SPRING 2018 DHS-OHA CASELOAD FORECAST

Budget Planning and Analysis
Office of Forecasting, Research and Analysis

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Executive Summary

The 2017-19 **Aging and People with Disabilities Long–Term Care (LTC)** biennial average forecast is 35,407 clients, which is 1.8 percent lower than the Fall 2017 forecast. The 2019-21 biennial average forecast is 37,304 clients, which is 5.4 percent higher than the 2017-19 forecast average.

The 2017-19 **Child Welfare (CW)** biennial average forecast is 21,951 children, which is 1.6 percent lower than the Fall 2017 forecast. The 2019-21 biennial average forecast is 22,151 children, which is 0.9 percent higher than the 2017–19 forecast average.

The 2017-19 **Health Systems Medicaid (HSM)** biennial average forecast for Total Medicaid (which does not include the non-Medicaid Cover All Kids group) is 1,042,591 clients, which is 0.9 percent higher than the Fall 2017 Forecast. The 2019-21 biennial average forecast is 1,036,627 clients, which is 0.6 percent lower than the 2017-19 forecast average.

The 2017-19 **Intellectual and Developmental Disabilities Case Management (I/DD)** biennial average forecast is 27,946 clients, which is 0.7 percent lower than the Fall 2017 forecast. The 2019-21 biennial average forecast is 30,732 clients, which is 10 percent higher than the 2017-19 forecast average.

The 2017-19 **Mental Health (MH)** biennial average forecast is 48,027 adults. This includes 43,411 Never Committed clients, 2,788 Previously Committed clients, 998 Civilly Committed clients, and 830 Forensic clients. The forensic count includes 583 clients who are Guilty Except for Insanity and 247 Aid and Assist clients. The 2019-21 biennial forecast average is 49,336 adults, which is 2.7 percent higher than the 2017-19 forecast average.

The 2017-19 **Supplemental Nutrition Assistance Program (SNAP)** biennial average forecast is 364,346 households, which is 0.9 percent higher than the Fall 2017 forecast. The 2019-21 biennial average forecast is 327,783 households, which is 10.0 percent lower than the 2017-19 forecast average.

The 2017-19 T**emporary Assistance to Needy Families (TANF)** biennial average forecast is 18,520 families, which is 0.2 percent lower than the Fall 2017 forecast. The 2019-21 biennial average forecast is 16,381 families, which is 11.5 percent lower than the 2017-19 forecast average.

The 2017-19 **Vocational Rehabilitation (VR)** biennial average forecast is 10,357 clients, which is 1.7 percent lower than the Fall 2017 forecast. The 2019-21 biennial average forecast is 10,808 clients, which is 4.4 percent higher than the 2017-19 forecast average.

Introduction

This document summarizes the Spring 2018 forecasts of client caseloads for the Oregon Department of Human Services (DHS) and Oregon Health Authority (OHA). The Office of Forecasting, Research and Analysis (OFRA) issues these forecasts in the spring and fall each year. DHS caseload forecasts cover the major program areas administered by the department: Self Sufficiency Programs, Child Welfare, Vocational Rehabilitation, Aging and People with Disabilities, and Intellectual and Developmental Disabilities. OHA caseload forecasts cover the major program areas of Health Systems: Medicaid and Mental Health. Forecasts are used for budgeting and planning and usually extend through the end of the next biennium. Forecasts are developed using a combination of time-series techniques, input-output deterministic models, and expert consensus. Forecast accuracy is tracked via monthly reports that compare actual caseload counts to the forecasted caseload, and through the annual forecast quality report which compares forecast accuracy across programs and over time.[1]

Forecast Environment and Risks

Oregon's economy continues to expand, and although job growth is slower than the rates of 2014 and 2015, it has arrived at a "sweet spot" – growth in employment is generally equal to the number of people looking for work, whether they are new arrivals to Oregon or workers re-entering the labor market. Employment is expected to pick up a bit as the stimulative effects of federal tax cuts are felt.

The percentage of adults in the labor force in Oregon has returned to levels last seen before the Great Recession, meaning that there is no longer a reserve of potential workers looking for jobs. A tight labor market is now leading employers to look at those potential workers they might have skipped over in the past. The result of this good economic news is reductions in means-tested programs like SNAP and TANF, as well as movement of Oregon Health Plan clients from low-income rate groups to higher-income rate groups. Essentially, a reversal of the pattern seen during the Great Recession.

Oregon Minimum Wage

The Oregon legislature established a series of increases to the Oregon minimum wage, timed to the beginning of each state fiscal year. The first increase was in July 2016, the second in July 2017. These increases will continue through July 2022 (more on the rates can be found at the Oregon Bureau of Labor and Industries website: http://www.oregon.gov/boli/Pages/index.aspx).

After two rounds of rate hikes, the Office for Forecasting, Research and Analysis has found no demonstrable effects of raising the minimum way on our means tested caseloads. Given that a majority of recipients of means-tested programs have no income, and large numbers of those who do have income work part-time or part-year, this was expected (for a more comprehensive review of OFRA's findings on minimum wage, see the Fall 2017 DHS-OHA Caseload Forecast).

The Office of Forecasting Research and Analysis will monitor caseloads and wages paid to those on our caseloads for evidence of a "minimum wage effect," but at this point making specific, numerical changes to the way this office forecasts means-tested programs does not appear necessary or appropriate.

Policy Changes

Forecasts are based on current practices and policies. Potential changes to policy are always a risk to forecast accuracy, but cannot be accurately anticipated. This especially applies to policies in the discussion phase. More federal policy changes are being discussed than usual, but few are fully developed. Some reforms – such as tax cuts, deregulation, and infrastructure spending – do not directly impact DHS and OHA caseloads, but could have an indirect effect by stimulating the state's economy while other changes, most especially to the Affordable Care Act and the funding mechanisms for TANF or SNAP, would. The single largest impact would likely be the roll back of Medicaid expansion. Reductions or rollbacks would directly impact the Health Systems forecast by changing the current formulation of eligibility groups. Indirectly, a reduction in Medicaid spending would have a negative impact on the state's economy, as revenue to Oregon's local health care system is reduced.

The potential number of federal policy changes represents a higher degree of uncertainty and risk to the forecasts than usual. However, we cannot anticipate future policy changes, and must only forecast with the current policy environment in mind.

General Assumptions

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

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

The Office of Economic Analysis (OEA) identifies major risks to Oregon's economy in its quarterly forecasts. Some of the major risks listed in the first quarter 2018 edition include volatility of the U.S. economy in general, the affordability (or more precisely, the unaffordability) of housing, federal fiscal policy, climate change, and restructuring of federal timber payments (the full OEA economic forecast can be found at http://www.oregon.gov/DAS/OEA/Pages/index.aspx).

Department of Human Services

Total Department of Human Services Biennial Average Forecast Comparison

	2017-19 Biennium			% Change Between Forecasts	Spring 2018 Forecast			% Change Between Biennia
	Fall 17 Forecast	Spring 18 Forecast	Change		2017-19	2019-21	Change	
Aging & People with Disabilities								
Long-Term Care: In Home	19,773	19,172	-601	-3.0%	19,172	20,761	1,589	8.3%
Long-Term Care: Community Based	11,933	11,887	-46	-0.4%	11,887	12,213	326	2.7%
Long-Term Care: Nursing Facilities	4,341	4,348	7	0.2%	4,348	4,330	-18	-0.4%
Child Welfare (children served)								
Adoption Assistance	10,857	10,676	-181	-1.7%	10,676	10,556	-120	-1.1%
Guardianship Assistance	1,905	1,918	13	0.7%	1,918	2,149	231	12.0%
Out of Home Care[1]	7,807	7,717	-90	-1.2%	7,717	7,838	121	1.6%
Child In-Home	1,752	1,640	-112	-6.4%	1,640	1,608	-32	-2.0%
Intellectual and Developmental Disabilities								
Total Case Management Enrollment[2]	28,133	27,946	-187	-0.7%	27,946	30,732	2,786	10.0%
Total I/DD Services[3]	18,748	18,830	82	0.4%	18,830	19,440	610	3.2%
Self Sufficiency								
Supplemental Nutrition Assistance Program (Households)	361,036	364,346	3,310	0.9%	364,346	327,783	-36,563	-10.0%
Temporary Assistance for Needy Families (Families: Cash/Grants)	18,559	18,520	-39	-0.2%	18,520	16,381	-2,139	-11.5%
Vocational Rehabilitation	10,537	10,357	-180	-1.7%	10,357	10,808	451	4.4%

1. Includes residential and foster care.
2. Some clients enrolled in Case Management do not receive any additional I/DD services.
3. Total I/DD services will not include Brokerage Enrollment. Brokerage Enrollment caseload forecast will be discontinued beginning Fall 2017.

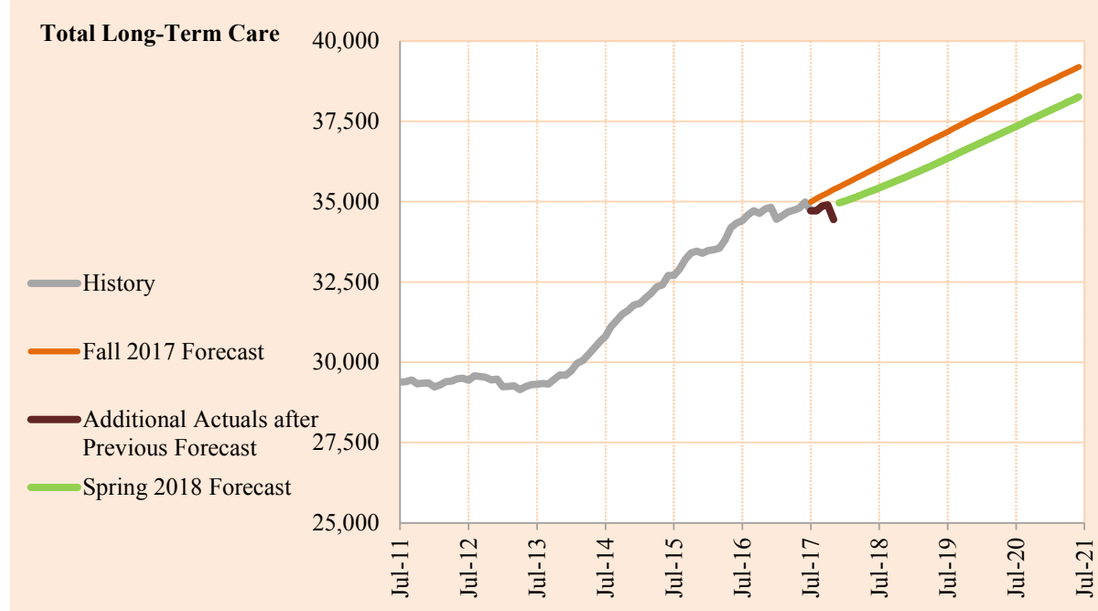
Aging and People with Disabilities (APD)

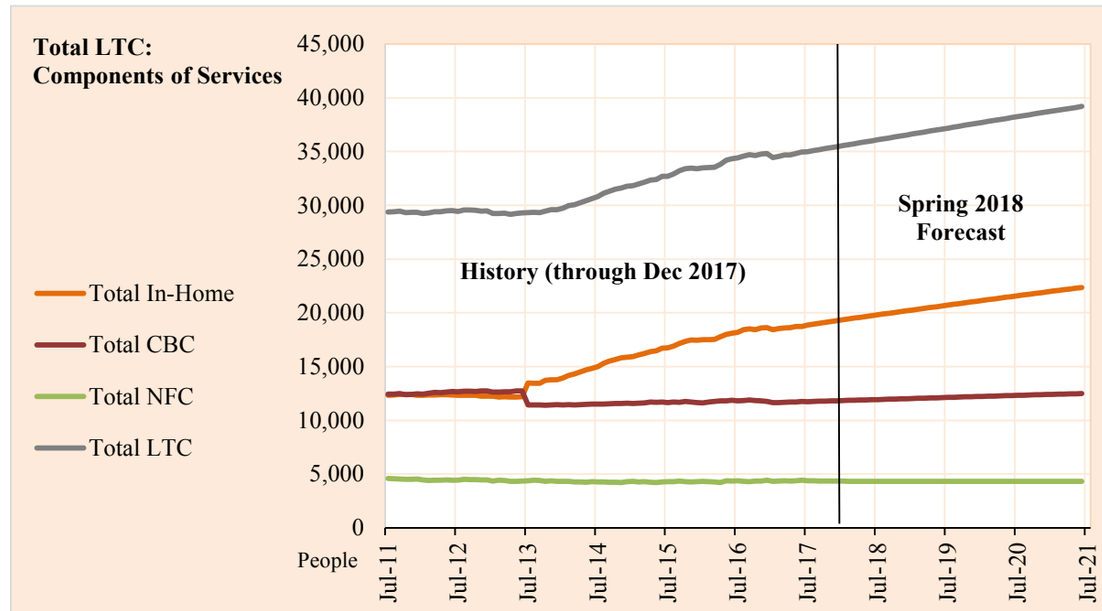
Historically, Oregon's Long Term Care (LTC) services were provided under the authority of a Medicaid 1915 (c) Home and Community-Based Services (HCBS) Waiver. Starting in July 2013, Oregon began offering services through the Community First Choice Option under 1915 (k) of the Social Security Act (referred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

Prior to 2008, there was a large 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. During the last 10 years, the total Long-Term Care (LTC) caseload has varied from a low of 25,900 clients in May 2008 to a high of 34,900 clients in June 2017. From 2008 to 2013 the caseload grew by an average of 2.5 percent a year, despite a serious recession, driven in part by a significant growth in the number of Oregon seniors. Between 2013 and 2016, the average annual caseload grew by 5.3 percent due to factors such as implementation of the K-Plan, expansion of Medicaid, policy changes to make in-home care more attractive, and continued growth in the number of Oregon seniors.

The LTC forecast is divided into three major categories: In-Home, Community-Based Care (CBC), and Nursing Facilities. Most of the projected increase from 2015-17 to 2017-19 and 2019-21 is in In-Home Care. In-Home Care continues to be a popular placement choice, particularly since 2013 when APD implemented several changes designed to make In-Home services comparatively more attractive to clients. However, starting in October 2017, APD implemented new guidelines for Client Assessment and Planning System (CAPS) Assessment. As a result of these changes, many clients will have their In-home service hours reduced or will become ineligible for In-home services. CBC is still forecasted to grow, although at a reduced rate to reflect the anticipated shift toward In-Home Care. Community-Based Care will continue to be a stable placement choice for many LTC clients because this type of care is easier to set up and coordinate than In-Home Care, and because hospitals prefer discharging patients to higher service settings in order to reduce the risk of repeat emergency visits or readmission. On the other hand, Medicaid reimbursement rates continue to lag behind private market rates, thus making Medicaid clients relatively less attractive to CBC providers.

Total Long-Term Care (LTC) – A total of 34,440 clients received long-term care services in November 2017. The 2015-17 biennial average is at 34,086 clients. The 2017-19 forecast average of 35,407 is 3.8 percent higher than the forecast for 2015-17. The caseload is expected to average 37,304 over 2019-21, which is 5.4 percent higher than the 2017-19 biennial average forecast.





In-Home Care – In November 2017, 18,344 clients received In-Home Care, which accounted for 54.1 percent of total LTC services. The caseload is expected to average 19,172 for the 2017-19 biennium, which is 3.0 percent lower than the Fall 2017 forecast. The caseload is expected to average 20,761 over the 2019-21 biennium, which is 8.3 percent higher than the 2017-19 biennial average forecast, and by June 2021 In-Home Care is projected to be 56.4 percent of total LTC services.

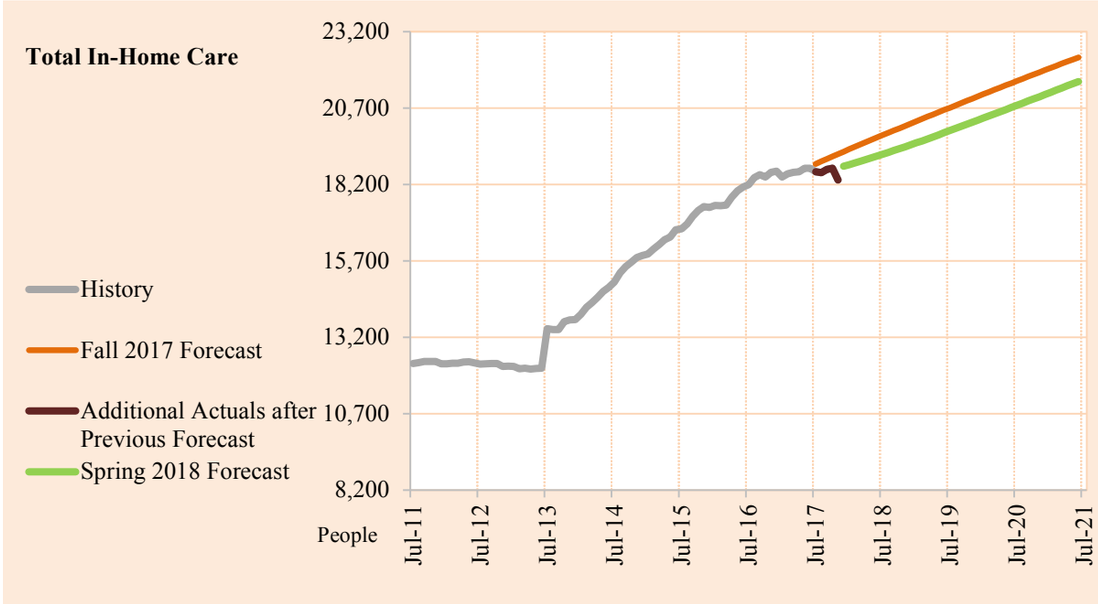
From July 2013 to December 2015, In-Home Care caseload grew by 29 percent. The In-Home Care caseload growth is attributed to several factors including implementation of the K-Plan, expansion of Medicaid, and implementation of policy and program changes intended to promote the use of In-Home Care rather than more expensive forms of service. For example, under the new rules, clients who want long-term care services are required to contribute to their own support by relinquishing to the State all income over $1,210 per month. Previously, the limit for how much a client could keep was $710 per month – an amount that was difficult to live on. Clients who may have been reluctant to relinquish some of their limited income, even in exchange for needed supports, might now find the program more attractive. In addition, the fact that options exist which allow family members, friends, or neighbors (natural supports) to be paid (under certain circumstances) for providing services may lead more individuals to request In-Home Care.

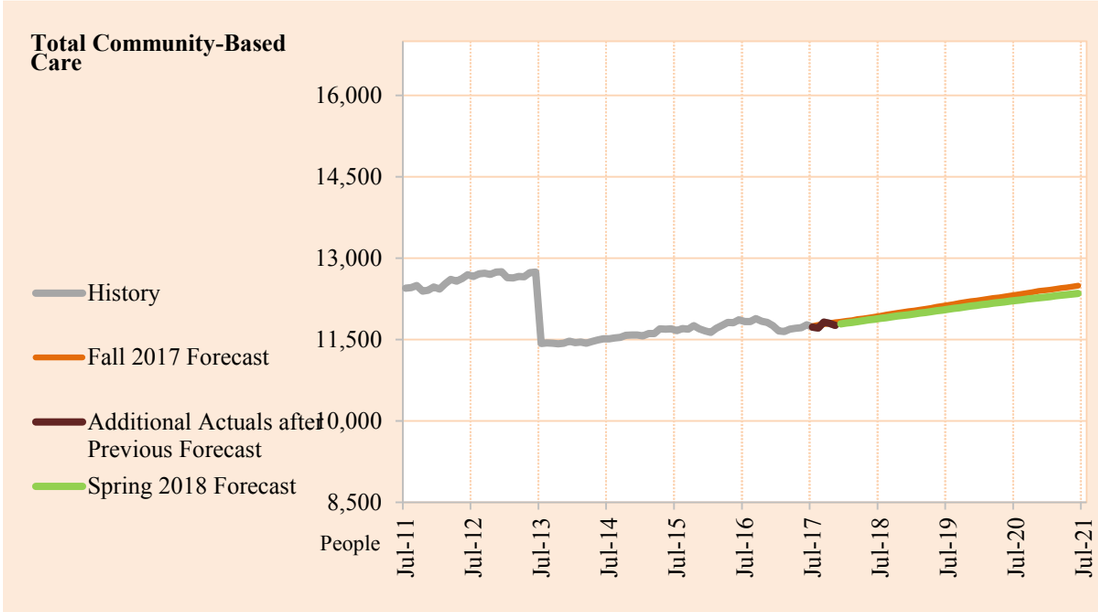
However, in recent years this caseload growth has slowed down considerably and grew by 7 percent between January 2016 and September 2017. Between October and November 2017, the In-home care caseload declined by 2.1 percent as a result of implementation of new guidelines regarding CAPS assessment criteria. For additional information, see the Risks and Assumptions" section below.

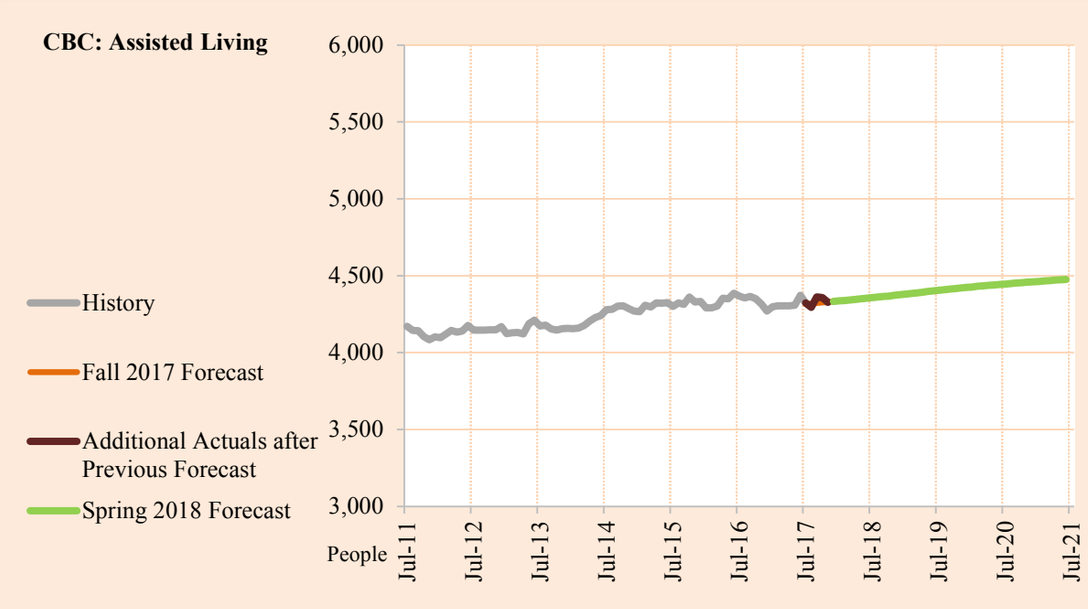
Community-Based Care (CBC) - In November 2017, 11,760 clients received Community-Based Care, which accounted for 33.9 percent of total LTC. The CBC caseload growth has slowed in recent months since the Fall 2017 forecast. The caseload is expected to average 11,887 which is 0.4 percent lower than the Fall 2017 forecast. The caseload is expected to average 12,213 over the 2019-21 biennium, which is 2.7 percent higher than the 2017-19 biennial average forecast, and by June 2021 Community-Based Care is forecasted to be 32.2 percent of total LTC.

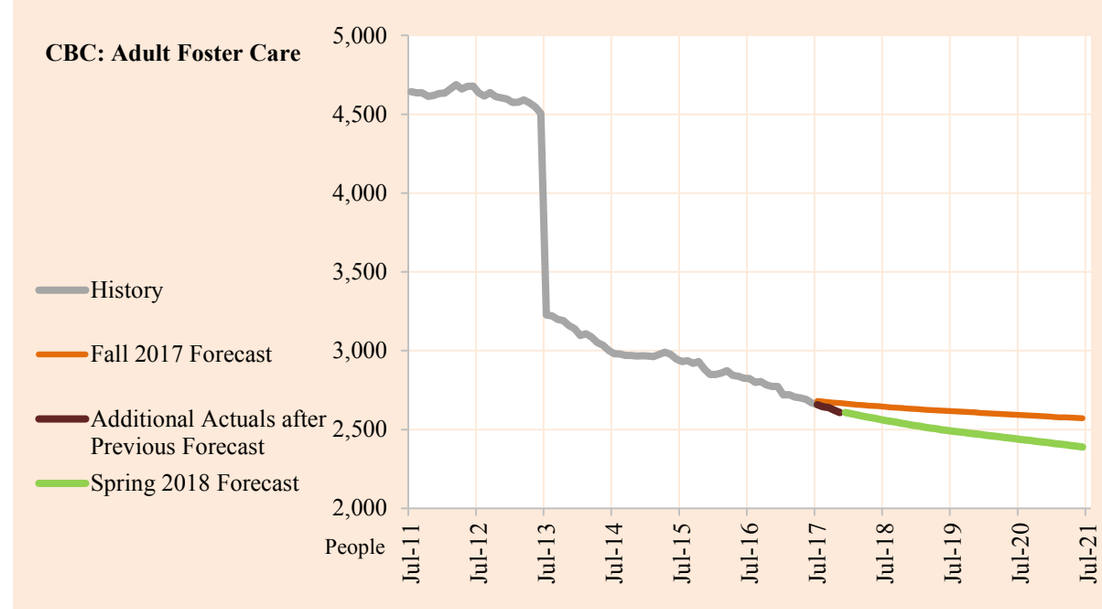
Community-Based Care includes several different types of services. Each caseload type is revised to more accurately reflect clients' recent, actual utilization of services. Consequently, Assisted Living and Residential Care have become a larger portion of the forecast, while Adult Foster Care (AFC) became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

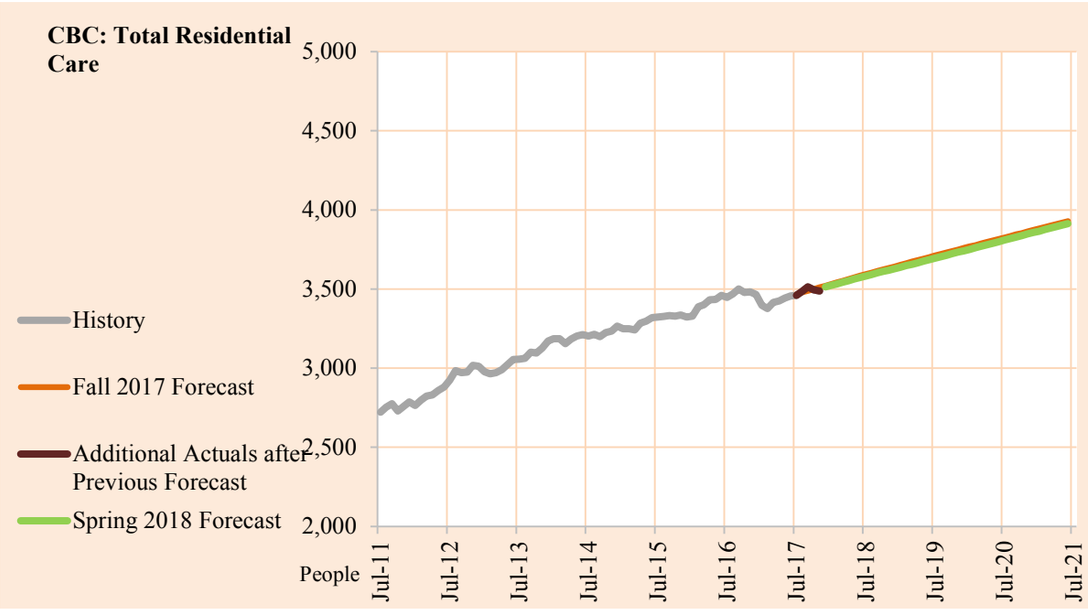
Several factors are contributing to the recent decline in AFC caseload: policy changes that make In-Home Care more attractive; providers' perception of inadequate reimbursement rates; increasing adversarial relationship between workers and providers; and declining capacity as individual providers retire.

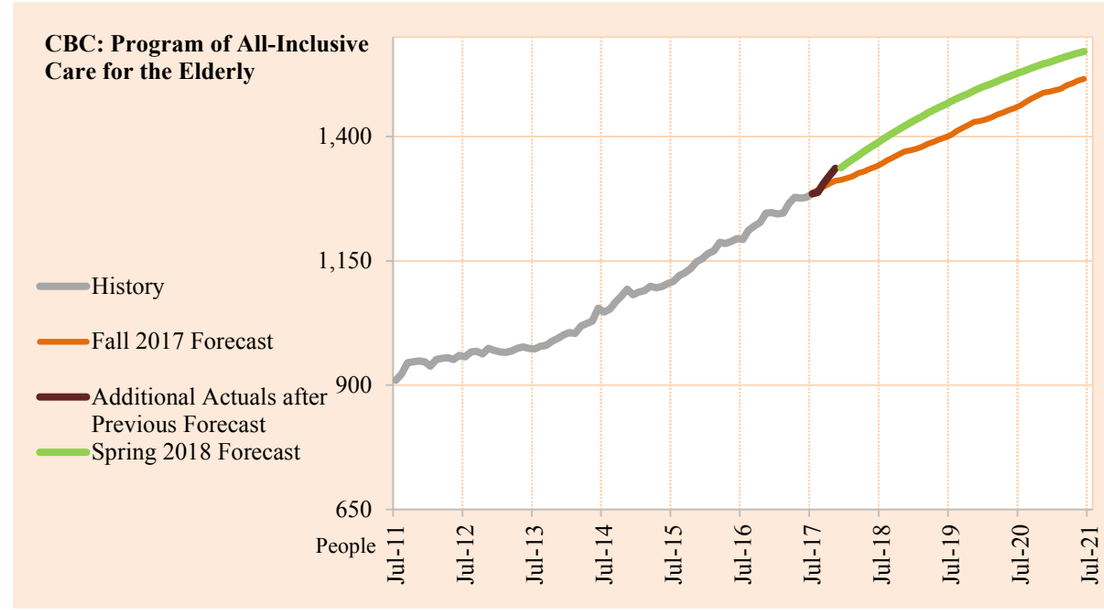




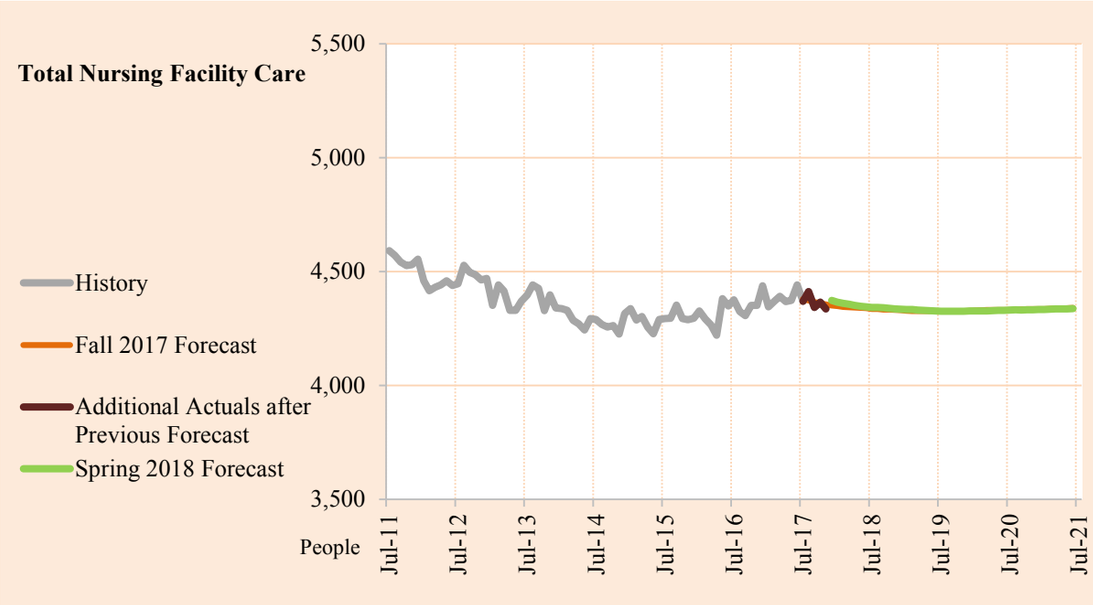

CBC: Assisted Living
History
Fall 2017 Forecast
Additional Actuals after Previous Forecast
Spring 2018 Forecast
6,000
5,500
5,000
4,500
4,000
3,500
3,000
People
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19
Jul-20
Jul-21


CBC: Adult Foster Care
History
Fall 2017 Forecast
Additional Actuals after Previous Forecast
Spring 2018 Forecast
5,000
4,500
4,000
3,500
3,000
2,500
2,000
People
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19
Jul-20
Jul-21


CBC: Total Residential Care
History
Fall 2017 Forecast
Additional Actuals after Previous Forecast
Spring 2018 Forecast
5,000
4,500
4,000
3,500
3,000
2,500
2,000
People
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19
Jul-20
Jul-21


CBC: Program of All-Inclusive Care for the Elderly
History
Fall 2017 Forecast
Additional Actuals after Previous Forecast
Spring 2018 Forecast
1,400
1,150
900
650
People
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19
Jul-20
Jul-21

Nursing Facility Care – In November 2017, 4,336 clients received Nursing Facility Care, which accounted for 12.0 percent of total LTC. The caseload is expected to average 4,348, which is slightly higher than the Fall 2017 forecast. The caseload is expected to average 4,330 over the 2019-21 biennium and continue to remain stable throughout the biennium. Nursing Facility Care is forecasted to be 11.4 percent of Total LTC.



