the state. The benefits vary by income level and disability status. For clients who are eligible for both Medicaid and Medicare, the state provides: Medicaid services not covered by Medicare, Medicare Part A/B premiums, and cost sharing (co-payments, deductible, etc.). Qualified Medicare Beneficiaries (QMB) receive Medicare Part A/B premium assistance and cost sharing from the state. Individuals with incomes up to 133% FPL that do not qualify for traditional Medicaid or QMB receive just Medicare Part B premium assistance. Medicare Part A is a count of individuals receiving state assistance with Medicare Part A premiums, regardless of what caseload group they are in. Similarly, Medicare Part B is a count of individuals receiving state assistance with Medicare Part B premiums, regardless of what caseload group they are in. Medicare Part A and Medicare Part B counts are not mutually exclusive, in fact most individuals receiving Part A premium assistance also receive Part B premium assistance (the opposite is not true).

MENTAL HEALTH (MH)

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

The mental health caseload groups have been redefined starting with the Fall 2014 forecast. The MH caseload forecast is the total number of 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 until they are fit to stand trial. "Fitness to Proceed" means that the client is able to understand and assist the attorney. Clients in the Aid and Assist caseload receive psychiatric assessment and treatment until they are able to assist their attorney and stand trial.

Guilty Except for Insanity (GEI)

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

Civil Commitment

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

Previously Committed

This is a new caseload. The Previously Committed caseload includes people who were previously either civilly or criminally committed but whose commitment period has ended. These clients continue to receive individual services, counseling, training, and/or living supports. About 85 percent of these clients are served in non-residential settings.

Never Committed

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



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.