Affordable Care Act (ACA) Long-Term Care

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

These clients constitute a small sub set of the total LTC population, but their funding sources are significantly different. Consequently, OFRA is tracking these clients separately within the LTC population. The ACA LTC data accounts for about 2 percent of the total LTC caseload.

Risks and Assumptions

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

At roughly the same time, Oregon chose to extend Medicaid coverage (including long-term care) to a significantly larger pool of low income adults. To qualify for LTC under the prior HCBS Waiver, clients had to meet four separate criteria: 1) be assessed as needing the requisite Level of Care; 2) be over 65 years old or have an official determination of disability; 3) have income below 300 percent of SSI (roughly 225 percent of FPL); and 4) have very limited assets. However, under the ACA's K-Plan option, clients only need to meet two criteria: 1) be assessed as needing requisite Level of Care; and 2) have income below 138 percent of FPL. Note that the HCBS Waiver allows clients with higher incomes than the K-Plan; but the K-Plan has no asset limits and no requirement that clients be over 65 or officially determined disabled. Recent changes in the pattern of new clients entering long-term care indicates that the ACA (the combined effects of the K-Plan and Medicaid expansion) is contributing to long-term care caseload growth.

In-Home Care Policy and Program Changes – Another significant risk was created by policy and program changes regarding In-Home Care services. Four key changes were made: 1) Changes to existing rules regarding ADL assessment; 2) Adjustments to In-home hours; 3) Transition from Live-in to Hourly services; and 4) In-Home Care workers' two-week service authorization. As a result of the changes to ADL rules, some clients may no longer meet the new assessment criteria. This may also reduce hours for other In-Home clients, and many of the clients that do not meet the new assessment criteria may receive new transition services. At the time of this reporting, these changes are still being implemented and its impact remains to be measured. APD, in response to the complaints by initial groups of clients who lost service eligibility, is in the process of reviewing assessments of those clients considered ineligible. As a result, services and hours of many of these ineligible clients are likely to be restored by June 2018. New clients and those who are due for annual reassessment, however, will be assessed using the new criteria. Therefore, In-Home care caseload is adjusted downward by lowering the new client intake by 4 percent. The timeline and volume of service restoration will be difficult to estimate. This process has, and will continue to have a dampening effect on the In-Home Care caseload and be a large risk to the in-home caseload forecast.

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

Aging and People with Disabilities Biennial Average Forecast Comparison

	2017-19 Biennium			*% Change Between Forecasts*	Spring 2018 Forecast			*% Change Between Biennia*
	Fall 17 Forecast	**Spring 18 Forecast**	**Change**		**2017-19**	**2019-21**	**Change**	
AGING AND PEOPLE WITH DISABILITIES								
In-Home Hourly without SPPC	14,729	14,341	-388	-2.6%	14,341	15,506	1,165	8.1%
In-Home Agency without SPPC	2,245	2,047	-198	-8.8%	2,047	2,205	158	7.7%
In-Home Live-In	19	25	6	31.6%	25	0	-25	-100.0%
In-Home Spousal Pay	44	41	-3	-6.8%	41	45	4	9.8%
Independent Choices	554	533	-21	-3.8%	533	630	97	18.2%
Specialized Living	249	244	-5	-2.0%	244	281	37	15.2%
In-Home K Plan Subtotal	**17,840**	**17,231**	**-609**	**-3.4%**	**17,231**	**18,667**	**1,436**	**8.3%**
In-Home Hourly with State Plan Personal Care	1,505	1,512	7	0.5%	1,512	1,632	120	7.9%
In-Home Agency with State Plan Personal Care	428	429	1	0.2%	429	462	33	7.7%
In-Home non-K Plan Subtotal	**1,933**	**1,941**	**8**	**0.4%**	**1,941**	**2,094**	**153**	**7.9%**
Total In-Home	**19,773**	**19,172**	**-601**	**-3.0%**	**19,172**	**20,761**	**1,589**	**8.3%**
Adult Foster Care	2,647	2,566	-81	-3.1%	2,566	2,440	-126	-4.9%
Assisted Living	4,356	4,359	3	0.1%	4,359	4,443	84	1.9%
Contract Residential Care	2,674	2,670	-4	-0.1%	2,670	2,903	233	8.7%
Regular Residential Care	912	907	-5	-0.5%	907	902	-5	-0.6%
Program of All-Inclusive Care for the Elderly	1,344	1,385	41	3.1%	1,385	1,525	140	10.1%
Community-Based Care Subtotal	**11,933**	**11,887**	**-46**	**-0.4%**	**11,887**	**12,213**	**326**	**2.7%**
Basic Nursing Facility Care	3,663	3,646	-17	-0.5%	3,646	3,629	-17	-0.5%
Complex Medical Add-On	602	628	26	4.3%	628	625	-3	-0.5%
Enhanced Care	48	46	0	0.0%	46	48	2	4.3%
Pediatric Care	28	28	0	0.0%	28	28	0	0.0%
Nursing Facilities Subtotal	**4,341**	**4,348**	**7**	**0.2%**	**4,348**	**4,330**	**-18**	**-0.4%**
Total Long-Term Care	**36,047**	**35,407**	**-640**	**-1.8%**	**35,407**	**37,304**	**1,897**	**5.4%**

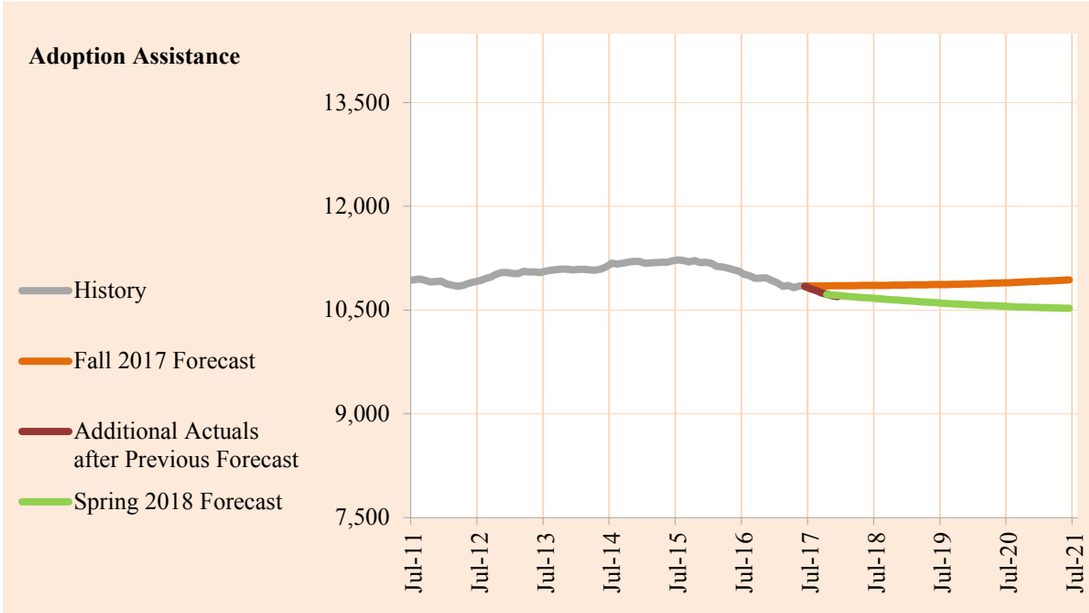
Child Welfare (CW)

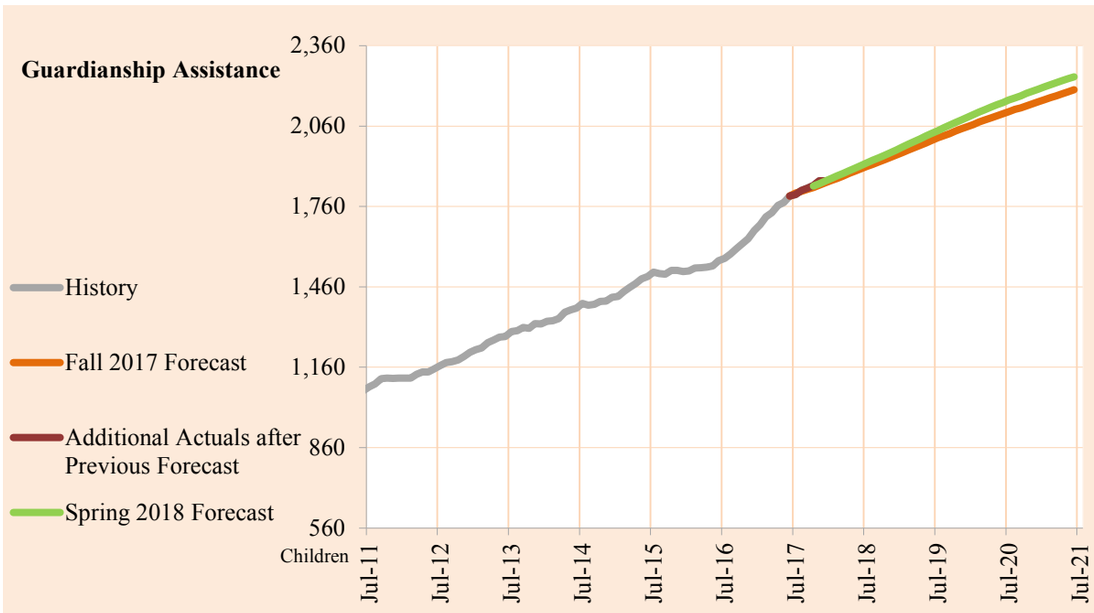
Four main groups are forecast for Child Welfare: Adoption Assistance, Guardianship Assistance, Out of Home Care, and Child In-Home. Children may move between these groups and typically first enter the Child Welfare system via an Assessment. In mid-2016 a clean-up process to close over-due assessments took place, and the numbers of children on open assessments decreased from 33,112 to 24,124, a 27 percent decrease. In the months following this clean-up, the number of children on open assessments has almost doubled, and as of November 2017 was 42,002. There is an executive directive for branches to complete assessments in less than sixty days. However, unless there is an explicit focus on this work, the caseload will continue to grow.

Adoption Assistance – This caseload has been relatively flat since 2011. The caseload climbed modestly between 2012 and 2015, from 10,843 in March 2012 to 11,223 in July 2015, a 4 percent increase. Since then the caseload has decreased 4.4 percent, and there were 10,725 children on the caseload as of October 2017. Almost all new clients are from paid foster care, so changes to the foster care caseload can directly increase or decrease the adoption assistance caseload. The caseload is expected to average 10,676 for the 2017-19 biennium, which is 1.7 percent lower than the Fall 2017 forecast. Over the 2019-21 biennium the caseload is expected to average 10,556, which is 1.1 percent lower than the 2017-19 biennial average forecast.

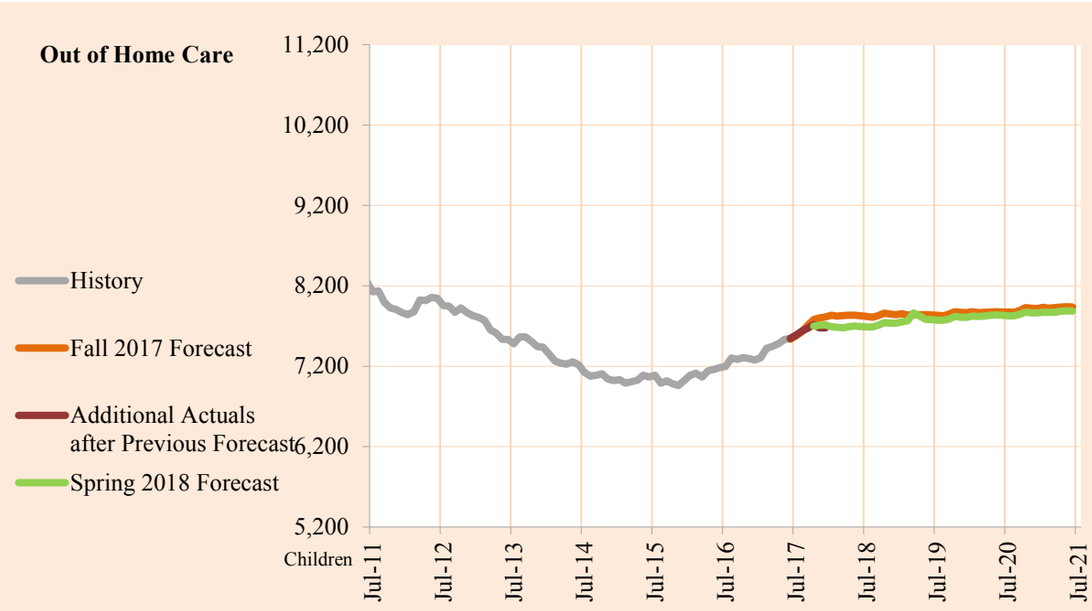
Guardianship Assistance – This caseload has exhibited steady growth for its entire history. Policies are in place to shorten the length of time to permanent placement, so this caseload will continue to increase as children move out of foster care. Workers have re-prioritized work around safety issues, and this can affect caseload numbers. Actuals following the Fall 2017 forecast have closely followed the forecast line. The new forecast for this caseload is expected to average 1,918 for the 2017-19 biennium, which is 0.7 percent higher than the Fall 2017 forecast. Over the 2019-21 biennium, the caseload is expected to average 2,149, which is 12 percent higher than the 2017-19 biennial average forecast.

Out of Home Care – This caseload is comprised of paid foster care, non-paid foster care (including trial home visits), and residential care. Paid foster care is the largest portion of the group. The total foster care caseload experienced a 16.5 percent drop between 2010 and 2015, declining from 8,408 children in December 2010 to 7,024 children in December 2015. During this period, the number of children supervised in-home also declined overall, as well as the percentage of in-home children who transferred into foster care. During that time period, initiatives were put into place designed to decrease the foster care caseload. However, for the past two years, the caseload has been growing. Between November 2015 and October 2017, the caseload grew 10.6 percent. The caseload is expected to average 7,717 for the 2017-19 biennium, which is 1.2 percent lower than the Fall 2017 forecast.

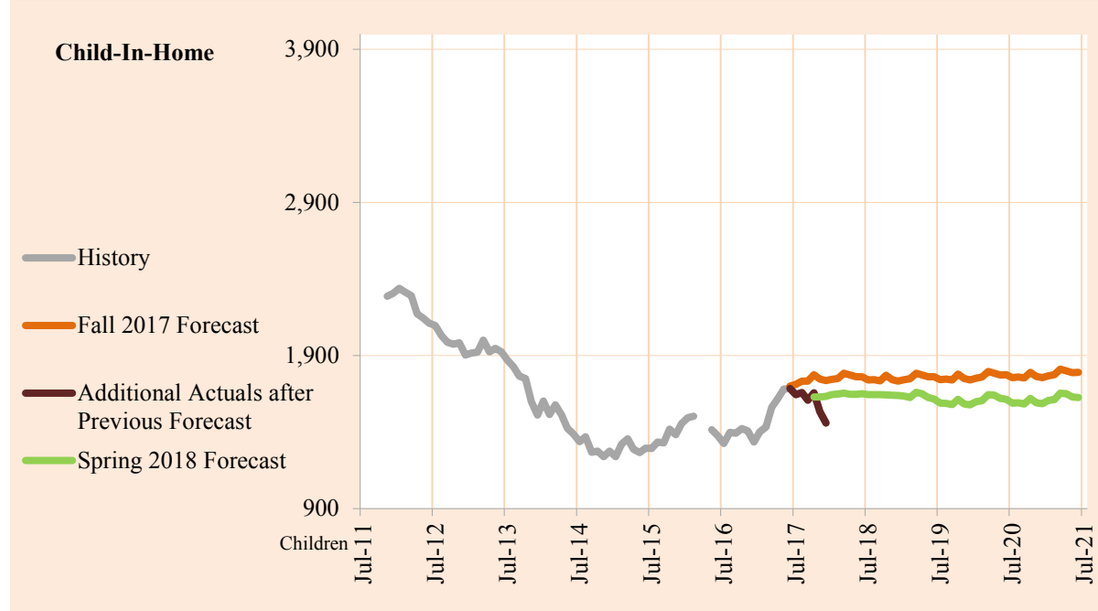


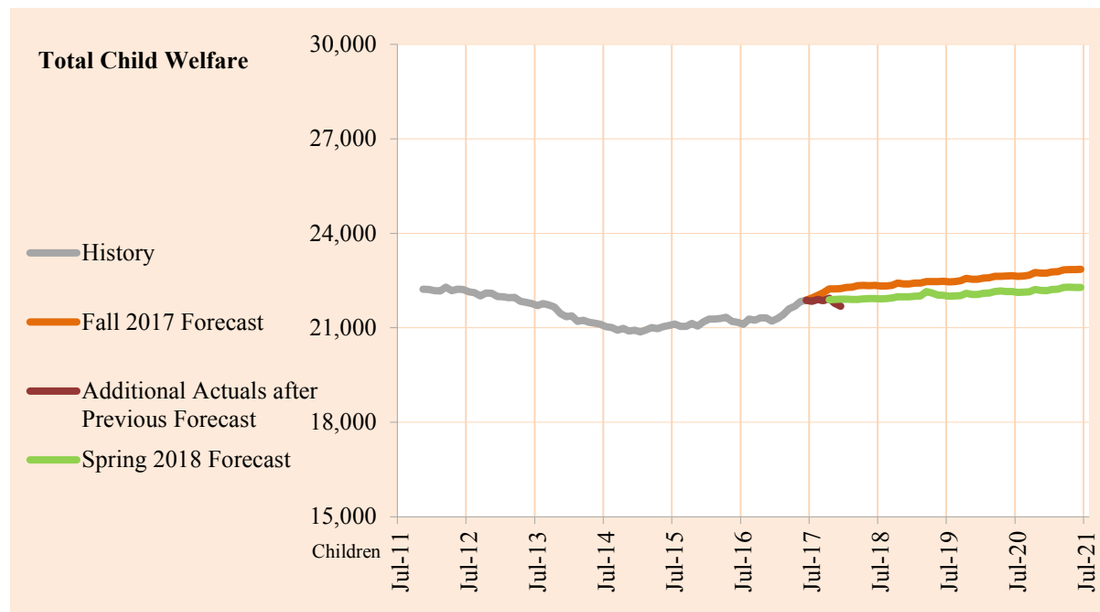


Over the 2019-21 biennium, the caseload is expected to average 7,838, which is 1.6 percent higher than the 2017-19 biennial average forecast.



Child In-Home – Following implementation of the OR-KIDS data system in 2011, this caseload exhibited an almost continuous decline until 2015. Beginning in 2015, the caseload started climbing and rose to almost 1,600 before falling in April 2016. The caseload drop between April and June 2016 was due to the focused clean-up of overdue assessments that occurred at that time. Between December 2016 and May 2017, the caseload grew 24 percent, from 1,335 children in December 2016 to 1,655 in May 2017. Between May and October 2017, the caseload decreased 3 percent. One possibility for these fluctuations may be a change in reporting. Over the past two years, the Safety Program has partnered with OR-Kids trainers in getting safety plans entered into OR-Kids. Work that wasn't captured in the past is now being recorded. The caseload is expected to average 1,640 for the 2017-19 biennium, which is 6.4 percent lower than the Fall 2017 forecast. Over the 2019-21 biennium, the caseload is expected to average 1,608, which is 2 percent lower than the 2017-19 biennial average forecast.





Risks and Assumptions

For the past several years, the Child Welfare Program has experienced changes in leadership and increased public scrutiny. There is a new review process for licensed residential facilities. There has also been a shift in prioritization to child protective services work, and this may affect all caseloads.

Risks to the Out of Home Care caseload mainly involve the treatment foster care program. Investments to increase capacity are underway, but 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. Over the past year, the capacity for psychiatric residential care has been cut in half. However, from October 2017 through 2018, there is the expectation that the number of residential placements will grow due to recently signed legislation for increased funding. The children in need are currently being served in Behavior Rehabilitation Services, family foster care, special contracts, or out of state.

The definition of Child In-Home is now based on the safety plan rather than the case plan. There has also been a change in the way OR-Kids operates, so that a case cannot move forward until a caseworker enters an initial safety plan. This may impact the number of children counted in this caseload. Another risk to the forecast of the Child In-Home caseload is the number of overdue or unclosed assessments that have not been entered into the data system. If, and when, overdue assessments are closed, the Child In-Home caseload may increase.

Child Welfare Biennial Average Forecast Comparison

	2017-19 Biennium			% Change Between Forecasts	Spring 2018 Forecast			% Change Between Biennia
	Fall 17 Forecast	Spring 18 Forecast	Change		2017-19	2019-21	Change	
CHILD WELFARE (Children)								
Adoption Assistance	10,857	10,676	-181	-1.7%	10,676	10,556	-120	-1.1%
Guardianship Assistance	1,905	1,918	13	0.7%	1,918	2,149	231	12.0%
Out of Home Care[1]	7,807	7,717	-90	-1.2%	7,717	7,838	121	1.6%
Child In-Home	1,752	1,640	-112	-6.4%	1,640	1,608	-32	-2.0%
Total Child Welfare	**22,321**	**21,951**	**-370**	**-1.7%**	**21,951**	**22,151**	**200**	**0.9%**

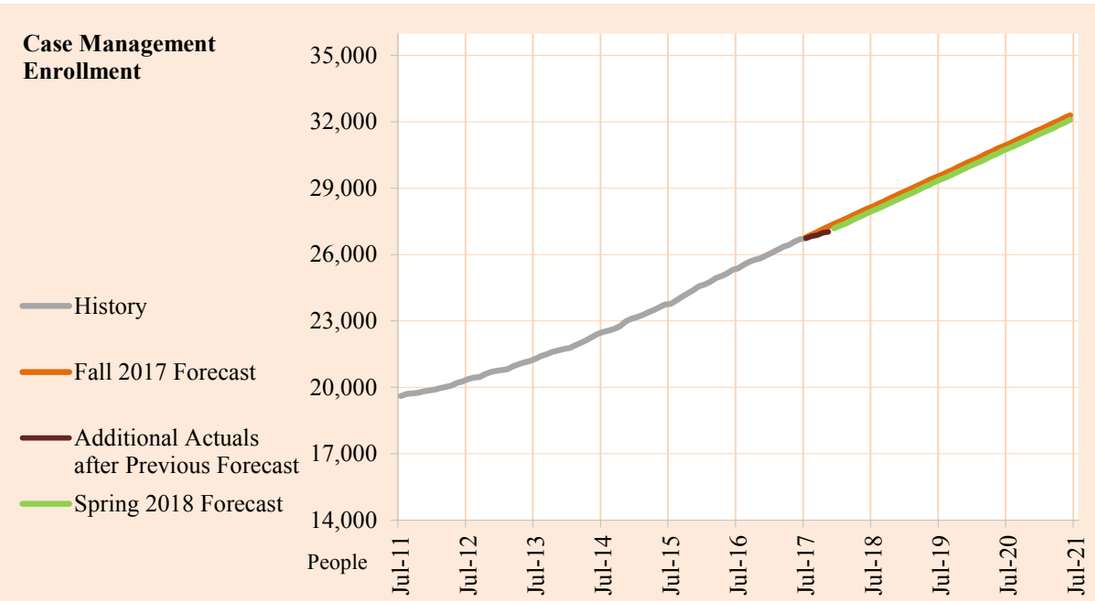
1. Includes residential and foster care.

Intellectual and Developmental Disabilities (I/DD)

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

Case Management Enrollment

This is an entry-level eligibility, evaluation, and coordination service available to all individuals determined as having intellectual and developmental disabilities, regardless of income level. In 2015-17, Case Management Enrollment averaged 25,306 and is projected to increase to 27,946, or by 10.4 percent, in 2017-19. In 2019-21 the Case Management biennial average caseload is projected to increase to 30,732, or by 8.3 percent. Enrollment is projected to grow rapidly until most I/DD individuals have enrolled. Human Services Research Institute (HSRI), under the contract with Oregon's Office of Developmental Disabilities Services (ODDS), has tried to estimate the “natural limit,” where caseload would plateau, using the Oregon’s youth and adult populations likely to seek I/DD services through 2019 by applying national prevalence estimates to Oregon’s youth and adult populations.



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

Adult Services

I/DD adult services was reorganized in the Fall of 2017 to combine Comprehensive In-Home Services and Brokerage Services as a new caseload category - Adult In-Home Support. This new caseload category accounts for 76 percent of Brokerage services and 24 percent of Community Developmental Disabilities Programs (CDDP) In-Home Services. Also, OFRA does not report a separate forecast of Brokerage enrollment.

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

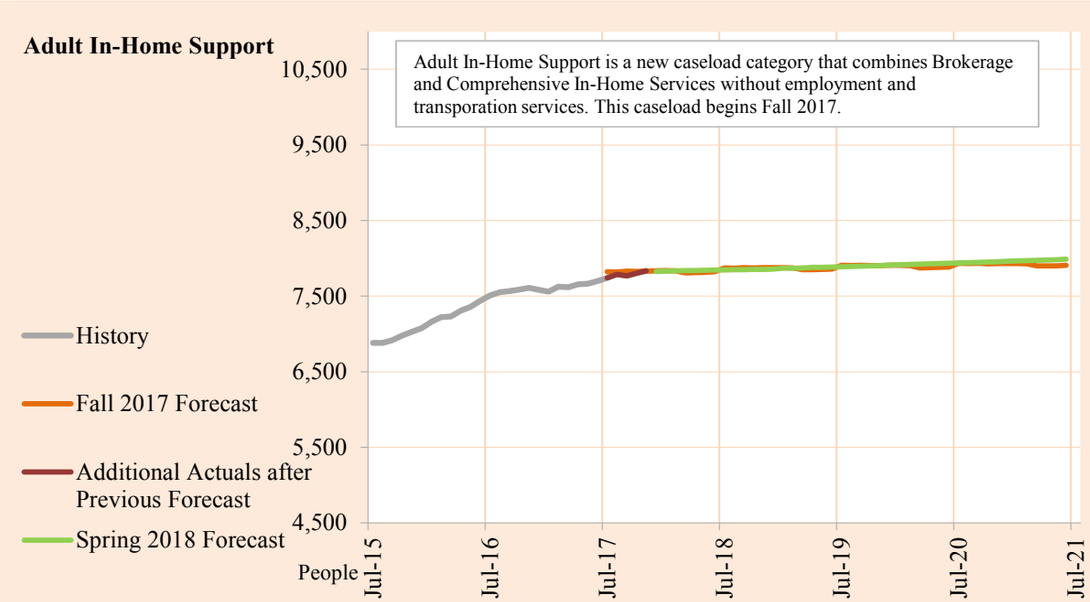
The 2017-19 biennial average forecast is expected to average 7,840, which remain unchanged from the Fall 2017 forecast. The caseload is expected to average 7,938 over the 2019-21 biennium, which is 1.3 percent higher than the 2017-19 biennium

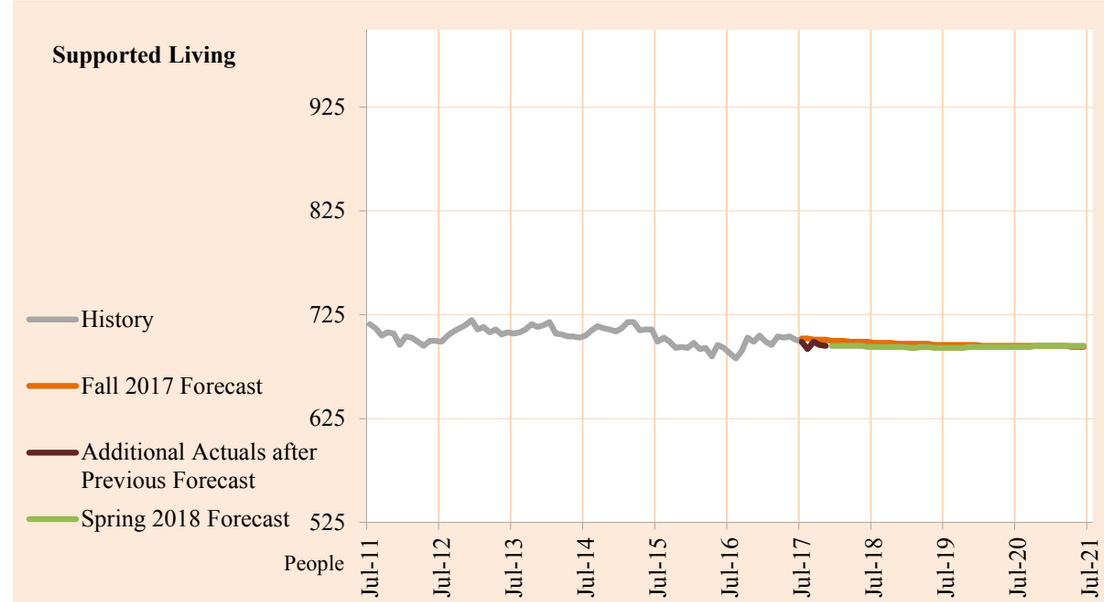
24-Hour Residential Care – The 2017-19 biennial average forecast is expected to average 2,913, which remains unchanged from the Fall 2017 forecast. The caseload is expected to average 2,996 over the 2019-21 biennium, which is 2.8 percent higher than the 2017-19 biennium.

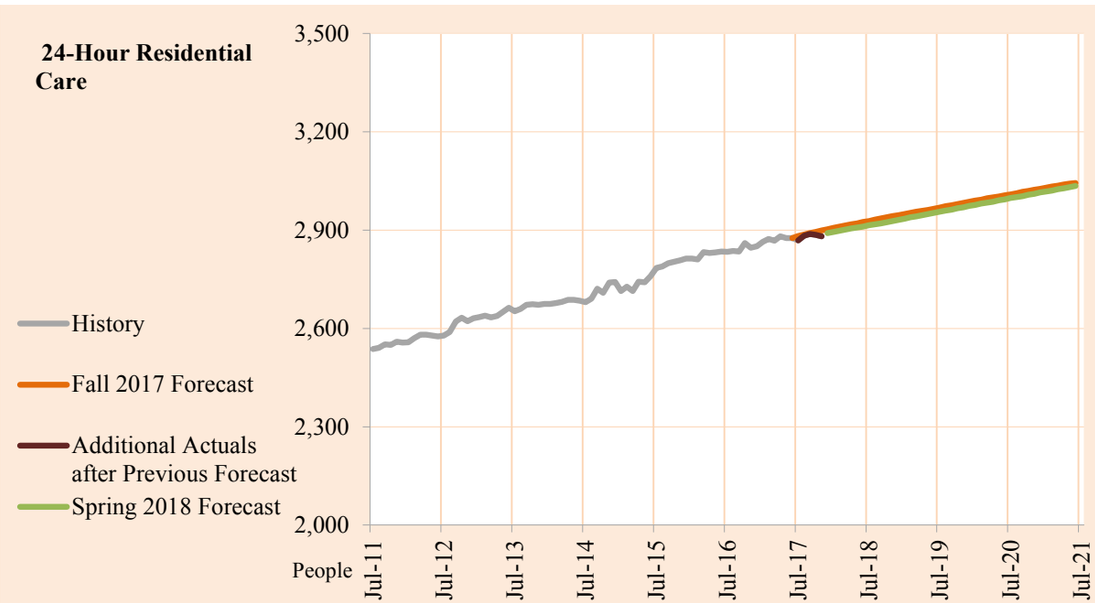
Supported Living – The 2017-19 biennial average forecast is expected to average 695, which remains unchanged from the Fall 2017 forecast. The caseload is expected to average 694, slightly lower over the 2019-21 biennium.

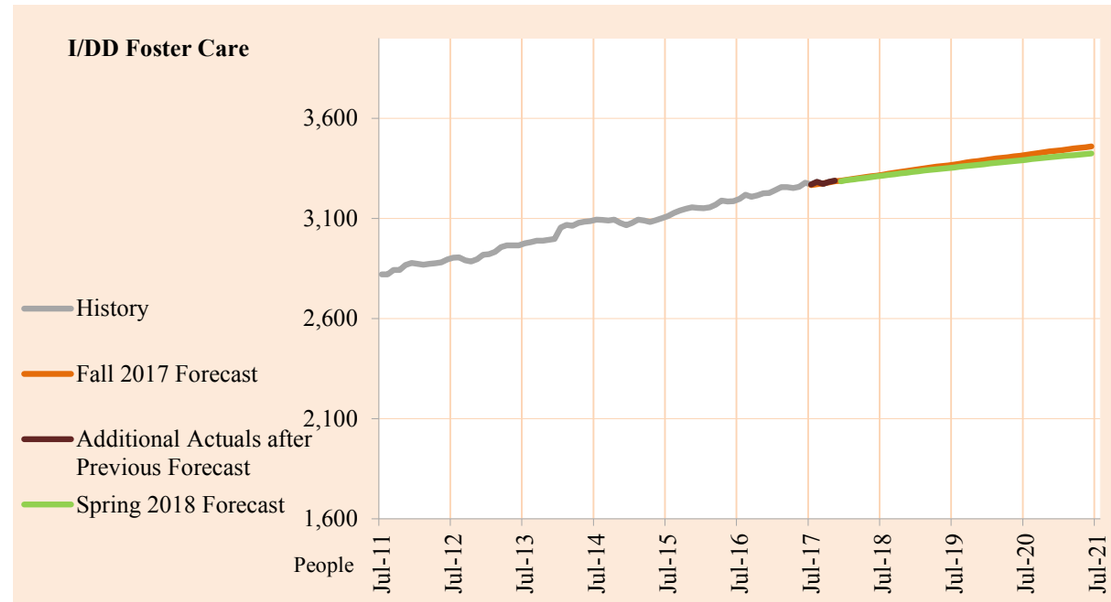
I/DD Foster Care – I/DD Foster Care serves both adults and children, with children representing approximately 13.6 percent of the caseload. I/DD Foster Care for Adults is expected to average 2,888, about 1.0 percent higher over the Fall 2017 forecast. The caseload is expected to average 2958 over the 2019-21 biennium, which is 2.4 percent higher than the 2017-19 biennium.

Stabilization and Crisis Unit – The Stabilization and Crisis Unit serves both adults and children, with children representing approximately 10.0 percent of the caseload. This caseload is limited by bed capacity and is expected to remain at the current level of 99 for both 2017-19 and 2019-21.


Adult In-Home Support
Adult In-Home Support is a new caseload category that combines Brokerage and Comprehensive In-Home Services without employment and transporation services. This caseload begins Fall 2017.
10,500
9,500
8,500
7,500
6,500
5,500
4,500
People
History
Fall 2017 Forecast
Additional Actuals after Previous Forecast
Spring 2018 Forecast
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19
Jul-20
Jul-21


Supported Living
925
825
725
625
525
People
History
Fall 2017 Forecast
Additional Actuals after Previous Forecast
Spring 2018 Forecast
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19
Jul-20
Jul-21


24-Hour Residential Care
3,500
3,200
2,900
2,600
2,300
2,000
People
History
Fall 2017 Forecast
Additional Actuals after Previous Forecast
Spring 2018 Forecast
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19
Jul-20
Jul-21


I/DD Foster Care
3,600
3,100
2,600
2,100
1,600
People
History
Fall 2017 Forecast
Additional Actuals after Previous Forecast
Spring 2018 Forecast
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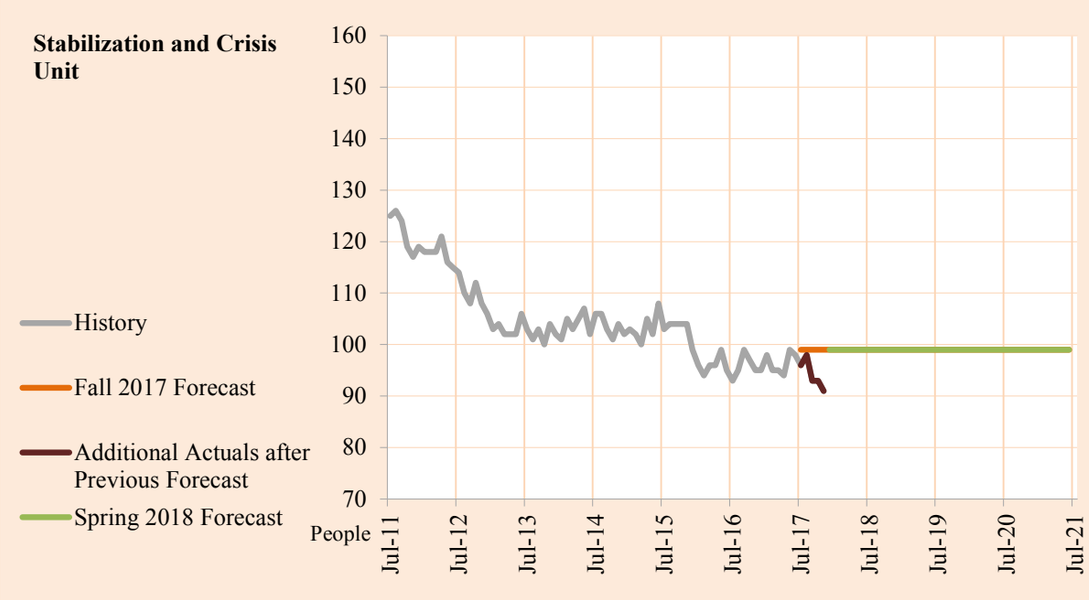
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19
Jul-20
Jul-21



Children Services

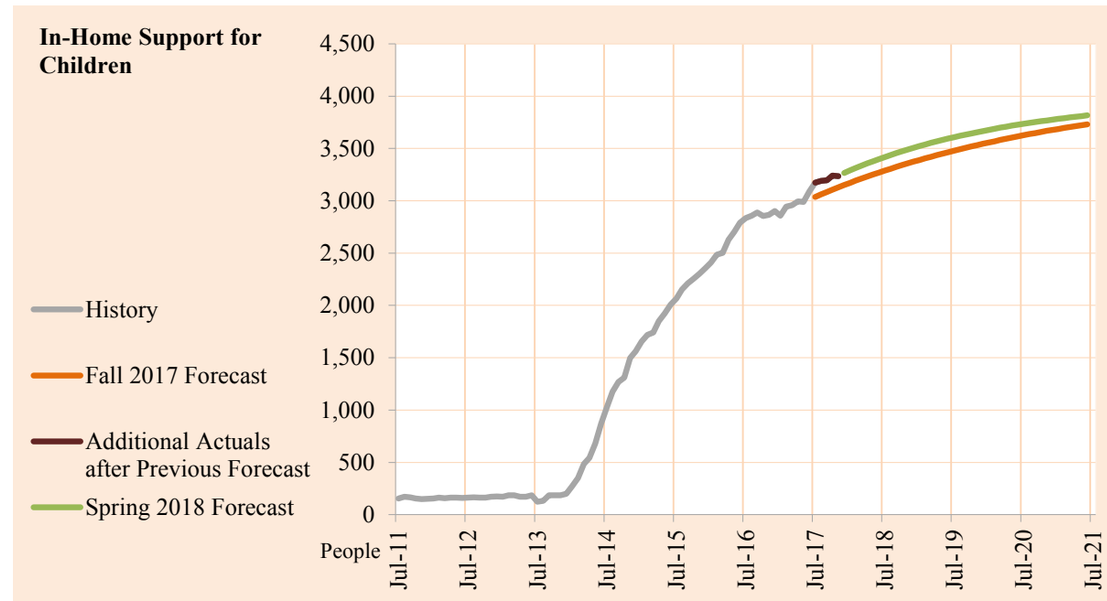
In-Home Support for Children (IHSC) – This caseload started growing rapidly in late 2013 as the K-Plan was implemented. While a rapid and significant rise was anticipated, the exact timing and magnitude has been difficult to project. The caseload was 187 clients in mid-2013; and the caseload grew a dramatic fifteen-fold to 2,790 by mid-2016. This caseload growth has slowed considerably to 3,089 in mid-2017. In-Home Support for Children is forecasted to grow slowly in 2017-19 to a biennial average of 3,396 clients, which is 3.9 percent higher over the Fall 2017 forecast. The caseload is expected to average 3,724 over the 2019-21 biennium, which is 9.7 percent lower over the 2017-19 biennium.

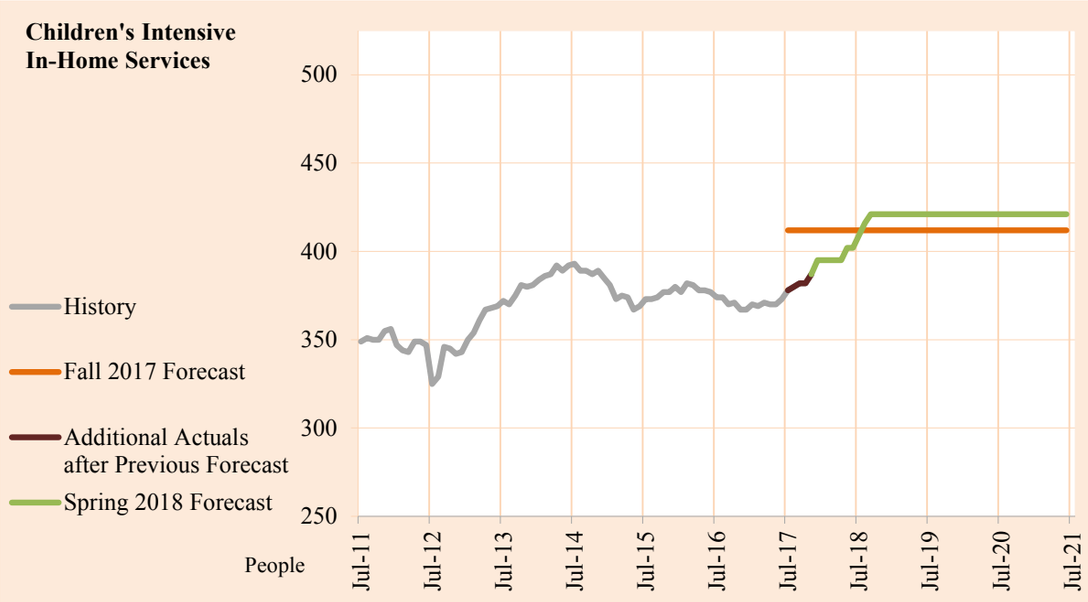
Growth in this caseload is primarily due to implementation of the Community First Choice Option (K-Plan), which allows individuals eligible for the Oregon Health Plan to receive In-Home services if they have an extended need for assistance with Activities of Daily Living. In addition, the income criteria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

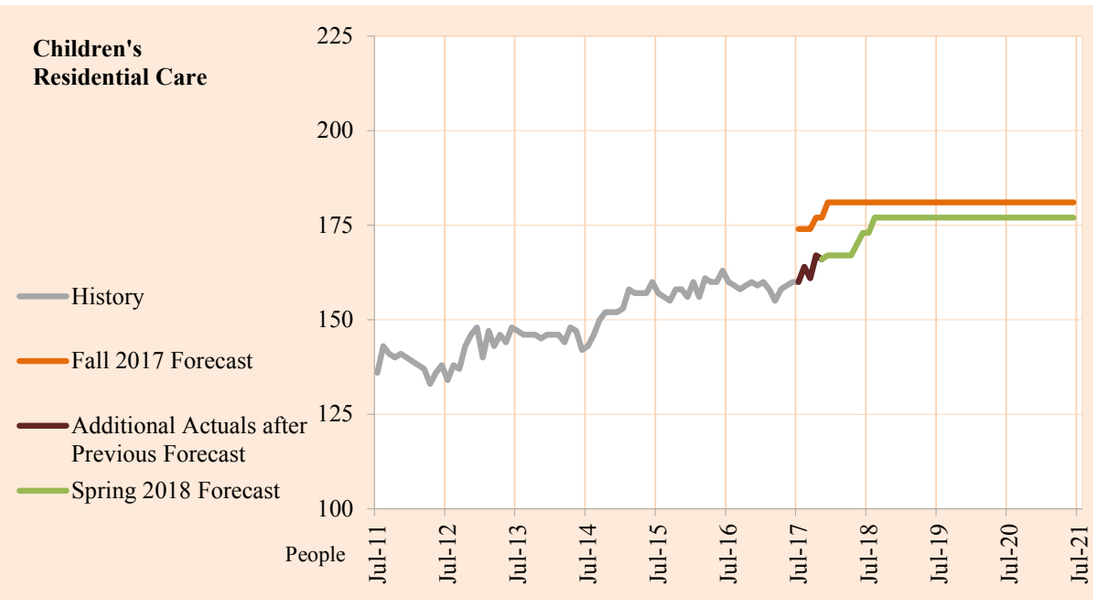
Children Intensive In-Home Services (CIIHS) – This caseload includes Medically Fragile Children Services, Intensive Behavior Programs, and Medically Involved Program. This caseload is limited by capacity and is expected to grow gradually to 421 by September 2018 and remain at that level for 2017-19 and 2019-21.

Children Residential Care – This caseload is expected to grow to 177 by August 2018 and remain at that level for 2017-19 and 2019-21 from the current level of 167.

There is a crisis in residential resources for children, including overlap with children served by Child Welfare and Developmental Disabilities. Children have been placed in inappropriate or unsafe placements, including hotels, DHS offices, hospital emergency rooms, and in family homes where family members and providers feel unsafe. In response to this crisis, several new group homes licensed for 18 new beds will be opened in 2017 to serve children/youth with significant behavioral challenges who are not able to be supported in their family home or in foster care.







Other Services

Employment and Day Support Services – In order to better reflect recent 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. However, Employment claims data have a significant longer lag time than the customary 3 months due to delayed billing and claims processing. Therefore, OFRA has based the Fall 2017 forecast on estimated preliminary actuals. The preliminary actuals accounts for the difference between the initially observed caseload and the caseload observed (completed) at later date.

Steps involved in calculation of preliminary actuals:

1. Calculate the ratios of the previous 10 months of actuals to 3 month matured reported actuals
2. Calculate a three month moving average
3. The estimated actuals are calculated by applying the moving average ratios to initially reported actuals

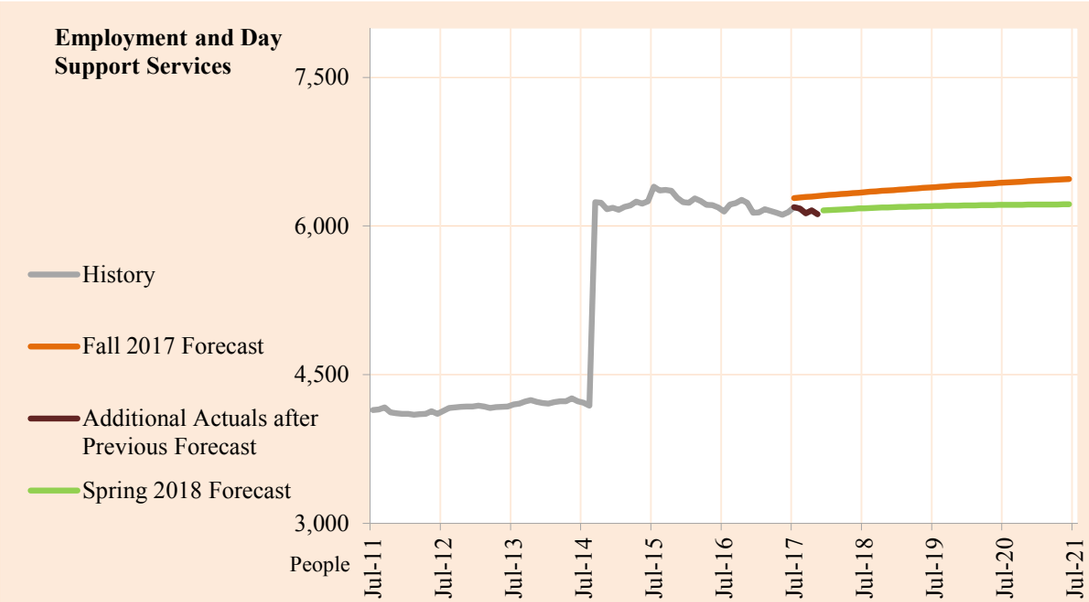
The 2017-19 biennial average forecast is expected to average 6,174, which represents a 2.6 percent decrease over the Spring 2017 forecast. The caseload is expected to average 6,212 over the 2019-21 biennium, which is slightly higher than the 2017-19 biennium.

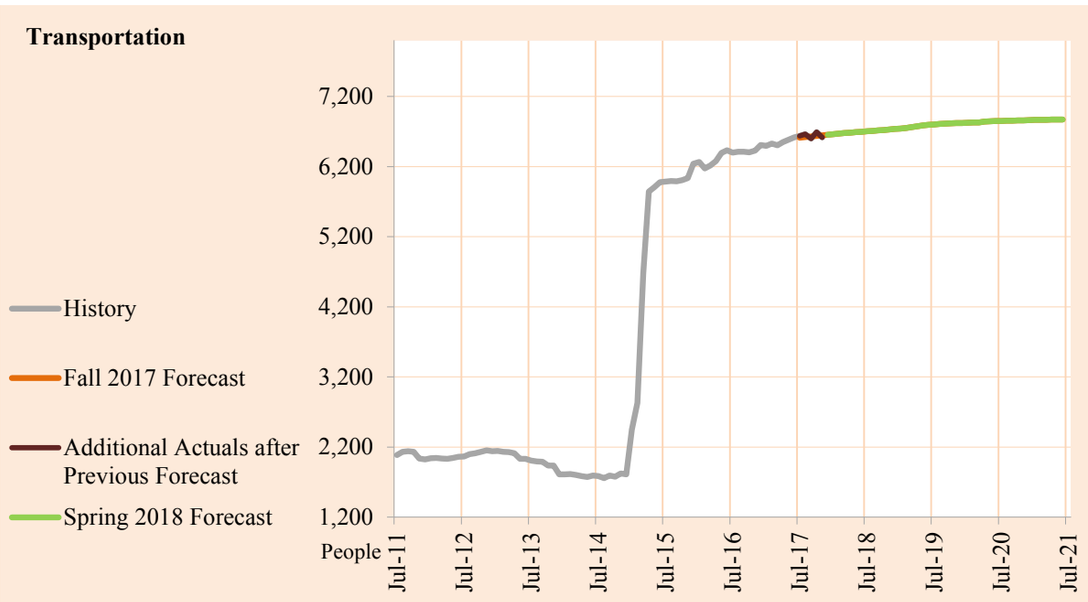
Employment and Day Support Services will be reported together as Total Employment and Day Support Services. Recent history show that about 55 percent of clients in this caseload utilized Day Support Services with or without employment services.

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

The 2017-19 biennial average forecast is expected to average 6,703, which remains unchanged over the Fall 2017 forecast. The caseload is expected to average 6,843 over the 2019-21 biennium, which is 2.1 percent higher than the 2017-19 biennium.

Total Transportation Services will be reported as Total Transportation and Other Transportation Services. Recent history show that about 23.3 percent of clients in this caseload utilized Other Transportation Services.


Employment and Day Support Services
7,500
6,000
4,500
3,000
People
History
Fall 2017 Forecast
Additional Actuals after Previous Forecast
Spring 2018 Forecast
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19
Jul-20
Jul-21


Transportation
7,200
6,200
5,200
4,200
3,200
2,200
1,200
People
History
Fall 2017 Forecast
Additional Actuals after Previous Forecast
Spring 2018 Forecast
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19
Jul-20
Jul-21

Risks and Assumptions

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

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

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

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

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

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

Intellectual and Developmental Disabilities Biennial Average Forecast Comparison

	2017-19 Biennium			% Change Between Forecasts	Spring 2018 Forecast			% Change Between Biennia
	Fall 17 Forecast	Spring 18 Forecast	Change		2017-19	2019-21	Change	
INTELLECTUAL AND DEVELOPMENTAL DISABILITIES								
Total Case Management Enrollment [1]	**28,133**	**27,946**	**-187**	**-0.7%**	**27,946**	**30,732**	**2,786**	**10.0%**
Adult								
Adult In-Home Support[2]	7,846	7,840	-6	-0.1%	7,840	7,938	98	1.3%
I/DD Foster Care[2,3]	2,866	2,888	22	0.8%	2,888	2,958	70	2.4%
24 hrs Residential Care[2]	2,926	2,913	0	-0.4%	2,913	2,996	83	2.8%
Supported Living[2]	699	695	-4	-0.6%	695	694	-1	-0.1%
Stabilization and Crisis Unit	99	98	0	-1.0%	98	99	1	1.0%
Children								
I/DD Foster Care	451	423	-28	-6.2%	423	433	10	2.4%
In-Home Support for Children	3,269	3,396	127	3.9%	3,396	3,724	328	9.7%
Children Intensive In-Home Services	412	405	-7	-1.7%	405	421	16	4.0%
Children Residential Care	180	172	-8	-4.4%	172	177	5	2.9%
Total I/DD Services	**18,748**	**18,830**	**82**	**0.4%**	**18,830**	**19,440**	**610**	**3.2%**
Other I/DD Services								
Employment & Day Support Activities[4]	6,338	6,176	-162	-2.6%	6,176	6,212	36	0.6%
Transportation	6,700	6,703	3	0.0%	6,703	6,843	140	2.1%

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

2. Starting in Fall 2017, Comprehensive In-Home Services and Brokerage Services will be combined to create a new caseload - Adult In-Home Support. Brokerage Enrollment caseload forecast will be discontinued.
Adult In-Home Support is a new caseload category that combines Brokerage and Comprehensive In-Home Services without employment and transportation services. Adults In-Home Support uses plan of care codes instead of service elements. Adult In-Home Support, I/DD Foster Care, 24 hr Residential Care and Supported Living are defined as person served with service priority. These new caseloads begin Fall 2017.

3. I/DD Foster Care caseload is seperated into adult and children services caseloads starting in Spring 2018.

4. Employment and DSA actuals from November 2016 to June 2017 are estimated to account for under reporting of delayed claims.

Self Sufficiency Programs (SSP)

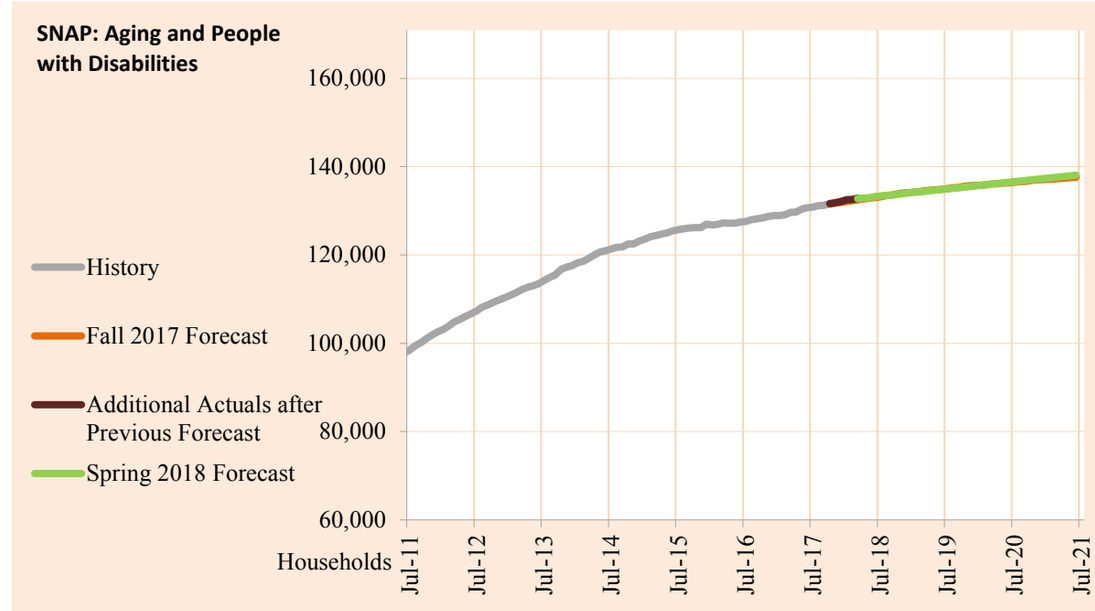
Supplemental Nutrition Assistance Program (SNAP) – In February 2018 there were 375,196 households (649,621 persons) receiving SNAP benefits, which constitutes approximately 15.5 percent of all Oregonians. The SSP portion of SNAP (made up mostly of parents and children) rose rapidly in 2009 and continued to grow until leveling off in mid-2012 when it began to decline. The caseload has declined by 90,728 households since June 2012. The smaller APD SNAP caseload (designed for people aged 60 and older) also rose rapidly due to the Great Recession, but now is returning to its traditional, less-steep growth pattern. The combined 2017-19 SNAP biennial average forecast is 364,346 households, which is 0.9 percent higher than the Fall 2017 forecast. This slight revision upward is the result of a modest increase in SNAP for SSP in January 2018. Winter tends to be a time of modest job growth in Oregon, and this may have produced a seasonal shift in SNAP SSP. This modest seasonality is now built into the new forecast.

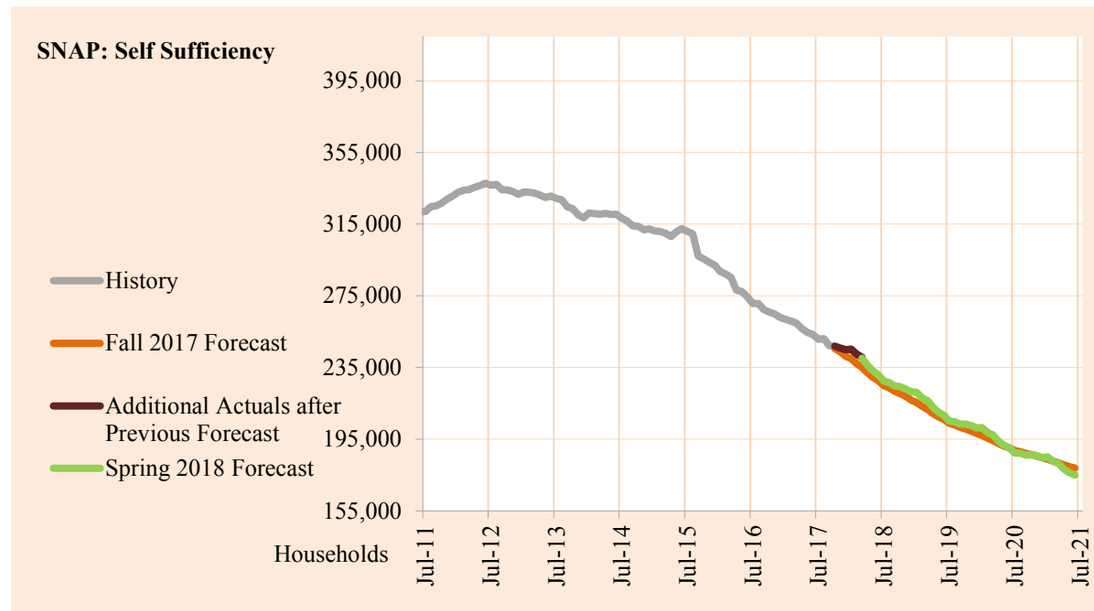
The projected biennial average for 2019–21 is 327,783 households, which is ten percent lower than the 2017-19 biennial average forecast.

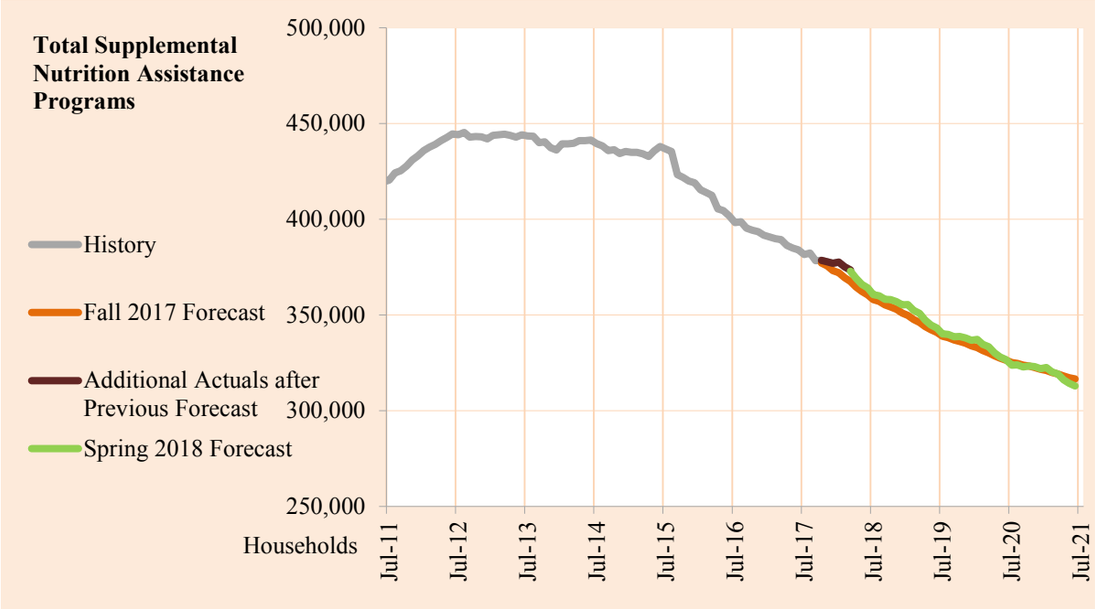
APD SNAP - APD SNAP has moved from a 12-month to 24-month redetermination schedule (redeterminations are the formal scheduled re-evaluation of eligibility). This policy was implemented on August 1, 2016 and will have the effect of reducing "churn" in this caseload. Churn occurs when clients do not complete the redetermination process in a timely manner and temporarily drop off the caseload. This change will likely influence only a small number of cases, as the exit rate for APD SNAP is much smaller than for SSP SNAP. But the effect will likely be persistent, and should be considered a risk.

SNAP Self Sufficiency - The "Able Bodied Adults without Dependents", or ABAWD rule, is a three-month limit to SNAP benefits that applies to non-disabled adults without dependents age 50 and under. Oregon was granted an exemption from this time limit for all counties during the Great Recession. The federal government reinstated the ABAWD rule in January 2016 for Washington and Multnomah Counties, and to Clackamas County in the fall of 2016. Beginning in January 2018, four additional counties – Benton, Lane, Marion, and Yamhill – also reinstated the ABAWD policy. Although reintroduction of this rule is likely to have only a minor impact on the caseload, it must be considered a risk to the forecast.

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







Temporary Assistance for Needy Families (TANF) – In February 2018, there were 19,532 families receiving TANF benefits, representing 53,818 persons. The TANF caseload underwent nearly uninterrupted growth from January 2008 until February 2013. The caseload then declined rapidly, and is currently 17,079 cases below its February 2013 peak, a drop of almost 47 percent. The 2017-19 TANF biennial average forecast is 18,520 families, which is 0.2 percent lower than the Fall 2017 forecast. The 2019-21 biennial average is 16,381 families, which is 11.5 percent lower than the biennial average forecast for 2017-19.

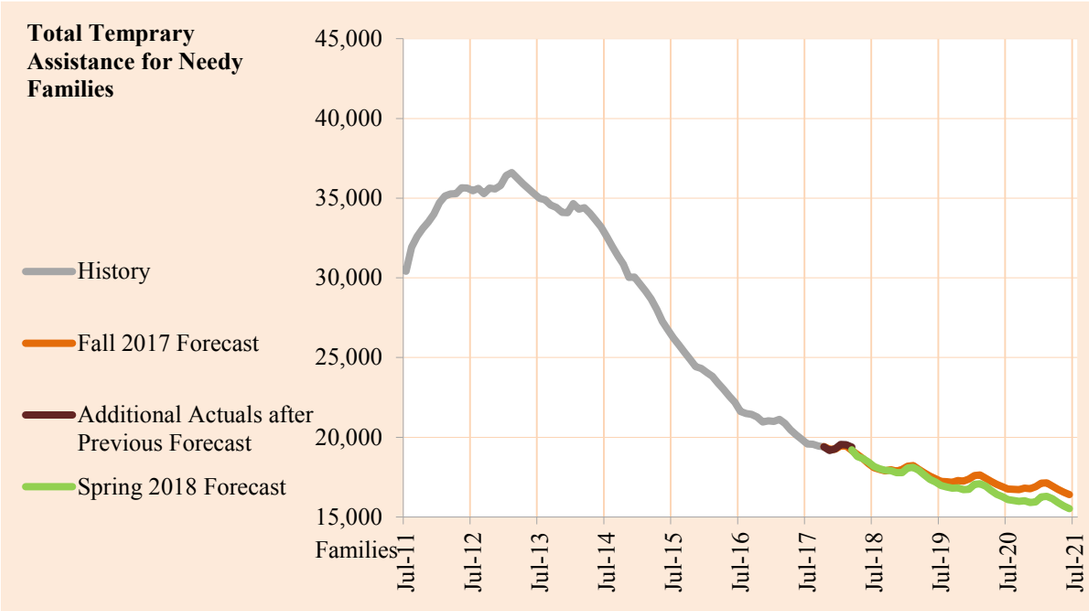
TANF is expected to fall to pre-recession levels by the middle of 2019, and drop even further to levels not seen since the earliest days of the program. Part of this reduction is due to previously enacted changes in eligibility rules for non-needy caretakers of disabled relatives, which reduced that portion of the caseload in 2009. However, the lion's share of the reduction is due to a continued good economy. The economic expansion is expected to continue to move TANF recipients off the caseload and into the world of work, and although the forecasted decreases are not as vigorous as those experienced in 2015 and 2016, they will be enough to move the caseload into new territory.

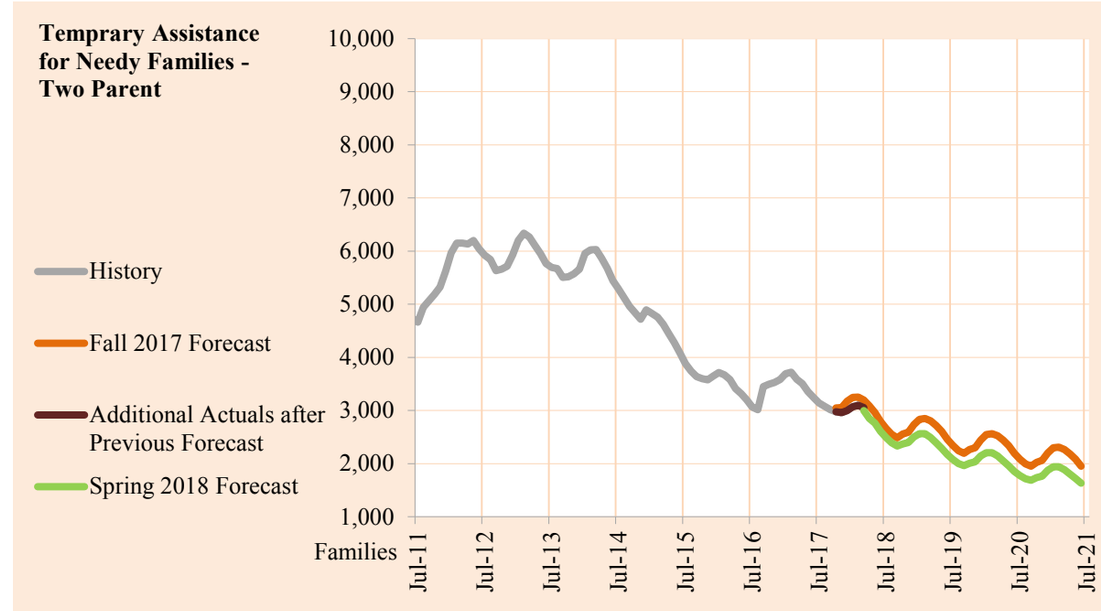
TANF Reinvestment - The 2015 Legislature passed two acts designed to modify TANF in order to provide better opportunities for families to successfully transition out of the program. This set of policy changes are commonly called "TANF Reinvestment." These reforms began in May 2016.

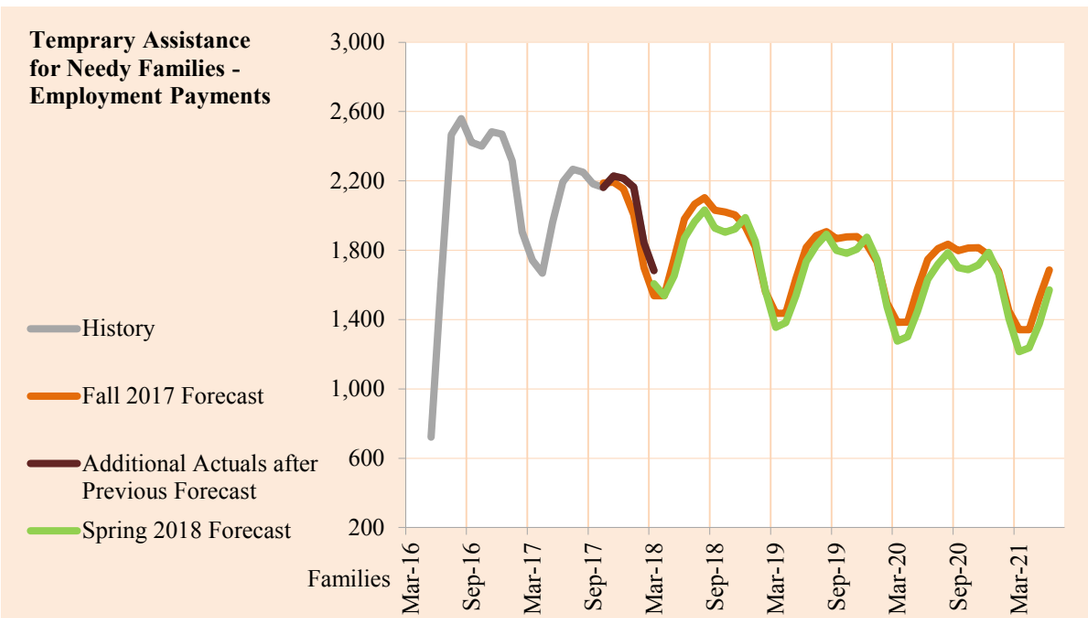
The elements of TANF Reinvestment that were expected to impact caseloads by reducing the rate of exit – and were built into past forecasts – included an increase in the income limit for existing TANF households, expanding the definition of a caretaker relative, and the elimination of deprivation as an eligibility requirement. However, none of the expected caseload impacts have been detected. Instead, TANF has continued to decline in the same pattern as before implementation. The most likely explanation of this lack of effect is that the economy is moving people off the caseload and into employment at a rate that has rendered the impact of TANF reinvestment moot. However, the influence of TANF reinvestment, especially as the forecast reaches pre-recession levels, must be considered a risk to forecast accuracy.

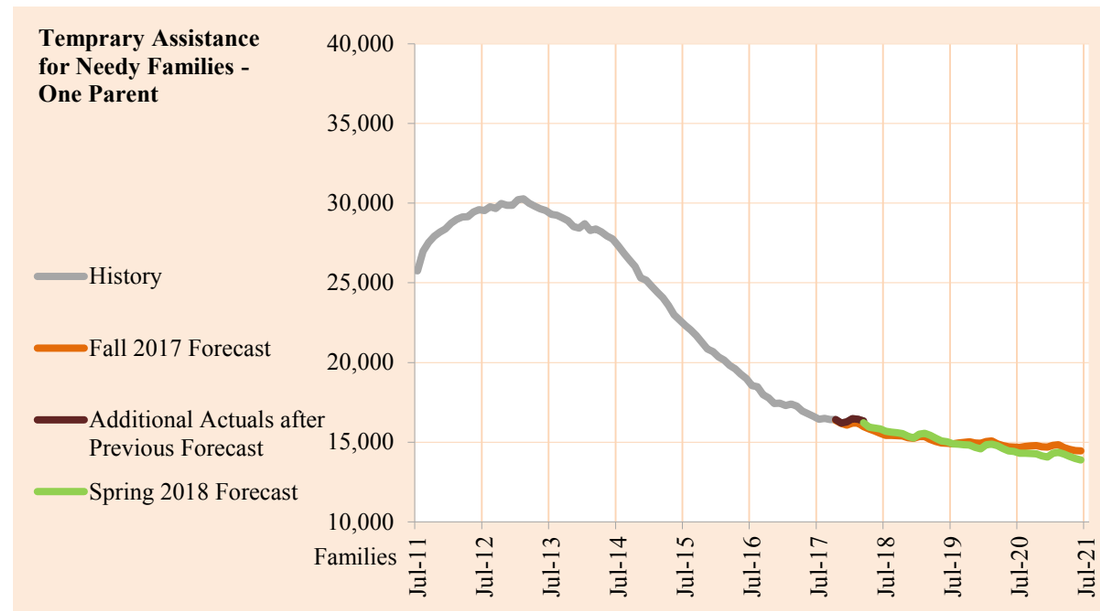
In addition to the reforms listed above, TANF Reinvestment created a new case category, called TANF Employment Payments (TANF-EP), which provides a cash payment for three months to TANF households exiting the program due to employment. The creation of TANF-EP led to an unintended consequence in the area of data accuracy. For caseloads to be accurately forecast, a case must be in one program – and only one program – within a given month. However, in some reports issued by DHS, TANF-EP cases are counted in both the TANF category and the EP category. The forecasted values contained in this report do not have duplicate counts, therefore they may not agree with some other DHS-reported values.

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


Total Temprary Assistance for Needy Families
History
Fall 2017 Forecast
Additional Actuals after Previous Forecast
Spring 2018 Forecast
45,000
40,000
35,000
30,000
25,000
20,000
15,000
Families
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19
Jul-20
Jul-21

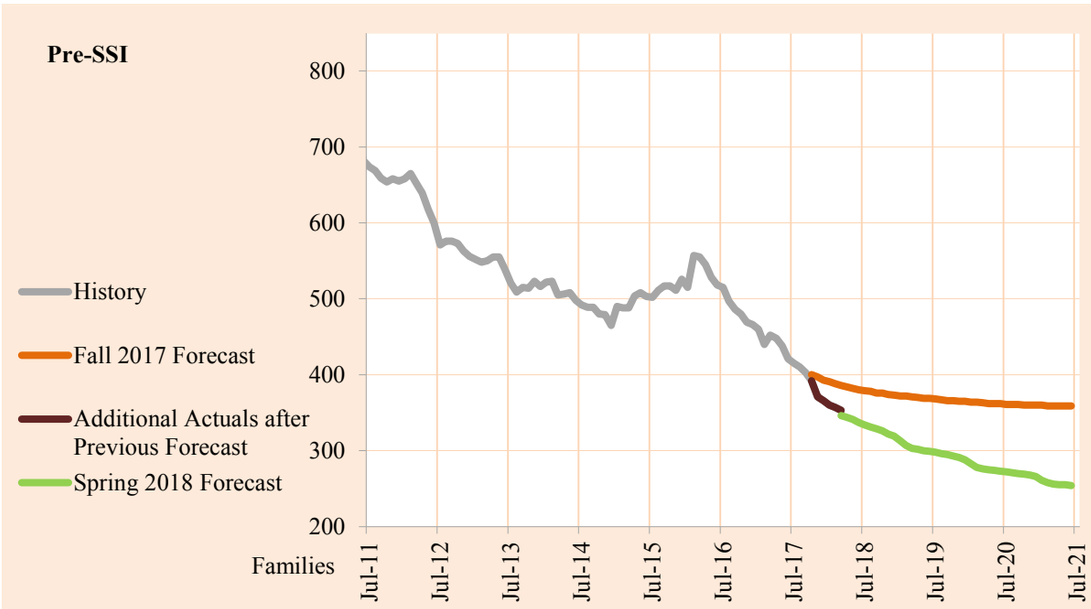

Temprary Assistance for Needy Families - Two Parent
History
Fall 2017 Forecast
Additional Actuals after Previous Forecast
Spring 2018 Forecast
10,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
Families
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19
Jul-20
Jul-21


Temprary Assistance for Needy Families - Employment Payments
History
Fall 2017 Forecast
Additional Actuals after Previous Forecast
Spring 2018 Forecast
3,000
2,600
2,200
1,800
1,400
1,000
600
200
Families
Mar-16
Sep-16
Mar-17
Sep-17
Mar-18
Sep-18
Mar-19
Sep-19
Mar-20
Sep-20
Mar-21


Temprary Assistance for Needy Families - One Parent
History
Fall 2017 Forecast
Additional Actuals after Previous Forecast
Spring 2018 Forecast
40,000
35,000
30,000
25,000
20,000
15,000
10,000
Families
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19
Jul-20
Jul-21

Pre SSI – Pre-SSI provides temporary assistance for families while they apply for Supplemental Security Income, a benefit for the aged, blind, and disabled who have little or no income. Almost all Pre-SSI cases are transfers from TANF, and the percentage of TANF cases moving to Pre-SSI has been steadily going down, from four percent in 2009 to one percent in 2017. In addition, there are simply fewer TANF exits, given that the total volume of TANF cases has been dropping since 2013. These two factors have led to a long-term pattern of decline in the caseload, with the exception of a short period where a backlog of applications was addressed. Furthermore, the Social Security Administration (SSA) has become more stringent in their interpretation of disability criteria – most recently their mental health criteria.

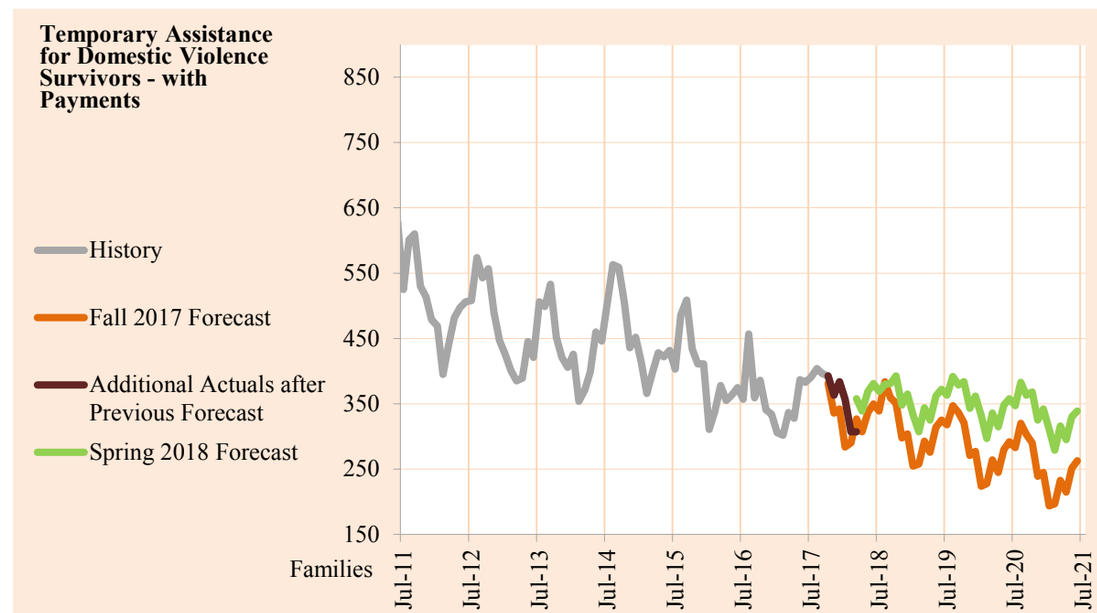
The Spring 2018 forecast assumes that the long-term pattern of caseload reductions will continue through the spring of 2021, after which the caseload will stabilize at about 255 cases per month. The 2017–19 biennial average forecast for Pre-SSI is 343 families, which is 10.7 percent lower than the Fall 2017 forecast. The 2019-21 biennial average caseload is expected to be 274 families, which is 20.1 percent lower than the forecast for the current biennium.

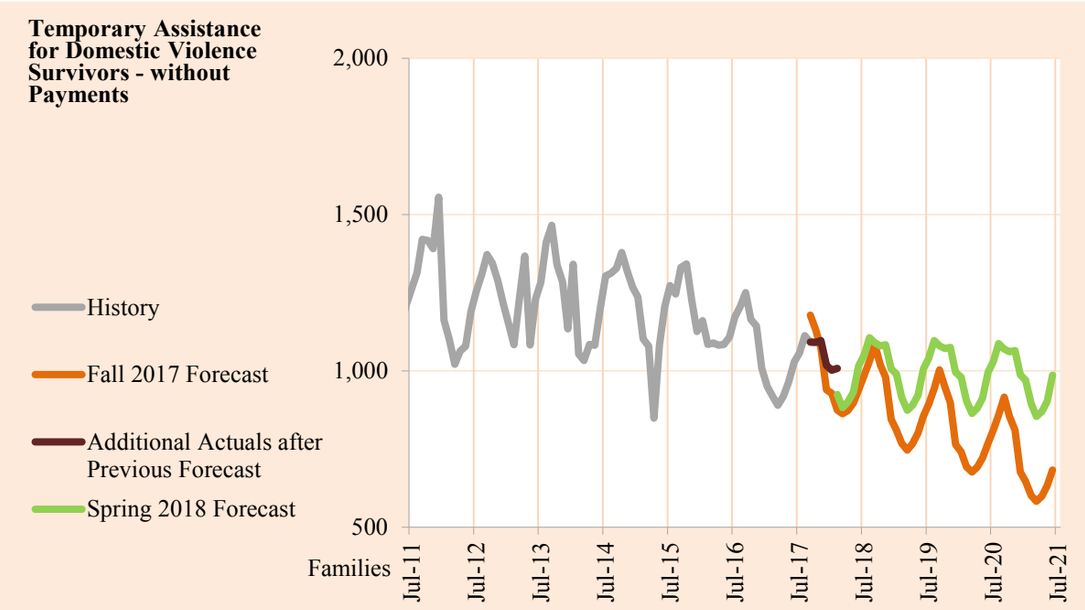


Temporary Assistance for Domestic Violence Survivors (TA-DVS) – In the past, the portion of the TA-DVS program that was forecast in this document was limited to those domestic violence survivors who accepted TA-DVS payments (which are used to help defray the costs of housing). Over the course of the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

The TA-DVS with-payment caseload is a relatively small caseload that has been falling steadily amid strong seasonal fluctuations. Lately, these seasonal fluctuations have become less strong – reducing the extreme difference between the lowest caseload values in the winter months and the highest caseload values in the summer months. This suggests a caseload that has reached (or will soon reach) a “floor” with less volatility than in the past. The average caseload for the current biennium is forecasted to be 363 families per month, which is 10.4 percent higher than the Fall 2017 forecast. This caseload is expected to fall only modestly to an average of 342 families per month during the 2019–21 biennium, a reduction of 5.9 percent.

The TA-DVS without-payment caseload had been holding relatively steady until the fall of 2016, when the caseload failed to reach its usual, seasonal high-point immediately before the resumption of the school year. Since then, the caseload has been falling. Much like the with-payment group, TA-DVS without-payment is forecasted to continue to fall more gradually than before, within the usual seasonal pattern, with an average of 1,006 cases per-month through the 2017-19 biennium, and a monthly average of 986 cases in the 2019-21 biennium, a reduction of only 1.9 percent.




Temporary Assistance for Domestic Violence Survivors - without Payments
2,000
1,500
1,000
500
Families
History
Fall 2017 Forecast
Additional Actuals after Previous Forecast
Spring 2018 Forecast
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19
Jul-20
Jul-21

Self Sufficiency Biennial Average Forecast Comparison

	2017-19 Biennium			% Change Between Forecasts	Spring 2018 Forecast			% Change Between Biennia
	Fall 17 Forecast	Spring 18 Forecast	Change		2017-19	2019-21	Change	
SELF SUFFICIENCY PROGRAMS								
Supplemental Nutrition Assistance Program (Households)								
Children, Adults and Families	227,978	231,232	3,254	1.4%	231,232	191,266	-39,966	-17.3%
Aging and People with Disabilities	133,058	133,114	56	0.0%	133,114	136,517	3,403	2.6%
Total SNAP	**361,036**	**364,346**	3,310	0.9%	**364,346**	**327,783**	-36,563	-10.0%
Temporary Assistance for Needy Families (Families: Cash/Grants)								
One-Parent	15,687	15,831	144	0.9%	15,831	14,458	-1,373	-8.7%
Two-Parent	2,872	2,689	-183	-6.4%	2,689	1,923	-766	-28.5%
Total TANF	**18,559**	**18,520**	**-39**	**-0.2%**	**18,520**	**16,381**	**-2,139**	**-11.5%**
TANF Employment Payments	1,900	1,881	-19	-1.0%	1,881	1,614	-268	-14.2%
Pre-SSI	384	343	-41	-10.7%	343	274	-69	-20.1%
Temp. Assist. For Dom. Violence Survivors (Families)								
TADVS: with Payment	329	363	34	10.3%	363	342	-21	-5.8%
TADVS: without Payment	940	1,006	66	7.0%	1,006	986	-20	-2.0%
Total TADVS	**1,269**	**1,369**	**100**	**7.9%**	**1,369**	**1,328**	**-41**	**-3.0%**

Vocational Rehabilitation (VR)

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

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

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

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

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

The new caseload groups are assigned as follows:

1) First, clients who had an I/DD record in the 12 months prior to applying for VR services are identified by matching VR clients to I/DD eligibility and enrollment records.

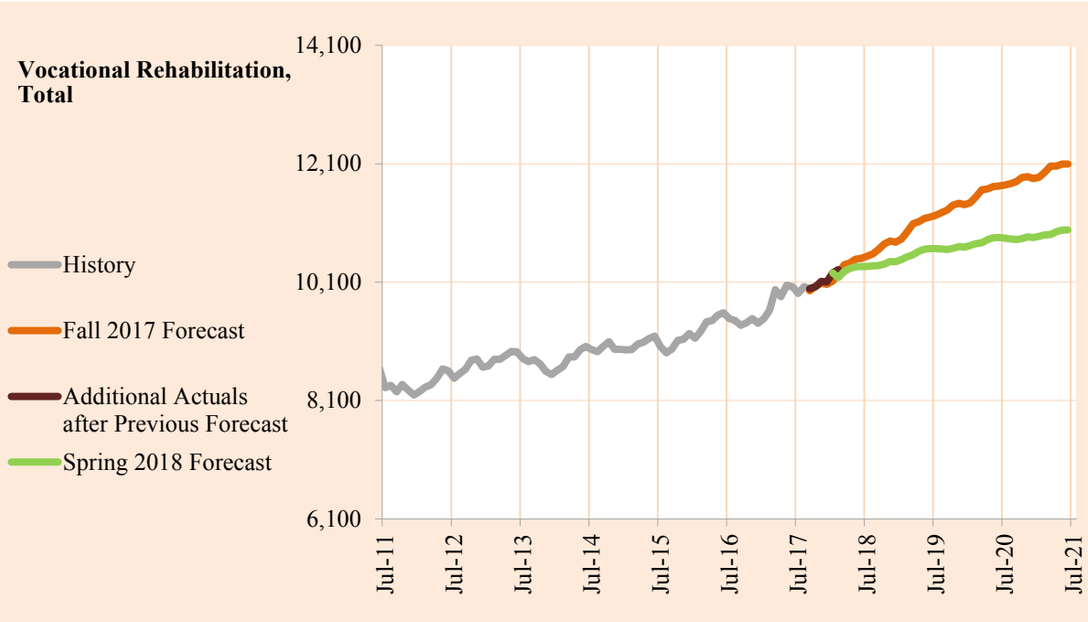
2) The remaining VR clients are placed into one of the other four caseload groups based on their primary disability type (Cognitive Impairments, Psychosocial & Other Mental Impairments, Deafness/Blindness, and Physical Impairments).

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

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

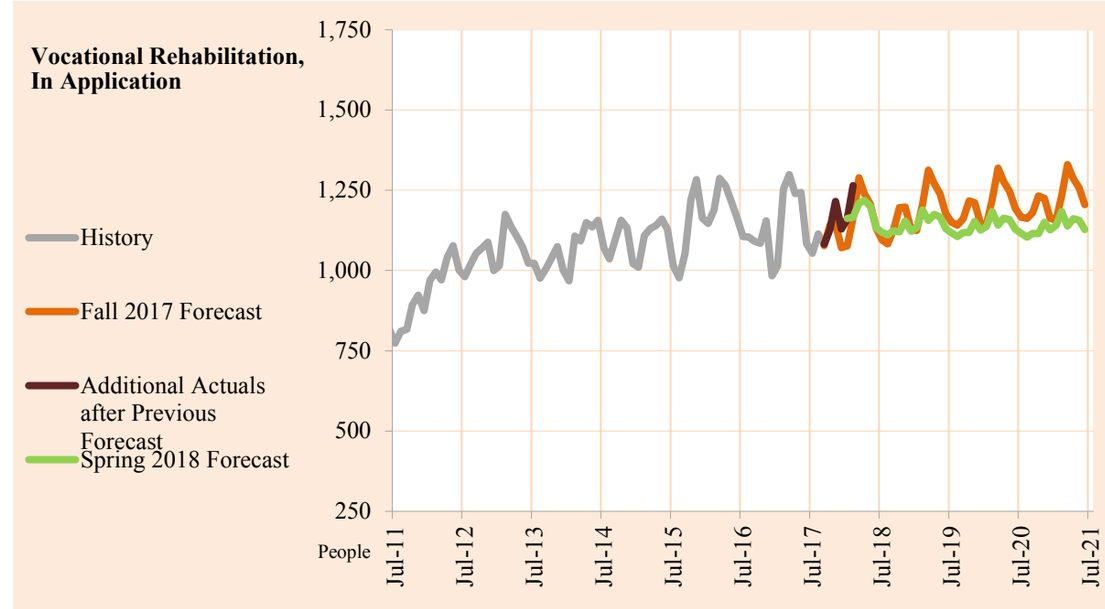
The **Total Vocational Rehabilitation** (Total VR) forecast is the sum of In Application, In Eligibility, In Plan, and Post-Employment Services. It can also be derived as a sum of total caseloads in all five disability-based caseload groups and Post-Employment Services.

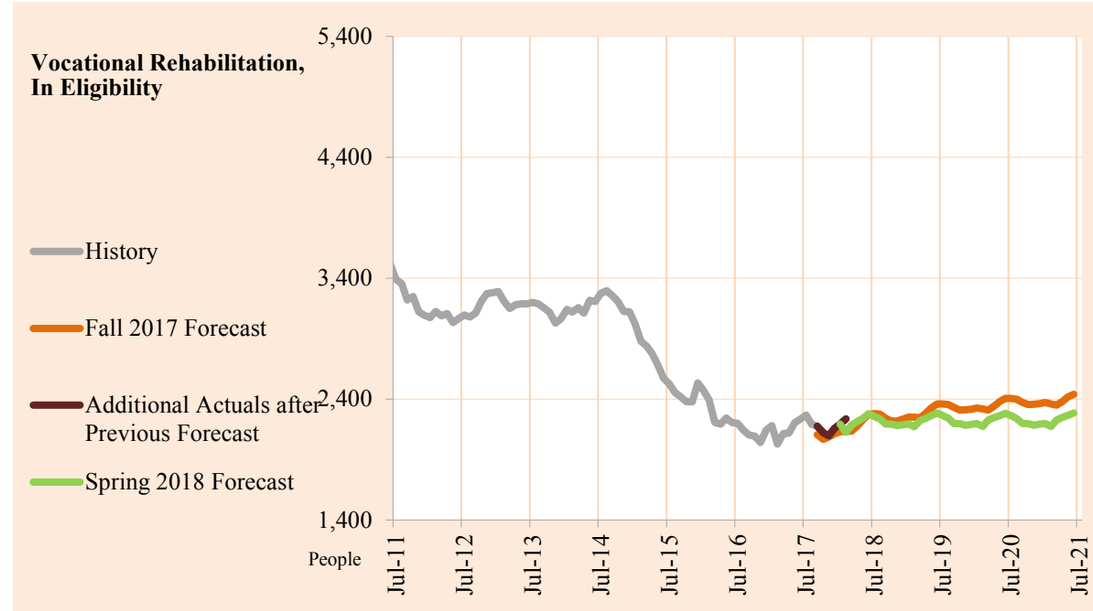
Total Vocational Rehabilitation – The average count of clients in VR for the 2017-19 biennium is expected to be 10,357 clients per month, a 1.7% decrease compared to the Fall 2017 forecast of 10,537 per month. Moderate growth is expected through the 2019-21 biennium, with an average of 10,808 clients per month, a 4.4% increase compared to the 2017-19 biennial average.



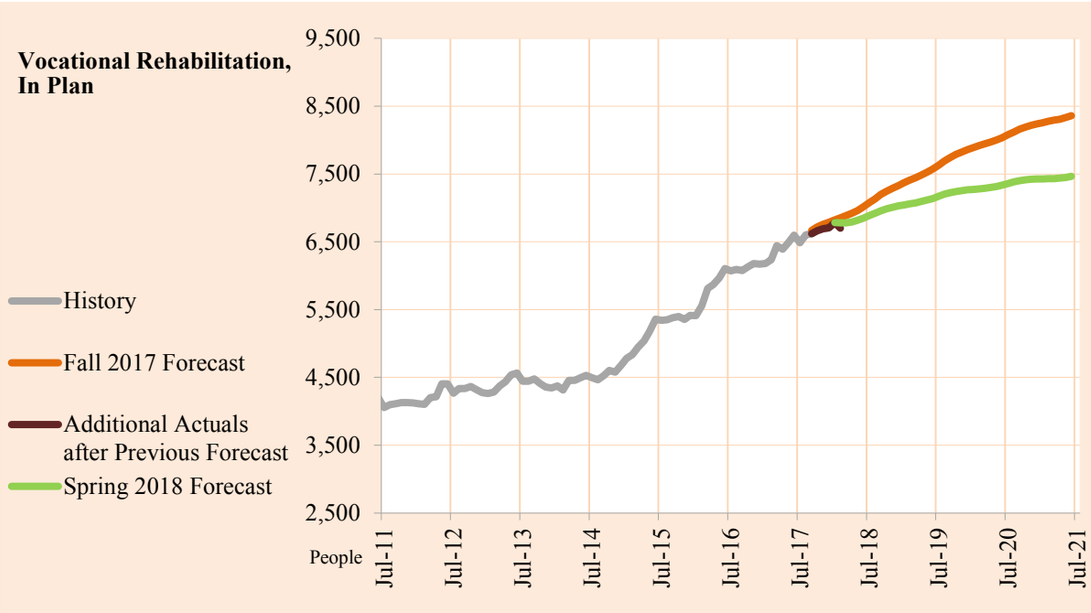
In Application – The average count of clients in the application stage for the 2017-19 biennium is anticipated to be 1,146 clients per month, a 1.3% decrease compared to the Fall 2017 forecast of 1,161 per month. It is expected to remain somewhat flat through the forecast horizon and average 1,137 for the 2019-21 biennium.

In Eligibility – The average count of clients in the eligibility stage for the 2017-19 biennium is anticipated to be 2,203 clients per month, a 0.4% decrease compared to the Fall 2017 forecast of 2,212 per month. It is expected to grow slightly through the forecast horizon and average 2,222 for the 2019-21 biennium.



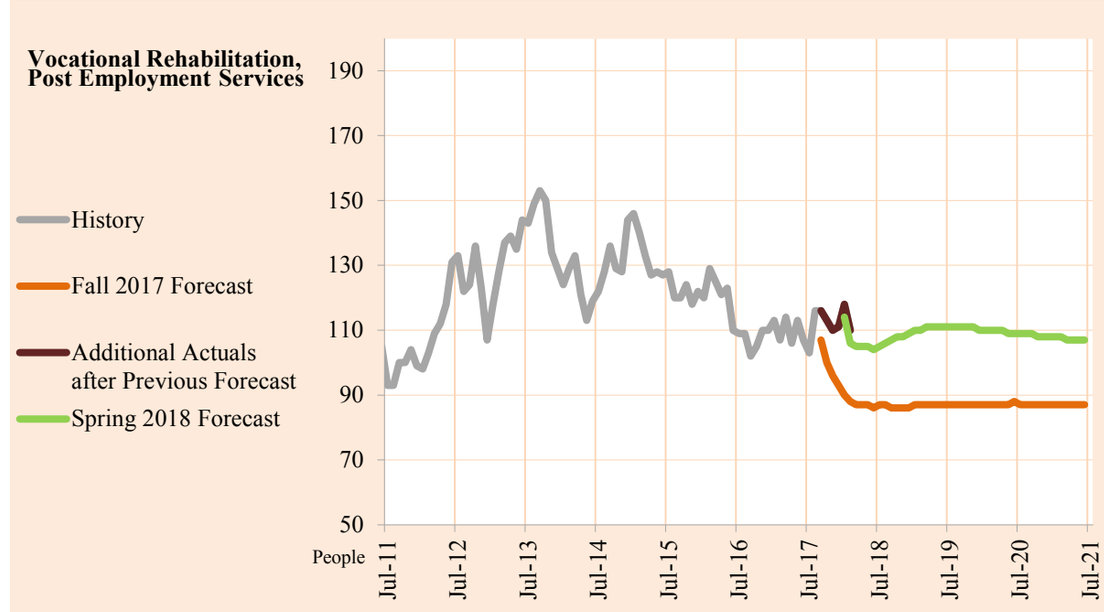


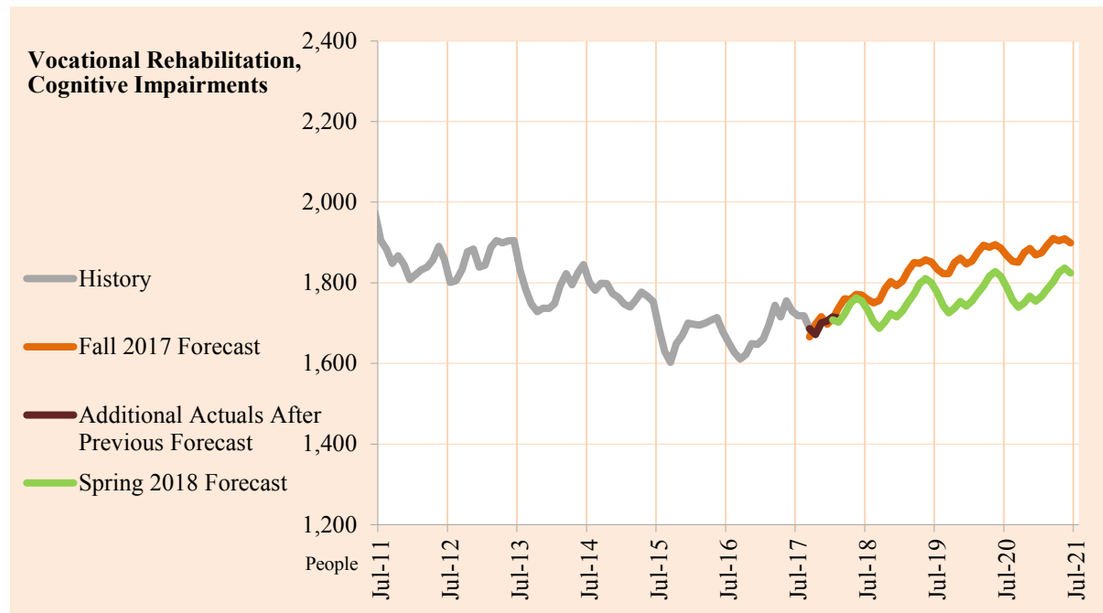
In Plan - The average count of clients in plan stage for the 2017-19 biennium is anticipated to be 6,870 clients per month, a 2.8% decrease compared to the Fall 2017 forecast of 6,243 per month. It is expected to grow moderately through the forecast horizon and average 7,342 for the 2019-21 biennium.



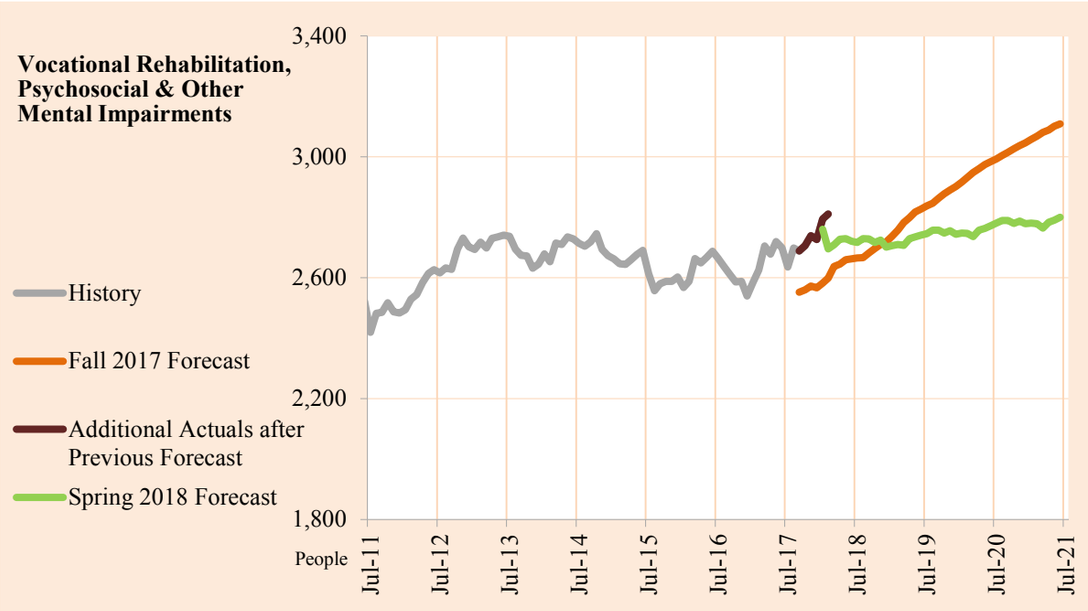
Post Employment Services – The average count of clients in the Post-Employment Services stage for the 2017-19 biennium is anticipated to be 109 clients per month, a 21.1% increase compared to the Fall 2017 forecast of 90 per month.

Cognitive Impairments – The average count of clients in this caseload group for the 2017-19 biennium is anticipated to be 1,730 clients per month, a 2.0% decrease compared to the Fall 2017 forecast of 1,766 per month. It is expected to grow through the forecast horizon and average 1,777 for the 2019-21 biennium.



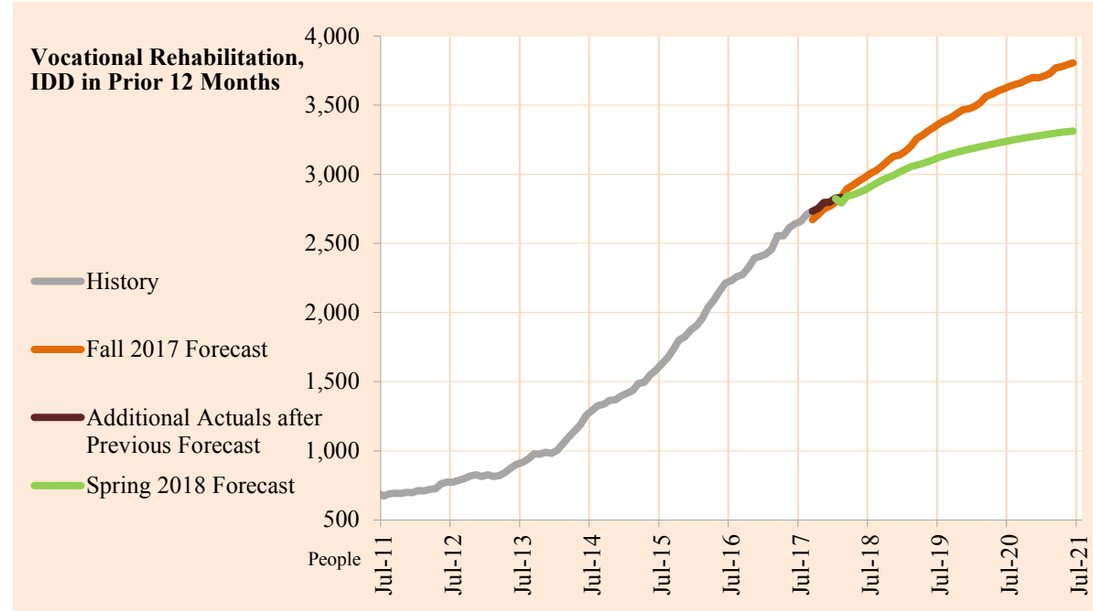


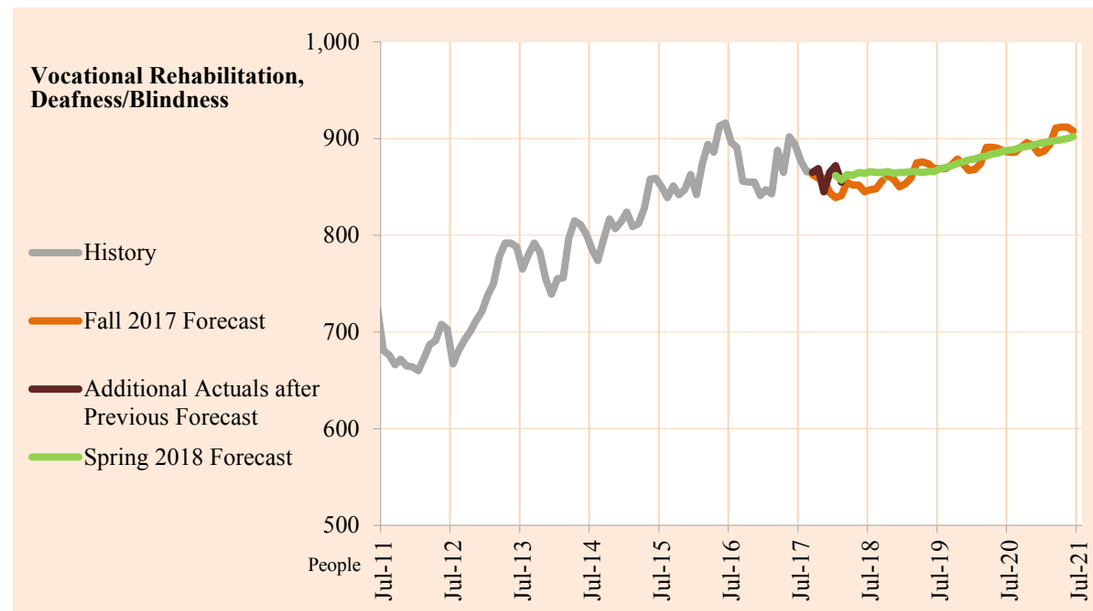
Psychosocial & Other Mental Impairments - The average count of clients in this caseload group for the 2017-19 biennium is anticipated to be 2,715 clients per month, a 1.5% increase compared to the Fall 2017 forecast of 2,674 per month. It is expected to grow slightly through the forecast horizon and average 2,768 for the 2019-21 biennium.



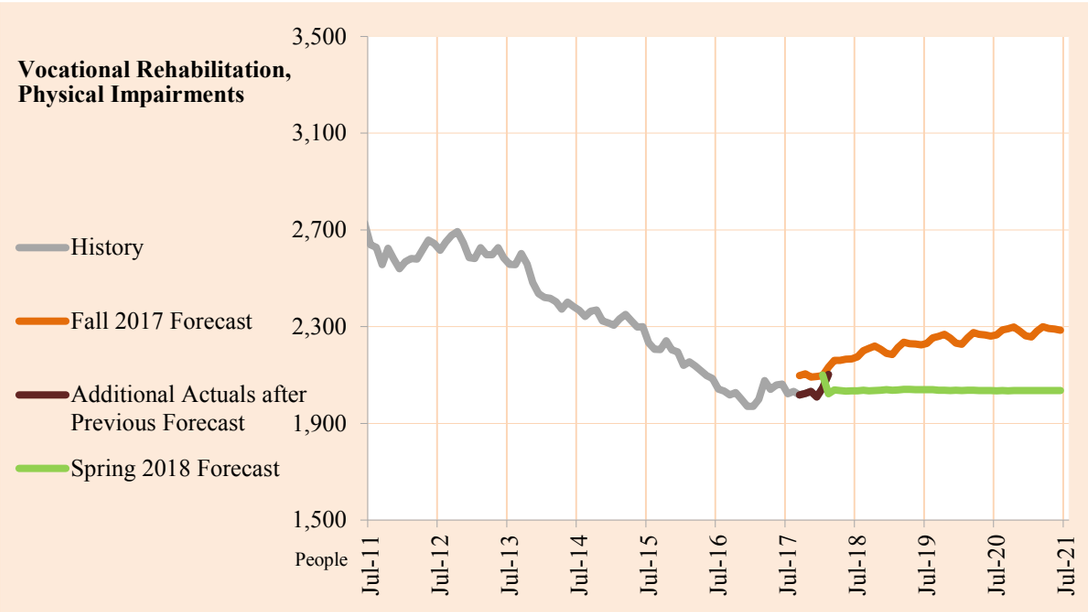
I/DD in Prior 12 Months – The average count of clients in this caseload group for the 2017-19 biennium is anticipated to be 2,906 clients per month, a 2.7% decrease compared to the Fall 2017 forecast of 2,986 per month. It is expected to grow through the forecast horizon and average 3,233 for the 2019-21 biennium.

Deafness/Blindness – The average count of clients in this caseload group for the 2017-19 biennium is anticipated to be 864 clients per month, a 0.7% increase compared to the Fall 2017 forecast of 858 per month. It is expected to grow slightly through the forecast horizon and average 887 for the 2019-21 biennium.





Physical Impairments – The average count of clients in this caseload group for the 2017-19 biennium is anticipated to be 2,037 clients per month, a 5.8% decrease compared to the Fall 2017 forecast of 2,163 per month. It is expected to remain flat through the forecast horizon and average 2,036 for the 2019-21 biennium.



Risks and Assumptions

1. Budget limitations may push program in "order of selection".

2. Changes in Economy

3. Ongoing ORCA clean up

4. Lane vs. Brown settlement

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

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

Vocational Rehabilitation Biennial Average Forecast Comparison

	2017-19 Biennium			*% Change Between Forecasts*	Spring 2018 Forecast			*% Change Between Biennia*
	Fall 17 Forecast	**Spring 18 Forecast**	**Change**		**2017-19**	**2019-21**	**Change**	
VOCATIONAL REHABILITATION								
Cognitive Impairments	1,766	1,729	-37	-2.1%	1,729	1,777	48	2.8%
Psychosocial & Other Mental Impairments	2,674	2,715	41	1.5%	2,715	2,768	53	2.0%
IDD in Prior 12 Months	2,986	2,905	-81	-2.7%	2,905	3,232	327	11.3%
Deafness/Blindness	858	864	6	0.7%	864	886	22	2.5%
Physical Impairments	2,163	2,036	-127	-5.9%	2,036	2,036	0	0.0%
Post Employment Services	90	108	18	20.0%	108	109	1	0.9%
Total Vocational Rehabilitation	**10,537**	**10,357**	**-180**	**-1.7%**	**10,357**	**10,808**	**451**	**4.4%**
In Application	1,161	1,146	-15	-1.3%	1,146	1,137	-9	-0.8%
In Eligibility	2,212	2,203	-9	-0.4%	2,203	2,222	19	0.9%
In Plan	7,066	6,870	-196	-2.8%	6,870	7,342	472	6.9%

Oregon Health Authority

Total Oregon Health Authority Biennial Average Forecast Comparison

	2017-19 Biennium			% Change Between Forecasts	Spring 2018 Forecast			% Change Between Biennia
	Fall 17 Forecast	Spring 18 Forecast	Change		2017-19	2019-21	Change	
Health Systems - Medicaid								
OHP								
Children's Medicaid	303,228	306,433	3,204	1.1%	306,433	297,619	-8,814	-2.9%
Children's Health Insurance Program	82,605	84,391	1,787	2.2%	84,391	91,598	7,207	8.5%
Foster, Substitute and Adoption Care	21,093	20,849	-244	-1.2%	20,849	21,512	663	3.2%
Aid to the Blind and Disabled	84,819	84,998	179	0.2%	84,998	86,928	1,930	2.3%
Old Age Assistance	45,512	45,104	-408	-0.9%	45,104	47,527	2,423	5.4%
Pregnant Women	11,813	10,357	-1,456	-12.3%	10,357	9,711	-646	-6.2%
Parent, Caretaker Relative	72,340	69,726	-2,613	-3.6%	69,726	65,125	-4,601	-6.6%
ACA Adults	344,281	353,497	9,216	2.7%	353,497	348,806	-4,691	-1.3%
Total OHP	**965,690**	**975,355**	**9,664**	**1.0%**	**975,355**	**968,825**	**-6,529**	**-0.7%**
Other Medical Assistance Total	67,259	67,236	-23	0.0%	67,236	67,802	565	0.8%
Cover All Kids [1]	8,727	3,930	-4,797	-55.0%	3,930	6,758	2,829	72.0%
Total Medical Assistance	**1,041,677**	**1,046,520**	**4,844**	**0.5%**	**1,046,520**	**1,043,385**	**-3,135**	**-0.3%**
Mental Health [2]								
Under Commitment								
Total Forensic Care	836	830	-6	-0.7%	830	820	-10	-1.2%
Civilly Committed	1,007	998	-9	-0.9%	998	969	-29	-2.9%
Previously Committed	2,774	2,788	14	0.5%	2,788	2,767	-21	-0.8%
Never Committed	46,984	43,411	-3,573	-7.6%	43,411	44,780	1,369	3.2%
Total Served	51,601	48,027	-3,574	-6.9%	48,027	49,336	1,309	2.7%

1. Cover All Kids is a new non Medicaid caseload that started Jan 2018. It includes clients under age 19 who were previously in CAWEM as well as new entries entering the program directly. The 2017-2019 Biennium is the monthly average over 24 months, but the caseload was zero for the first 6 months of the biennium, from July to December 2017. Over the last 18 months of the 2017-19 Biennium, when the program is operational, the forecasted average monthly caseload will be 5,239.

2. Numbers reported represent adults only.

Health Systems Medicaid (HSM)

Starting with the ACA Expansion in January 2014, the caseload grew in fits and starts related to open enrollment and delayed redeterminations until March 2016. Starting in March 2016, the backlog of redeterminations were restarted on a regular basis, leading to sharp steady declines. This continued until February 2017 when there was a two-month lull in the number of redeterminations tied to the timing of the earlier restart of redeterminations. There was another burst of cleanup of older caseloads in June, July, and August 2017 that led to another three months of decline. Most recently, the timing of the open enrollment period for the Health Exchange and the increase in referrals from the federal marketplace occurred mostly in November and December 2017, roughly one month ahead of the previous year. This moved the bump in caseloads related to open enrollment up a month relative to previous years.

Automated Renewals

Starting with the renewals scheduled for the end of February 2018, Oregon transitioned to a system of automated renewals (sometimes called passive or ex parte renewals). Automated Renewals is a system under which OHA automatically renews a client's Medicaid Eligibility if they have all the required information and the Client is eligible. That data may be from a number of databases, including the IRS, Social Security Administration, local Employment records or other Oregon data. This system is in place in most states and is required by CMS. This means, in cases where OHA already has access to the necessary information to make a positive eligibility determination, they will do so and send notice to the client. The client is not required to respond in order to maintain eligibility. If OHA cannot verify eligibility with the available data, the client will go through the normal, active renewal process.

This has the potential to have large impacts on the rate at which people exit Medicaid and thus the caseload. A large fraction of case closures occur during renewal and a majority of renewal closures are closed for non-response. We assume at the very least the system will result in fewer cases being closed due to failure to return the renewal form in a timely manner. We see a large spike in the rate at which people exit at 12 and 24 months in some caseloads (ACA and PCR are particularly pronounced). We also see large numbers of clients return a few months after their case has been closed (effectively "churn").

This change to the renewal process was modeled in the current forecast from February 2018 onward. Specifically, adjustments were made to the survival curves for 4 programs (ACA Adults; Parent, Other Caretaker, Relative; Children's Medicaid; and CHIP) at the 12th and 24th month. In addition, New Enters for those 4 programs were reduced to account for the estimated decline in "churn". If automated renewals have the impact we expect on caseloads, we should see a significant reduction in percentage of clients who leave after 12 months and to a lesser extent after 24 months. We should also see concomitant reduction in clients who return after 2-4 months.

Cover All Kids

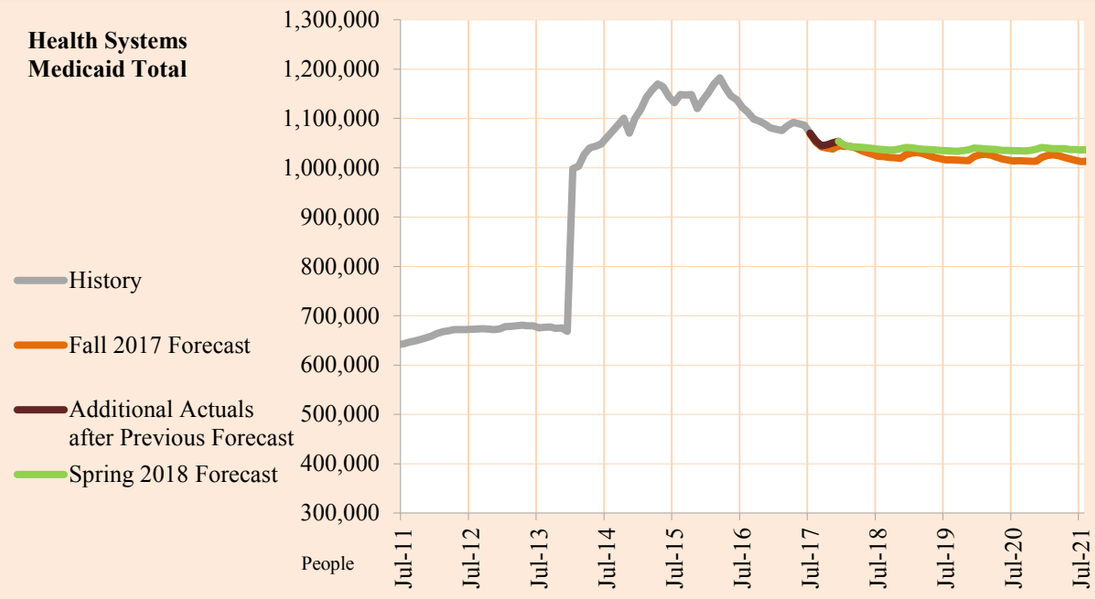
The original forecast for Cover All Kids was created when the legislation was written and was used for the Fall 2017 forecast. The original forecast estimated the pool of potentially eligible children and assumed rapid take up rates for the program (50% in the first month and 100% after two years). We have two months of preliminary data, showing new enters coming in at roughly 250 children a month, which is significantly lower than would be necessary to meet the original forecast.

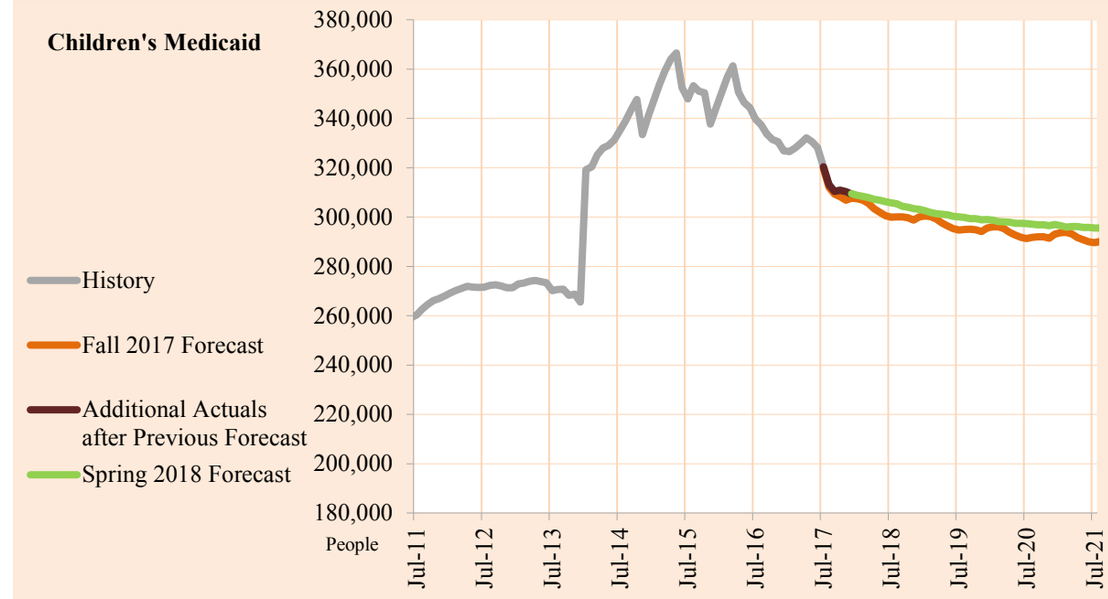
Given the national environment regarding undocumented immigrants and the difficulty in reaching this population, we revised the Spring 2018 Forecast for Cover All Kids down significantly. To be clear, we still think there is a pool of roughly 15,000 eligible children in the state of Oregon. Our forecast is an estimate of how many we think will be served under current circumstances.

This forecast does have a lot of uncertainty until we obtain actual program data. It assumes that children will leave the program at roughly the rates of Children's Medicaid. It also implicitly assumes program participation will reach roughly 50% over the next two years, in line with California's recent experience with a similar program.

Caseload Actuals and Trends

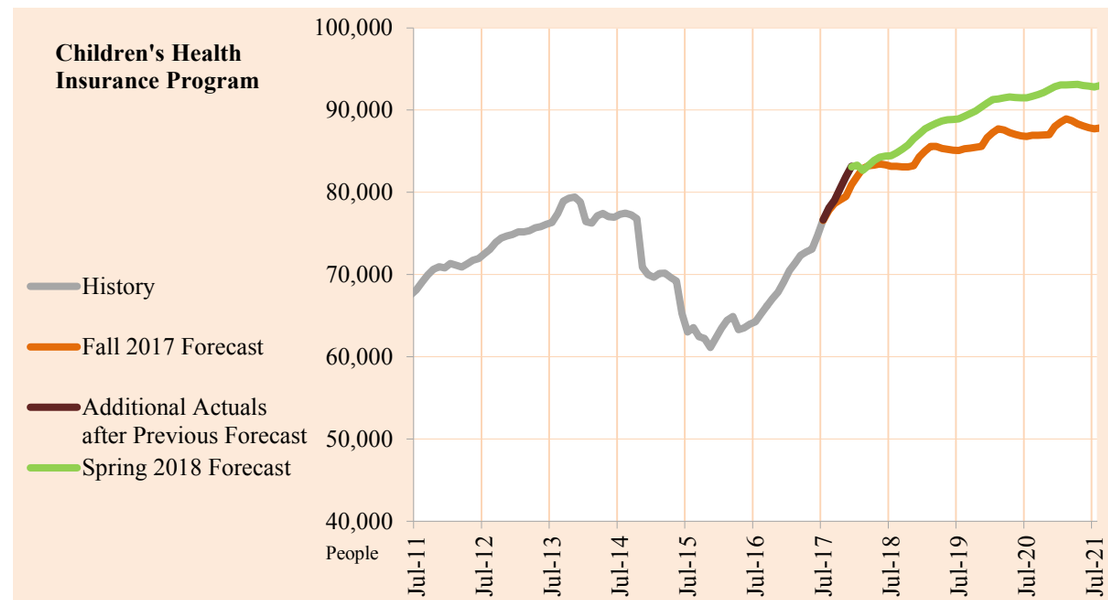
As of November 2017, the Medicaid caseload was 1,050,731 and the preliminary estimate for February 2018 is 1,042,799. In general, the caseloads will continue to decline very slowly with smaller seasonal bumps related to open enrollment in the Federally-facilitated Marketplace. This will continue through the forecast horizon as long as the economy remains in its current state and there are no important policy changes.



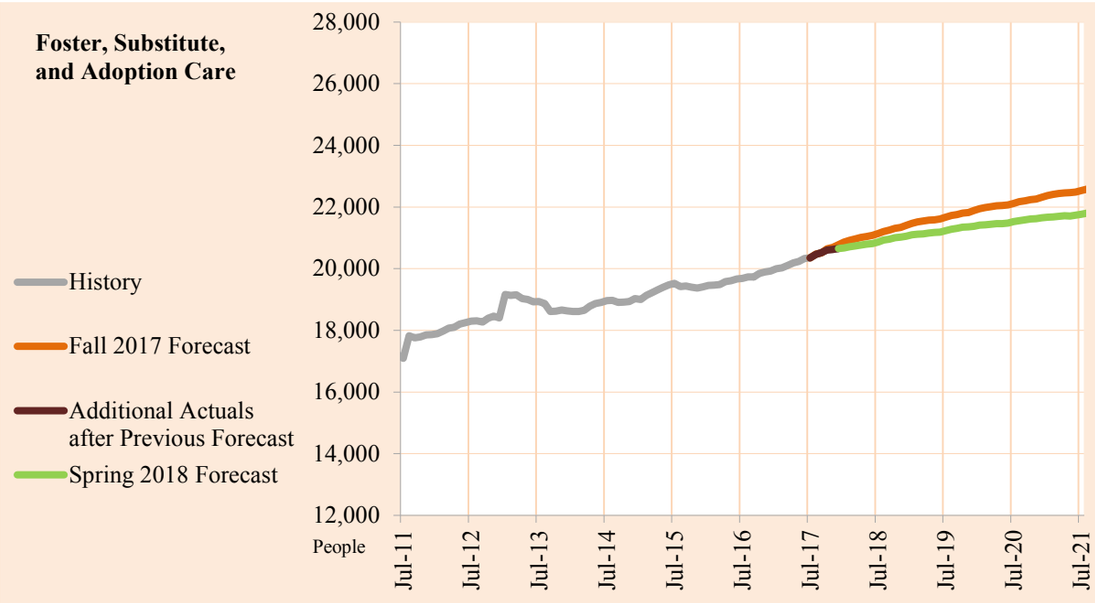


Children's Medicaid – This caseload shows a slight decline in recent months. The most recent preliminary estimate for February 2018 shows 308,347 clients on this caseload. By the end of 2017-2019 biennium there will be 300,369 clients on this caseload and it will account for about 29 percent of the total Medicaid caseload.

Children's Health Insurance Program (CHIP) – The most recent preliminary estimate for February 2018 shows 82,673 children on this caseload. Most of the growth in this program comes from transfers from Children's Medicaid, which shows a lot of recent variance and increases the uncertainty of this caseload forecast. The caseload is expected to continue to grow going forward, with 88,861 by the end of 2017-2019 biennium and by then it will account for 8.6 percent of the total Medicaid caseload.

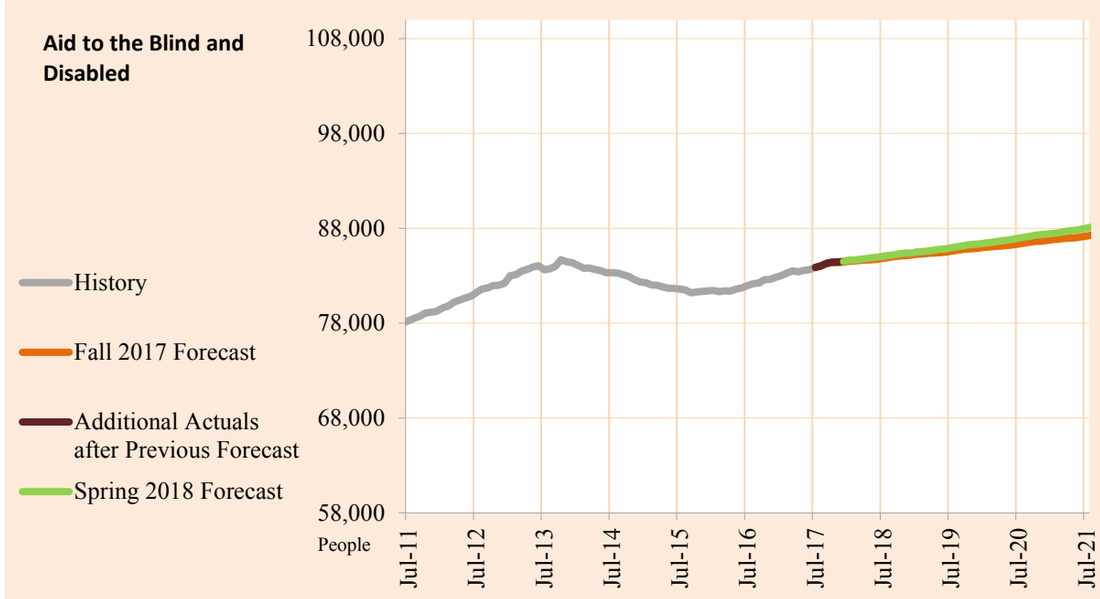


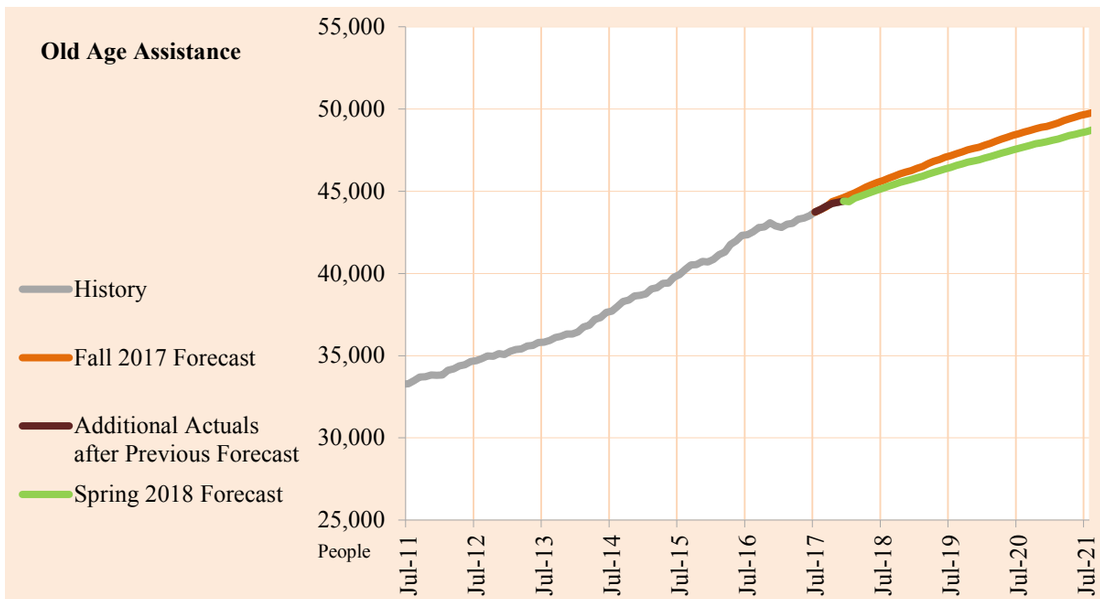
Foster, Substitute and Adoption Care – The most recent preliminary estimate for February 2018 shows 20,706 children on this caseload. This caseload is growing slowly with the increased Foster Care caseload. By the end of 2017-2019 biennium there will be 21,185 clients on this caseload and it will account for 2.0 percent of the total Medicaid caseload.



Aid to the Blind and Disabled (ABAD) – The most recent preliminary estimate for February 2018 shows 84,662 clients on this caseload. Historically, this caseload grew steadily, however, the ACA reform caused a temporary lull. First, the availability of health insurance to low income adults (ACA Adults caseload) and, second, the availability of K-Plan (access to long term care without having to obtain a federal designation of disability) temporarily reduced the number of new enters. New enters have started increasing again, although, not quite back to their pre-ACA levels. This has caused the caseload to start growing again, although at a more moderate growth rate. The caseload is expected to grow to 85,828 by the end of 2017-2019 biennium and will account for 8.3 percent of the total Medicaid caseload.

Old Age Assistance (OAA) – The most recent preliminary estimate for February 2018 shows 44,569 clients on this caseload. The caseload is projected to grow slowly, but steadily in line with the elderly population growth through the foreseeable future. The caseload is expected to be 46,351 by the end of 2017-2019 biennium and will account for 4.5 percent of the total Medicaid caseload.



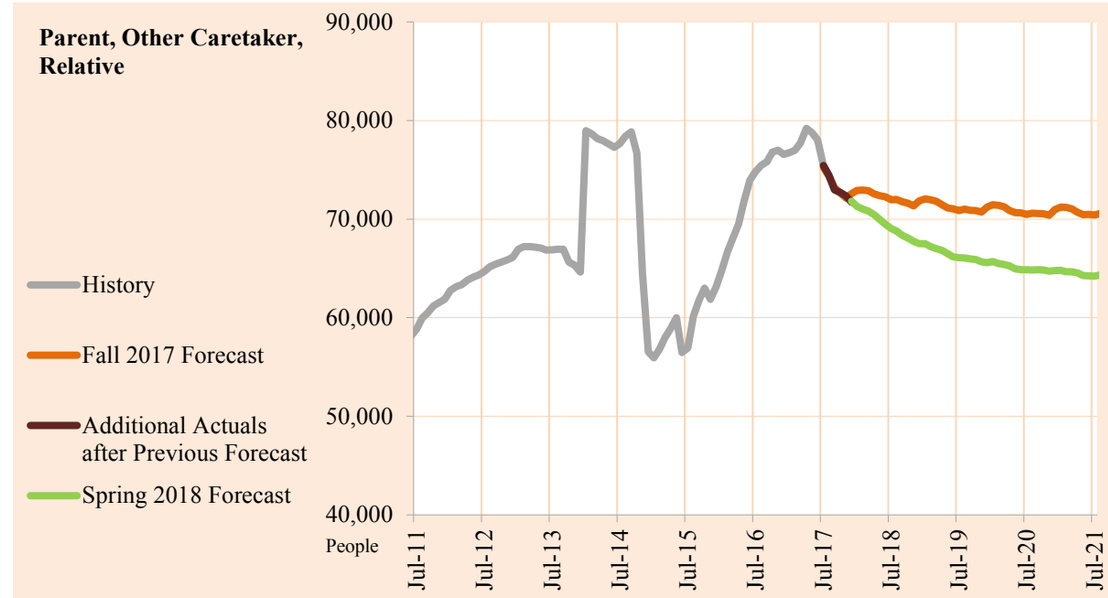


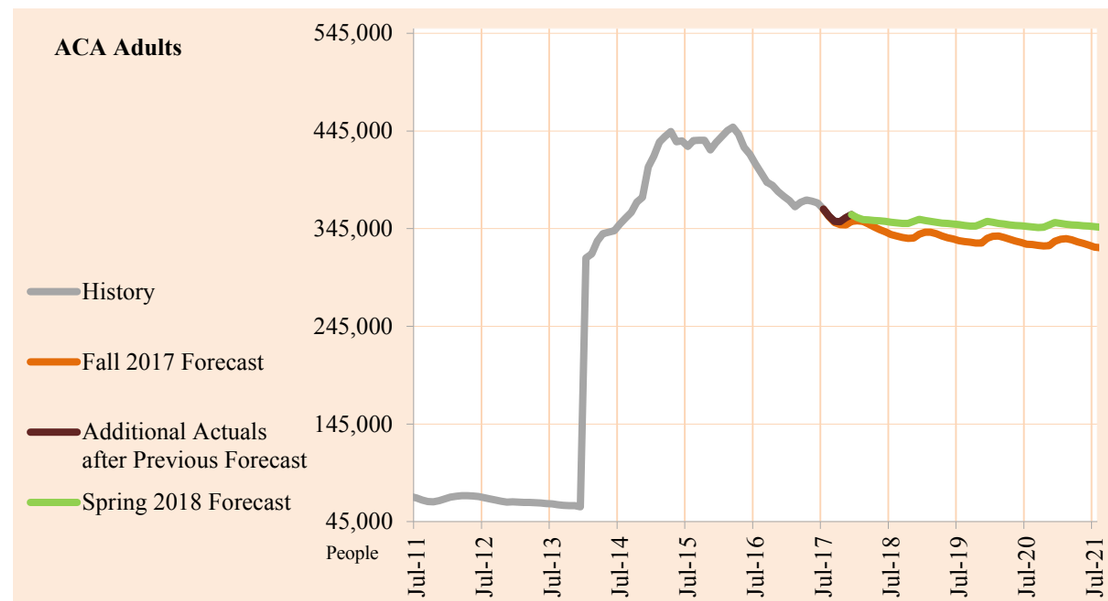
Pregnant Women – The most recent preliminary estimate for February 2018 shows 10,484 women on this caseload. The caseload has been declining steadily over the last year and a half as redeterminations were resumed. It showed a particularly steep drop during the "clean up". It is too early to be certain, but the number of live births in the state of Oregon during 2017 also appeared to decline slightly. In addition, clients are staying on this caseload for shorter periods of time before transferring or exiting. The caseload is expected to be 9,689 at the end of 2017-2019 biennium and will account for 0.9 percent of the total Medicaid caseload.

Parent, Other Caretaker, Relative – Although the improving economy puts downward pressure on this caseload, the inflow from other programs as a result of redeterminations caused the caseload to grow. Following the most recent "clean up", inflows have decreased and the caseload has showed moderate declines. There have also been some recent system changes regarding flagging Other Caretaker or Relative that could reduce the number of clients placed in this category. The most recent preliminary estimate for February 2018 shows 71,013 clients on this caseload. The caseload is expected to drop to 66,164 by the end of 2017-2019 biennium and will account for about 6.4 percent of the total Medicaid caseload.

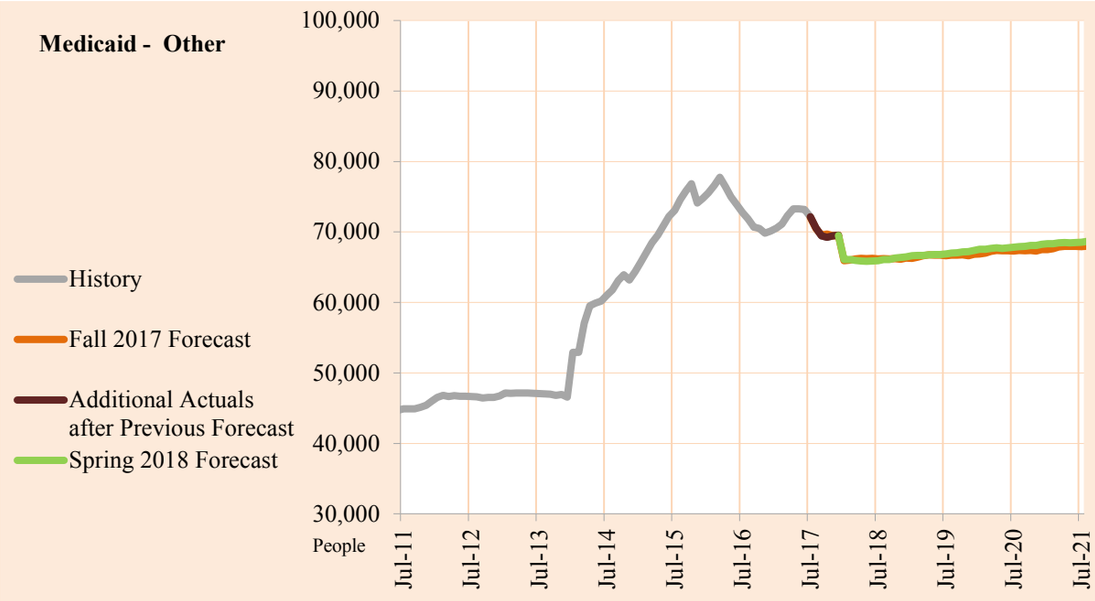
ACA Adults – This program shows the "open enrollment bump' in November and December. The most recent preliminary estimate for February 2018 shows 354,259 clients on this caseload. The caseload is expected to drop to 349,771 by the end of 2017-2019 biennium and will account for about 33.8 percent of the total Medicaid caseload.

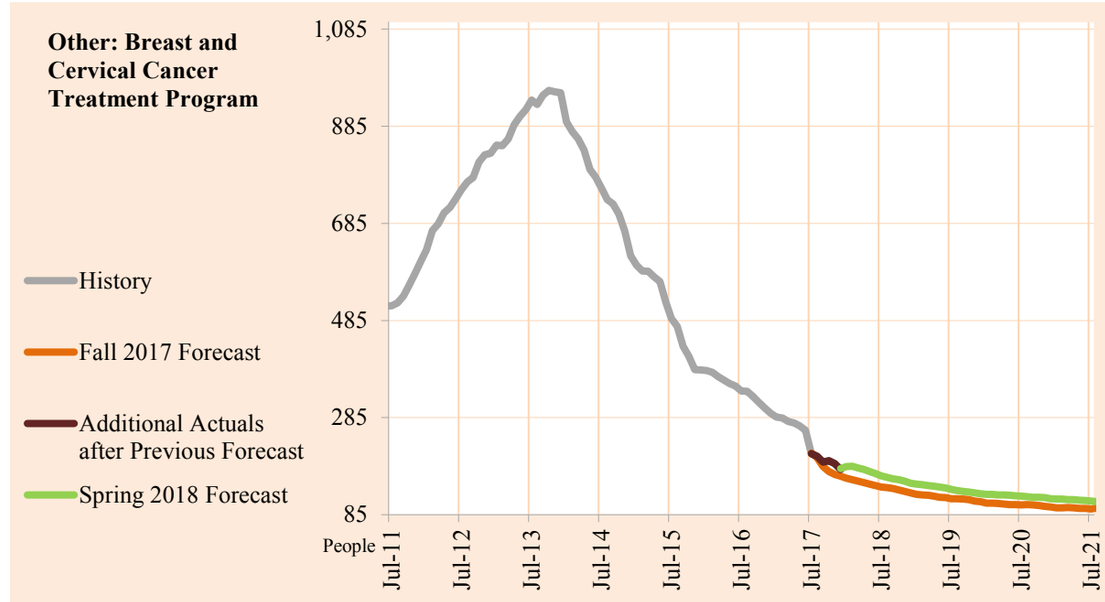
The caseload is expected to continue declining very slowly with smaller seasonal bumps related to the open enrollment period through 2017-2019 biennium.





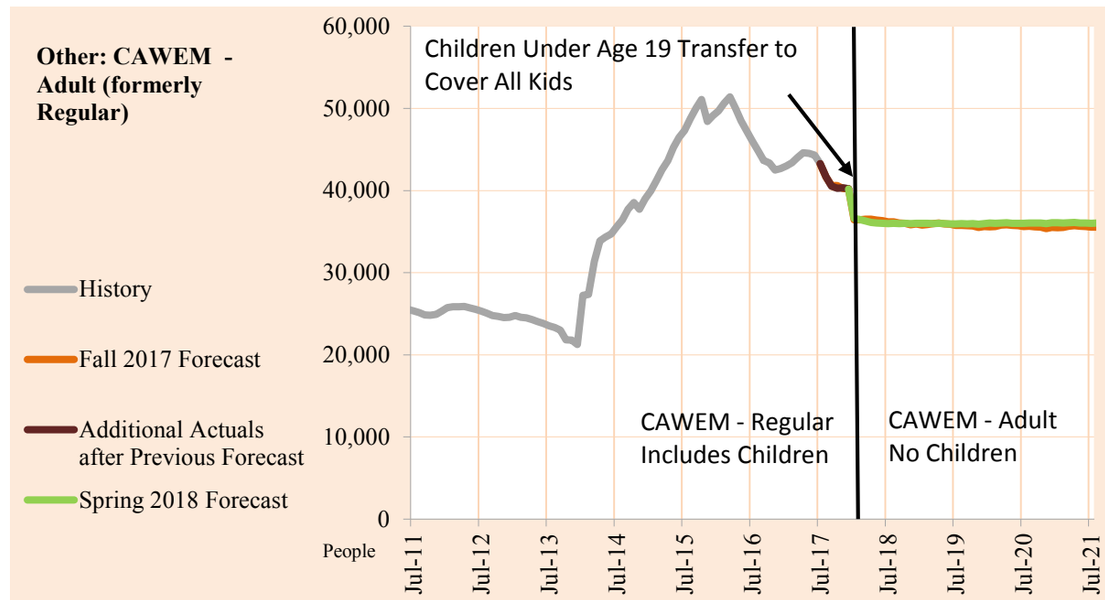
Other Medicaid Assistance Programs





Breast and Cervical Cancer Treatment Program (BCCTP) – The most recent preliminary estimate for February 2018 shows 185 clients on this caseload. The caseload has been declining steadily over the last year and a half as redeterminations were resumed. It showed a particularly steep drop during the "clean up". This caseload is expected to be 140 by the end of 2017-2019 biennium. This caseload is forecast to continue declining since ACA has reduced the number of uninsured adults who might otherwise qualify for the program.

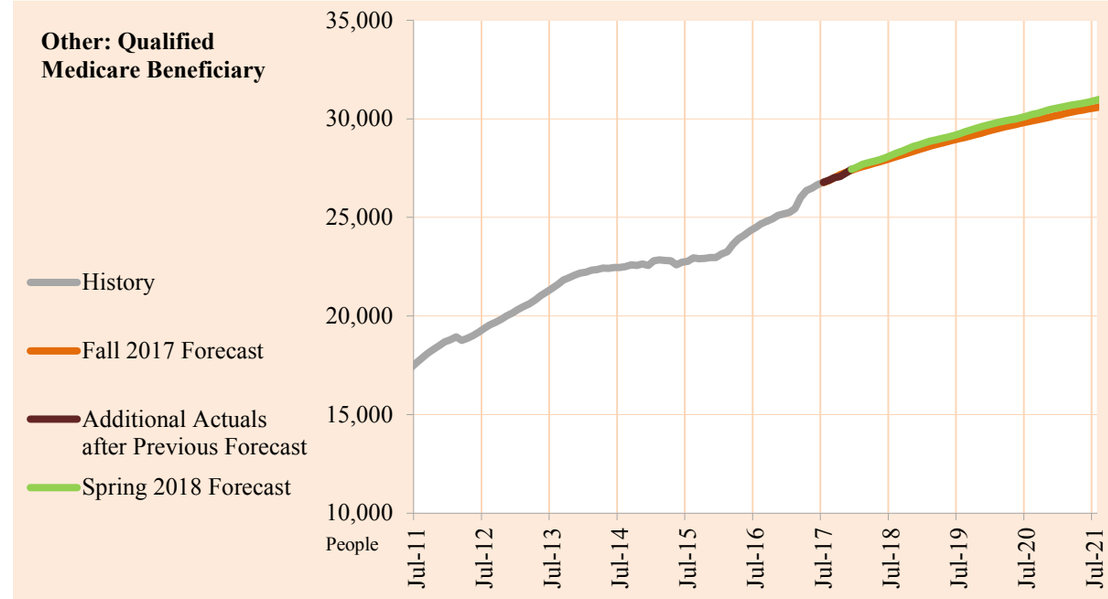
Citizen-Alien Waived Emergent Medical - Adult (CAWEMA) – This caseload was formerly known as CAWEM – Regular and contained both children and adults. However in January 2018 all the children under age 19 in this caseload (roughly 3,600) moved to the new Cover All Kids caseload. This caused a level shift down. The most recent preliminary estimate for February 2018 shows 36,465 clients on this caseload. Other than the level shift down in January 2018 when the children move to Non Medicaid Covered Children and Teens, the caseload is expected to remain mostly flat, reaching 35,945 at the end of 2017-2019 biennium.

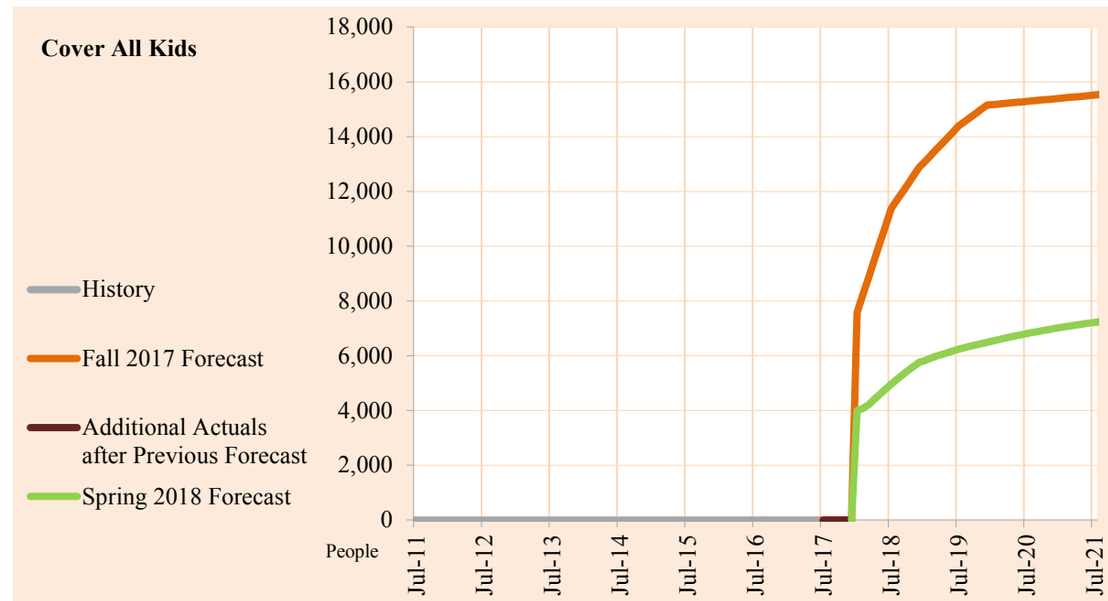


Citizen-Alien Waived Emergent Medical - Prenatal (CAWEMP) – The most recent preliminary estimate for February 2018 shows 1,733 clients on this caseload. This caseload dropped sharply in March and April of 2016 when redeterminations were restarted and the prenatal cases were reviewed first. The caseload has been mostly flat or declining slowly since then until the "clean up" in June, July, and August 2017 when it showed another sharp decline. The caseload is expected to be 1,573 by the end of 2017-2019 biennium.

Qualified Medicare Beneficiary (QMB) – The most recent preliminary estimate for February 2018 shows 27,703 clients on this caseload. There was a small level shift up in March 2017 related to Cost of Living Adjustments (COLA) in Social Security payments. This caseload is expected to be 29,143 by the end of 2017-2019 biennium and will account for about 2.8 percent of the Medicaid caseload. This caseload has grown consistently since January of 2009 and is expected to continue growing through the forecast horizon.

Cover All Kids (CAK) – This is a new state funded program that began January 1, 2018. It provides medical assistance similar to the Oregon Health Plan to all children in Oregon under the age of 19, who are under 300% of the Federal Poverty Level (FPL), and are otherwise eligible for Medicaid except for U.S. Residency/Citizenship status. These clients are not counted in the Medicaid caseload, but would be part of Total Medical Assistance. The most recent preliminary estimate for February 2018 shows 4,072 clients on this caseload. Roughly 3,600 of those were transfers from CAWEM, and the remainder were new enters. This caseload is expected to grow to 6,176 by the end of 2017-2019 biennium.

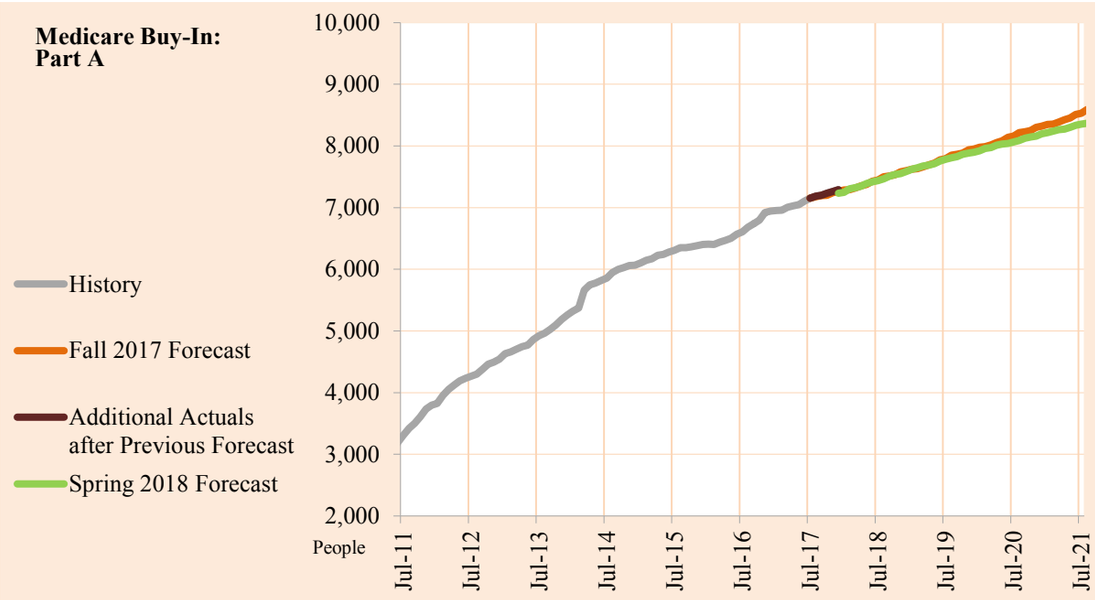


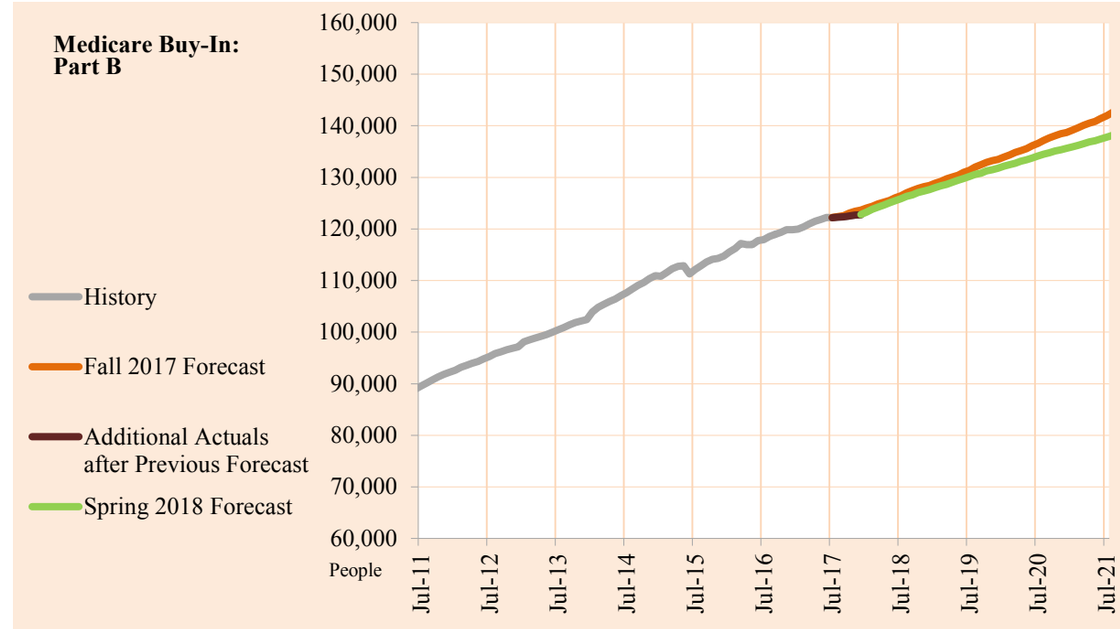


Medicare Part A/B Premium Assistance Programs

Medicare Part A Premium Assistance – The most recent preliminary estimate for February 2018 shows 7,302 clients on this caseload. This caseload is expected to grow through the foreseeable future, and is expected to be 7,754 by the end of 2017-2019 biennium.

Medicare Part B Premium Assistance – The most recent preliminary estimate for February 2018 shows 123,796 clients on this caseload. This caseload is projected to continue growing steadily, similar to the OAA and QMB caseloads. It is expected to be 129,758 by the end of 2017-2019 biennium. Twenty-Nine percent of those receiving Medicare Part B assistance are in OAA caseload; 25% are in ABAD; 22% are in QMB; and most of the remaining 24% are in the Partial Dual eligible caseloads.





Risks and Assumptions

The lack of stable and consistent data still remains the greatest and largest source of forecasting uncertainty. The period since the “clean up” in June, July, and August, 2017 has begun to show some stability, although even that period has been impacted by the open enrollment period of the Federal Health Care Exchanges. The delays in redeterminations over the last 4 years caused periods of caseload growth and decline. This has made it difficult to detect the true trends underlying the data. This impacted not only the overall caseload, but also all of the underlying model components – survival curves (used to predict leavers), new client flow, and transfer rates between caseloads. The data is starting to improve, however it might take an additional year until the new patterns are established. It is our hope that we will see more stable Medicaid data in the months ahead, leading to better forecasts in the long run.

The biggest known specific risks for the current forecast are: 1) the implementation of Automated Renewals; 2) Cover All Kids; 3) the rate of transfers from Children’s Medicaid to CHIP; 4) PCR entries, exits and transfers to ACA; 5) the next phase of Integrated Eligibility implementation and system changes; 6) the Minimum Wage increase; and 7) an Economic downturn.

Automated Renewals were modeled in this Forecast (they were not modeled in the Fall 2017 forecast). That modeling was based on the current levels of “churn” we see in caseloads that show clear patterns related to renewal timing. Data from other states did not show a clear analogy to the Oregon situation, where there was a sudden switch to Automated Renewals sometime after the ACA had already been in place for a period of time. We feel fairly confident that Automated Renewals will have some impact on caseloads, and there is risk associated with the magnitude of that change.

The magnitude was estimated by looking at how many clients have cases closed only to return to the caseload a short while later. There can be two conflicting sources of error with that method. Some clients whose cases are closed at renewal really were not eligible for some short period of time before regaining eligibility, due to seasonal work for example. In other circumstances, a case is closed at renewal for non response and the client never reapplies, or reapplies at a much later date. Accounting for these two factors would serve to both decrease and increase our estimates respectively of the increase in caseload due to automated renewals. Without historical data to draw on any estimate is going to be inherently more risky.

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

The Cover All Kids was revised down substantially in this forecast. That change was based on the first couple of months of preliminary data and California’s experience from a similar program. All of the following represent risks to the Cover All Kids forecast; if the rate of entries changes substantially in the coming months, if Oregon’s experience differs substantially from California’s, if the exit behavior is substantially different than Children’s Medicaid, or if the national environment surrounding undocumented immigrants changes, then the estimates of the Cover All Kids caseload could be off.

Starting with the resumption of renewals in March 2016 and continuing right up through the last 3 months of “clean up”, there has been an increasing rate of transfers between Children’s Medicaid and the Children’s Health Insurance Program (CHIP). A fairly large number of transfers would be expected as family income improves for some children. However, some of those transfers were also assumed to be children who had been misplaced during the Cover Oregon failure and children who had not had a recent annual renewal. It was expected that the rate of transfer would decline somewhat after all the children had gone through a recent renewal and they were re-entered into the ONE system. That has not been the case. If anything, the rate of transfer has increased in recent months, even outside of the recent “clean up”. This is a case where we simply need more data to more accurately determine what the natural rate of transfers is between these two groups, so it remains a risk to the forecast.

There has been a systems change in the ONE system related to how Other Caretaker and Relatives are classified that may reduce the number of new enters or transfers to the Parent, Other Caretaker, Relatives (PCR) caseload. It does seem like there has been a decline just in the last couple of months of preliminary data, but the extent of that impact is not clear yet. The current forecast does forecast some declines in new entries and transfers, but without any longer history there is a particular risk to this caseload. An improving economy also places downward pressure on the caseload and these two impacts may be combined and difficult to disentangle.

In recent months, operations of the ONE system have transferred from OHA to DHS, while work on Integrated Eligibility continues. As a large technical IT project, being moved from one department while simultaneously undergoing major revisions, the ONE system creates a risk of technical issues. In a separate, but related issue, this forecast assumes that all clients are currently in the correct caseload category, have been renewed in the last year, and that there are no current unknown or hidden eligibility issues. If that is not true, it represents a risk to the forecast.

The increasing minimum wage is discussed in some detail in the general Forecasting Environment and Risks section. To recap, specifically regarding Medicaid, the state minimum wage is scheduled to increase annually on July 1st, each year through 2022, after which it will increase with inflation. While the impact of a large minimum wage increase is hotly contested, the impact for Medicaid would most likely be felt in the ACA adult caseload, among 1 or 2 person households working full time. These are a relatively small portion of the total ACA adult caseload. While we do account for generally improving economic conditions in the forecast of new enters into the ACA adult caseload, we do not make a separate special adjustment for the minimum wage increase, and it remains a risk to the forecast.

It should be noted that the Spring 2018 Forecast would have shown more robust declines without the impact of automated renewals. Without automated renewals, the ACA caseload would have been forecasted to decline 4.1% between the 2017-2019 Biennium and the 2019-2021 Biennium. With automated renewals it is forecasted to decline only 1.3%. So the number of clients eligible may be declining, but separately we are signing up and retaining a higher proportion of them, somewhat mitigating the overall decline. The total Medicaid caseload is forecasted to decline, but pretty slowly.

Counterbalancing that, there is also always the risk of an economic downturn. We have no reason to think it is greater or less than normal. However, this forecast covers a 3 ½ year span and assumes continuing economic growth for that whole period. It should also be noted that the new ACA Adults caseload and the CHIP and Children's Medicaid caseloads may be more sensitive to economic changes than other, older and more traditional, Medicaid caseloads.

Health Systems Medicaid Biennial Average Forecast Comparison

	2017-19 Biennium			% Change Between Forecasts	Spring 2018 Forecast			% Change Between Biennia
	Fall 17 Forecast	Spring 18 Forecast	Change		2017-19	2019-21	Change	
HEALTH SYSTEMS - MEDICAID								
OHP								
Children's Medicaid	303,228	306,433	3,204	1.1%	306,433	297,619	-8,814	-2.9%
Children's Health Insurance Program	82,605	84,391	1,787	2.2%	84,391	91,598	7,207	8.5%
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Total OHP	**965,690**	**975,355**	**9,664**	**1.0%**	**975,355**	**968,825**	**-6,529**	**-0.7%**
Other Medical Assistance								
Breast and Cervical Cancer Treatment Program	149	169	20	13.3%	169	124	-45	-26.8%
Citizen-Alien Waived Emergent Medical - Adult [1]	37,379	37,327	-52	-0.1%	37,327	36,025	-1,302	-3.5%
Citizen-Alien Waived Emergent Medical - Prenatal	1,796	1,672	-124	-6.9%	1,672	1,549	-123	-7.3%
Qualified Medicare Beneficiary	27,935	28,069	133	0.5%	28,069	30,104	2,036	7.3%
Other Subtotal	**67,259**	**67,236**	**-23**	**0.0%**	**67,236**	**67,802**	**565**	**0.8%**
Total Medicaid	**1,032,950**	**1,042,591**	**9,641**	**0.9%**	**1,042,591**	**1,036,627**	**-5,964**	**-0.6%**
Cover All Kids [2]	8,727	3,930	-4,797	-55.0%	3,930	6,758	2,829	72.0%
TOTAL MEDICAL ASSISTANCE	**1,041,677**	**1,046,520**	**4,844**	**0.5%**	**1,046,520**	**1,043,385**	**-3,135**	**-0.3%**
Medicare Part A	7,439	7,436	-3	0.0%	7,436	8,058	622	8.4%
Medicare Part B	126,332	125,636	-696	-0.6%	125,636	133,886	8,250	6.6%

1. CAWEM - Adult is a new caseload replacing CAWEM - Regular. Clients under age 19 were counted in CAWEM - Adult until Jan 2018 when they all (~3,600) moved over to Cover All Kids. After Jan 2018 there are no clients under age 19 in the CAWEM - Adult caseload.

2. Cover All Kids is a new non Medicaid caseload that started Jan 2018. It includes clients under age 19 who were previously in CAWEM as well as new entries entering the program directly. The 2017-2019 Biennium is the monthly average over 24 months, but the caseload was zero for the first 6 months of the biennium, from July to December 2017. Over the last 18 months of the 2017-19 Biennium, when the program is operational, the forecasted average monthly caseload will be 5,239.

Mental Health (MH)

This forecast includes adults who are receiving mental health services from the Oregon Health Authority. For budgeting purposes, the Mental Health caseload is divided between Mandated and Non-Mandated populations. Oregon law requires Mandated populations, including criminally and civilly committed patients, to receive mental health services. There are three Mandated populations: (1) Aid and Assist, served at the State Hospital; (2) Guilty Except for Insanity (GEI), served at the State Hospital and in the community; and (3) Civilly Committed, also served at both the State Hospital and in the community. The Non-Mandated populations include two groups: (1) Previously Committed individuals, served mostly in the community; and (2) Never Committed individuals, also served mostly in the community. As service providers have become more consistent in their use of the Measures and Outcomes Tracking System (MOTS), data for the Civilly Committed, Previously Committed, and Never Committed populations continue to be refined.

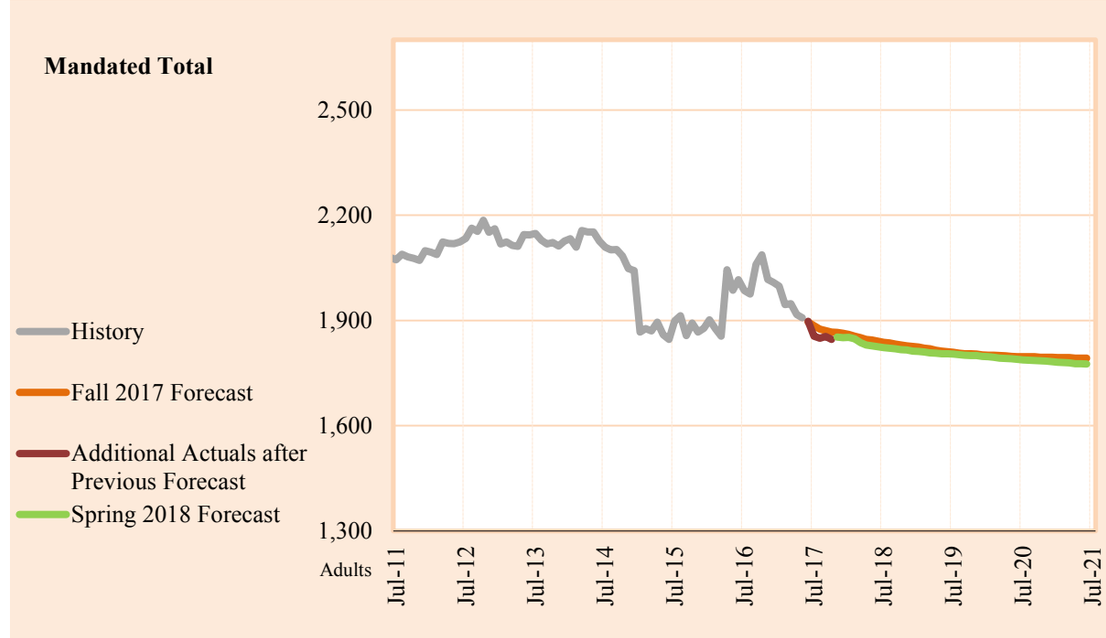
Mandated mental health services are provided through community programs, including residential care, and the Oregon State Hospital system. Non-Mandated services are primarily provided in community outpatient settings. Community programs provide outpatient services including intervention, therapy, case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

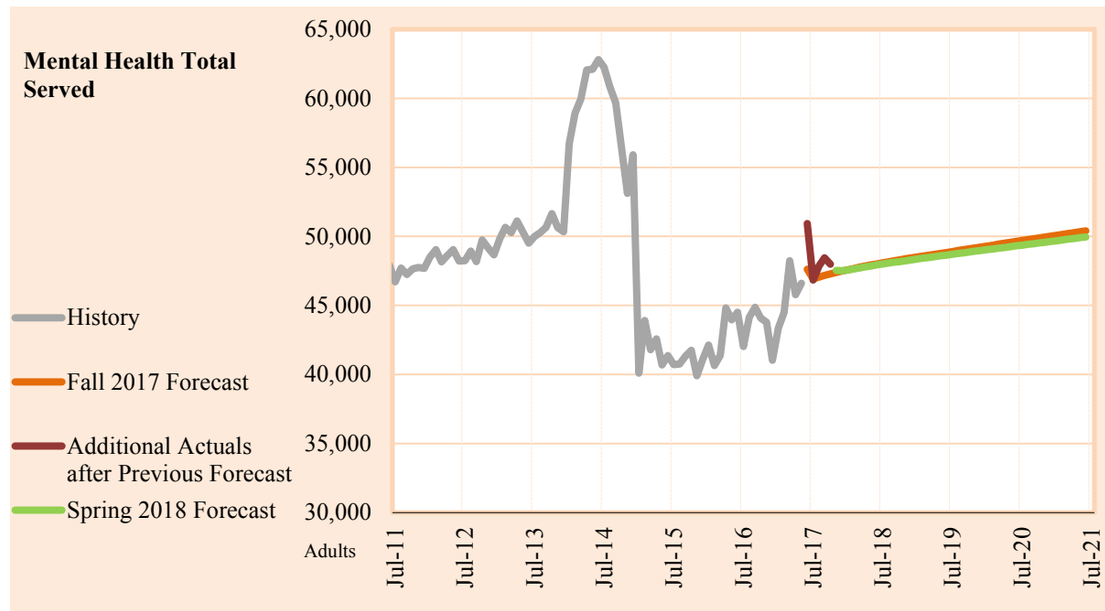
Total Mandated Mental Health Services

The mandated caseload encompasses the committed caseload (Aid and Assist, GEI, and Civilly Committed clients). The 2017-19 biennial average forecast is 1,829 clients. The 2019-21 biennial average is 1,789 clients, which is 2.2 percent lower than the 2017-19 biennial average. As with all MH categories forecasted in this report, the Mandated population includes only adults.

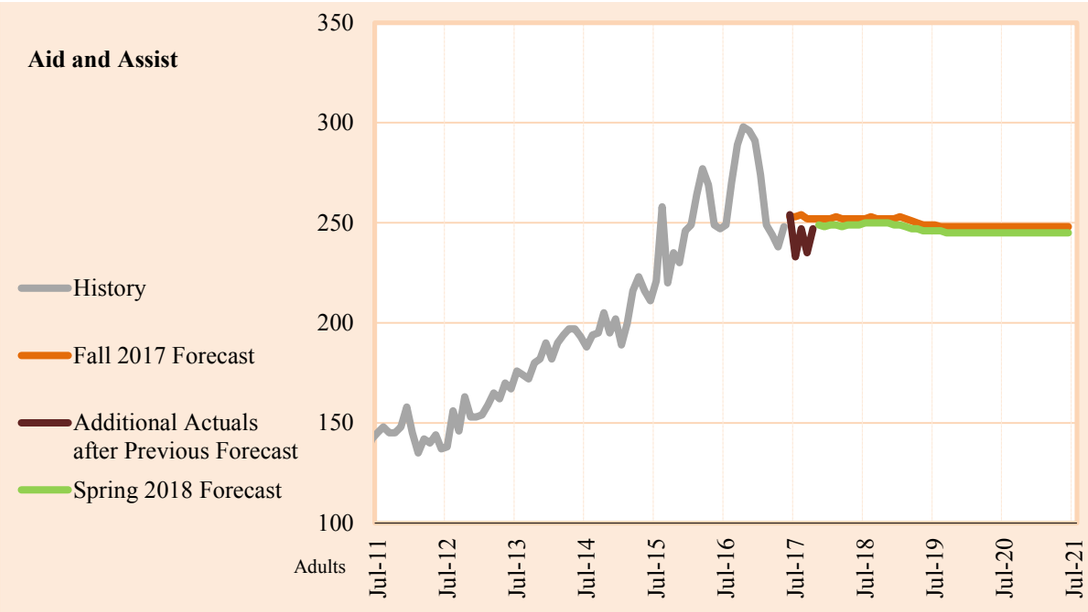
Total Forensic Mental Health Services

The forensic caseload encompasses the Aid and Assist and GEI clients. The 2017-19 biennial average forecast is 830 clients. The 2019-21 biennial average is 820 clients, which is 1.2 percent lower than the 2017-19 biennial average.



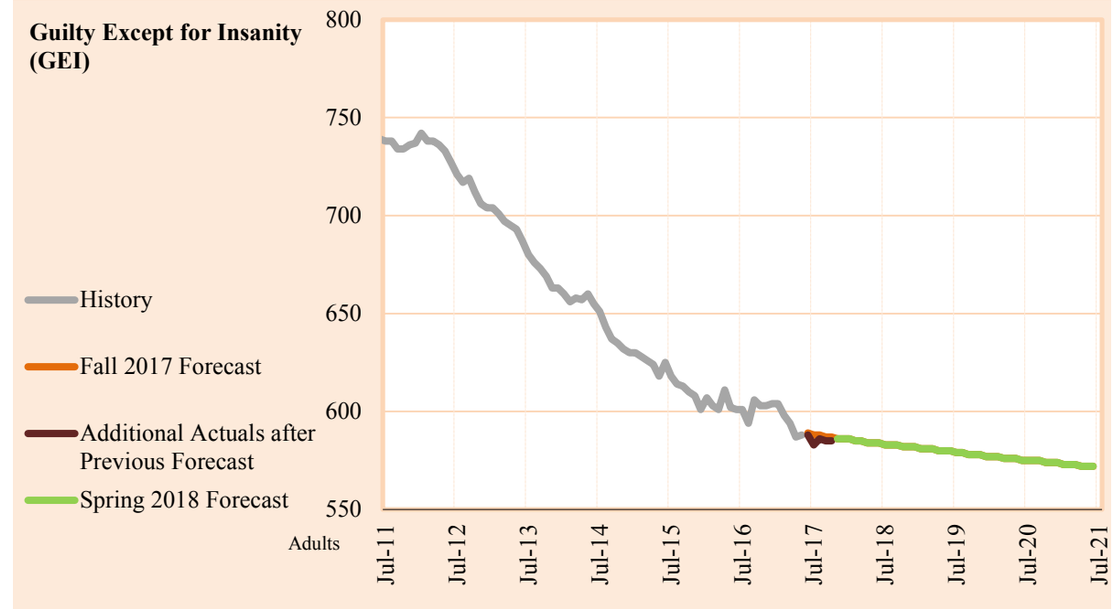


Aid and Assist – This caseload exhibited steady growth throughout 2013, 2014, 2015 and into 2016. There was a dip in the second half of 2016, followed by another jump, up to almost 300 clients in October 2016. Since that time the caseload has dropped to the 250 level and is hovering there. Aid and Assist currently counts only clients served at the State Hospital. The 2017-19 biennial average forecast is 247 clients. The 2019-21 biennial average is 245 clients, which is 0.9 percent lower than the 2017-19 biennial average forecast.



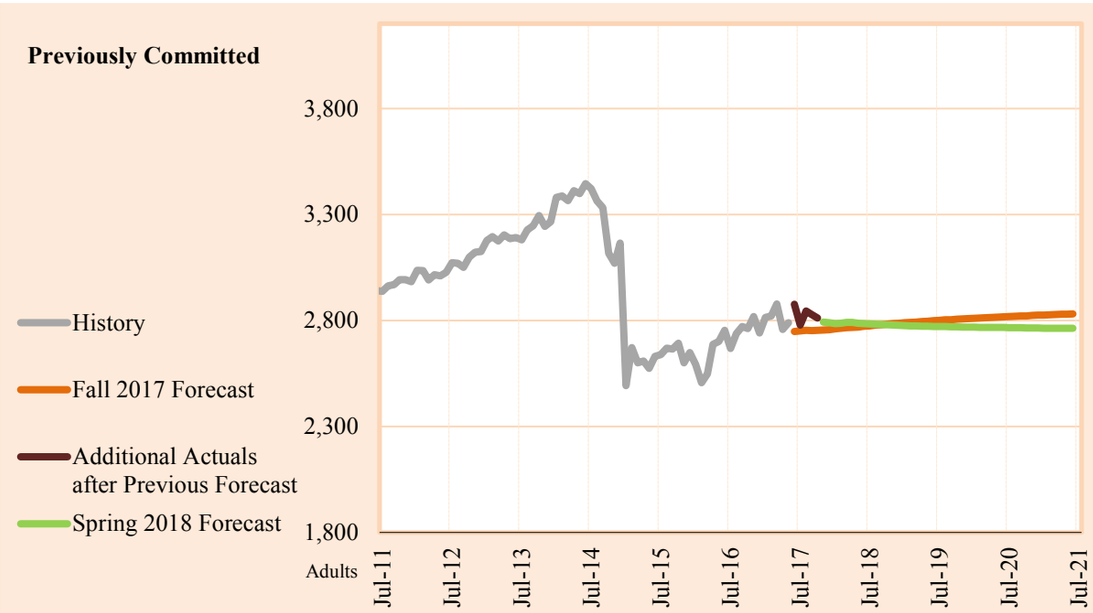
Guilty Except for Insanity (GEI) – These clients are under the jurisdiction of the Psychiatric Security Review Board and State Hospital Review Panel. Nationally, violent crimes are down despite population growth. For the past several years the Total GEI caseload in Oregon has steadily declined, and 2016 was especially high for end of jurisdictions. The 2017-19 biennial average forecast is 583. The 2019-21 biennial average is 575, which is 1.4 percent lower than the 2017-19 biennial average forecast.

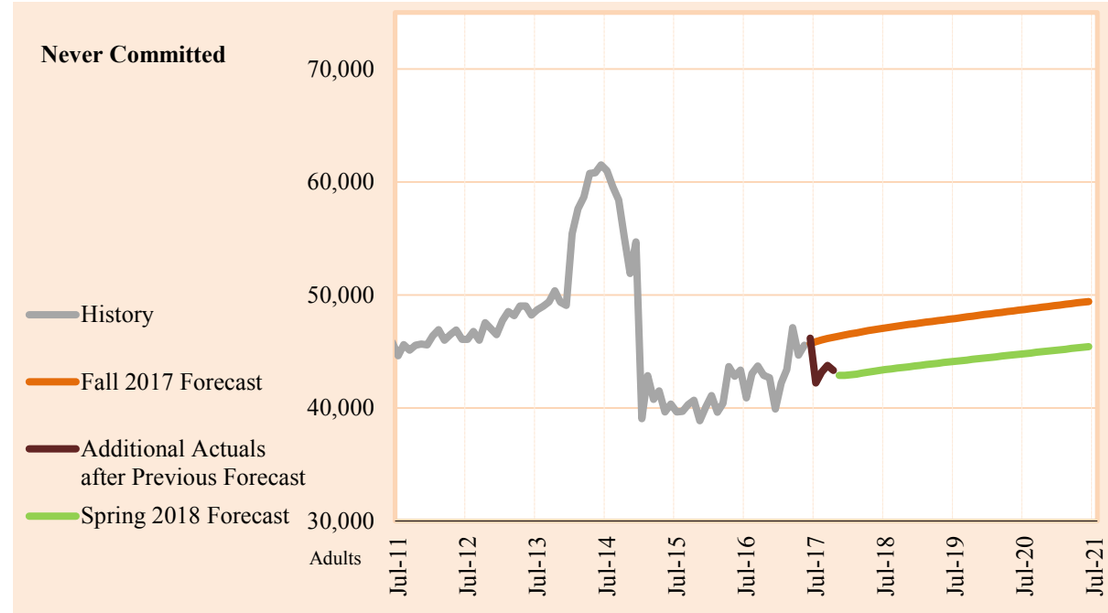
Civil Commitments – This caseload is subject to the interaction of reporting practices, data system changes, and data warehouse activities, and work is still underway to improve data accuracy. Given available data, the caseload has been declining for the past three years. This may be due in part to the expansion of Medicaid. It is also possible that community behavioral health investments are helping to reduce this caseload. The 2017-19 biennial average forecast is 998 clients. The 2019-21 biennial average is 969 clients, which is 2.9 percent lower than the 2017-19 biennial average.



Previously Committed – This caseload captures clients receiving mental health services that had been civilly or criminally committed at some time since the year 2000. About 80 percent of these clients are served in non-residential settings, and the rest are served in residential settings, the State Hospital, or Acute Care hospital settings. The 2017-19 biennial average forecast is 2,788 clients. The 2019-21 biennial average is 2,767 clients, which is 0.7 percent lower than the 2017-19 biennial average.

Never Committed – This caseload captures clients receiving mental health services that have not been civilly or criminally committed since the year 2000. More than 99 percent of these clients are served in non-residential settings. The 2017-19 biennial average forecast is 43,411 clients. The 2019-21 biennial average is 44,780 clients, which is 3.2 percent higher than the 2017-19 biennial average.





Risks and Assumptions

The Aid and Assist caseload may be impacted by community level efforts to keep people out of the State Hospital. Program leadership has been promoting the idea that Aid and Assist can be provided locally, not just at the Oregon State Hospital. Resource development is under way, and funding is going to high-utilizing areas. If this is successful, the caseload is under counting the actual number served since data are not currently available for Aid and Assist clients served outside the State Hospital. Additionally, the Aid and Assist caseload is subject to variation at the county level. For example, differences in police training as well as local judges can affect the Aid and Assist caseload at the Oregon State Hospital.

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

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

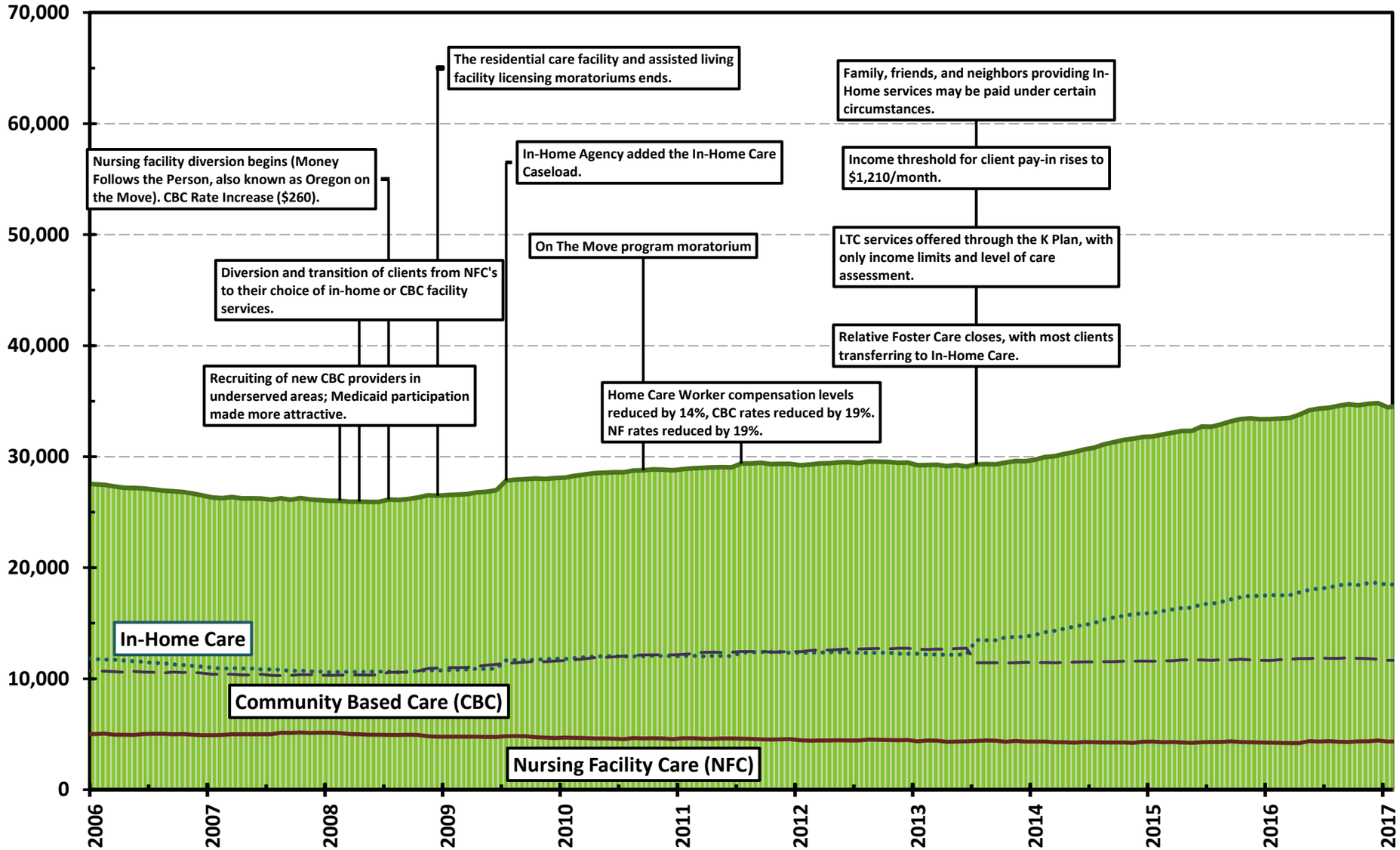
Mental Health Biennial Average Forecast Comparison

	2017-19 Biennium			*% Change Between Forecasts*	Spring 2018 Forecast			*% Change Between Biennia*
	Fall 17 Forecast	**Spring 18 Forecast**	**Change**		**2017-19**	**2019-21**	**Change**	
MENTAL HEALTH [1]								
Under Commitment								
Aid and Assist	252	247	-5	-2.0%	247	245	-2	-0.8%
Guilty Except for Insanity	584	583	-1	-0.2%	583	575	-8	-1.4%
Total Forensic Care	**836**	**830**	**-6**	**-0.7%**	**830**	**820**	**-10**	**-1.2%**
Civilly Committed	1,007	998	-9	-0.9%	998	969	-29	-2.9%
Previously Committed	2,774	2,788	14	0.5%	2,788	2,767	-21	-0.8%
Never Committed	46,984	43,411	-3,573	-7.6%	43,411	44,780	1,369	3.2%
Total Served	**51,601**	**48,027**	**-3,574**	**-6.9%**	**48,027**	**49,336**	**1,309**	**2.7%**

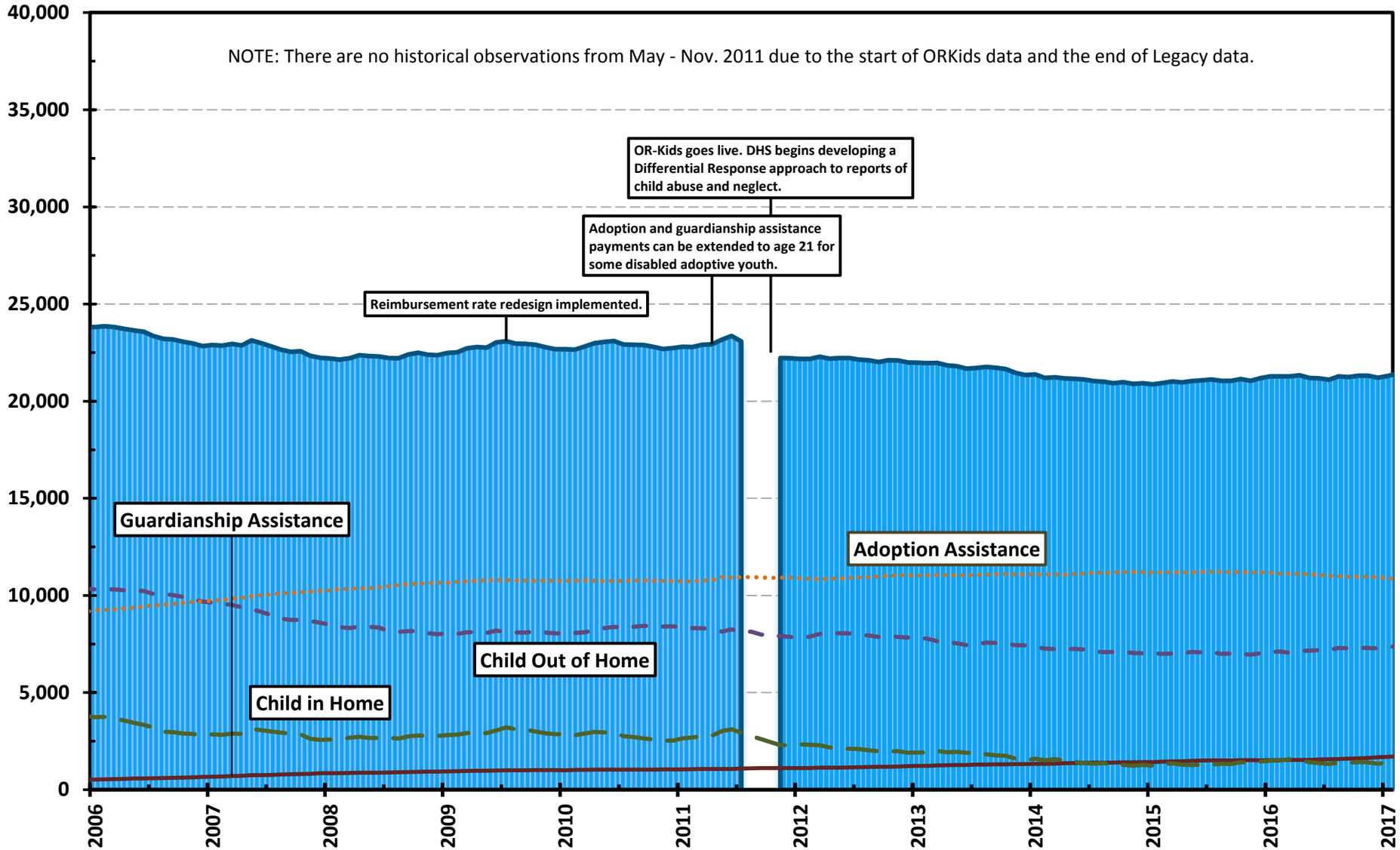
1. Numbers reported represent adults only.

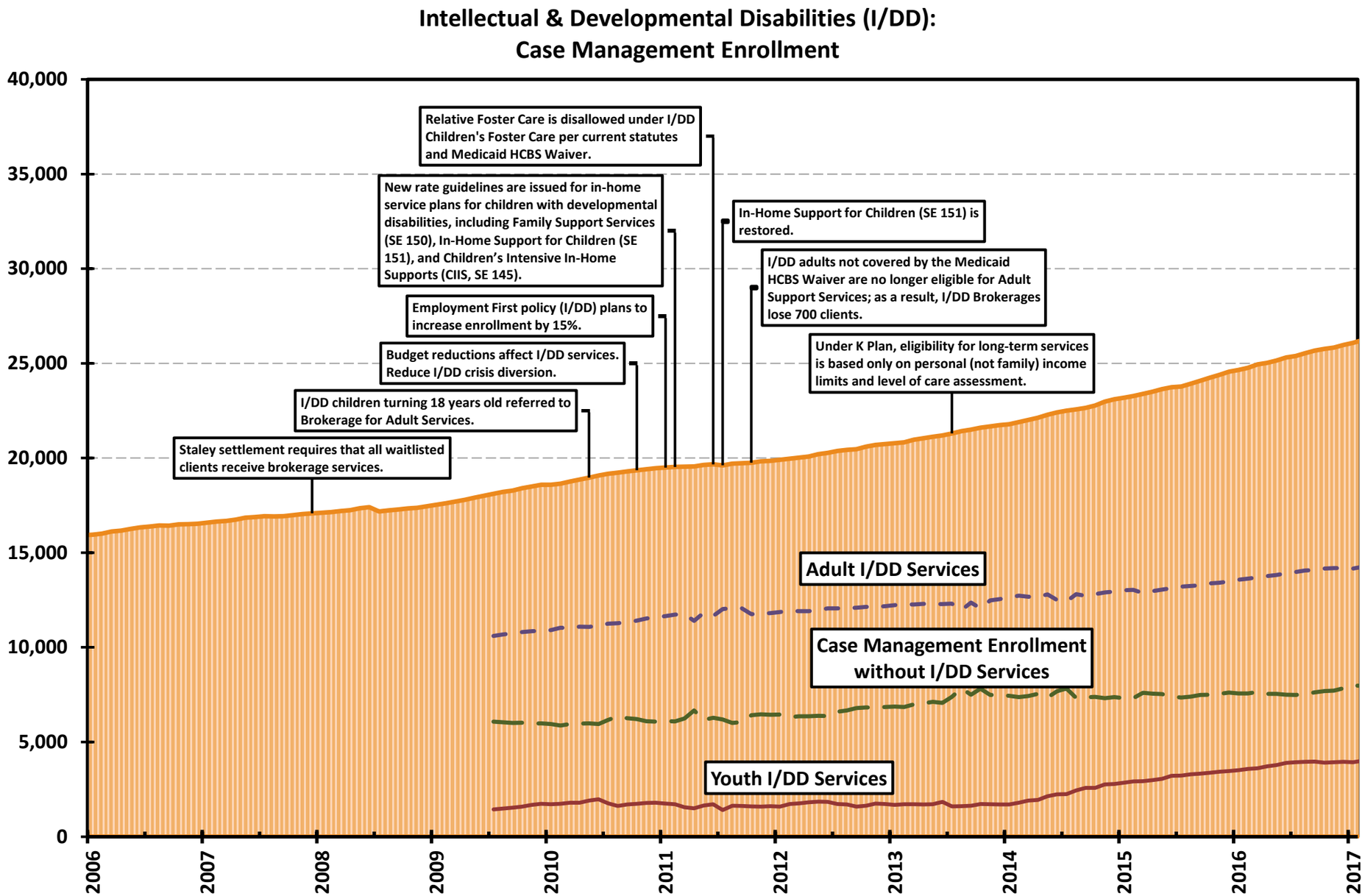
Appendix I
DHS Caseload History & Definitions

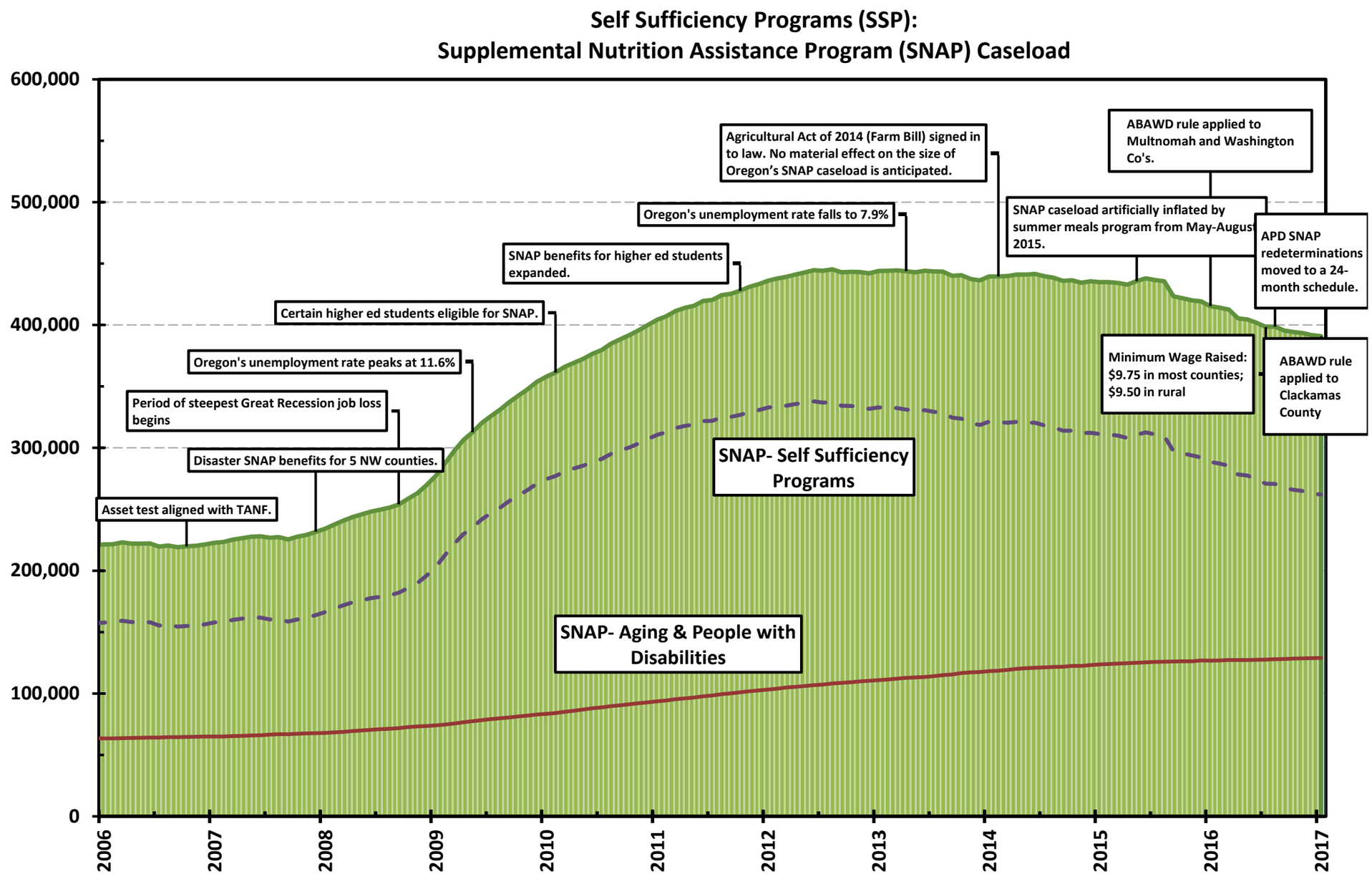
Aging and People with Disabilities (APD) Caseload



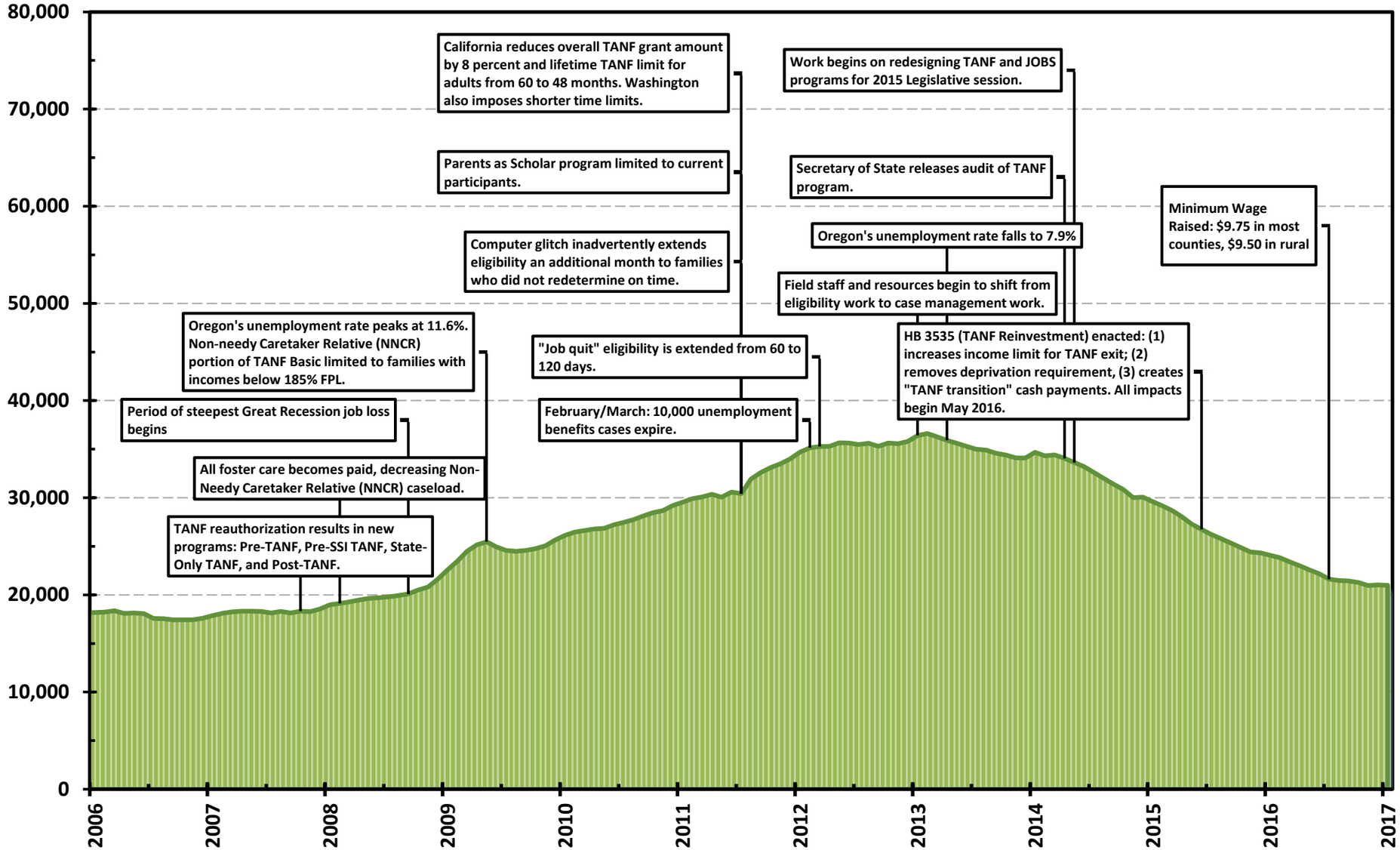
Child Welfare (CW) Caseload



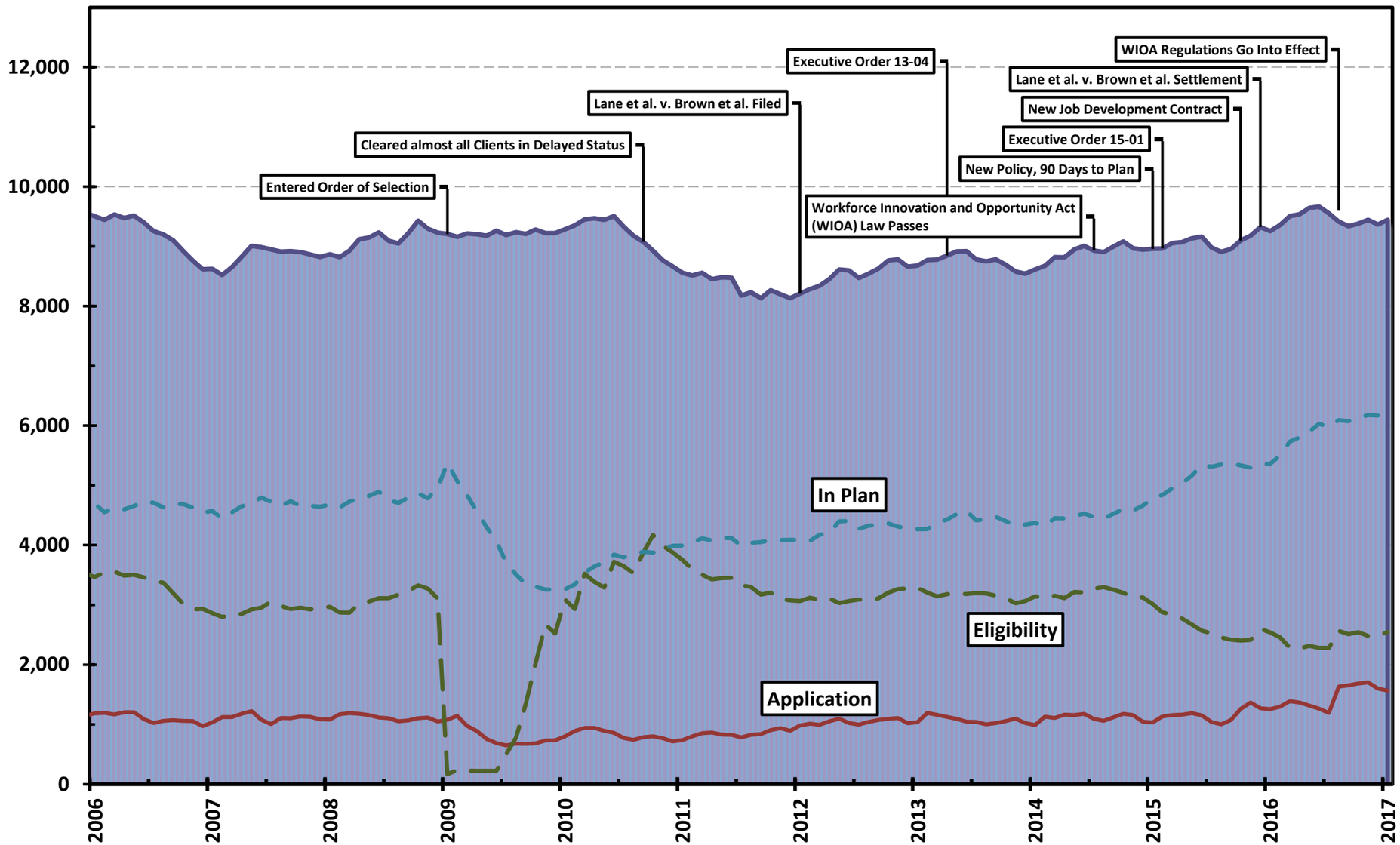

Intellectual & Developmental Disabilities (I/DD):
Case Management Enrollment
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
Relative Foster Care is disallowed under I/DD Children's Foster Care per current statutes and Medicaid HCBS Waiver.
New rate guidelines are issued for in-home service plans for children with developmental disabilities, including Family Support Services (SE 150), In-Home Support for Children (SE 151), and Children's Intensive In-Home Supports (CIIS, SE 145).
In-Home Support for Children (SE 151) is restored.
I/DD adults not covered by the Medicaid HCBS Waiver are no longer eligible for Adult Support Services; as a result, I/DD Brokerages lose 700 clients.
Employment First policy (I/DD) plans to increase enrollment by 15%.
Under K Plan, eligibility for long-term services is based only on personal (not family) income limits and level of care assessment.
Budget reductions affect I/DD services. Reduce I/DD crisis diversion.
I/DD children turning 18 years old referred to Brokerage for Adult Services.
Staley settlement requires that all waitlisted clients receive brokerage services.
Adult I/DD Services
Case Management Enrollment without I/DD Services
Youth I/DD Services


Self Sufficiency Programs (SSP):
Supplemental Nutrition Assistance Program (SNAP) Caseload
600,000
500,000
400,000
300,000
200,000
100,000
0
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
Asset test aligned with TANF.
Disaster SNAP benefits for 5 NW counties.
Period of steepest Great Recession job loss begins
Oregon's unemployment rate peaks at 11.6%
Certain higher ed students eligible for SNAP.
SNAP benefits for higher ed students expanded.
Oregon's unemployment rate falls to 7.9%
Agricultural Act of 2014 (Farm Bill) signed in to law. No material effect on the size of Oregon's SNAP caseload is anticipated.
SNAP caseload artificially inflated by summer meals program from May-August 2015.
ABAWD rule applied to Multnomah and Washington Co's.
APD SNAP redeterminations moved to a 24-month schedule.
Minimum Wage Raised: $9.75 in most counties; $9.50 in rural
ABAWD rule applied to Clackamas County
SNAP- Self Sufficiency Programs
SNAP- Aging & People with Disabilities

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



Vocational Rehabilitation



DHS Caseload Definitions

Federal Poverty Level (FPL)

"The set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. Public assistance programs, such as Medicaid in the U.S., define eligibility income limits as some percentage of FPL[3]."

2018 Poverty Guidelines for Oregon

Person in family/ household	Poverty Guideline
1	$12,140
2	$16,460
3	$20,780
4	$25,100
5	$29,420
6	$33,740
7	$38,060
8	$42,380

3. Source: Annual Update of the HHS Poverty Guidelines; HHS Notice on January 18, 2018, 83 Fed. Reg. 2642. See: https://www.federalregister.gov/documents/2018/01/18/2018-00814/annual-update-of-the-hhs-poverty-guidelines

Aging and People with Disabilities (APD)

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

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

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

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

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

In-Home Programs

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

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

In-Home Agency - 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 - provider caseload includes clients who hire a live-in home care worker to provide 24-hour care.

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

Specialized Living - 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) - services are available to people who are eligible for Medicaid, but not eligible for waivered services. Services supplement the individual's own personal abilities and resources, but are limited to assistance with Activities of Daily Living and Instrumental Activities of Daily Living.

Community-Based Care (CBC)

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

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

Adult Foster Care - 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 - 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) - 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 - 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 - clients have medical conditions that require additional nursing services and staff assistance beyond Basic 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 - clients are children under 21 who receive nursing care in pediatric nursing facility units.

Child Welfare (CW)

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

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

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

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

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

Intellectual and Developmental Disabilities (I/DD)

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

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

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

Case Management Enrollment

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

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

Adult Services

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

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

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

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

I/DD Foster Care - provides 24-hour care, supervision, provision of room and board, and assistance with activities of daily living for both adults and children (approximately 82 percent and 14 percent respectively).

Stabilization and Crisis Unit - 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 90 percent and 10 percent respectively).

Children's Services

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

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

Other I/DD Services

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

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

Self Sufficiency Programs (SSP)

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

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

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

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

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

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

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

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

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

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

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 a severe physical or mental impairment(s) that has been assessed and determined to meet the program impairment criteria by the program's disability analyst.

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

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

Vocational Rehabilitation (VR)

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

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

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

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

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

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

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

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

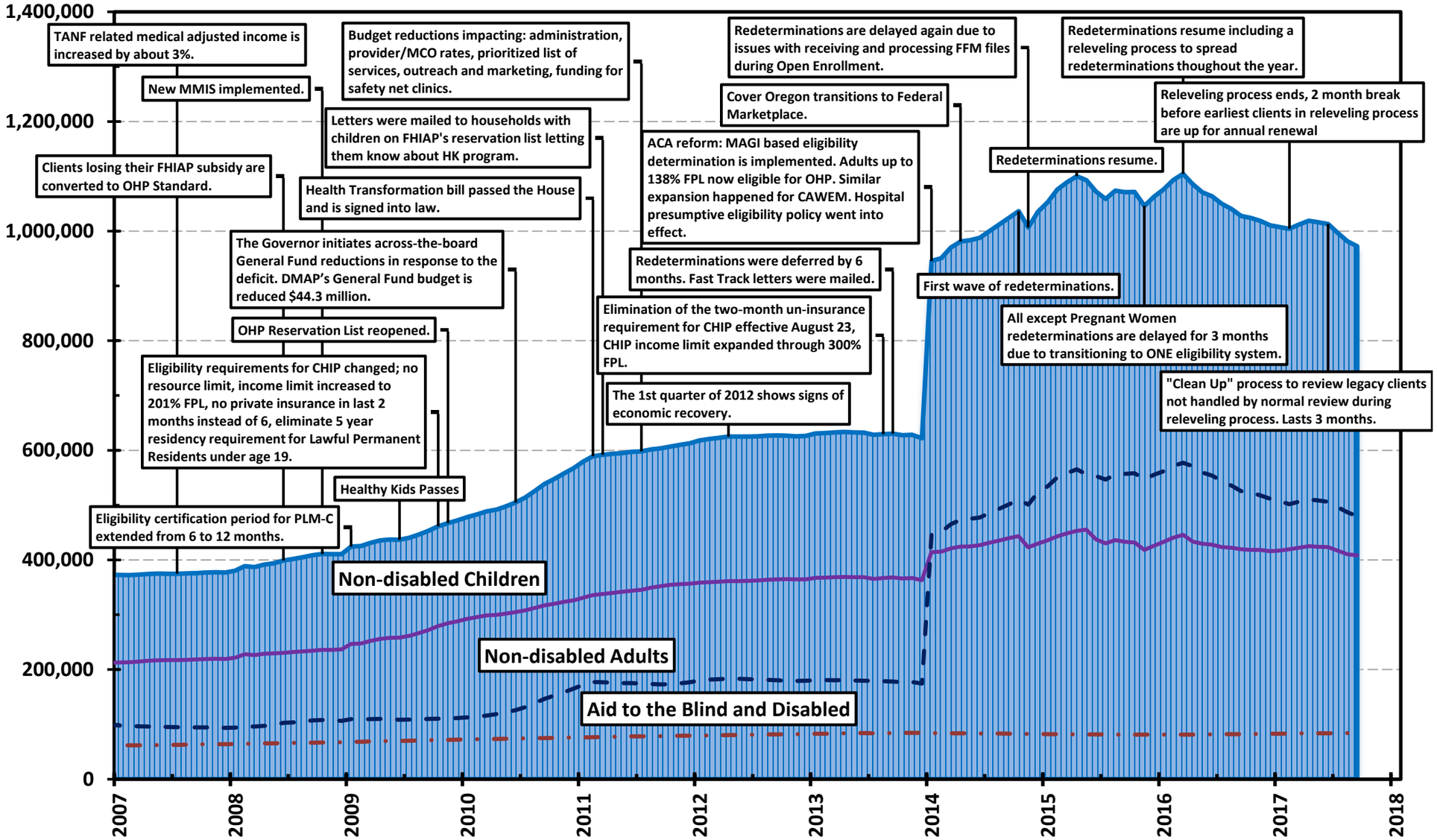
I/DD in Prior 12 Months - includes those who had an I/DD record in the 12 months prior to applying for VR services, identified by matching VR clients to I/DD eligibility and enrollment records.

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

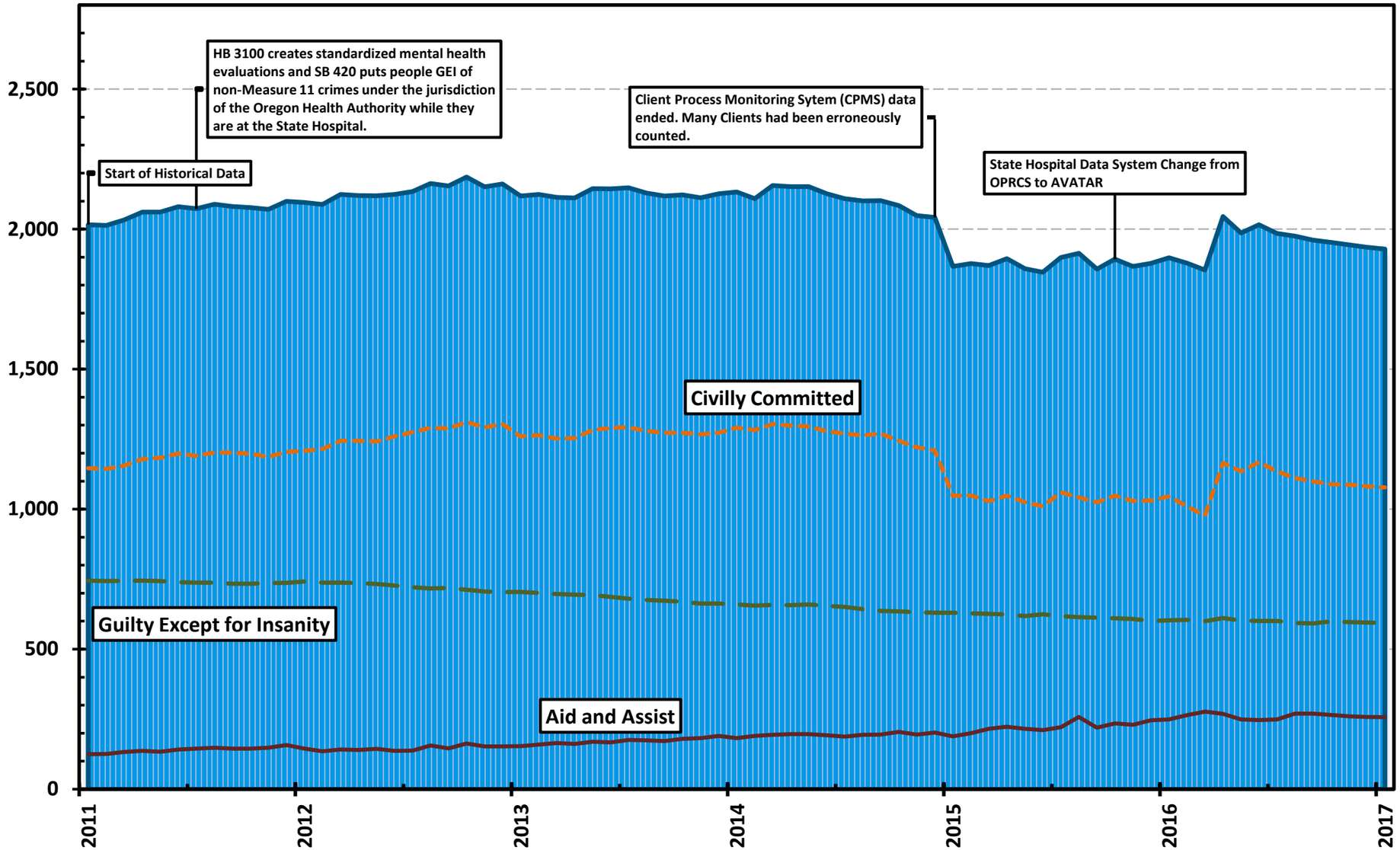
Physical Impairments - includes individuals who are in Application, Eligibility, or In Plan stage and have one of the following primary disability impairments: mobility; manipulation; mobility and manipulation; other orthopedic impairments; respiratory impairments; general physical debilitation; other physical impairments not listed elsewhere; dexterity orthopedic/ neurological impairments; and other (no impairment or missing impairment field). Except if counted in I/DD in Prior 12 Months caseload.

Appendix II
OHA Caseload History & Definitions

Health Systems - Medicaid, Total Oregon Health Plan



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



OHA Caseload Definitions

Federal Poverty Level (FPL)

"The set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. Public assistance programs, such as Medicaid in the U.S., define eligibility income limits as some percentage of FPL[4]."

2018 Poverty Guidelines for Oregon

Person in family/ household	Poverty Guideline
1	$12,140
2	$16,460
3	$20,780
4	$25,100
5	$29,420
6	$33,740
7	$38,060
8	$42,380

4. Source: Annual Update of the HHS Poverty Guidelines; HHS Notice on January 18, 2018, 83 Fed. Reg. 2642. See: https://www.federalregister.gov/documents/2018/01/18/2018-00814/annual-update-of-the-hhs-poverty-guidelines

Health Systems - Medicaid (HSM)

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

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

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

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

Temporary Assistance for Needy Families (TANF) - This old caseload has been replaced, with the 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 caseload.

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

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

Children's Health Insurance Program (CHIP) - This caseload covers uninsured children from birth through age 18 living in households with income from 134 to 300 percent of FPL. Previously, this caseload covered children from households with income from 100 to 200 percent of FPL.

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

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

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

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

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

ACA Adults - This caseload represented the expansion of Medicaid under the United States Federal Patient Protection and Affordable Care Act of 2010 (ACA). This caseload includes citizens 18 to 64 years old with incomes up to 138 percent of FPL, who are not pregnant or disabled.

OHP Standard Benefit Package (discontinued December 31, 2013) - This program has ended, with clients transferred to the new ACA Adults caseload. Prior to ACA, clients in OHP Standard were not eligible for traditional Medicaid programs. OHP Standard provided a reduced package of services compared to the OHP Plus program. OHP Standard also required participants to share some of the cost of their medical care through premiums and co-payments.

Other Medicaid (Non-OHP Benefit Packages)

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 benefits. Clients are eligible until either reaching the age of 65, obtaining other coverage, or ending treatment. This program is available for both citizens and non-citizens/aliens.

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

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

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

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

Cover All Kids (CAK) - is a new state funded program that began on January 1, 2018. It provides medical assistance similar to the Oregon Health Plan to all children in Oregon under the age of 19, who are under 300% of the Federal Poverty Level (FPL) and are otherwise eligible for Medicaid except for U.S. Residency/Citizenship status.

Medicare Part A/B Premium Assistance Programs[5]

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

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

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

Mental Health (MH)

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

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

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

Guilty Except for Insanity (GEI) - caseload includes clients who are under the jurisdiction of the Psychiatric Security Review Board and 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. OHA is required by Oregon law to provide treatment and supervision for these individuals, either in the community or in a State Hospital. Clients in this caseload receive a full range of counseling, medication, skills training and supports to assist their progress toward recovery.

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

Previously Committed - caseload includes people who were previously either civilly or criminally committed but whose commitment period has ended. These clients continue to receive individual services, counseling, training, and/or living supports. About 80 percent of these clients are served in non-residential settings.

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

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.